Worcestershire Acute Hospitals NHS Trust

Worcestershire Royal Hospital

Quality Report

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Date of inspection visit: 12, 12 and 25 April 2017
Date of publication: 08/08/2017

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

Urgent and emergency services	
Medical care (including older people's care)	
Surgery	
Maternity and gynaecology	
Services for children and young people	

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) previously carried out a comprehensive inspection in November 2016, which found that overall; the trust had a rating of 'inadequate'.

We carried out an unannounced focused inspection on 11 and 12 April 2017. We also visited on 25 April 2017, specifically to interview key members of the trust's senior management team. This was in response to concerns found during our previous comprehensive inspection in November 2016 at Worcestershire Royal Hospital, the Alexandra Hospital Redditch and Kidderminster Hospital and Treatment Centre whereby the trust was served with a Section 29a Warning Notice. The Section 29a Warning Notice required the service to complete a number of actions to ensure compliance with the Health and Social Care Act 2008 Regulations. The trust had produced an action plan, which reflected these requirements as well as additional aims and objectives for the service. This inspection looked specifically at the issues identified in the warning notice and therefore no services were rated as a result of this inspection.

Focused inspections do not look at all five key questions; is it safe, is it effective, is it caring, is it responsive to people's needs and is it well-led, they focus on the areas indicated by the information that triggered the focused inspection.

The inspection focused on the following services: adult emergency department (ED), medical care, surgery, maternity and gynaecology and children and young people. We inspected parts of the five key questions for these services but did not rate them.

Areas where significant improvements included in the Section 29a Warning Notice had not been made were:

- In the emergency department (ED), essential risk assessments were not completed when required to keep patients safe from avoidable harm. There were not effective systems in place to assess and manage risks to patients in the ED. Staff did not always identify and respond appropriately to changing risks to patients, including deteriorating health and wellbeing.
- There was no appropriate mental health room available in the ED within which to safely care for patients.
- The children's ED area was not consistently attended by staff except via CCTV surveillance to the nurses/doctors station in the major's area. Patients and their parents/carers were left alone after assessment and while they waited to see a doctor.
- There were insufficient numbers of consultants in the ED on duty to meet national guidelines.
- Staff were not using privacy screens to respect patients' privacy and dignity whilst being cared for in the ED corridor area. Patients were given meals in their hands by the staff but there was nowhere to rest plates and cups so they could eat their food with dignity. Routine nursing observations, conversations about care and eating of meals were undertaken in a public space with other patients and relatives passing by.
- There was no effective plan in place to effectively manage the overcrowding in the ED. Actions already identified by the trust as necessary to mitigate patient care being compromised from overcrowding in the ED were either yet to be implemented or were not effective in reducing the risk. There was no tangible improvement in performance. The ED's patient safety matrix showed 'critical' or 'overwhelmed' for much of the two days we visited the trust. Patients were being cared for on trollies in the ED corridor. This action had become an institutionalised means of managing the 'flow' through the ED, including on occasions when ED cubicles were empty. The number of patients waiting between four and twelve hours to be admitted or discharged was consistently higher than the national average. The trust senior leaders were not effectively addressing these risks through a whole hospital approach.
- In medical care and surgical wards visited, venous thromboembolism assessments and 24-hour reassessments were not always carried out for all patients in line with trust and national guidance.
- We observed that staff did not always wash their hands before and after patient contact in ED, medical care and surgical wards in line with national guidance.

Summary of findings

- In the ED, time critical medications were not always administered to patients who had been assessed as needing them on time.
- Patients declining to take prescribed medication on Evergreen 1 ward and Beech ward were not always referred to medical staff for a review and were not always reviewed by medical staff. We raised this as an urgent concern with senior staff.
- In the surgery service, anticoagulation medicine had not always been administered as prescribed.
- Fridge temperatures for the storage of medicines in exceeded recommended ranges in two surgical areas visited and in the maternity and gynaecology service, staff did not consistently follow trust processes for storing medicines at the recommended temperatures, despite there being policies in place.
- Although perinatal mortality and morbidity meetings were minuted, there was no evidence that action was taken to address learning from case reviews. We were not assured an effective system was in place to ensure learning from these meetings was shared, and actions were taken to improve the safety and quality of patient care. In addition were not multidisciplinary and only attended by medical staff in the children and young people's service.
- Whilst some improvements were observed in completion of Patient Early Warning Scores charts, not all charts had been completed in accordance with trust policy. We also found there was not always evidence of appropriate escalation for medical review when required.
- In the paediatric ward, one to one care for patients with mental health needs was not consistently provided by a member of staff with appropriate training and reliance was, on occasion, placed on parents or carers.

Additional areas of concern, that were not included in the Section 29a Warning Notice, that we found during this inspection were:

- There was an inconsistent approach to following both the ED's child and adult safeguarding processes. Staff training compliance for both adult and children's safeguarding was a significant concern and very low, significantly worse than the trust target.
- Pain relief given to children in the ED was not evaluated for its effectiveness for all patients.
- There was no significant change in streaming for self-presenting patients with an operating model based on urgent care GP streaming.
- On the haematology ward staff handled food with their hands without the use of gloves; this was not in line with national and trust guidelines.
- The recording of patients' weights on drug charts on some medical care wards had not improved.
- In medical care wards, only 31% of staff were up-to-date on medicines' management training and this was below the trust target of 90%.
- Patient records were left unsecured on a number of medical care wards we visited and there was a risk that personal information was available to members of the public. This was raised as a concern during the last inspection in November 2016.
- Some risk assessment records in medical care wards were not routinely completed in their entirety, including elderly patient risk assessments and sepsis bundle assessments. We were not assured that inpatient wards were effectively following the trust's sepsis pathway when required.
- In the surgery service, some patients were prescribed inappropriate doses of anticoagulation medication without regard to their weight.
- Some surgical wards did not display their planned staff on duty only their actual staff on duty.
- Visitors to surgical wards could see patient identification details on electronic white boards.
- Senior leaders in surgery were aware of the trust's failure to follow national guidance in relation to venous thromboembolism risk assessments (VTE) and hand hygiene. However, we saw examples throughout the service where compliance with trust and national guidance had not significantly improved. When risks had been escalated, there was a lack of follow up and resolution. Effective action following the reporting of high fridge temperatures for storage of medicines was not evident.

Summary of findings

- There was no system in place to ensure medicines stored in the emergency gynaecology assessment unit were safe for patient use. Immediate action was taken by the trust once we raised this as a concern.
- In the maternity and gynaecology service, training data showed that 86% of midwifery staff and 53% of medical staff had completed safeguarding children level three training. This was an improvement from our previous inspection. However, compliance was still below the trust target of 90%, particularly with medical staff.
- The waiting room and toilet facilities for patients attending the emergency gynaecology assessment unit were mixed sex, as these were shared with the respiratory outpatient clinic. Furthermore, this assessment unit did not have appropriate facilities such as bathrooms, to facilitate personal care for patients who had to stay overnight at times of increased bed pressures.
- In the children and young people's service, safeguarding children's level three training was below the trust's target of 85% and future training sessions had been cancelled. Compliance rates for this essential training were no better or worse in April 2017 in some staff teams compared to November 2016.
- The children and young people's service became busy at times and staff said activity had increased since the service reconfiguration. However, there was limited monitoring of assessment and admission to inpatient areas. This meant that service leaders were not in a position to understand current and future performance and to be able to drive improvements for better patient outcomes.
- The risk register for the children and young people's service had been updated to include two additional risks identified during the November 2016 inspection, but not all risks found on this inspection had been identified, assessed, and recorded. For example, the increased activity in the service following the transformation process.

Areas where we found improvements included in the Section 29a Warning Notice had been made were:

- Staff felt supported to report incidents including occasions when they judged patients unsafe because the emergency department (ED) was 'overwhelmed'. An electronic patient safety matrix and ED occupancy tool was in place showing real time data about ED capacity, which gave oversight of the pressures in ED.
- The trust had implemented a 'Full Capacity Protocol' that was activated when the emergency department safety matrix status showed critical or overwhelmed status.
- Most patients were assessed within 15 minutes of arriving to the ED by senior nurses.
- Nurse breaks in the clinical decision unit were now covered by other nurses. Most ED staff were attentive, discrete as possible and considerate to patients.
- During this inspection, all 21 records looked on the acute stroke unit, Avon 3, Evergreen 1 and 2 wards showed NEWS charts were completed fully and patients were escalated for medical review appropriately when required.
- There had been improvements in the monitoring of medicines' fridge temperatures in medical care wards visited.
- All staff we saw in surgical clinical areas had 'arms bare below elbows'.
- Infection control protocols were followed in the children and young people's service.
- There were appropriate arrangements in place for management of medicines in the children and young people's service, which included their safe storage.
- All patients admitted to the paediatric ward because of an episode of self-harm or attempted suicide had a risk assessment on file.

Areas of improvement, that were not included in the Section 29a Warning Notice, found from the last inspection were:

- There was a senior initial assessment nursing system in place for patients arriving by ambulance to the ED. Staff told us the flow had improved since two 'ambulance access' cubicles were specifically allocated in the department.
- Health care assistants were undertaking comfort rounds for patients' cared for in the corridor area of ED, completing documentation and giving patients a leaflet explaining why they were waiting in a corridor.
- The ED was managed locally by the matron and senior ED consultant. Staff were very committed to their work and doing the best they could for their patients even under regular and consistent heavy pressure.
- The medical care service had taken steps to improve the management of medical patients on non-medical speciality wards.

Summary of findings

- The medical care service had improved patient flow in the hospital to minimise patient moves.
- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard (SQuID). This was being used as to drive improvement and had improved staff's understanding of safety and quality in the service.
- There were fewer reported surgical staff shortages and shortfalls were escalated and risk assessed so patients' needs were met.
- Effective systems had been introduced to ensure emergency equipment was checked daily in the maternity and gynaecology service. Equipment was well maintained and had been safety tested to ensure it was fit for purpose.
- The hospital did not have a dedicated gynaecology inpatient ward. This meant some patients stayed overnight in the outpatient emergency gynaecology assessment unit and were nursed in medical wards. However, the trust had put processes in place to ensure patients were cared for in environments that were suitable for their needs.
- Daily ward rounds by a gynaecology consultant and nurse were carried out to ensure gynaecology patients were appropriately reviewed and managed, regardless of location within the trust.
- Staff caring for gynaecology patients on Beech B1 ward had received training on bereavement care, including early pregnancy loss and the management of miscarriage.
- Risks identified in the maternity and gynaecology service were reviewed regularly with mitigation and assurances in place. Staff were aware of the risks and the trust board had oversight of the main risks within the service.
- The majority of staff in the children and young people's service had been competency assessed in medical devices used to help patients breathe more easily.

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

Importantly, the trust must:

- Ensure that patients in the ED receive medication prescribed for them at the correct time and interval.
- Ensure that all patients' conditions are monitored effectively to enable any deterioration to be quickly identified and care and treatment is provided in a timely way.
- Ensure that staff complete all of the risk assessments and documentation required to assess the condition of patients and record their care and treatment.
- Ensure all patients have a venous thromboembolism (VTE) assessment and are reassessed 24 hours after admission in accordance with national guidance.
- Ensure that the privacy and dignity of all patients in the ED is supported at all times, including when care is provided in corridor areas.
- Ensure that systems or processes are fully established and operated effectively to assess, monitor and improve the quality and safety of the services provided within the ED.
- Ensure that systems or processes are fully established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety, and welfare of patients while using the ED.
- Ensure mental health assessment room in the emergency department is appropriate to meet needs of patients.
- Ensure the children's ED area is consistently monitored by staff via appropriate CCTV surveillance at the nurses/ doctors station in the major's area.
- Ensure patient weights are recorded on drug charts.
- Ensure there are processes in place to ensure that any medicine omissions are escalated appropriately to the medical team.
- Where patients refuse to take prescribed medication, ensure it is escalated to the medical team for a review.
- Ensure all anticoagulation medication is administered as prescribed. All non-administrations must have a valid reason code.
- Ensure all medicines are stored at the correct temperature. Systems must be in place to ensure medication, which has been stored outside of manufactures recommended ranges, remains safe or is discarded.
- Ensure patient identifiable information is stored securely and not kept on display

Summary of findings

- Ensure all staff comply with hand hygiene and the use of personal protective equipment policies.
- Ensure all staff are up-to-date on medicines' management training.
- Ensure all staff have completed their Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training.
- Ensure all staff have completed the required level of safeguarding training.
- Ensure all patients in the children and young people's service with mental health needs have the appropriate level of staff one to one care in accordance with their risk assessments.
- Ensure paediatric assessment area activity is monitored effectively so the service can drive improvements in patient flow.
- Ensure the risk registers reflects all significant risks in the service and effective mitigating actions are in place to reduce potential risks to patients.
- Ensure safeguarding referrals are made when required for patients seen in the ED.
- Ensure the sepsis pathway is fully embedded in inpatient wards.

In addition the trust should:

- Achieve the required numbers of consultants in the ED on duty to meet national guidelines.
- Continue to monitor the effectiveness of the sepsis pathway in the ED.
- Review systems in place so food is served using either gloves or tong in accordance with trust policy.
- Review processes for maintaining patient confidentiality during nursing handovers.
- Review systems in place to manage the safe and effective use of controlled drugs within the discharge lounge.
- Consider displaying actual and planned staff numbers in all clinical areas.
- Consider using a standard risk assessment to assess and identify the needs of patients admitted to the paediatric ward with mental health needs. All forms should be kept updated as required for the duration of the patient's stay.
- Review how pain relief given to children in the emergency department is evaluated for its effectiveness for all patients.
- Consider possible changes in streaming for self-presenting patients with an operating model based on urgent care GP streaming.
- Review the waiting room, bathroom and toilet facilities for patients attending the emergency gynaecology assessment unit as these were mixed sex being shared with the respiratory outpatient clinic.
- Review systems in place for the monitoring of assessment and admission to inpatient areas in the children and young people's service.

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?
Urgent and emergency services		We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of four of the five key questions but did not rate them. We found significant improvements had not been made in these areas: • Staff did not follow good hand hygiene practice at all times. • Time critical medications were not always administered to patients who had been assessed as needing them on time. • Essential risk assessments were not completed when required to keep patients safe from avoidable harm. There were not effective systems in place to assess and manage risks to patients in the ED. • Staff did not always identify and respond appropriately to changing risks to patients, including deteriorating health and wellbeing, including making required safeguarding referrals. • There was no appropriate mental health room available within which to safely care for patients. • The children's ED area was not consistently attended by staff except via CCTV surveillance to the nurses/ doctors station in the major's area. Patients and their parents/carers were left alone after assessment and while they waited to see a doctor. • There were insufficient numbers of consultants in the ED on duty to meet national guidelines. • Staff were not using privacy screens to respect patients' privacy and dignity whilst being cared for in the ED corridor area. Patients were given meals in their hands by the staff but there was nowhere to rest plates and cups so they could eat their food with dignity. • There was no effective plan in place to effectively manage the overcrowding in the ED. The ED's patient safety matrix showed critical or 'overwhelmed' for much of the two days we visited the trust. Patients

Summary of findings

were being cared for on trollies in the ED corridor had become an institutionalised means of managing the 'flow' through the ED, including on occasions when ED cubicles were empty.

- The number of patients waiting between four and twelve hours to be admitted or discharged was consistently higher than the national average.
- Adult patients were routinely cared for in the corridor of the department for long periods of time after decision to admit or awaiting therapist assessment for safe discharge. There was no space between the trollies and no screens around them. This happened including during periods when cubicles providing better privacy were vacant within the ED. Routine nursing observations, conversations about care and eating of meals were undertaken in a public space with other patients and relatives passing by.
- Actions already identified by the trust as necessary to mitigate patient care being compromised from overcrowding in the ED were either yet to be implemented or were not effective in reducing the risk.
- There was no tangible improvement in performance, caring for patients in the corridors had become institutionalised and we found patient's privacy, dignity and effective care remained compromised.
- The trust senior leaders were not effectively addressing these risks through a whole hospital approach.

We also found other areas of concern:

- There was an inconsistent approach to following both the ED's child and adult safeguarding processes. Staff training compliance for both adult and children's safeguarding was significantly worse than the trust target.
- Pain relief given to children was not evaluated for its effectiveness for all patients.
- There was no significant change in streaming for self-presenting patients with an operating model based on urgent care GP streaming.

However, we observed improvements for the following:

- Staff felt supported to report incidents including occasions when they judged patients to be unsafe because the ED was 'overwhelmed'.

Summary of findings

- An electronic patient safety matrix and ED occupancy tool was in place showing real time data about ED capacity, which gave oversight of the pressures in ED.
- Most patients were assessed within 15 minutes of arriving by senior nurses.
- Nurse breaks in the clinical decision unit were now covered by other nurses.
- Most staff were attentive, discrete as possible and considerate to patients.
- There was a senior initial assessment nursing system in place for patients arriving by ambulance. Staff told us the flow had improved since two 'ambulance access' cubicles were specifically allocated in the department.
- There was a patient co-ordinator on duty at senior sister level responsible for managing the flow of patients. The ED matron reported two hourly the ED status to a capacity hub meeting that overviewed the situation across the trust throughout the day and night.
- Health care assistants were undertaking comfort rounds for patients' cared for in the corridor area of ED, completing documentation and giving patients a leaflet explaining why they were waiting in a corridor.
- The ED was managed locally by the matron and senior ED consultant. Staff were very committed to their work and doing the best they could for their patients even under regular and consistent heavy pressure.
- The trust had put in place an electronic safety and capacity matrix that reported data about the ED flow in real time: this enabled the executive team to have a clear line of sight to the risks at any and all times.
- The trust had implemented a 'Full Capacity Protocol' that was activated when the emergency department safety matrix status showed critical or overwhelmed status.

Medical care (including older people's care)

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of four of the five key questions but did not rate them. We found significant improvements had not been made in these areas:

Summary of findings

- Venous thromboembolism (VTE) assessments were not always carried out for all patients in line with trust and national guidance.
- We observed that most staff did not generally wash their hands before and after patient contact on the acute stroke unit, Avon 2 ward and the medical assessment unit (MAU) in line with national guidance.
- Patients declining to take prescribed medication on medical care wards were not always referred to medical staff for a review and were not always reviewed by medical staff.

Areas where improvements had been made were:

- All 21 records looked at showed NEWS charts were completed fully and patients were escalated for medical review appropriately when required.
- There had been improvements in the monitoring of medicines' fridge temperatures.
- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard (SQuID). This was being used as to drive improvement and had improved staff's understanding of safety and quality in the service.

Additional areas of concern found on this inspection were:

- We observed staff handling food on the haematology ward with their hands without the use of gloves, which was not in line with national and trust guidelines.
- We found that the recording of patients' weights on drug charts on some medical care wards had not improved.
- In medical care wards, only 31% of staff were up-to-date on medicines' management training and this was below the trust target of 90%.
- We found patient records left unsecured on a number of wards we visited and there was a risk that personal information was available to members of the public. This was raised as a concern during the last inspection in November 2016.
- Staff compliance with Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training was 45%, which was below the trust target of 90%.
- Some risk assessment templates were not routinely completed in their entirety, including elderly patient

Summary of findings

risk assessments and sepsis bundle assessments. We were not assured that inpatient wards were effectively following the trust's sepsis pathway when required.
- The medical service leadership team had not addressed all concerns and risks identified as areas for improvement in our last inspection.

Surgery

We carried out this focused I and inspected four of the five key questions but we did not rate them. This was a focused inspection to review concerns found during our previous comprehensive inspection in November 2016 and therefore we did not inspect every aspect of each key question. We found significant improvements had not been made in these areas:

- Venous thromboembolism risk assessments (VTE) and 24 hour reassessments were not completed in line with national guidance.
- Some staff did not clean their hands before or after patient contact and some staff wore personal protective equipment inappropriately.
- Fridge temperatures for the storage of medicines exceeded recommended ranges in two areas visited
- Anticoagulation medicines had not always been administered as prescribed.

We also found other areas of concern on this inspection :

- Some patients were prescribed inappropriate doses of anticoagulation medication without regard to their weight.
- Some wards did not display their planned staff on duty only their actual staff on duty.
- Visitors to wards could see patient identification details on electronic white boards.
- Senior leaders were aware of the trust's failure to follow national guidance in relation to venous thromboembolism risk assessments (VTE) and hand hygiene. However, we saw examples throughout the service where compliance with trust and national guidance had not significantly improved.
- When risks had been escalated, there was a lack of follow up and resolution. Effective action following the reporting of high fridge temperatures for storage of medicines was not evident.

However, we observed improvements for the following:

- All staff we saw in clinical areas had 'arms bare below elbows'.
- There were fewer reported staff shortages and shortfalls were escalated and risk assessed so patients' needs were met.
- The hospital had implemented a new quality dashboard. The dashboard provided monthly quality data for all wards and clinical areas.

Maternity and gynaecology

We carried out a focused inspection to review concerns found during our previous comprehensive inspection on 22 to 25 November 2016. We inspected parts of four of the five key questions but did not rate them. We found significant improvements had not been made in these areas:

- Although perinatal mortality and morbidity meetings were minuted, there was no evidence that action was taken to address learning from case reviews. We were not assured an effective system was in place to ensure learning from perinatal mortality and morbidity meetings was shared, and actions were taken to improve the safety and quality of patient care.
- Staff did not consistently follow trust processes for storing medicines at the recommended temperatures, despite there being policies in place.

We also found other areas of concern:

- There was no system in place to ensure medicines stored in the emergency gynaecology assessment unit were safe for patient use. Immediate action was taken by the trust once we raised this as a concern.
- Training data showed that 86% of midwifery staff and 53% of medical staff had completed safeguarding children level three training. This was an improvement from our previous inspection. However, compliance was still below the trust target of 90%, particularly with medical staff.
- The waiting room and toilet facilities for patients attending the emergency gynaecology assessment unit were mixed sex, as these were shared with the respiratory outpatient clinic. Furthermore, this assessment unit did not have appropriate facilities such as bathrooms, to facilitate personal care for patients who had to stay overnight at times of increased bed pressures.

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However, we observed improvements for the following:

- Standards of cleanliness and hygiene were well maintained. Staff adhered to infection control and prevention guidance.
- Effective systems had been introduced to ensure emergency equipment was checked daily. Equipment was well maintained and had been safety tested to ensure it was fit for purpose.
- The hospital did not have a dedicated gynaecology inpatient ward. This meant some patients stayed overnight in the outpatient emergency gynaecology assessment unit and were nursed in medical wards. However, the trust had put processes in place to ensure patients were cared for in environments that were suitable for their needs.
- The number of staff who had completed Mental Capacity Act and Deprivation of Liberty Safeguards training had improved.
- Daily ward rounds by a gynaecology consultant and nurse were carried out to ensure gynaecology patients were appropriately reviewed and managed, regardless of location within the trust.
- Staff caring for gynaecology patients on Beech B1 ward had received training on bereavement care, including early pregnancy loss and the management of miscarriage.
- Risks identified were reviewed regularly with mitigation and assurances in place. Staff were aware of the risks and the trust board had oversight of the main risks within the service.

Services for children and young people

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of four of the five key questions (safe, effective, responsive, well-led) but did not rate them. We did not inspect the caring key question. We found significant improvements had not been made in these areas:

- Whilst perinatal mortality and morbidity meetings were minuted and well attended, which was an improvement since the previous inspection, there was no evidence that action was taken to address learning from patient case reviews.
- Paediatric mortality and morbidity meetings were not multidisciplinary and only attended by medical staff.

Summary of findings

- Whilst some improvements were observed in completion of Patient Early Warning Scores charts, not all charts had been completed in accordance with trust policy. We also found there was not always evidence of appropriate escalation for medical review when required.
- One to one care for patients with mental health needs was not consistently provided by a member of staff with appropriate training and reliance was, on occasion, placed on parents or carers.

We also found other areas of concern:

- Safeguarding children's level three training was below the trust's target of 85% and future training sessions had been cancelled. Compliance rates for this essential training were no better or worse in April 2017 in some staff teams compared to November 2016.
- The department became busy at times and staff said activity had increased since the service reconfiguration. However, there was limited monitoring of assessment and admission to inpatient areas.
- The risk register had been updated to include two additional risks identified during the November 2016 inspection, but not all risks found on this inspection had been identified, assessed and recorded. For example, the increased activity in the service following the transformation process.
- There was limited oversight and planning with regards to the increased activity in the service. This meant that service leaders were not in a position to understand current and future performance and to be able to drive improvements for better patient outcomes.

However, we observed improvements for the following:

- Paediatric mortality and morbidity meetings for paediatrics were now held and minuted.
- Infection control protocols were followed.
- There were appropriate arrangements in place for management of medicines, which included their safe storage.
- All patients admitted to the ward because of an episode of self-harm or attempted suicide had a risk assessment on file.

Summary of findings

- The majority of staff had been competency assessed in medical devices used to help patients breathe more easily.

Worcestershire Royal Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Maternity and gynaecology; Services for children and young people.

Detailed findings

Contents

Background to Worcestershire Royal Hospital

Worcestershire Royal Hospital provides acute healthcare services to a population of around 580,000 in Worcestershire and the surrounding counties.

There are approximately 500 inpatient and day case beds, of which 70 are maternity and 18 are critical care. The hospital provides a comprehensive range of surgical, medical and rehabilitation services, including stroke services and cardiac stenting. The trust employs 5,053 staff, including 725 doctors, 1,843 nursing staff and 2,485 other staff.

In 2015/16, the trust had an income of £368,816,000 and costs of £428,732,000; meaning it had a deficit of £59,916,000 for the year. The deficit for the end of the financial year for 2016/17 was predicted to be £34,583,000.

Our first comprehensive inspection took place in July 2015, when Worcestershire Royal Hospital was rated as inadequate and the trust entered special measures. We carried out a second comprehensive inspection of the trust in November 2016 on this occasion; the trust was rated as inadequate and remained in special measures.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultants and nurses from surgical services and general medicine and emergency department doctors and nurses. The team also included an executive director and a governance specialist.

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 of people's needs?
- Is it well-led?

We reviewed a range of information we held about Worcestershire Acute Hospitals NHS Trust and asked other organisations to share what they knew about the

hospital. These included the clinical commissioning group, NHS Improvement, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch.

We spoke with people who used the services and those close to them to gather their views on the services provided. Some people also shared their experience by email and telephone.

We carried out this inspection as part of our programme of re-visiting hospitals to check improvements had been made. We undertook an unannounced inspection from 11 to 12 April 2017 and an announced inspection on 25 April 2017.

Facts and data about Worcestershire Royal Hospital

The trust primarily serves the population of the county of Worcestershire with a current population of almost 580,000, providing a comprehensive range of surgical, medical and rehabilitation services.

The trust's main clinical commissioning groups (CCG) are NHS Redditch and Bromsgrove CCG, NHS Wyre Forest CCG and NHS South Worcestershire CCG.

The health of people in Worcestershire is varied compared to the England average. Deprivation is lower than average and about 15% (14,500) children live in poverty. Life expectancy for both men and women is similar to the England average.

As at August 2016, the trust employed 5,053.82 staff out of an establishment of 5,532.69, meaning the overall vacancy rate at the trust was 9%.

In the latest full financial year, the trust had an income of £368.8m and costs of £428.7m, meaning it had a deficit of £59.9m for the year. The trust predicts that it will have deficit of £ 34.5m in 2016/17.

In the last financial year the trust had:

- 120,278 A&E attendances.
- 139,022 inpatient admissions. (2014/15 financial year)
- 588,327 outpatient appointments.
- 5,767 births.
- 2,181 referrals to the specialist palliative care team.
- 51,444 surgical bed days.
- 1,945 critical care bed days (March to August 2016).

Urgent and emergency services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The emergency department (ED) at Worcestershire Royal Hospital provides a 24-hour, seven-day a week service. There is a trauma unit but the hospital is not a trauma centre. From October 2015 to September 2016 the ED saw 66,375 patients; of these attendances 11,750 (18%) were under the age of 16. Overall there had been an increase of 4% in attendances than the previous year. Paediatric attendances at Worcestershire Royal Hospital had increased since September 2016 due to reconfiguration of these services onto this site. The trust anticipates this increase to remain consistent.

The ED consists of a minor's area with seating and five assessment/treatment rooms, a major area consisting of 16 cubicles and three side rooms, and a resuscitation area with four bays. The department has a paediatric area with a waiting area and three cubicles. The ED corridor is utilised to care for up to 10 patients who have been seen in the ED and are awaiting a bed in the hospital or safe discharge after therapist assessment. At the upper end of the ED corridor there is an ambulance entrance with two recently introduced assessment cubicles. The corridor in this area is used to care for ambulance patients when they cannot be handed over due to capacity or when they have been assessed and are waiting for a cubicle. There is a four cubicle 'step down' area for resuscitation patients.

There is an eight-bedded observation ward adjoined to the ED, known as the clinical decisions unit.

During our inspection, we spoke to 17 patients and reviewed associated records of 30 patients and spoke with 14 staff. We also reviewed the trust's ED performance data. Urgent and emergency services provided by this trust were located on three hospital sites, the others being Alexandra Hospital and Kidderminster Hospital and Treatment Centre. Services at the other sites are included in separate reports. Services on all hospital sites were run by one urgent and emergency services management team. As such they were regarded within and reported upon by the trust as one service, with some staff working at all sites. For this reason it is inevitable there is some duplication contained in the three reports.

Urgent and emergency services

Summary of findings

We carried out an unannounced focused inspection to look specifically at the issues identified in the warning notice issued following our comprehensive inspection in November 2016. We inspected parts of four of the five key questions but did not rate them. We found significant improvements had not been made in these areas:

- Staff did not follow good hand hygiene practice at all times.
- Time critical medications were not always administered to patients who had been assessed as needing them on time.
- Essential risk assessments (such as Paediatric Early Warning Scores) were not completed when required to keep patients safe from avoidable harm. There were not effective systems in place to assess and manage risks to patients in the ED.
- Staff did not always identify and respond appropriately to changing risks to patients, including deteriorating health and wellbeing, including making required safeguarding referrals.
- There was no appropriate mental health room available within which to safely care for patients.
- The children's ED area was not consistently attended by staff except via CCTV surveillance to the nurses/ doctors station in the major's area. Patients and their parents/carers were left alone after assessment and while they waited to see a doctor.
- There were insufficient numbers of consultants in the ED on duty to meet national guidelines.
- Staff were not using privacy screens to respect patients' privacy and dignity whilst being cared for in the ED corridor area. Patients were given meals in their hands by the staff but there was nowhere to rest plates and cups so they could eat their food with dignity.
- There was no effective plan in place to effectively manage the overcrowding in the ED. The ED's patient safety matrix showed critical or 'overwhelmed' for much of the two days we visited the trust. Patients were being cared for on trollies in the ED corridor had become an institutionalised means of managing the 'flow' through the ED, including on occasions when ED cubicles were empty.
- The number of patients waiting between four and twelve hours to be admitted or discharged was consistently higher than the national average.
- Adult patients were routinely cared for in the corridor of the department for long periods of time after decision to admit or awaiting therapist assessment for safe discharge. There was no space between the trollies and no screens around them. This happened including during periods when cubicles providing better privacy were vacant within the ED. Routine nursing observations, conversations about care and eating of meals were undertaken in a public space with other patients and relatives passing by.
- Actions already identified by the trust as necessary to mitigate patient care being compromised from overcrowding in the ED were either yet to be implemented or were not effective in reducing the risk.
- There was no tangible improvement in performance, caring for patients in the corridors had become institutionalised and we found patient's privacy, dignity and effective care remained compromised.
- The trust senior leaders were not effectively addressing these risks through a whole hospital approach.

We also found other areas of concern:

- There was an inconsistent approach to following both the ED's child and adult safeguarding processes. Staff training compliance for both adult and children's safeguarding was a significant concern and very low, significantly worse than the trust target.
- Pain relief given to children was not evaluated for its effectiveness for all patients.
- There was no significant change in streaming for self-presenting patients with an operating model based on urgent care GP streaming.

However, we observed improvements for the following:

- Staff felt supported to report incidents including occasions when they judged patients to be unsafe because the ED was 'overwhelmed'.
- An electronic patient safety matrix and ED occupancy tool was in place showing real time data about ED capacity, which gave oversight of the pressures in ED.

Urgent and emergency services

- Most patients were assessed within 15 minutes of arriving by senior nurses.
- Nurse breaks in the clinical decision unit were now covered by other nurses.
- Most staff were attentive, discrete as possible and considerate to patients.
- There was a senior initial assessment nursing system in place for patients arriving by ambulance. Staff told us the flow had improved since two 'ambulance access' cubicles were specifically allocated in the department.
- There was a patient co-ordinator on duty at senior sister level responsible for managing the flow of patients. The ED matron reported two hourly the ED status to a capacity hub meeting that overviewed the situation across the trust throughout the day and night.
- Health care assistants were undertaking comfort rounds for patients' cared for in the corridor area of ED, completing documentation and giving patients a leaflet explaining why they were waiting in a corridor.
- The ED was managed locally by the matron and senior ED consultant. Staff were very committed to their work and doing the best they could for their patients even under regular and consistent heavy pressure.
- The trust had put in place an electronic safety and capacity matrix that reported data about the ED flow in real time: this enabled the executive team to have a clear line of sight to the risks at any and all times.
- The trust had implemented a 'Full Capacity Protocol' that was activated when the emergency department safety matrix status showed critical or overwhelmed status.

Are urgent and emergency services safe?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found significant improvements had not been made in these areas:

- Staff did not follow good hand hygiene practice at all times.
- Time critical medications were not always administered to patients who had been assessed as needing them on time.
- Essential risk assessments were not completed when required to keep patients safe from avoidable harm. There were not effective systems in place to assess and manage risks to patients in the ED.
- There was no appropriate mental health room available within which to safely care for patients.
- The children's ED area was not consistently attended by staff except via CCTV surveillance to the nurses/doctors station in the major's area. Patients and their parents/ carers were left alone after assessment and while they waited to see a doctor.
- There were insufficient numbers of consultants in the ED on duty to meet national guidelines.

We also found other areas of concern:

- Staff did not always identify and respond appropriately to changing risks to patients, including deteriorating health and wellbeing.
- There was an inconsistent approach to following both the ED's child and adult safeguarding processes. Staff training compliance for both adult and children's safeguarding was a significant concern and very low, significantly worse than the trust target.

However, we observed improvements for the following:

- Staff felt supported to report incidents including occasions when they judged patients to be unsafe because the ED was 'overwhelmed'.
- An electronic patient safety matrix and ED occupancy tool was in place showing real time data about ED capacity, which gave oversight of the pressures in ED.
- Most patients were assessed within 15 minutes of arriving by senior nurses.

- Nurse breaks in the clinical decision unit were now covered by other nurses.
- Patients were assessed for risk of pressure damage to their skin.

Incidents

- At our inspection in November 2016, we found staff in the emergency department (ED) were discouraged from reporting incidents relating to high capacity and care in the corridor. This meant there was a risk of staff stopping reporting safety and capacity incidents. Medical staff were told in November 2016 by the trust governance team that their incident reports relating to patients being cared for in areas they considered to be unsafe were inappropriate and were being deleted. This had not been previously identified by the trust as a risk and did not appear on the divisional or corporate risk register.
- The trust provided us with information in January 2017, which detailed immediate and ongoing actions that had been taken to address this problem. These actions including reiteration to staff by senior managers that they should report incidents relating to high capacity and corridor care.
- On this inspection, we found that staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. This included to report when capacity in the ED was at risk of compromising patient safety when crowding and poor flow through the hospital overwhelmed the service.
- Data sent by the trust reported relating to the patient safety matrix showed critical or 'overwhelmed' 27 days out of 31 in the period 1 to 31 March 2017. During the two days of our visit on 11 and 12 April 2017, we saw between three and five patients at any time being cared for in the ED corridor. The trust referred to this as 'reverse queuing' as these patients had been seen and were waiting to be admitted to wards or safely discharged home.
- The matron showed us global risk assessment tool sheets, which were being first implemented in the department on the day of our visit. One assessment was for each patient waiting more than 60 minutes to be formally handed over from ambulance crew and another was for each patient waiting more than six hours in the emergency department. The risk levels assessed ranged from 'no concerns' (about the patient's condition) to repeat assessment in two hours and the third risk level was 'escalate to co-coordinator red risk patient'. The ED co-ordinator was expected to complete the red risk assessment to reduce the risk and escalate the situation. Senior sisters told us incidents of crowding in the ED were now reported through this global risk assessment tool.
- We spoke with a regular locum consultant who confirmed that they were encouraged and supported to report incidents by the lead consultant and most consultants did so. After our inspection visit, we asked the trust to send us an account of ED incident reports for the week of our visit when we had seen the ED declared as 'overwhelmed' on the trust's status matrix during both days.
- After the inspection, the trust sent us information that showed from January to March 2017, 15 incidents had been reported due to capacity concerns and staffing pressures in the ED. However, it was not clear to see if all staff were consistently reporting all incidents linked to when the ED was 'overwhelmed'.

Cleanliness, infection control and hygiene

- In keeping with accepted good practice and trust policy, staff were 'arms bare below the elbows' and did not wear jewellery or loose ties. However, we noted over the two days of our visit that staff at all levels and within all roles failed to routinely clean their hands when attending to patients and when entering and leaving clinical areas within the ED. For example, we observed six staff including one in outdoor clothes (just arrived on duty) pass through the door into the minor injuries stream area without using the hand gel positioned on the wall on either side of the doors. Two of this group returned through the doors a few minutes later and did not use the hand gel on that occasion either. We noted staff routinely leave and enter the major injuries/illness stream area without using hand gel.
- We raised this with the matron who told us that a lot of work had been put into reinforcing good hand hygiene practice among ED staff but the internal audit score for March 2017 had been a disappointing 85% compliance, below the trust target of 95%. Before we left, the matron told us that the hand hygiene audit co-ordinator had been tasked to re-run training for all ED staff within two weeks of our visit.

Environment and equipment

- We did not gather evidence for this as part of the inspection.

Medicines

- At our inspection in November 2016, we found that doses of time critical medicines were not being administered to patients, including those with Parkinson's disease and diabetes whilst they were queued in the ED in corridor.
- The trust provided us with the following assurances in January 2017 that 'the supply of time critical medicines was a key priority and an audit of missed doses had been undertaken as part of the trust's 'Medicines Optimisation Audit Plan'. The results of the audit were not provided. However, the trust presented a three-month plan stating how the administration of time critical medications would be incorporated into medicines' management training for staff and training outcomes would be monitored.
- On this inspection, we found that two of three patients waiting in the ED 'reverse queue' for admission to a ward or discharge after therapist assessment had not had the required medicine on time. One patient with identified sepsis was four hours overdue for their second dose of antibiotics and second bag of intavenous fluids at the critical interval required and prescribed, and they were asking staff for these medications. A second patient had hip pain after a fall (scored at three on the pain chart) on arrival at 2am, however records showed analgesia was not given until 5am.

Records

- We did not gather evidence for this as part of the inspection.

Safeguarding

- There was an inconsistent approach to following both the ED's child and adult safeguarding processes. Staff training compliance for both adult and children's safeguarding was significantly worse than the trust target.
- At our inspection in November 2016, we found nursing staff within the ED had not completed a valid level 3 safeguarding training course. Level 2 and 3 training had been completed online, when the requirement is for this to be face to face in line with national guidance.
- The trust provided information following this inspection that showed at the end of April 2017 for level 2 adults' safeguarding training, 15 out of 89 staff in the ED at WRH had completed face to face training (17%) and 24 had done online training (27%).
- For level 2 children's' safeguarding training, one out of 89 staff had completed face to face training (1%) with 19 out of 89 having online training (21%).
- For level 3 children's' safeguarding training, 41 out of 89 staff had completed face to face training (46%) with 46 out of 89 having online training (52%).
- The trust told us that the ED had a plan to achieve 100% compliance with safeguarding training based on available courses and was expected to be completed by October 2017.
- Of the seven paediatrics patients records we looked at covering patients who presented to the ED on 9 April and on 11 April 2017 we noted each documented staff had checked the patient's name against the at risk register. Five of the seven records documented staff had checked if the patient had a social worker.
- Two paediatric patient's records we looked at for the weekend before our visit, indicated consideration should be given to a safeguarding referral. One patient was entered in the health visitors' book for a follow up visit; the other was not followed up or referred to the local safeguarding authority. We raised this with the matron who undertook to look into this and later informed us appropriate procedures were set in motion.
- In the clinical decisions unit (CDU), we looked at five adult patient records as they had admitted from the ED and a safeguarding referral may have been appropriate: three did not have an adult safeguarding form completed.

Mandatory training

- We did not gather evidence for this as part of the inspection.

Assessing and responding to patient risk

Time to assessment from arrival

- Reception staff triaged patients who arrived on foot into a minor injuries/illness stream, major injuries/illness or paediatric (children) areas on booking in to the department. Patients arriving by ambulance were assessed in two dedicated cubicles in the major's area

and triaged; there were four 'high care' beds for patients being stepped down from the resuscitation cubicles. Triage could result in some patients being taken to the minor's area if more appropriate.

- The median average time from arrival by ambulance to assessment was ten minutes in February 2017 and seven minutes in March 2017.
- Staff told us a consultant led rapid assessment and treat (RAT) process had been piloted in the department in early March 2017. However, there were no RAT processes in place when we visited on 11 April 2017. For patients arriving by ambulance the trust had put in place a 'senior initial assessment nursing' (SIAN) process and we saw this was led by senior nurse sisters.
- Each of seven records we checked showed paediatrics patients were triaged/assessed by a registered practitioner within 15 minutes (recommended time) of booking into the ED. Time to see a doctor (or emergency nurse practitioner in one case) ranged between one to four hours.
- For six adult patients whose records we looked at, the arrival to triage/assessment time ranged between four minutes and 22 minutes. Time to see a doctor ranged between one hour and two hours and 20 minutes.

Risk assessments and management of deteriorating patients

- Risk assessments were not completed when required to keep patients safe from avoidable harm. There were not effective systems in place to assess and manage risks to patients in the ED.
- We noted at times over the two days of our visit there were cubicles free within the majors, minors and high care areas of the ED and yet some patients were being cared for in corridor queues. A consultant explained that they did use the minors area if necessary for low risk ambulatory processes but they found making regular use for majors' patients compromised the minor's stream; they put patients whose status was known and stabilised in the corridor and not new arrivals.
- However, we saw from patients records and from talking to patients, that staff did not always identify and respond appropriately to changing risks to people who used the ED service, including deteriorating health and wellbeing.
- For example, although there was a sepsis pathway established in the ED, we found a patient who had flagged for sepsis and who had other co-morbidities, was given antibiotics and intravenous (IV fluids) within minutes of arriving and this reduced their temperature. However, when we met them they were being nursed in the corridor on a trolley waiting for admission to a ward. They told us and their records confirmed the second dose of antibiotics and fluid were four hours overdue at that time. When we raised this with a senior sister on duty, they found the patient's temperature beginning to rise again. This omission occurred whilst they were being nursed in the corridor although at that time we saw cubicles were available in the major's area of ED. The service took a series of actions after we escalated this concern, which included a review of prescribing practice for sepsis antibiotics to ensure administration details were clear on drug charts.
- The trust provided data that showed the percentage of adult patients who presented with severe sepsis, 'Red Flag' Sepsis or septic shock to the ED and were administered intravenous antibiotics within one hour of presentation and had an antibiotics review carried out by a competent decision maker by day three of them being prescribed was 72 % in November 2016, and 65% in December 2016.
- The trust had implemented the 'Guidelines for the management of Sepsis and Septic Shock in Adults',inpatient and ED suspected sepsis screening tools and inpatient and ED sepsis patient pathways in September 2016. These were available on the trust treatment pathways intranet site. The trust was in the process of data collection for quarter one (April to June 2017) for the 2017/18 Sepsis Commissioning for Quality and Innovation (CQUIN) and therefore did have data available to evidence compliance from April 2017 at the time of the inspection.
- A young child arrived just after midnight with a temperature of 38.5°C and was triaged/assessed within one minute. However, no anti-pyrexical medicine was given to reduce the temperature until after 3am when the temperature had risen to over 39. The parents left the ED with the child after four hours without seeing a doctor and this meant there was a risk that the child may have left hospital without a proper assessment of their condition.
- A patient also cared for in the corridor had presented with symptoms of a stroke. They had been transferred from another acute hospital within the trust, given

aspirin and were awaiting a stroke review. Their 'intentional care round' records showed a two hours and thirty minutes gap between checks which was not in line with trust policy.

- The notes of a patient who attended the ED presenting with stroke symptoms, during the weekend before our visit, showed they waited one and a half hours to be seen by a doctor. Recommended guidelines are that suspected stroke patients should be seen within one hour of arrival.
- A third patient cared for in the corridor at the time of our inspection visit had presented with hip pain from a fall at 2am. They were triaged within four minutes and had a pain score of three but pain relief was not given until 5am. National guidance on fractured neck of femurs recommends that effective analgesia should be given at the earliest opportunity to enhance recovery rate.
- At our inspection in November 2016, we found that risk assessments templates were not routinely completed, including elderly patient risk assessments, dementia assessments, venous thromboembolism (VTE) assessments and sepsis bundle assessments. We found cannula care assessments were not completed for seven patients' records out of 14, and dementia assessments were not completed for four out of five patients that met the criteria for requiring it.
- On this inspection, we looked at the records of twenty-one patients including eight children and found the National Early Warning Score assessment (NEWS) and the Paediatric Early Warning Score assessment (PEWS) had been undertaken for 18 of them. The NEWS and PEWS system was used for identifying and escalating deteriorating patients. This system alerts nursing staff to escalate patients for review if routine vital signs were abnormal.
- Three of the eight children had no PEWS record: these included a baby who had no observations recorded.
- For an adult patient who fell at home, a falls risk assessment and falls' referral centre form were not completed which was not in line with trust policy.
- The sample of seven patient's records we looked at in the clinical decisions unit (CDU) demonstrated their admission to that unit via the ED was appropriate, although the CDU admissions' pathway forms were not always completed. We found four did not have a completed CDU pathway form on file.
- Records for these seven patients showed the admitting ED team had undertaken VTE assessments for only two out of these patients. The service used a venous thromboembolism and risk of bleeding assessment tool, which should be completed on admission and re-assessed within 24 hours of admission.
- Three out of five patients in a sample of seven for whom it would have been appropriate, had not been assessed and did not have completed records of assessment for the elderly screening of dementia. Two of those patients were known to have dementia or Alzheimer's disease.
- All seven of these patient's records showed emergency admission nursing notes that included Waterlow assessment which, gives an estimated risk for the development of a pressure sore in a patient.
- The ED used a 'Global Risk Assessment Tool' (GRAT) which had been introduced in May 2017 for patients waiting more than six hours in ED. Higher Care needs were escalated according to the level of risk for the patient. The ED care and comfort round chart had been adapted to incorporate the GRAT assessment into it so this aimed to ensure that the assessment was repeated as indicated and actions taken were recorded. In addition, the Waterlow skin care assessment score helped staff to identify those patients who are at high risk of pressure damage and would therefore need to be cared for on a hospital bed. Senior managers told us this assessment should be completed within four hours of arrival to ED. All staff were aware of the high risk conditions which would require a patient to be cared for on a hospital bed as opposed to a trolley.

Care of deteriorating paediatric patients

- At our inspection in November 2016, we found that there were a lack of policies and procedures in place to outline staff roles and responsibilities for the care of paediatric patients whilst in the emergency department. During our comprehensive inspection, paediatric patients within the emergency department were left for periods of time with no staff available in the paediatric area.
- The trust provided us with the assurances that there were now five registered nurses RN (Child Branch and 12 with Enhanced Paediatric Assessment Skills). Staff in the emergency department could also get additional support from children's ward nurses.
- On this inspection, we found a risk of deterioration of children or young person was entered on the emergency medicine risk action summary report in February 2017

and rated as 'low', for review in May 2017. The trust emergency medicine risk action summary report also identified a 'moderate' rated risk, entered in February 2017 with a review date of May 2017, 'PEWS escalation trigger is 3, NEWS trigger is 5 therefore there was a risk of staff in non-paediatric areas delaying escalation'.

- The children's ED suite was not consistently attended by staff except via CCTV surveillance to the nurses/doctors' station in the major's area. A junior sister, who came into the suite while we were there and no patients were present, told us a nurse was always allocated to work in the paediatric suite. As the suite was quiet over both days of our visit we could not assess the effectiveness of the 'allocated' staffing arrangement. However, a parent of one four year old patient in the paediatric suite told us 'they just leave you…' We noted from the one patient's records that they were triaged within 13 minutes of arrival; their observations were done within 12 minutes of triage but not again for 1hr and 50 minutes. The child had presented after a fall and bang on the head and neurological observations were not undertaken for over four hours: not on arrival or when the parent later reported, by a second adult present using the alarm in the paediatric suite waiting area (the parent could not reach it), that the child was pyrexical, still and floppy. The parent told us it still took 15 minutes for staff to respond. This meant there was a risk that deteriorating children were not being effectively monitored by staff.

Mental health assessment room

- At our inspection in November 2016, we found that there was not an appropriate mental health room in the ED to care for patients presenting with mental health conditions. There was a room that complied with some of the national guidance but furniture was not secured, there were ligature points and exits were not clear from obstacles. Patients were not cared for in this room and they were rotated in and out. Patients with mental health conditions (both adults/paediatrics) were cared for in the main ED with other patients. Risk assessments were carried out on all patients presenting with mental health conditions, however even if high risk this did not change where the patient was cared for. We observed one paediatric patient who presented with a mental health condition being cared for within the paediatric waiting area, and another patient who presented with mental health problems being cared for in the corridor. This practice had not been risk assessed and there were no plans in place to change it. The lack of an appropriate mental health room to care for patients was not on the divisional or corporate risk register.
- The trust provided us with the assurances that the ED was an adult and paediatric emergency department. Children and young people who presented with mental health issues were risk assessed and accommodated where it was safest for the young person in terms of visibility, ligature assessment, collapsible bed rails and privacy and dignity. The paediatric environment was cubicle-based and a nurse who was competent in assessing was always on duty in the ED children area. Ideally, the young person should be assessed by psychiatric services and a care plan agreed. If this could not be achieved and the young person was to be transferred to the paediatric inpatient facility, a single room, which was ligature free and risk assessed was made available.
- On this inspection, staff told us the mental health designated room was used for interviewing patients only and not for caring for them. The room had two exit doors and contained three chairs, a coffee table and had air conditioning. There were alarm buttons on the wall for the interviewer to summon assistance. We noted on the emergency medicine risk action report the only remaining ligature point at February 2017 was an air conditioning duct and this was rated as 'low' risk to be reviewed in July 2017.
- The matron told us a number of stakeholders and external bodies had made recommendations about the room and changes had been made but the position remained patients who needed 'high visibility' (in case their condition deteriorated) were cared for where staff could easily keep them under observation. A clinical lead doctor on duty told us patients were not left alone in the mental health assessment room and the mental health team were happy about interviewing patients in this room. After 10pm, the crisis assessment and section 136 suite (place of safety) managed by the crisis team situated very near the ED was used. The suitability of the mental health room within ED to meet national guidance had still not been addressed.
- On day two of our visit, we followed the care pathway of one young adult patient we had noted arriving by ambulance the day before, and who seemed to present with mental health issues and challenging behaviour. We noted from their records that they were cared for in a

'high care' cubicle, had seen a consultant within 35 minutes of arrival, the medical team six hours after arrival and discharged from the high care area to the Acute Medical Unit over 10 hours after arrival with a plan that included a mental health review.

Nursing staffing

- At our inspection in November 2016 we found that the clinical decision unit (CDU) was staffed by one registered nurse (RN) and one health care assistant (HCA) per shift. When the RN went on a break, the area was covered by only the HCA. This left one HCA caring for eight patients. Staff told us this was a regular occurrence.
- On this inspection, we found that the CDU had between seven to eight patients at all times and there was one nurse and one HCA on duty. Staff told us that all staff breaks were covered by another RN.
- A registered children's nurse was allocated to the paediatric area 24 hours a day. If they were not available, a registered nurse with enhanced Paediatric skills would be available. The ED had six qualified paediatric nurses with an additional two nurses due to start in September 2017. There were also 22 registered nurses in the adult ED who had completed additional paediatric training and were European Paediatric Life Support (EPLS) trained. Should there not be a paediatric nurse available to cover a shift, there is a RGN with EPLS and enhanced paediatric training who will be allocated to cover the area. We saw the planned rotas and that the ED had a weekly shift allocation sheet, which showed all paediatric nurses and EPLS trained nurses to ensure the relevant staff were allocated to that area.

Medical staffing

- At our inspection in November 2016, we found that the ED had 3.7 whole time equivalent (WTE) full-time consultants, with one additional locum consultant. The trust provided us with the assurances in January 2017 that it was actively recruiting for substantive consultants replace the locums being used in the ED, however this risk remained.
- On this inspection, we found that this risk remained active on the ED's risk register. The number of substantive WTE consultants in the ED was 5.7 WTE. The trust had agreed that the consultant establishment at WRH was 8 WTE. The recruitment process to appoint up to the establishment of 8 WTE was underway. A business plan was required to recruit a further two consultants which would achieve the goal of 10 WTE. The business plan was in development.
- During the week, an ED consultant was on duty covering 9am to 7pm followed by locum consultant cover until 12pm. This achieved consultant cover of 15 hours per day, slightly below the Royal College of Emergency Medicine's emergency medicine recommendations to provide consultant presence in all EDs for 16 hours a day, seven days a week as a minimum. Staff told us this level was maintained over weekends also. We requested the ED consultant rota but this was not provided: the trust informed us that, during the week, ED consultants worked 9am to 7pm, and were on call for one week in five on the rota. An additional locum consultant worked 4pm to 12 midnight.
- The trust told us that, at weekends, a one in eight week rota was in place with ED consultants working 9am to 5pm ED, being on call for the remaining time. An additional locum consultant worked 4pm to 12 midnight.
- We observed a board round with the ED consultant and nurse co-ordinators and noted every patient was discussed in depth with the junior doctors. A 'touch base' meeting was held at 8am, 1pm and 5pm. It was led by a consultant, with the sister in charge present. The touch base meeting was held in a small seminar room away from clinical area. They discussed the patients in the department in different areas that had been seen and also any issues with any patients and staffing. There was some clinical learning for the junior doctors as part of the meeting.
- The capacity hub meeting we attended at 9am reported the ED was one 'middle grade' doctor short that day but an extra consultant was placed in the medical assessment unit.

Major incident awareness and training

- We did not gather evidence for this as part of the inspection.

Urgent and emergency services

Are urgent and emergency services effective?
(for example, treatment is effective)

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found that:

- Pain relief given to children was not evaluated for its effectiveness for all patients.

Pain relief

- We noted paediatric patients had a pain score recorded on their notes. However, for two of the three patients for which it would have been appropriate, the analgesia given was not evaluated after 60 minutes.

Are urgent and emergency services caring?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found significant improvements had not been made in these areas:

- Staff were not using privacy screens to respect patients' privacy and dignity whilst being cared for in the ED corridor area.
- Patients were given meals in their hands by the staff but there was nowhere to rest plates and cups so they could eat their food with dignity.

However, we observed improvements for the following:

- Most staff were attentive, discrete as possible and considerate to patients.

Compassionate care

- At our inspection in November 2016, we found that patients were routinely cared for within the ED corridor. Trolleys in the corridor had no space between them and no screens were used to maintain privacy. Confidential conversations relating to patients clinical care could be heard by all patients, non-clinical staff and visitors. There was no privacy for assessments or handovers. We observed distressed patients in the corridor and also elderly patients with only thin blankets covering legs and a nightgown. Although privacy screens were available, staff informed us that if they were used other trolleys would not be able to pass due to the narrow corridor. We observed patients who were distressed and confused being cared for in this bright, noisy environment. Whilst a letter had been developed to provide patients with information regarding their care in the corridor, and call buzzers had been installed in the corridors for patient use, this did not mitigate the lack of consideration for their dignity and privacy.
- The trust provided us with assurances this issue was being addressed, but the documents provided after the inspection did not address the privacy and dignity issues involved in providing care in this corridor area.
- On this inspection, we found that adult patients were routinely cared for in the corridor of the department for long periods of time after decision to admit or awaiting therapist assessment for safe discharge. There was no space between the trollies and no screens around them. Staff did not use screens as a matter of course.
- We saw health care assistants undertaking comfort rounds, completing patient's documentation and giving patients a leaflet explaining why they were waiting in a corridor. Most staff were attentive, discrete as possible and considerate, for example fetching a dressing gown for a patient to help them to the toilet. We observed only one diversion from this when a staff member who approached the patient, completed their notes and hurried away again without speaking or giving eye contact.
- We noted patients were given meals in their hands by the staff but there was nowhere to rest plates and cups so they could eat their food with dignity.
- We observed three adult patients being cared for on trollies in the corridor at breakfast time. One had a cup of hot tea in one hand and a slice of toast with a pat of butter and knife on a plate in the other hand. However, they had no means of spreading the butter or eating the toast, with both hands full and no place to rest anything. The patient told us staff had offered no assistance.
- A second, elderly patient had water provided but it was out of their reach. They told us they did not mind as although staff had taken them out of the corridor to a 'short' cubicle within the ED when they pressed the buzzer for a bed pan: they were reluctant to drink and go through the process again.

- A third patient on a trolley in the corridor 'bolted' the meal they were given with their head ducked down to look inconspicuous to the steady stream of people passing by.

Understanding and involvement of patients and those close to them

- We did not gather evidence for this as part of the inspection.

Emotional support

- We did not gather evidence for this as part of the inspection.

Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found significant improvements had not been made in these areas:

- There was no effective plan in place to effectively manage the overcrowding in the ED. The ED's patient safety matrix showed critical or 'overwhelmed' for much of the two days we visited the trust. Patients were being cared for on trollies in the ED corridor had become an institutionalised means of managing the 'flow' through the ED, including on occasions when ED cubicles were empty.
- The number of patients waiting between four and twelve hours to be admitted or discharged was consistently higher than the national average.
- Adult patients were routinely cared for in the corridor of the department for long periods of time after decision to admit or awaiting therapist assessment for safe discharge. There was no space between the trollies and no screens around them. This happened including during periods when cubicles providing better privacy were vacant within the ED. Routine nursing observations, conversations about care and eating of meals were undertaken in a public space with other patients and relatives passing by.

We also found other areas of concern:

- There was no significant change in streaming for self-presenting patients with an operating model based on urgent care GP streaming.

However, we observed improvements for the following:

- There was a senior initial assessment nursing system in place for patients arriving by ambulance. Staff told us the flow had improved since two 'ambulance access' cubicles were specifically allocated in the department.
- There was a patient co-ordinator on duty at senior sister level responsible for managing the flow of patients. The ED matron reported two hourly the ED status to a capacity hub meeting that overviewed the situation across the trust throughout the day and night.
- Health care assistants were undertaking comfort rounds, completing documentation and giving patients a leaflet explaining why they were waiting in a corridor.

Service planning and delivery to meet the needs of local people

- We did not gather evidence for this as part of the inspection.

Meeting people's individual needs

- Adult patients were routinely cared for in the corridor of the department for long periods of time after decision to admit or awaiting therapist assessment for safe discharge. There was no space between the trollies and no screens around them. Patients who had been assessed in the senior initial assessment nursing (SIAN) area were positioned in another queue alongside the nurse's desk when they needed to wait for a cubicle in the major's area. SIAN was a streaming process for patients arriving by ambulance, being led by senior nurses.
- We saw this consistently over two days of our visit and heard staff speak about it as part of a natural process within the department. This meant routine nursing observations, conversations about care and eating of meals were undertaken in a public space with other patients and relatives passing by to the X ray area. We saw patients with their faces turned to the wall including a young adult patient with a blanket covering her face. Their relative told us the blanket was to protect their eyes from the light in the corridor ceiling right above them so they could sleep. We saw a patient rapidly eating a meal and looking embarrassed.

- Health care assistants were undertaking comfort rounds, completing patient's documentation and giving patients a leaflet explaining why they were waiting in a corridor.

Access and flow

- At our inspection in November 2016, we found patients were cared for in corridors in the ED for extended periods of time (during inspection some over 22 hours) due to lack of flow out of the department. Trolleys in the corridor had no space between them.
- The trust provided us with assurances that a 'Full Capacity Protocol' had been implemented daily from 19 December 2016 to 2 January 2017. The trust outlined additional actions it had taken to manage the overcrowding issues in the ED including implementing a capacity command, control and co-ordination hub in order to have a robust overview of trust capacity issues and to manage daily objectives and actions. The trust reported it had also created a number of 'medical hot clinics' so patients were not reviewed in the ED and a trust operational daily dashboard to allow the executive team to monitor the capacity across the trust. A 'daily situation/operational representatives' proforma that allowed all the executive team to monitor all operational key performance indicators (KPIs) including current bed capacity, number of breaches, escalation level and staffing hotspots had been put in place and was to be used from 17 January 2017. This was to include measurement of patients being nursed on the corridor in ED, awaiting cubicle allocation. In addition to the daily ward round cover, a full range of specialty hot clinics were reported to be in place by that time and an agreed approach to ensuring and monitoring consultant level specialty review in the ED within 60 minutes of a patient arriving. The trust told us that one registered nurse (RN) and a health care assistant (HCA) were allocated to the SIAN area which allowed care to be provided for a maximum of eight patients. Additional resources were re-allocated from the minor's area during times of high pressure. The trust also reported an additional two RN's were allocated to the corridor area which allowed for care to be provided for a maximum of eight patients and a safety and comfort checklist was put in place for patients placed in a corridor.
- On this inspection, we found that patients were being cared for on trollies in the corridor waiting admission to wards or therapist input for safe discharge. Patients were also being cared for in the corridor beyond the SIAN area whilst awaiting a cubicle in the major area of the ED. There was a patient co-ordinator on duty at senior sister level responsible for managing the flow of patients. The patient safety matrix showed critical or 'overwhelmed'/level three escalation for much of the two days we visited. This situation was confirmed in 'priority' discussions at the capacity hub meetings in place and that we attended at 9am and 12noon on 12 April 2017. The ED matron reported to the capacity hub meeting from the two hourly ED review at 12 noon that the situation was 'under control', the 'overwhelmed' status had triggered because of the number and length of time patients were waiting in the 'reverse queue ' in the corridor.
- Data showed in December 2017 and January 2017 almost 60% of ambulance crew waited for more than 30 minutes after arrival to handover their patient to the ED staff. Data collected by the local NHS trust ambulance service showed in February 2017, that 118 patients waited for more than one hour to handed over to the ED staff at the and in March 2017, it was 52 patients.
- The percentage of patients who spent more than four hours from admission to transfer from the ED in December 2016 fell to 75% from the previous month and then rose slightly to 77% in January 2017, against an England average of approximately 86% for the same period.
- For December 2016 and January 2017, the number of patients waiting four to twelve hours from the decision to admit to admission was respectively 32% and 45% against the England average of 17% and 20% for the same period. The figures were 45% in February 2017 and 40% in March 2017.
- Between February 2016 and January 2017, trustwide data showed that 312 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in January 2017, when 167 patients waited more than 12 hours. This is part of a longer increasing trend covering November and December 2016, when 37 and 84 patients waited more than 12 hours respectively.
- Data sent to us by the trust showed for February 2017, 41% speciality medical attendance requests within the ED were responded to within the target time of 60

minutes, and in March 2017, this had increased slightly to 50%. The average waiting time to see a speciality doctor was two hours and eight minutes in February 2017 and two hours and one minute in March 2017.

- When we visited the ED unannounced on 11 April 2017 at 9.30am, we noted six patients had been waiting in the ED for admission/discharge in excess of four hours, of those three had waited in excess of 10 hours. Seven out of ten patients waiting at 8.30am were referrals for the medical care service and by 2.10pm, three of those remained waiting. When we completed our visit at 3pm on 12 April 2017, the matron told us she had 20 patients awaiting admission to medical, surgical or ears nose and throat wards.
- We noted over both days of our inspection that patients were being cared for on trollies in the corridor, including at times when there were free cubicles within the ED major's area and empty treatment rooms within the minors' area. For example, at 10.0am on 12 April 2017, five examination rooms in the minor's area were empty and there were only two people waiting in the main ED reception area. No patients were waiting in the corridor in the SIAN area, there was one patient in an ambulance triage cubicle and one cubicle free in 'high care'. However, there were still three patients being cared for on trollies in the corridor in the 'reverse queue'.
- Adult patients were routinely cared for in the corridor of the department for long periods of time after decision to admit or awaiting therapist assessment. For example, we spoke with one patient who told us at 2.30pm they were being taken to the medical assessment unit (MAU) by a porter: they said they had been in the corridor queue since 4am that morning.
- We saw the 'reverse queuing' in operation consistently over two days of our visit and heard staff speak about it as part of a natural process within the department. They were proactive in getting patients out into the corridor area as a progress in flow. So entrenched was this within the ED's culture, even the weekly divisional safety and risk review meeting minutes refer to 'patients being admitted to the corridor'. The paper patient's records filing system had seven slots labelled for 'corridor patients'.
- ED staff told us the flow had improved since two ambulance access cubicles were specifically allocated in the department. However, we noted at times during our two day inspection visit that patients were queuing on trollies in the corridor after undergoing their SIAN process led by senior sisters. At one point in the middle of the afternoon, we saw five patients in this position.
- There was no consultant-led senior initial assessment team in place to stream patients to the appropriate point of delivery focusing on maximising flow to non-emergency department assessment units and/ or the minors unit. There was no significant change in streaming for self-presenting patients with an operating model based on urgent care GP streaming.

Learning from complaints and concerns

- We did not gather evidence for this as part of the inspection.

Are urgent and emergency services well-led?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found significant improvements had not been made in these areas:

- Actions already identified by the trust as necessary to mitigate patient care being compromised from overcrowding in the ED were either yet to be implemented or were not effective in reducing the risk.
- There was no tangible improvement in performance, caring for patients in the corridors had become institutionalised and we found patient's privacy, dignity and effective care remained compromised.
- The trust senior leaders were not effectively addressing these risks through a whole hospital approach.
- The ED safety and capacity matrix data was not regularly reported to the trust Board and collection of this data was having little impact on how the risks were being managed by the trust's senior managers.

However, we observed improvements for the following:

- The ED was managed locally by the matron and senior ED consultant. Staff were very committed to their work and doing the best they could for their patients even under regular and consistent heavy pressure.

- The trust had put in place an electronic safety and capacity matrix that reported data about the ED flow in real time: this enabled the executive team to have a clear line of sight to the risks at any and all times.
- The trust had implemented a 'Full Capacity Protocol' that was activated when the emergency department safety matrix status showed critical or overwhelmed status.

Leadership of service

- Leadership within the ED was not effective. The ED was managed overall by the medicine directorate. The directorate was led by a divisional medical director, a divisional director of operations and a divisional director of nursing. Leaders in the service and at trust level had not driven improvements in the service at the pace required to address the risks we identified at the last inspection. Senior leaders were not effectively addressing these risks to patient safety.
- The ED was managed locally by the matron and senior ED consultant. Staff were very committed to their work and doing the best they could for their patients even under regular and consistent heavy pressures.

Vision and strategy for this service

- We did not gather evidence for this as part of the inspection in the department.

Governance, risk management and quality measurement

- On our inspection in November 2016, we noted in the board assurance framework (BAF) risk report provided for that month (risk number 2790) had a risk rated as 'high' which stated "as a result of high occupancy levels, patient care may be compromised". This had been on the trust risk register since 2 February 2015. The impact was detailed as 'overcrowding in ED, increased quality and safety risk due to suboptimal location of patients, multiple transfers between wards/departments/sites, lack of privacy and dignity for patients, and increased length of stay'. Actions to reduce this risk included improving patient flow by increasing ambulatory care provision, redesigning the bed model in the service, and improving the discharge processes. The expected completion of these actions was 31 December 2016.
- We found that these actions were either yet to be implemented or were not effective in reducing the risk as the data reported nationally and provided by the trust demonstrated there was subsequently no tangible improvement in performance.
- The trust further assured us in December 2016 that "we are concerned about the need to place patients in the corridor and recognise that this does not provide the privacy and dignity our patients deserve". Actions proposed by the trust to improve the situation included 'reverse queuing, 'halo staff' and care and comfort rounds'. However, all of these strategies were in place during our November 2016 inspection and patients' privacy and dignity remained compromised despite these actions.
- At this inspection, we found the situation had not significantly improved in that patients were still being cared for in the corridor, patients' privacy, dignity and in some cases effective care, remained compromised and this practice had become institutionalised within the flow management arrangement.
- On 27 April 2017, the trust electronic safety matrix report sent to us showed in real time, that the number of patients on trollies at any one time in the 24 period ranged from 16 to 30. At the time of peak of pressure between 7pm and 8pm, there were 58 patients in the ED (excluding the clinical decisions unit): 33 of these were on trollies and 14 were waiting for beds in the hospital. This use of this safety matrix had only recently started and as it was not yet fully embedded, there was not yet a clear oversight of all safety and quality concerns in the ED.
- We asked the trust to send us the current emergency medicine risk register. We noted there were four 'high' (red rated) risks on this directly related to patient flow through the department but no corresponding identification of these risks on the risk register for the medicine division. This suggested the 'overwhelmed' ED, patients being cared for in corridors, long waits to see a speciality doctor and long waits for admission to medical wards were being managed by the trust senior leaders as the risk for only the emergency medicine division and not the whole hospital system.
- The trust had a 'Full Capacity Protocol' that could be activated between 7am and 5pm. We noted during our inspection visit that the matron went from the two hourly ED review to a capacity hub meeting when the emergency department safety matrix status was

showing critical or overwhelmed. The capacity hub meetings had representation from all divisions present including surgical and medical specialities. These meetings overviewed the situation across the trust at 9am, 12 noon, 4pm, 6pm and one overnight with the potential to escalate to the local clinical care group's (CCG) on call director when the ED capacity level reached level four.

- Risk managers told us they had 'requested that a specific report on ED crowding and the safety matrix was made available to the trust board every month; however, this has not been done and the service has not progressed it either.'

Culture within the service

- We did not gather evidence for this as part of the inspection.

Public engagement

- We did not gather evidence for this as part of the inspection.

Staff engagement

- We did not gather evidence for this as part of the inspection.

Innovation, improvement and sustainability

- We did not gather evidence for this as part of the inspection.

Medical care (including older people's care)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Worcestershire Royal Hospital (WRH) is part of Worcestershire Acute Hospitals NHS Trust. This main hospital was opened in 2002 and built under the private finance initiative (PFI) and opened in 2002. The Worcestershire oncology centre opened in January 2015, providing radiotherapy services for patients with cancer, the first time these services have been available in the county.

The medical care service at WRH provides care and treatment for cardiology, clinical haematology, clinical oncology, gastroenterology, general medicine, geriatric medicine, infectious diseases, medical oncology, respiratory medicine, and stroke medicine. There are 211 medical inpatient beds and no day-case beds located across the acute stroke unit, Evergreen 1 and 2, Avon 2, Avon 3, Avon 4, Avon discharge, cardiac catheter laboratory, Laurel 1 cardiology – cardiac care unit (CCU), Laurel 2, Laurel-haematology unit, medical assessment unit (MAU), medical high care & short stay, radiotherapy (oncology) centre, Rowan suite and Silver unit.

In November 2016, the Care Quality Commission (CQC) inspected the medical care service at WRH and found it inadequate for safe and well led, requires improvement for effective and responsive, and good in caring. The service was rated overall as inadequate. We carried out a focused inspection on the 11 and 12 April 2017 to follow concerns identified during our previous inspection in November 2016.

During this inspection, we visited Avon 2 and Avon 3 wards, Evergreen 1 and 2 wards, the haematology ward, the acute stroke unit, the medical assessment unit (MAU), the discharge lounge and visited non-medical speciality wards which cared for medical outliers (medical patients). We spoke with twelve patients and their relatives, spoke with 15 staff and looked at 34 patient records.

Medical care (including older people's care)

Summary of findings

We carried out a focused inspection to review the concerns found during our previous comprehensive inspection in November 2016. We inspected elements of four of the five key questions but did not rate them. We found significant improvements had not been made in these areas:

- Venous thromboembolism (VTE) assessments and 24-hour reassessments were not always carried out for all patients in line with trust and national guidance.
- We observed that most staff did not generally wash their hands before and after patient contact on the acute stroke unit, Avon 2 ward and the medical assessment unit (MAU) in line with national guidance.

We also found other areas of concern in this inspection :

- We observed staff handling food on the haematology ward with their hands without the use of gloves which was not in line with national and trust guidelines.
- We found that the recording of patients' weights on drug charts had not improved.
- Patients declining to take prescribed medication on medical care wards were not always referred to medical staff for a review and were not always reviewed by medical staff.
- Only 31% of staff were up-to-date on medicines' management training and this was below the trust target of 90%.
- Patient records were left unsecured on a number of wards we visited and there was a risk that personal information was available to members of the public. This was raised as a concern during the last inspection in November 2016.
- Some risk assessment templates were not routinely completed in their entirety, including elderly patient risk assessments and sepsis bundle assessments. We were not assured that inpatient wards were effectively following the trust's sepsis pathway when required.
- Staff compliance with Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training was 45%, which was below the trust target of 90%.
- The medical service leadership team had not addressed all concerns and risks identified as areas for improvement in our last inspection.

However, we observed improvements for the following:

- During this inspection, all 21 records looked at showed NEWS charts were completed fully and patients were escalated for medical review appropriately when required.
- There had been improvements in the monitoring of medicines' fridge temperatures.
- The service had taken steps to ensure that patient hydration was recorded accurately. This was raised as an issue during our last inspection.
- The service had taken steps to improve the management of medical patients on non-medical speciality wards.
- The service had improved patient flow in the hospital to minimise patient moves.
- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard (SQuID). This was being used as to drive improvement and had improved staff's understanding of safety and quality in the service.

Medical care (including older people's care)

Are medical care services safe?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found significant improvements had not been made in these areas:

- Venous thromboembolism (VTE) assessments and 24-hour reassessments were not always carried out for all patients in line with trust and national guidance.
- We observed that most staff did not generally wash their hands before and after patient contact on the acute stroke unit, Avon 2 ward and the medical assessment unit (MAU) in line with national guidance.
- Patients declining to take prescribed medication on medical care wards were not always referred to medical staff for a review and were not always reviewed by medical staff.

We also found other areas of concern:

- We observed staff handling food on the haematology ward with their hands without the use of gloves, which was not in line with national and trust guidelines.
- Only 31% of staff were up-to-date on medicines' management training and this was below the trust target of 90%.
- We found that the recording of patients' weights on drug charts had not improved since the last inspection.
- The service had not taken measures to ensure the safety of patient information and records. For example, patient notes were insecurely stored on unlocked trolleys, and ward white boards containing patient confidential details were on display and visible to staff and visitors.
- Some risk assessment templates were not routinely completed in their entirety, including elderly patient risk assessments and sepsis bundle assessments. We were not assured that inpatient wards were effectively following the trust's sepsis pathway when required.

However, we found improvements in some areas:

- During this inspection, all 21 records looked at showed NEWS charts were completed fully and patients were escalated for medical review appropriately when required.
- There had been improvements in the monitoring of medicines' fridge temperatures.

Incidents

- We did not gather evidence for this as part of the inspection.

Safety thermometer

- We did not gather evidence for this as part of the inspection.

Cleanliness, infection control and hygiene

- During our inspection in November 2016, we saw poor adherence to infection prevention and control practices with doctors not 'arms bare below the elbow', a lack of hand washing and incorrect use of personal protective equipment by staff. In response to this concern, the trust told us a task and finish implementation plan had been developed. Key themes from the plan included refreshing the trust's hand hygiene campaign to raise the focus, re-energising hand hygiene audits and ensuring staff were 'arms bare below the elbows'.
- During this inspection, we observed that staff did not generally wash their hands before and after patient contact on the acute stroke unit, Avon 2 and the medical assessment unit (MAU) in line with the World Health Organisations (WHO) "Guidelines on Hand Hygiene in Health Care' (2009). Although the service had implemented processes to address the poor adherence to infection prevention and control practices, concerns remained regarding poor infection prevention and control practices. Hand hygiene audit results by ward for medical wards at WRH were requested, but the trust did not provide these.
- We observed some nursing staff not adhering to the Food Safety Act 1990 and the Food Hygiene (England) Regulations 2006 (Temperature Control Schedule 4- EU Regulation No.852/2004). For example, we observed staff handling food on the haematology ward with their hands without the use of gloves. Food Hygiene Regulation 2006 guidelines stipulate that foods must always be handled using serving tongs. The trust's food and fluid hygiene policy 2015 wholly accepts legal duty to comply with the Food and Safety Act 1990 and states that staff should clean their hands and disposable gloves should be worn before serving patients' meals.
- All staff adhered to the "arms bare below the elbows" policy in the clinical areas we visited. Staff were observed wearing personal protective equipment, such as gloves and aprons while delivering care.

- Adequate hand washing facilities and hand gel were available for use at the entrance to the ward areas, within the wards, at the entrance to bays and side rooms.
- There was prominent signage reminding people of the importance of hand washing at the entrances to wards and within the toilet and bathroom areas.
- The haematology ward had protective isolation precaution signs in place to ensure patient safety from infection and staff followed infection control procedures as per trust policy.

Environment and equipment

- We did not gather evidence for this as part of the inspection.

Medicines

- During the last inspection in November 2016, we found that fridge temperatures were either below or above the recommended fridge temperature (between 2°C and 8°C) on the acute stroke unit and on Avon 3 ward. During this inspection, we saw that the fridge on the acute stroke unit had been replaced. The fridge temperature was monitored daily and remained between 2°C and 8°C.
- We also saw on Evergreen 1 ward that the temperature of the medicine refrigerator was not recorded daily. Over 24 days we checked, only 12 days temperature records were documented which were within the safe range of 2 to 8°C. It was therefore not possible to determine if medicines were always stored at the correct temperature. During this inspection, there had been an improvement. We saw that the drug fridge temperature was not checked on two out of 31 days in March and on four out of 12 days in April 2017. The fridge temperature was within the manufacturer's recommended range on the days checked. Senior staff said they would continue to closely monitor fridge temperatures as per guidance.
- Doctors did not always review drug charts to ensure patients were either taking their medication as prescribed or declining to take them. For example, we saw on Evergreen 1 ward and Beech ward that two patients had been declining antibiotics for eight days and anticoagulant (blood thinning) medication for seven days and this had not been escalated and reviewed by a doctor at the time of our inspection. This was not in line with the National Institute for Health and Care Excellence (NICE) 'Medicines Optimisation Guidance' (2015). This was raised as a concern to medical staff at the time of our inspection who too action to address this.
- During our inspection in November 2016, we identified concerns with recording of patient weights on drug charts. We raised this with senior staff following our inspection. On this inspection, we found that the recording of patients' weights had not improved. We reviewed 21 drug charts and found that patient weights were not recorded on 13 out 21 of them on acute stroke unit (ASU), Beech ward, Avon wards 2 and 3 and Evergreen wards1 and 2. Recording a patient's weight is important as it is often used to calculate the appropriate individual medicine dosage. We raised this with medical staff on duty during our inspection who acknowledged recording of patient weights was a concern.
- During this inspection, figures provided by the trust showed that only 31% of staff were up-to-date on the medicines' management training, below the trust target of 90%. This meant that not all staff had up-to-date knowledge relating to potential risks associated with medicines. The trust responded that this had been raised as a concern to be addressed and we saw there was an action plan in place to address this.
- The discharge lounge (medical day case unit) was used as an escalation area for patients who required overnight stay due to lack of beds on medical wards. It did not have facilities to store controlled drugs (CDs) for patients staying overnight. Staff had to collect CDs from a nearby ward.
- If patients were allergic to any medicines, this was recorded on their drug chart. Of the 21 drug charts we looked at we found that allergies had been recorded on all charts.
- All prescription charts were signed and dated appropriately and there were no missed doses in the drug charts we looked at.
- The temperatures in the treatment rooms were recorded daily and were within the recommended storage temperature for medicines stored in an ambient environment of 25°C.

Records

- Following the inspection in November 2016, feedback was given to senior managers about safe storage of patients' records and patient identifiable information being shared on ward boards. The hospital was asked to

improve the safe storage of patient records and address patient identifiable information being shared on ward boards. During this inspection, we saw the trust had not taken steps to address issues identified in the November 2016 inspection.

- Notes such as risk assessments and observation charts were by the patient's bedside while medical notes were stored in lockable trolleys at either the nurse's station or the entrance to bays. However, we found that these trolleys were left unlocked in some medical wards (acute stroke unit, Evergreen ward, Avon 2 and Avon 3 wards) meaning that patient confidential records were potentially accessible to unauthorised individuals.
- White electronic boards were used to display patient name and location on the wards, which included some care and treatment information. On most wards, these were visible to staff and visitors, therefore we were not assured that patient confidentiality was maintained.
- Patients had paper care records and drug charts. We saw that all records were legible. However, there were limited details relating to the dates and signatures of medical staff who completed the risk assessments. This does not comply with guidance from the General Medical Council ('Keeping records' 2013) guidance on maintaining contemporaneous patient records.
- The prescribing doctor's signature and bleep number was not recorded on eight out of 21 drug charts reviewed.

Safeguarding

- We did not gather evidence for this as part of the inspection.

Mandatory training

- We did not gather evidence for this as part of the inspection.

Assessing and responding to patient risk

- The National Early Warning Score (NEWS) system was used for identifying and escalating deteriorating patients. This system alerted nursing staff to escalate patients for review if routine vital signs were abnormal. During our inspection in November 2016, we identified concerns with escalating NEWS for deteriorating patients. In response to the warning notice, the trust had introduced staff competencies relating to accurate NEWS scoring and escalation across clinical areas. NEWS training has been included in the mandatory training and training compliance for registered nurses was 91%.
- During this inspection, all records looked at showed NEWS charts were completed fully and patients were escalated for medical review appropriately when required. We looked at 21 sets of patient's records on the acute stroke unit, Avon 3, Evergreen 1 and 2 wards and found NEWS assessment scores and rounding charts were fully completed and up-to-date.
- However, the trust was monitoring NEWS escalation scores and their own data showed that only 50% of patients with a NEWS score above five were referred for a medical review. This remained the same as last inspection with no improvement identified despite the introduction of a quality improvement plan. This meant there was a continuing risk of deteriorating patients not being appropriately referred and seen by the medical team.
- During our inspection in November 2016, we identified concerns with carrying out venous thromboembolism (VTE) assessments on admission and reassessment within 24 hours. The service used a venous thromboembolism and risk of bleeding assessment tool, which should be completed on admission and re-assessed within 24 hours of admission.
- In response to our concerns raised at the last inspection, the trust told us it had established a VTE rapid improvement working group. Actions from the group included, a proposed new VTE assessment form, further education for medical staff, training for ward administrators on data input and regular audits and feedback to senior managers. During this inspection, we saw that the service did not always follow the National Institute for Health and Care Excellence (NICE) (QS3 Statement 4) 'Reducing VTE risk in hospital patients' guidelines on all wards. For example, no initial VTE assessments were carried out on 7 out of 21 records on the acute stroke unit (ASU), Evergreen 1 and Avon 3 ward. In addition, it was difficult to establish if any patients had been reassessed within 24 hours of admission. This meant we could not be assured that patients had received the relevant assessment to manage their care and patients risk of thrombosis (blood clot) or risk of bleeding could not be determined. The service had not taken appropriate steps to address concerns identified in the previous inspection.

Medical care (including older people's care)

- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard (SQuID). The dashboard was developed to include performance indicators specific to the service. Data from the SQuiD showed that from January 2017 to March 2017, VTE assessment rates for the medicine division (across Worcestershire Acute Hospital, Alexandra Hospital and Kidderminster Hospital and Treatment Centre) was 89% which was below the trust target of 100%.
- We found that some risk assessment templates were not routinely completed in their entirety, including elderly patient risk assessments and sepsis bundle assessments. We saw that some templates were left blank and did not include any patient assessment details. When risk assessments were completed, there were consistently no dates or signatures to indicate when they were completed (in seven out of 21 records seen).
- The trust had implemented the 'Guidelines for the management of Sepsis and Septic Shock in Adults',inpatient ward and EDsuspected sepsis screening toolsand inpatient ward and ED sepsis patient pathways in September 2016. These were available on the trust treatment pathways intranet site. The trust was in the process of data collection for quarter one (April to June 2017) for the 2017/18 Sepsis Commissioning for Quality and Innovation (CQUIN) and therefore did have data available to evidence compliance from April2017 at the time of the inspection.
- The trust provided data from inpatient wards that showed the percentage of adult patients who presented with severe sepsis, 'Red Flag' Sepsis or septic shock to the ED and were administered intravenous antibiotics within one hour of presentation and had an antibiotics review carried out by a competent decision maker by day three of them being prescribed was 15% in November 2016, and 33% in December 2016.

Nursing staffing

- We did not gather evidence for this as part of the inspection.

Medical staffing

- We did not gather evidence for this as part of the inspection.

Major incident awareness and training

- We did not gather evidence for this as part of the inspection.

Are medical care services effective?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected elements of this key question but did not rate it. We found that:

- Fluid balance charts were mostly fully completed and this was an improvement from our last inspection.

However, we also found that:

- Staff compliance with Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training was 45%, which was below the trust target of 90%.

Nutrition and hydration

- Staff used fluid balance charts to monitor patients' fluid intake. During our last inspection in November 2016, the fluid input and output was not totaled in seven out of 13 fluid balance charts we checked. This meant that accurate hydration status of patients could not be easily measured. During this inspection, we saw this had been totaled and was accurate in 15 out of 17 records seen.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- During the November 2016 inspection, we found that 41% of staff across the medical service had completed their Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. During this inspection, we saw that 45% of staff had completed the MCA/DoLS training and this was below the trust target of 90%.
- Staff understood their responsibilities in relation to gaining consent from patients, including those who lacked mental capacity to consent to their care and treatment. Staff said they would seek advice from a senior member of staff should a formal assessment of mental capacity require completing.

Are medical care services caring?

We have not rated the service for caring. As this was a focused inspection, we did not inspect all elements of this key question.

Medical care (including older people's care)

Compassionate care

- Interactions between staff and patients were caring and compassionate.
- We observed staff respecting the privacy and dignity of patients during our inspection.

Are medical care services responsive?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected elements of this key question but did not rate it. We found that:

- The service had taken steps to improve the management of medical patients on non-medical specialty wards.
- The service had improved patient flow in the hospital to minimise patient moves.

Access and flow

- The service had improved patient flow in the hospital to minimise patient moves. There were 918 medical patient moves at night from 10pm to 6am from January to April 2017, with an average move of 229 per month. This was a significant drop from 3,293 moves across all medical wards with average bed moves of 411 (13%) per month identified during our last inspection in November 2016.
- The trust was not collecting separate data for the number of bed moves due to clinical reasons and non-clinical reasons (for example, to alleviate bed capacity issues) but was planning to do so.
- The discharge lounge (medical day case unit) was used as an escalation area for patients who required overnight stay due to a lack of beds on medical wards at times of peak demand. Data provided by the trust showed that the discharge lounge was occupied overnight from January to March 2017 at different intervals by 29 medical patients. Standard operating procedures governing the use of escalation areas at WRH were requested, but were not provided by the trust.
- Our last inspection identified concerns with bed moves overnight. The trust had a patient transfer policy which stated that internal transfers between wards should occur between 7am and 9pm. Out of hours internal transfers should occur if clinically indicated. Information showing the reasons why these moves had taken place during the night was not available because the service was not recording reasons for bed moves. The service was monitoring the number of moves within the departments. During this inspection, data provided by the trust showed from January 2017 to April 2017, a total of 918 medical patients at the three hospitals were transferred to another ward from 10pm to 6am at night with an average bed move of 229 per month. This was an improvement from the last inspection.
- Medical patients on surgical wards were routinely reviewed by medical doctors. We saw evidence that where they were unwell and escalated to medical staff by nurses, they were reviewed in a timely manner. These patients were included as part of the medical consultant's ward rounds. Appropriate admission criteria for patients using these areas were in place. The Theatre Assessment Unit was not being used as an escalation area for medical patients at the time of this inspection.

Are medical care services well-led?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected elements of this key question but did not rate it. We found that:

- The medical service leadership team had not addressed all concerns and risks identified as areas for improvement in our last inspection.
- There was not effective oversight and management of risks in the service. Known risks had not yet been addressed.

However, we observed the following improvements had been made:

- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard (SQuID). This was being used as to drive improvement and had improved staff's understanding of safety and quality in the service.

Leadership of service

- Divisional medical directors, a director of operations, clinical directors, a divisional director of nursing,

medical governance lead and a quality governance lead led the medical care directorate. Nursing staff reported that clinical leads within specialities were visible and easily accessible.

- We found that the leaders had not always responded and acted upon known concerns. For example, during our last inspection in November 2016, we identified issues with lack of oversight for venous thromboembolism (VTE) assessment. During this inspection, we still found poor practice in these areas. This meant that there were still potential risks to the safety and quality of care and treatment of patients' care.

Vision and strategy for this service

- We did not gather evidence for this as part of the inspection

Governance, risk management and quality measurement

- During our last inspection, we identified issues with poor escalation of the national early warning scores (NEWS), poor assessment and reassessment of VTE after 24 hours and insufficient recording of patient weights on drug charts. The trust told us that audit processes for NEWS have been supplemented by weekly notes audits which also review NEWS compliance and had launched a web based assurance system to highlight performance around quality and safety. During this inspection, we still found poor practice in these areas. This meant that whilst some improvement had been made, overall, there was insufficient oversight and management of risk to patient safety.
- The last inspection highlighted concerns with inadequate storage of medicines and generally this had improved in some areas. For example, medication was stored in a fridge in the acute stroke unit where temperatures were either below or above manufacturers recommended fridge temperatures. During this inspection, we saw the fridge had been replaced and temperatures were recorded and up-to-date. However, on Evergreen ward 1, we saw that recording of fridge temperatures remained inconsistent.
- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard (SQuID). Staff we spoke with were aware of SQuID and demonstrated how to access the dashboard on the trust intranet. The dashboard was developed to include performance indicators specific to the service. This was used as a drive for improvement and had improved staff's understanding of safety and quality in the service. However, despite the introduction of this quality dashboard, some issues identified had shown no improvement and there was insufficient oversight and management of these risks. For example, there was lack of oversight VTE assessments, recording of patient weights on drug charts and inconsistent compliance with hand hygiene. This demonstrated that the service's governance system in relation to the management of VTE risk and hand hygiene did not operate effectively to ensure that senior leaders effectively managed the risk of harm to patients.
- The quality improvement plan for April 2017 identified that NEWS and VTE assessments had been added to the risk register.
- The trust had a divisional framework for governance arrangements in medical care services. During the last inspection, sharing of information was not established at ward level. During this inspection, this had improved in some areas and ward managers attended divisional meetings. There was evidence of ownership and improvement at ward level.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Surgery services provided by Worcestershire Acute Hospitals NHS trust are located on four hospital sites. Worcestershire Royal Hospital is the main site with Alexandra Hospital, Kidderminster Hospital and Treatment Centre and Evesham Community Hospital as additional sites. The trust provides services to a resident population of 550,000 people in Worcestershire.

Worcestershire Royal Hospital, Alexandra Hospital and Kidderminster Hospital and Treatment Centre were visited as part of the inspection process and each location has a separate report. Surgery services on all four hospital sites are run by one management team and are regarded by the trust as one service.

This report relates to surgery services provided at Worcestershire Royal Hospital. The service includes 131 surgical beds over five surgical wards, Beech A, Beech B1 and Beech B2 and Hazel ward plus a surgical clinical decisions unit (SCDU) and eight theatres to provide planned (elective), emergency and day case surgery. The SCDU has 13 beds which provide interim care for patients either referred by their GP or admitted via the emergency department, requiring an urgent surgical clinical assessment. There are nine theatres. Surgical service provision includes; general surgery, orthopaedics, trauma care, vascular surgery, breast surgery, ear, nose and throat (ENT) and oral and maxillofacial surgery and head and neck surgery.

From April 2015 to March 2016 there were 19,878 surgical admissions, with 50% day surgery, 20% elective spells and 30% emergency cases.

We carried this follow up focused inspection out because of concerns identified during our inspection of Worcestershire Acute Hospitals NHS Trust in November 2016. During that inspection, we found surgical services at the trust overall to be inadequate. At Worcestershire Royal Hospital surgical services were rated requires improvement.

We visited all surgical services as part of this focussed follow up inspection but we did not visit theatres. We spoke with 19 staff including, nurses, health care assistants, doctors and therapists. We spoke with 10 patients and reviewed 30 sets of patient notes.

Surgery

Summary of findings

We carried out this focused inspection and inspected parts of the five key questions but we did not rate them. This was a focused inspection to review concerns found during our previous comprehensive inspection in November 2016 and therefore we did not inspect every aspect of each key question. We found significant improvements had not been made in these areas:

- Venous thromboembolism risk assessments (VTE) and 24 hour reassessments were not completed in line with national guidance.
- Some staff did not clean their hands before or after patient contact and some staff wore personal protective equipment inappropriately.
- Fridge temperatures for the storage of medicines exceeded recommended ranges in two areas visited

We also found other areas of concern on this inspection :

- Some patients were prescribed inappropriate doses of anticoagulation medication without regard to their weight.
- Some wards did not display their planned staff on duty only their actual staff on duty.
- Visitors to wards could see patient identification details on electronic white boards.
- When risks had been escalated, there was a lack of follow up and resolution. Effective action following the reporting of high fridge temperatures for storage of medicines was not evident.
- Anticoagulation medications had not always been administered as prescribed.

However, we observed improvements for the following:

- All staff we saw in clinical areas had 'arms bare below elbows'.
- There were fewer reported staff shortages and shortfalls were escalated and risk assessed so patients' needs were met.
- The hospital had implemented a new quality dashboard. The dashboard provided monthly quality data for all wards and clinical areas.

Are surgery services safe?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found significant improvements had not been made in these areas:

- Venous thromboembolism risk assessments (VTE) and 24 hour reassessments were not completed in line with national guidance.
- Some staff did not clean their hands before or after patient contact and some staff wore personal protective equipment inappropriately.
- Fridge temperatures for the storage of medicines exceeded recommended ranges in two areas visited.

We also found other areas of concern on this inspection :

- Some patients were prescribed inappropriate doses of anticoagulation medication without regard to their weight.
- Anticoagulation medications had not always been administered as prescribed.
- Some wards did not display their planned staff on duty only their actual staff on duty.
- Visitors to wards could see patient identification details on electronic white boards.

However, we observed improvements for the following:

- All staff we saw in clinical areas had 'arms bare below elbows'.
- There were fewer reported staff shortages and shortfalls were escalated and risk assessed so patients' needs were met.
- Patients undergoing surgery had the correct consent form. Patients who lacked capacity had evidence of a mental capacity assessment being completed.

Incidents

- We did not gather evidence for this as part of the inspection.

Safety thermometer

- We did not gather evidence for this as part of the inspection.

Cleanliness, infection control and hygiene

Surgery

- During our inspection in November 2016, we reported some staff did not always follow the trust's infection prevention and control policy with regard to hand hygiene and the use of personal protective equipment (PPE). This remained the same during this inspection. We saw some staff failed to clean their hands prior to contact with patients and their environment. We also saw staff using PPE inappropriately. For example, a nurse took a patient's blood glucose measurement without cleaning their hands before or after the procedure. They also did not apply any gloves to take the blood sample. This was not in line with the trust's infection control guidance. We saw staff taking patient observations on different patients and writing in their end of bed folders without cleaning their hands in between. We raised this as a concern during the inspection.
- All staff we saw in clinical areas had 'arms bare below elbows'.
- Hand hygiene was brought to the attention of senior staff during our previous inspection in November 2016 and in January 2017 when we issued the trust with a warning notice to improve. The trust acknowledged it was not consistently meeting its own hand hygiene targets of 95% compliance and told us it had taken measures to improve. The trust provided us with an action plan to address this issue, which included further hand hygiene education and weekly audits, plus spot checks by the infection prevention team. We saw evidence that hand hygiene audits had been carried out. In surgery, the internal audits indicated that staff cleaned their hands 100% of the time.
- Hand hygiene training was carried out regularly. In trustwide data for surgical services, 87% of staff were up-to-date with their hand hygiene training which was slightly below the trust target of 90%.

Environment and equipment

- We did not gather evidence for this as part of the inspection.

Medicines

- During our inspection in November 2016, we found medicines that required refrigeration were usually kept at the correct temperature and that wards recorded fridge temperatures on most days. However, due to problems we identified with fridge temperature monitoring and recording at the trust's other surgical sites in November 2016, we issued the trust with a warning notice to improve. The trust acknowledged it did not have proper oversight of fridge temperature monitoring and it undertook several measures to improve. This included reviewing and assessing all medication fridges, staff training, introducing a new temperature recording chart and audits which would be reviewed by the trust's medicines optimisation group.
- During this inspection, temperatures were recorded on most days. However, two medication fridges out of four checked had recorded temperatures which exceeded the maximum of 8°C. For example, on Beech 1B ward, the fridge temperature exceeded this range for four consecutive days between 19 and 22 March 2017 and no action or escalation had been recorded. Additionally, on the same ward in January and February 2017, 15 days did not have a temperature recorded. The storage of medications outside manufactures recommended temperature ranges had not resulted in any reported incidents. Staff were not able to tell us what happened to the drugs in fridges where high temperatures had been reported. There was a lack of action taken to address this risk.
- Prescribed anticoagulation medication was not always recorded as being administered in line with the patient's prescription. We examined 30 drug charts and saw that 12 doses of anticoagulation medication had not been signed for. This affected six different patients and included one patient who had five missed doses between 30 March and 8 April 2017, three of which were recorded on sequential days without a valid reason code. In addition, a drug chart had a non-administration recorded at 6pm in the evening as 'patient away from ward', yet all other medication due at the same time had been recorded as given as had all of the 10pm medications. This means that although staff had the opportunity to administer the anticoagulation medicine, it had not been given.
- Some patients were prescribed anticoagulation medication without reference to a weight and therefore some patients may have received more or less medication than required. This did not follow the trust prescribing guidelines, which required dose related therapy at the extremes of body weight. We saw three drug charts that had changes to medicine dose recorded by pharmacy following initial prescribing by the medical team. From December 2016 to March 2017,

the service reported eight incidents of non-signed for anticoagulation therapy including two, which recorded minor harm to the patient as a result of missed medication.
- Prescribed doses of some anticoagulation medication had been changed on the drug charts without the prescription being crossed out and rewritten. It was unclear by who or when changes to the prescriptions had been made. It was unclear from the drug chart if any doses of medication had been administered at the incorrect dose.

Records

- During out last inspection, we found white electronic boards were used to display patient name and location on the wards, which included some care and treatment information. On most wards, these were visible to staff and visitors, therefore we were not assured that patient confidentiality was maintained. This was raised as a concern with senior staff during our previous inspection in November 2016. However, this remained the same during this inspection and the trust did not provide us with an update or an action plan regarding this.

Safeguarding

- We did not gather evidence for this as part of the inspection.

Mandatory training

- We did not gather evidence for this as part of the inspection.

Assessing and responding to patient risk

- The service was not always assessing and responding to risk in line with national guidance. We saw that the National Institute for Health and Care Excellence guidelines (NICE): 'venous thromboembolism: reducing the risk for patients in hospital' (2015) was not always being followed. This was raised with senior staff following our inspection in November 2016 and after, in January 2017 when we issued the trust with a warning notice to improve.
- In response to our concerns, the trust told us it had established a VTE rapid improvement working group. Recommendations from the group included, a proposed new VTE assessment form, further education for medical staff, training for ward administrators on data input and increased audit and feedback to senior managers. A review of funding was scheduled to recruit specialist VTE nursing staff. However, despite these measures, the issues remained. The service's own audit data showed a compliance of 92% for an initial VTE assessment. Reassessments within 24hours of admission were not audited.
- We reviewed 30 patient records across the surgical wards and found four patients that did not have a venous thromboembolism (VTE) risk assessment record. We also found three assessment charts that were left blank with no assessment boxes ticked other than a date and the doctors' initials. A further 11 VTE assessments had been undertaken more than 48 hours after the patient had been admitted. These patients had been commenced on anticoagulation therapy which had been administered without a documented assessment which meant some patients may have received medication which was unsuitable for them. The trust reported nine incidents relating to the administration of anticoagulation therapy.
- VTE reassessments following 24 hours of hospital admission were not carried out on patients in 29 out of 30 records reviewed. NICE guidance: 'Venous thromboembolism: reducing the risk for patients in hospital' (2015) recommends all patients are reassessed for VTE risk, 24 hours after admission.

Nursing staffing

- Nursing staff numbers, skill mix review and workforce indicators such as sickness and staff turnover were assessed using an electronic rostering tool. The surgical directorate used an acuity tool, dependency reviews, NICE guidelines and professional judgement to assess and plan staffing requirements.
- Vacancy rates in surgical services at Worcestershire Royal Hospital in March 2017 were 16%. This had increased from January 2017 when it was 9%. The nurse vacancy rate remained on the surgical risk register and actions to improve staffing which were reported to us during our November 2016 inspection to address this continued. This included the use of bank and agency staff and monthly reviews of recruitment. Since our last inspection, a new staffing application ('App') (an electronic tool which measured how many staff were on duty against how many should have been on duty) had been introduced. The App compared the number of planned nurses on duty with the number of actual nurses on duty and it help and staff to risk assess areas

identified as having staff shortages on a daily basis. The App also escalated staff shortages to senior managers responsible for the hospital and prompted incident reports where low staff numbers could put patients at risk.

- In March 2017, there were 744 unfilled nurse shifts and 339 unfilled healthcare assistant shifts in the surgical services at Worcestershire Royal Hospital. This is considerably worse than our last visit when the service reported that from May 2016 to October 2016, there were133 unfilled nurse shifts and 79 unfilled health care assistant shifts. Despite the number of unfilled shifts, and the new staffing App, the service reported no incidents due to staff shortages between January and March 2017.
- All wards displayed their actual staff numbers. However, the number of planned staff on duty each shift was not displayed on three of the six wards we visited. Staff on these wards were unaware of the reasons for this. Displaying both planned and actual staff is recommended to allow patients and visitors to identify when there are staff shortages and demonstrates greater transparency.
- During our visit, staff told us there were adequate staff on duty to meet the needs of the patients they were looking after. Wards that displayed both planned and actual staff numbers did have the appropriate number of nurses on duty most of the time. Any shortages identified had been put out to agency or the shift coordinator changed duty to work clinically and provide assistance with patient care.
- In March 2017, the sickness rate for registered nursing staff was 2%, which was lower than the trust target of 3.5% and lower than in January 2017 when it had been 7%. However, the average sickness rate for unregistered staff was 9% in March 2017 and 13% in January 2017.

Surgical staffing

- We did not gather evidence for this as part of the inspection.

Major incident awareness and training

- We did not gather evidence for this as part of the inspection.

Are surgery services effective?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found that:

- Patients undergoing surgery had the correct consent form. Patients who lacked capacity had evidence of a mental capacity assessment being completed.

However, we also found the following concerns:

- Less than 10% of nursing staff and 30% of medical staff had received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Some staff said they had received training in MCA and DoLS. All staff said they were aware of the requirement to attend training and that they had booked sessions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with understood consent, decision-making requirements, and guidance. There was an up to date consent policy for surgical treatment.
- The hospital had four nationally recognised consent forms in use and staff were able to describe the different uses for these. For example, staff described what would be required for patients who were unable to consent to surgery themselves.
- There was a trust policy to ensure staff were able to meet their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with were able to describe elements of the MCA and DoLS and understood their responsibilities for protecting patients. Some staff had not received training in MCA and DoLS but all were aware of their need to attend the training and some told us of training dates they had planned or booked.
- Patients who required a mental capacity assessment or a dementia screen received this in line with the trust policy. Dementia screens are simple tools which can help staff identify patients who may have dementia. Junior nursing staff told us they would contact senior nurses for help if they were required to make an application for a DoLS for patient.
- All patients we reviewed were consented for surgery using the correct form.

Surgery

- From April 2016 to March 2017, in surgery services at the hospital, 30% of medical staff and 10% of nursing staff had received training in Mental Capacity Act (MCA) and Deprivation of Liberty level one. This was significantly below the trust target of 90%.

Are surgery services caring?

We have not rated the service for caring. As this was a focused inspection, we did not inspect all elements of this key question.

Compassionate care

- Interactions between staff and patients were caring and compassionate.
- We observed staff respecting the privacy and dignity of patients during our inspection

Are surgery services responsive?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found that:

- The hospital had reconfigured its bed capacity, with some changed to medical care beds, which meant there were less beds available for surgical patients.

Access and flow

- During our inspection in November 2016, there was a high demand for medical beds and this affected surgical bed capacity and resulted in cancelled operations. During this inspection, we saw most surgical wards had few or no medical outliers. However, we noted that the service had reconfigured some of its wards and that some surgical beds had been changed temporarily to medical beds

Are surgery services well-led?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found that:

- Senior leaders were aware of the trust's failure to follow national guidance in relation to venous thromboembolism risk assessments (VTE) and hand hygiene. However, we saw examples throughout the service where compliance with trust and national guidance had not significantly improved.
- When risks had been escalated, there was a lack of follow up and resolution. Effective action following the reporting of high fridge temperatures for storage of medicines was not evident.

However, we also found that:

- The hospital had implemented a new quality dashboard. The dashboard provided monthly quality data for all wards and clinical areas.

Leadership of service

- The surgical division was led by a divisional director, a divisional manager and a director of nursing who led the surgical services care division. Senior leaders were aware of the trust's failure to follow national guidance in relation to venous thromboembolism risk assessments and monitoring drugs requiring refrigeration. However, we saw examples throughout surgery where national guidance had not been followed. This meant senior leaders had not driven the improvements required in the service to address the concerns we identified on the last inspection.

Vision and strategy for this service

- We did not gather evidence for this as part of the inspection.

Governance, risk management and quality measurement

- The trust had a divisional framework for governance arrangements in surgical services. During the last inspection, sharing of information was not established at ward level. During this inspection, we were told this had improved in some areas and ward managers attended divisional meetings. The service had developed a quality dashboard, which contained audit data for each ward and clinical area and included data on staffing, falls, hand hygiene compliance and VTE assessments plus other metrics. Ward sisters on the wards accessed the dashboard and demonstrated how it worked.
- However, despite the quality dashboard, some issues remained and there was a lack of consistent follow-up and improvement when issues were identified. For

example, VTE assessments were not been done in line with trust policy, and there was inconsistent compliance with hand hygiene. This demonstrated that the trust's governance system in relation to the management of VTE risk and hand hygiene did not operate to ensure that senior leaders effectively managed the risk of harm to patients.

- Similarly, effective action following the reporting of high fridge temperatures for storage of medicines was not evident. Staff demonstrated they had reported high temperatures but were unable to tell us if any action had been taken to ensure the medications within the fridge remained safe to use. This shows that there were not effective processes in place to ensure that the trust policy on medicines management was being adhered to, and this had not been recognised as a risk.

Maternity and gynaecology

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Worcestershire Acute Hospitals NHS Trust provides maternity and gynaecology services to women living in Worcestershire, surrounding counties and further afield, including Herefordshire, Dudley, South Staffordshire, Shropshire, Warwickshire and Birmingham. Since 5 November 2015, inpatient maternity services have solely been provided at Worcestershire Royal Hospital. Outpatient maternity services are also provided at Alexandra Hospital (Redditch) and Kidderminster Hospital and Treatment Centre. Inpatient gynaecology services are provided at Worcestershire Royal Hospital and Alexandra Hospital. Outpatient gynaecology services are provided at these three sites.

The maternity and gynaecology service is under the women and children division. The current leadership structure includes a divisional medical director, divisional director of nursing and midwifery, divisional director of operations and divisional governance and quality lead. A clinical director and medical governance lead for obstetrics and gynaecology, and matrons support this team.

The maternity service at Worcestershire Royal Hospital (WRH) provides antenatal, labour and postnatal care for women. Outpatient services are provided at the hospital site and in conjunction with community services and GP practices.

The hospital has a consultant led delivery suite with 11 beds, including one bereavement suite, and dedicated obstetric theatres. Women who have a straightforward pregnancy can have their baby at home or in the Meadow birth centre at WRH. The birth centre provides midwife-led care for women with uncomplicated pregnancies and who are anticipating a normal birth. The birth centre has four delivery rooms, three of which contain static birthing pools, and all rooms have ensuite facilities. The hospital also has a 20-bedded antenatal ward, four bedded triage area, and 32-bedded postnatal ward, which includes a transitional care bay for women with well babies born between 34 and 36 weeks who may require extra care and support.

There is no dedicated gynaecology inpatient ward at WRH. Six designated gynaecology beds are situated on Beech B1 ward, which specialises predominantly in maxillofacial and ear, nose and throat (ENT) surgery. A further four gynaecology beds are situated on the antenatal ward. The hospital also has an emergency gynaecology assessment unit, which includes an early pregnancy unit, situated within Clover Suite. The hospital provides outpatient clinics and services, which includes urogynaecology, fertility, hysteroscopy, colposcopy, endometriosis and pelvic pain service, and gynaecological oncology.

Worcestershire Acute Hospitals NHS Trust provides a termination of pregnancy service for fetal abnormality only.

The trust reported 5,426 births between October 2015 and September 2016. Of these births, 61% were normal (non-assisted) deliveries, which is slightly higher than the England average (60%). Additionally, 15% were elective caesarean deliveries, which is higher than the England average (12%), and 13% were emergency caesarean section deliveries, which is lower than the England average (15%).

In November 2016, we inspected maternity and gynaecology services at WRH, as part of our comprehensive inspection of the trust. We found the service was requires improvement for safe, effective and well-led, and good for caring and responsiveness. Overall, we rated the service as requires improvement.

We carried out a focused inspection on 11 and 12 April 2017 to review concerns found during our previous

Maternity and gynaecology

comprehensive inspection in November 2016. During this inspection, we visited clinical areas within the service including delivery suite, Meadow birth centre, antenatal and postnatal wards, gynaecology assessment unit, and Beech B1 ward. We spoke with 15 members of staff. We observed the environment and infection prevention and control practices, and reviewed other supporting information provided by the trust.

Summary of findings

We carried out a focused inspection to review concerns found during our previous comprehensive inspection on 22 to 25 November 2016. We inspected parts of the five key questions but did not rate them. We found significant improvements had not been made in these areas:

- Although perinatal mortality and morbidity meetings were minuted, there was no evidence that action was taken to address learning from case reviews. We were not assured an effective system was in place to ensure learning from perinatal mortality and morbidity meetings was shared, and actions were taken to improve the safety and quality of patient care.
- Staff did not consistently follow trust processes for storing medicines at the recommended temperatures, despite there being policies in place.

We also found other areas of concern:

- There was no system in place to ensure medicines stored in the emergency gynaecology assessment unit were safe for patient use. Immediate action was taken by the trust once we raised this as a concern.
- Training data showed that 86% of midwifery staff and 53% of medical staff had completed safeguarding children level three training. This was an improvement from our previous inspection. However, compliance was still below the trust target of 90%, particularly with medical staff.
- The waiting room and toilet facilities for patients attending the emergency gynaecology assessment unit were mixed sex, as these were shared with the respiratory outpatient clinic. Furthermore, this assessment unit did not have appropriate facilities such as bathrooms, to facilitate personal care for patients who had to stay overnight at times of increased bed pressures.

However, we observed improvements for the following:

- Standards of cleanliness and hygiene were well maintained. Staff adhered to infection control and prevention guidance.

Maternity and gynaecology

- Effective systems had been introduced to ensure emergency equipment was checked daily. Equipment was well maintained and had been safety tested to ensure it was fit for purpose.
- The hospital did not have a dedicated gynaecology inpatient ward. This meant some patients stayed overnight in the outpatient emergency gynaecology assessment unit and were nursed in medical wards. However, the trust had put processes in place to ensure patients were cared for in environments that were suitable for their needs.
- The number of staff who had completed Mental Capacity Act and Deprivation of Liberty Safeguards training had improved.
- Daily ward rounds by a gynaecology consultant and nurse were carried out to ensure gynaecology patients were appropriately reviewed and managed, regardless of location within the trust.
- Staff caring for gynaecology patients on Beech B1 ward had received training on bereavement care, including early pregnancy loss and the management of miscarriage.
- Risks identified were reviewed regularly with mitigation and assurances in place. Staff were aware of the risks and the trust board had oversight of the main risks within the service.

Are maternity and gynaecology services safe?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found significant improvements had not been made in these areas:

- Although perinatal mortality and morbidity meetings were minuted, there was no evidence that action was taken to address learning from case reviews. We were not assured an effective system was in place to ensure learning from perinatal mortality and morbidity meetings was shared, and actions were taken to improve the safety and quality of patient care.
- Staff did not consistently follow trust processes for storing medicines at the recommended temperatures, despite there being policies in place.

We also found other areas of concern:

- There was no system in place to ensure medicines stored in the emergency gynaecology assessment unit were safe for patient use. Immediate action was taken by the trust once we raised this as a concern.
- Training data showed that 86% of midwifery staff and 53% of medical staff had completed safeguarding children level three training. This was an improvement from our previous inspection. However, compliance was still below the trust target of 90%, particularly with medical staff.

However, we observed improvements for the following:

- Standards of cleanliness and hygiene were well maintained. Staff adhered to infection control and prevention guidance.
- Effective systems had been introduced to ensure emergency equipment was checked daily. Equipment was well maintained and had been safety tested to ensure it was fit for purpose.
- The hospital did not have a dedicated gynaecology inpatient ward. This meant some patients stayed overnight in the outpatient emergency gynaecology assessment unit and were nursed in medical wards. However, the trust had put processes in place to ensure patients were cared for in environments that were suitable for their needs.

Maternity and gynaecology

Incidents

- During our comprehensive inspection in November 2016, we found staff understood their responsibilities to raise concerns and felt confident in doing so. Lessons were learned from incidents and action was taken to improve safety within the service. However, we also found perinatal mortality and morbidity meetings were not formally minuted and any learning, including actions taken to prevent and/or minimise reoccurrence, were not clearly recorded. Furthermore, when actions were identified, no timescales for completion were documented, nor was it evident which member of staff was responsible for ensuring actions were completed. This meant we were not assured there was a robust system in place to ensure learning from perinatal mortality and morbidity meetings was shared and actions were addressed. We also reported that the service did not hold morbidity meetings within maternity and gynaecology. We were told that plans were in place for these to be introduced in 2017. National bodies, such as the Royal College of Obstetricians and Gynaecologists (RCOG), recommend that maternity care providers hold regular multidisciplinary team meetings to review perinatal and maternal mortality and morbidity, so that patient safety and quality of care is improved.
- In response to concerns found during our previous inspection, a quality improvement plan (QIP) had been developed by the trust to ensure county wide mortality and morbidity meetings were standardised, actions were taken and lessons learnt were shared. However, we found that this had not been applied consistently across the maternity and gynaecology service.
- The trust provided a schedule for perinatal, obstetrics and gynaecology mortality and morbidity meetings for 2017; nine perinatal, 11 obstetrics and 11 gynaecology mortality and morbidity meetings had been scheduled for 2017. The obstetrics and gynaecology mortality and morbidity meetings were not held separately, but were included as a standing agenda item within monthly governance meetings.
- We saw that the monthly gynaecology clinical governance meetings included mortality and morbidity as a standing agenda item. We reviewed three sets of minutes for meetings held in January, February and March 2017. However, we saw no evidence that mortality and morbidity reviews were discussed. Nor any evidence that any learning and improvement actions from mortality and morbidity reviews were identified. The minutes for the gynaecology clinical governance meeting held in February 2017 stated that this item was to be removed from the agenda. No explanation for this was provided.
- Similarly, we reviewed three sets of minutes for divisional governance meetings held in January, February and March 2017 and found no evidence that maternal mortality and morbidity reviews were discussed. This may have been due to the fact that maternal mortality is rare. The minutes we reviewed showed only issues relevant to perinatal mortality and morbidity were discussed, such as the child death overview panel report 2015/16. Therefore, we could not be assured that obstetrics and gynaecology mortality and morbidity reviews were held. We reported this as a concern.
- We requested the minutes of perinatal mortality and morbidity meetings held in January, February and March 2017, as per the trust's schedule, but were only provided with minutes for February and March 2017. Therefore, we were unable to determine whether the January 2017 meeting was held.
- In response to our concerns regarding the lack of formal minutes for perinatal mortality and morbidity meetings, since our previous inspection a member of the governance team had been employed to take the minutes. The meeting minutes for February and March 2017 included a list of attendees and their designation. This was an improvement from our previous inspection. The meetings were attended by members of the multidisciplinary team, including consultants, junior doctors, midwives, and student midwives. Case histories and learning points were documented. However, there was no evidence that any actions were taken as a result of learning points identified. Nor was it evident which member of staff was responsible for ensuring actions were completed, or how any learning would be shared within the division. Therefore, we were not assured an effective system was in place to ensure learning from perinatal mortality and morbidity meetings was shared, and actions were taken to improve the safety and quality of patient care. We had reported this as a concern following our previous comprehensive inspection.
- The divisional director of nursing and midwifery told us the service was in the process of introducing the

standardised clinical outcome review (SCOR), developed by the Perinatal Institute. SCOR would be used to review all perinatal deaths over 22 week's gestation, in line with national recommendations (MBRRACE). SCOR is a software tool, designed to facilitate the comprehensive review of perinatal deaths. It includes the identification of substandard care factors and system failures, and prompts an action plan to help implement multidisciplinary learning. We were told the SCOR was expected to be in use by mid-May 2017.

Safety thermometer

- We did not gather evidence for this as part of the inspection.

Cleanliness, infection control and hygiene

- During our previous comprehensive inspection, we found cleanliness, infection control and hygiene practices were generally maintained within the maternity and gynaecology service. However, we did observe poor adherence to infection prevention and control practices with doctors not being 'arms bare below the elbow', a lack of hand washing and the incorrect use of personal protective equipment across other services within the hospital. Therefore, we reviewed this element during our focused inspection to ensure standards within the service had been maintained.
- In response to concerns found during our previous inspection, the QIP included actions to address poor adherence to infection prevention and control practices, such as refreshing the hand hygiene campaign, staff training, and regular auditing of hand hygiene compliance. The chief nursing officer oversaw the improvement plan. A total of nine actions had been developed and according to the QIP dated 6 March 2017, the trust were 'on track' to complete all actions by the date specified.
- During this inspection, we found there were reliable systems in place within the service to protect people from a healthcare-associated infection, such as hand washing and correct use of personal protective equipment (PPE).
- The service participated in monthly hand hygiene and 'arms bare below the elbow' audits, in line with the trust's infection prevention programme. From December 2016 to March 2016, hand hygiene and arms bare below the elbow compliance on maternity inpatient wards averaged 98% and 100% respectively. For the same period, compliance on the emergency gynaecology assessment unit averaged 99% and 100% respectively.
- We observed clinical staff adhered to the trust's 'arms bare below the elbow' policy to enable effective hand washing and reduce the risk of infection. There was access to hand washing facilities and a supply of PPE, which included gloves and aprons, in all areas of maternity and gynaecology.
- Hand sanitising gel dispensers were available for staff, patients and relatives to use at the entrance and exit of each ward. We observed staff apply hand sanitising gel when they entered and/or left wards.
- We observed staff washing their hands between patient contact, in accordance with National Institute for Health and Care Excellence (NICE) guidance (Quality Standard (QS)61' Infection prevention and control: statement 3'(April 2014)).
- We saw two medical staff clean their hands and use appropriate PPE prior to entering the room of a patient with suspected infection. The two medical staff disposed of the PPE prior to leaving the room and cleaned their hands when they exited the room, in line with national guidance.
- We also observed midwifery staff wearing appropriate PPE, gloves and apron, whilst preparing intravenous medicines (medicines administered into a vein).
- We saw that all areas of the maternity and gynaecology service we visited were visibly clean and tidy during our inspection.
- Midwifery, nursing and auxiliary staff were responsible for cleaning the equipment and we saw that "I am clean" stickers were placed on items of equipment stating when they had last been cleaned. In all areas we visited, we observed that the equipment which was not in use had been cleaned that day.
- Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Bins were not overfilled. We saw all clinical areas had appropriate facilities for the disposal of clinical waste and sharps. All sharps bins we observed were clean, dated, not overfilled, and had temporary closures in place. Temporary closures are recommended to prevent accidental spillage of sharps if the bin is knocked over and to minimise the risk of needle stick injury.

Maternity and gynaecology

Environment and equipment

- During our previous comprehensive inspection, we found patients were being placed at risk of avoidable harm from equipment that had not been serviced, maintained, tested or calibrated. For example, we found eight pieces of equipment on the Meadow birth centre and delivery suite that had not been safety tested within the date indicated. We also found that the neonatal resuscitation trolley on the delivery suite was not consistently checked on a daily basis. We reviewed checklists from 1 September to 22 November 2016 and found 10 occasions when the neonatal resuscitation trolley had not been checked. Therefore, we were not assured there were effective governance systems in place to ensure that all equipment used for providing care or treatment to a patient was safe and fit for purpose.
- During this inspection, we found improvements had been made. We saw evidence that local equipment databases had been compiled to ensure all equipment was serviced within the required timeframes. For example, we reviewed the equipment database for the Meadow birth centre and found all equipment had been safety tested within the required timeframe.
- We reviewed 14 items of equipment from delivery suite, the postnatal and antenatal wards and Meadow birth centre. Stickers were placed on each item of equipment, which detailed the date the equipment had been serviced and the date the next service was due. All equipment was found to have been safety tested within the date indicated. Therefore, we were assured that the trust had taken action to ensure that the maintenance of equipment within the service kept people safe.
- Since our previous inspection, the service had introduced robust systems to ensure all emergency equipment was checked on a daily basis. The shift co-ordinator allocated the daily checking of emergency equipment to midwifery staff and countersigned the checklists to confirm the equipment had been checked. The service had also introduced an electronic application, which the unit co-ordinator completed on a daily basis to confirm that all emergency equipment had been checked. The electronic application sent an email alert to the matron if any omissions occurred.
- We reviewed the checklists for the neonatal resuscitation trolley on delivery suite from 1 February to 12 April 2017 and found it had been checked daily. This was an improvement from our previous inspection.
- Adult emergency equipment, such as defibrillator (device that gives a high energy electric shock to the heart through the chest wall to someone who is in cardiac arrest), oxygen and suction were available in all patient areas for use at short notice. The emergency equipment was checked daily to ensure it was in working order and fit for purpose. We saw checklists completed to confirm this. For example, we reviewed the checklists for the adult emergency trolley on the emergency gynaecology assessment unit from 20 February to 12 April 2017 and found it had been checked daily. We also reviewed the checklists for the adult emergency trolley on delivery suite and the antenatal ward from 27 February to 12 April 2017 and found both had been checked daily.
- Resuscitaires (used to support new-born babies who may need resuscitation after delivery) were available in all maternity inpatient areas. These were also checked daily to ensure they were in working order and equipment was fully stocked. We reviewed the checklists for 10 resuscitaires within the maternity service from 6 to 19 February 2017 and 1 to 12 April 2017 and found all resuscitaires had been checked on a daily basis. Therefore, since our previous inspection we were assured that the service had robust systems in place to ensure emergency equipment was checked daily and was fit for purpose.
- During our previous comprehensive inspection, we also found the hospital did not have a dedicated gynaecology inpatient ward. This meant there was a risk that patients were placed in an unsuitable environment. Gynaecology patients sometimes stayed overnight in the emergency gynaecology assessment unit (EGAU), which was an outpatient area. We were told that when patients stayed overnight in the EGAU, overlay mattresses were placed on top of the trolleys to convert the trolley into a bed. We requested the risk assessment for this during our comprehensive inspection, but staff were unable to provide this. Furthermore, there were no shower facilities available to patients within the EGAU and the one toilet was mixed sex, as it was shared with patients attending respiratory clinics.
- During this inspection, we found some improvements had been made. We saw that an environmental risk

assessment for the EGAU had been completed. The risk assessment detailed 16 potential hazards, including confused patients missing/absconding from the unit, patients at risk of self-harm, and the use of EGAU as an escalation area for inpatient use at times of increased bed capacity demands. Current measures in place to mitigate these risks and actions required to mitigate these risks further were included, with dates for completion. We saw that the majority of identified actions had been completed.

- The trust planned to develop the EGAU environment, which would include a dedicated EGAU reception. However, the building works did not allow for additional toileting facilities, bathroom, or separate waiting room. Therefore, patients who had to stay overnight in EGAU would still not have access to a bathroom to facilitate personal care, other than the single toilet available.
- A risk assessment regarding the emergency evacuation of a patient from EGAU had been completed, and included actions to mitigate potential risks, equipment and staffing required, and the patient transfer process.
- In response to concerns raised following our previous inspection, the trust told us they carried out individual patient risk assessments on outliers to ensure they were placed in a safe environment that met their clinical needs. The term 'outlier' refers to a patient who has been placed on a non-speciality ward, due to a lack of speciality beds. We requested the risk assessments for all gynaecology outliers from December 2016 to March 2017 but were told that no specific outlier risk assessments had been carried out. This meant we could not be assured that all patients were cared for in environments that were suitable for their needs, such as single sex wards.
- On this inspection, we saw that the trust had produced a flow chart, which advised staff of the assessment process for patients awaiting transfer from EGAU to an inpatient area. According to the flow chart, pregnant patients were only to be admitted to Beech B1 ward, where staff were experienced with pregnancy related problems. If no beds were available on Beech B1 ward, the patient should remain on EGAU with experienced staff. Any non-pregnant gynaecology patients must be discussed with a doctor to assess their suitability for transfer to another inpatient area. If again the patient was not suitable for transfer, the patient should remain in EGAU until a bed was available on Beech B1 ward. A risk assessment would be completed, an incident report submitted, and all decisions made should be documented in the patient notes. The capacity hub would also be made aware of the need for an inpatient bed on Beech B1 ward. If a patient was deemed suitable for transfer to another inpatient area, staff on the admitting ward should confirm they were able to care for the patient and their presenting condition, be made aware of contact numbers for the gynaecology team, and be advised that a member of the gynaecology team would visit the patient daily whilst on the ward. The trust had also produced a flow chart detailing the risk assessment process for patients staying overnight in the EGAU. Therefore, the trust had put processes in place to ensure patients were cared for in environments that were suitable for their needs. However, we were unable to determine the impact these processes had on care provision as they had not been implemented at the time of our focused inspection.

Medicines

- During our previous comprehensive inspection, we reported no concerns in relation to the safe storage of medicines within the maternity and gynaecology service. Medicines requiring refrigeration were stored appropriately. Temperatures were checked and recorded daily to ensure medicines stored were safe for patient use. We did find that the ambient room temperature was consistently above the recommended maximum storage temperature of 25°C on the postnatal ward, and had reached as high as 29°C on occasions. Staff had escalated this to estates and pharmacy and had been told to reduce the expiry dates of medicines if the room temperature exceeded 30°C. We saw no evidence that the room temperature had exceeded 30°C during our previous inspection. However, we did observe the unsafe storage of medicines with poor monitoring, escalation and insight into the effect of storing medicines above or below recommended temperatures across other services. This meant we were not assured that all medicines stored in both refrigerators and at ambient room temperature were safe for patient use.
- In response to concerns found during our previous inspection, the QIP included actions to ensure all medicines were stored at appropriate temperatures and any exceptions were escalated appropriately and in a timely manner. According to information provided by the trust, a simplified recording template for refrigerator

and ambient room temperatures had been introduced. Furthermore, training and written guidance had been provided and shared with all areas on refrigerator temperatures, the use of thermometers, temperature recording and escalation protocols.

- The revised recording template stated that the minimum, maximum and current temperature of the medicines room and fridge should be recorded daily. The template was based on a traffic light system, which alerted staff to take action if the temperature exceeded the required range. Guidance on what actions should be taken, and a table for staff to document actions they had taken, was included on the reverse of the template.
- During this inspection, we reviewed the refrigerator temperature records on the postnatal ward from 21 December 2016 to 12 April 2017 and found one occasion when the temperature had not been recorded (2 January 2017). We also found that from 21 December 2016 to 30 March 2017 only the current temperature had been recorded; minimum and maximum refrigerator temperatures had not been documented. This showed that trust policy was not consistently followed in all areas of the service. All current refrigerator temperatures were found to be within the required range. We also reviewed the refrigerator temperature records on Meadow birth centre /antenatal ward (the treatment room where medicines were stored was shared between these two areas), and delivery suite from 1 to 12 April 2017 and found all entries had been completed, including minimum, maximum and current temperatures. All temperatures recorded were within the required range.
- Similarly, we found inconsistencies with the monitoring and recording of ambient room temperatures. We reviewed the ambient temperature records on the postnatal ward from 21 December 2016 to 12 April 2017 and found three occasions when the temperature had not been recorded (5, 11 and 12 January 2017). We also found that from 21 December 2016 to 11 April 2017 only the current temperature had been recorded; again, the minimum and maximum ambient room temperatures had not been documented. We reviewed the ambient temperature records on delivery suite from 1 to 12 April 2017 and found five occasions when only the current temperature had been documented. This provided further evidence that trust policy was not consistently followed in all areas of the service. We also reviewed the ambient temperature records on Meadow birth centre/ antenatal ward for the same period and found all entries had been completed, in line with trust policy.
- We also found three occasions on delivery suite and one occasion on the postnatal ward where there was no evidence that any action had been taken to address exceeded ambient room temperatures. The exceeded temperatures were all 'amber' rated (between 25°C and 29.9°C) and according to trust policy, the nurse in charge and estates department should have been informed. This meant we were not assured that all staff adhered to trust policy and meant not all staff were aware of the importance of monitoring medicine storage temperatures, to ensure they were safe for patient use.
- During this inspection, we found that the ambient room temperature where medicines were stored on EGAU was not monitored. Therefore, we could not be assured these medicines were safe for patient use. We raised this concern at the time of our inspection. The trust told us this was an oversight and since our inspection, daily monitoring of the ambient room temperature had been introduced on EGAU. Furthermore, the pharmacy department had replaced all medicines stored in this area.

Records

- We did not gather evidence for this as part of the inspection.

Safeguarding

- During our previous inspection, we found that arrangements were in place to safeguard adults and children from abuse that reflected legislation and local requirements. Staff generally understood their responsibilities and adhered to safeguarding policies and procedures. However, we also found not all staff had completed the appropriate level of safeguarding children training. Furthermore, we found that there was poor awareness of female genital mutilation (FGM) and staff told us they had not received training in FGM identification or awareness.
- Training data provided during our previous comprehensive inspection showed that 44% of midwifery staff and 0% of medical staff had completed safeguarding children level two training, and 51% of midwifery staff and 19% of medical staff had completed safeguarding children level three training. The trust

target was 90%.This did not meet with national recommendations, which state that clinicians who are potentially responsible for assessing, planning, intervening and evaluating children's care, should be trained to safeguarding children level three (Working together to safeguard children, 2015; Intercollegiate Document, Safeguarding children and young people: roles and competences for health care staff, March 2014).

- As of April 2017, training data showed that 86% of midwifery staff and 53% of medical staff had completed safeguarding children level three training. This was an improvement from our previous inspection. However, compliance was still below the trust target of 90%. Senior staff told us safeguarding children training sessions had recently been cancelled by the safeguarding team. Staff would be rebooked when sessions were made available.
- Staff were required to complete safeguarding adults and children training on trust induction, following commencement of employment, and refresher training every three years. Refresher safeguarding training was completed via e-learning modules, with some ad hoc sessions provided for safeguarding children training. The safeguarding children e-learning module was developed in collaboration with experts from six safeguarding children boards and had been updated to include FGM, radicalisation, forced marriage, child trafficking and child sexual exploitation (CSE).
- Midwifery staff we spoke with told us they had completed safeguarding children level three training via the e-learning module and face-to-face sessions. Training included recognising children at risk, signs of abuse, FGM, CSE and how to report safeguarding concerns.
- We spoke with five midwives who told us that FGM was covered in safeguarding children level three training, and included women at risk of FGM and identifying the signs of FGM. Staff we spoke with had not had to make a safeguarding referral for FGM but could explain the process if they identified a concern. Staff could obtain additional support and/or advice from the safeguarding team as needed.
- We saw there were safeguarding policies in place and clear pathways to follow if staff had concerns. Pathways included CSE, domestic violence and FGM. Staff could access safeguarding adults and children information via the trust intranet. Support was also available from the lead midwife for safeguarding.

Mandatory training

- We did not gather evidence for this as part of the inspection.

Assessing and responding to patient risk

- We did not gather evidence for this as part of the inspection.

Midwifery staffing

- We did not gather evidence for this as part of the inspection.

Medical staffing

- We did not gather evidence for this as part of the inspection.

Major incident awareness and training

- We did not gather evidence for this as part of the inspection.

Are maternity and gynaecology services effective?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection on 22 to 25 November and 7 December 2016. We inspected parts of this key question but did not rate it. We found that:

- The number of staff who had completed Mental Capacity Act and Deprivation of Liberty Safeguards training had improved.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- During our previous inspection, we found that staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA). However, we also found not all staff had completed MCA and Deprivation of Liberty Safeguards (DoLS) training. Data provided

showed that as of September 2016, 37% of staff had completed MCA and DoLS training. The trust target was 90%. Therefore, we were not assured all staff had up-to-date knowledge of MCA and DoLS.

- During this inspection, we saw evidence that the trust had taken action to address our concerns and we found some improvements had been made.
- All clinical staff, which included consultants, junior doctors, midwives, nurses and healthcare assistants, were required to complete MCA and DoLS training three yearly. We were told that between January and March 2017, training had been prioritised by the trust. As of April 2017, training data showed that 80% of midwifery staff, 100% of staff on the early pregnancy assessment unit, and 95% of gynaecology ward staff had completed MCA and DoLS training. This was an improvement from our previous inspection.
- Senior staff (band 7) were also undertaking additional training in DoLS. At the time of our inspection, five members of staff had completed this training and a further three were booked to attend upcoming sessions.
- Staff we spoke with had not had to make mental capacity assessments or DoLS applications, but knew who to contact for advice and support if they had any concerns regarding a person's mental capacity.
- We observed DoLS prompt cards, and the contact details for MCA and DoLS leads displayed on staff noticeboards during our focused inspection.
- The trust had up-to-date policies regarding consent, MCA and DoLS. Staff could access these policies via the trust intranet.

Are maternity and gynaecology services caring?

We have not rated the service for caring. As this was a focused inspection, we did not inspect all elements of this key question.

Compassionate care

- Interactions between staff and patients were caring and compassionate.
- We observed staff respecting the privacy and dignity of patients during our inspection

Are maternity and gynaecology services responsive?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found that:

Overall, we observed the following improvements had been made:

- Daily ward rounds by a gynaecology consultant and nurse were carried out to ensure gynaecology patients were appropriately reviewed and managed, regardless of location within the trust.
- Staff caring for gynaecology patients on Beech B1 ward had received training on bereavement care, including early pregnancy loss and the management of miscarriage.
- There was no gynaecology inpatient ward at the hospital. The six nominated gynaecology beds on Beech B1 ward were not ring fenced. This meant there was a risk that gynaecology patients were cared for in the outpatient emergency gynaecology assessment unit (EGAU) or general medical wards. However, following our inspection, the trust had taken action to ensure gynaecology patients were cared for in environments that were suitable for their needs.

However, we also found:

- The waiting room and toilet facilities for patients attending the EGAU were mixed sex, as these were shared with the respiratory outpatient clinic. Furthermore, the EGAU did not have appropriate facilities such as bathrooms, to facilitate personal care for patients who had to stay overnight at times of increased bed pressures.

Service planning and delivery to meet the needs of local people

- During our previous inspection, we found that gynaecology services were not always responsive to patients' needs. There was no gynaecology inpatient ward at the hospital. Gynaecology patients were cared for on the antenatal ward, Chestnut ward (mixed sex surgical maxillofacial ward), or any available bed in the hospital. This meant there was a risk that women could be having a miscarriage in a bay on a mixed sex ward.

Due to bed pressures gynaecology patients also stayed overnight in the emergency gynaecology assessment unit (EGAU), an outpatient clinic area, which did not have appropriate facilities such as shower and single sex toilet, for inpatient stays. Furthermore, the waiting room for EGAU was shared with the mixed sex respiratory outpatient clinic. This meant that women experiencing miscarriage or suspected ectopic pregnancy had to wait in a mixed waiting room.

- During this inspection, we were not assured that gynaecology patient needs were always met. The trust told us that gynaecology patients who required an inpatient bed were cared for in a female surgical bed. The trust had six beds designated for emergency gynaecology patients on Beech B1 ward (a surgical ward, predominantly for maxillofacial patients). A further four beds were ring-fenced for elective gynaecology patients on the antenatal ward. However, as we previously found on Chestnut ward, the designated gynaecology beds on Beech B1 ward were not ring-fenced. This meant there was still a risk that gynaecology patients could be cared for in environments that were not suitable for their needs, such as mixed sex wards. According to Delivering Same-Sex Accommodation Guidance for Providers and Commissioners (including Worcestershire), placing a patient in mixed-sex accommodation because of a shortage of beds is a breach of national guidance (NHS England, November 2015).
- Following this inspection, we saw that the trust had produced operational flow charts to help ensure gynaecology patients were cared for in environments that were suitable for their needs. For example, a flow chart had been produced detailing the process for staff to follow when a patient was awaiting transfer from EGAU to an inpatient bed. All gynaecology patients must be discussed with a doctor to ensure they were suitable for transfer to a general medical ward. Any patients deemed suitable for transfer must then be discussed with the admitting ward, to ensure they were able to care for the patient and their presenting condition. The admitting ward were advised that a member of the gynaecology team would review the patient daily whilst on the ward. Contact numbers for the gynaecology team were also given should the admitting ward require assistance at any time. However, as these processes had been implemented following our focused inspection, we were unable to determine the impact they would have on service provision.
- According to the quality improvement plan (QIP) dated 3 March 2017, the trust planned to develop a dedicated EGAU, which would expand current service provision and improve patient flow. The building work plans included two additional treatment rooms, the widening of doorways to allow access for trolleys, and space for reclining chairs for women who were suitable for day case treatment, such as intravenous fluid hydration for women with hyperemesis gravidarum (a complication of pregnancy characterised by severe nausea and vomiting such that weight loss and dehydration occur). There would also be a dedicated gynaecology reception area, so that gynaecology patients did not have to book in at the general outpatient reception. Building work commenced in April 2017 and was expected to be completed by mid-June 2017. According to the trust, building work was on track to be completed by this date. As development of the EGAU had not been completed at the time of our focused inspection, we were unable to determine the impact it would have on service provision.
- The floor plans showed that the EGAU would still be shared with patients attending respiratory outpatient clinics, and building works did not allow for additional toileting and bathroom facilities, and separate waiting room. This meant that at times of increased bed pressures, EGAU did not have appropriate facilities such as bathrooms, to facilitate personal care for patients who had to stay overnight. Therefore, we were not assured that gynaecology patient needs were always met
- We found standard operating procedures for EGAU and antenatal ward had been produced to help ensure gynaecology patients were cared for in an appropriate environment. For example, the standard operating procedure for gynaecology patients on the antenatal ward included an admission criterion, which aimed to increase the bed capacity for gynaecology patients, reduce the cancellation of elective gynaecology patients and provide an environment where gynaecology patients were cared for by gynaecology nursing staff.

Senior staff told us that elective gynaecology patients were reviewed on a daily basis, one week prior to the patient's proposed admission date, to ensure they were allocated to the most appropriate ward.

- The divisional director of nursing and midwifery, matron for gynaecology, and bereavement lead midwife told us of plans to develop the bereavement service. This included the recruitment of two dedicated associate nurses (band 4) by the summer 2017, once they had completed training. Increased staffing levels would enable the service to expand bereavement care provision, including the development of follow up care for families who had suffered a pregnancy loss during the first trimester (week one to week 12 of pregnancy). At the time of our inspection, the additional associate nurses were not in post, and so we were unable to determine the impact these development plans would have on service provision.
- According to the corporate risk register, the trust had long-term plans in place to develop a women's surgical unit on the hospital site. Plans had been submitted to the Department of Health and the trust were awaiting confirmation as to whether funding had been approved. The expected completion date for the proposed building plans was 2019.

Access and flow

- Following our previous inspection, we reported that gynaecology patients were often nursed on general medical wards. We requested the number of gynaecology outliers from December 2016 to March 2017 but were told this information was not routinely collected. The trust did report a total of 19 gynaecology outliers for March 2017; eight patients were admitted to the surgical care decisions unit, and the remaining 11 were admitted to 'other' wards. Correspondence from the trust in April 2017 stated that outlier data would now be collected on a monthly basis.
- We were told that gynaecology outliers were discussed at each bed meeting, held four times a day. This was to ensure transfer to a designated gynaecology bed was expedited and appropriate care was provided whilst they were cared for on other wards.
- A gynaecology consultant and nurse undertook a daily ward round to ensure all gynaecology patients were appropriately reviewed and managed, regardless of patient location. Wards could also contact the EGAU for medical or nursing advice and support 24 hours a day, seven days a week. Staff we spoke with confirmed this during our inspection.
- There were no gynaecology outliers during this inspection. We reviewed the medical records of the one gynaecology patient who had been admitted to Beech B1 ward and saw evidence of daily gynaecology consultant review.
- In response to concerns raised following our previous inspection, the trust told us they carried out individual patient risk assessments on outliers to ensure they were placed in a safe environment that met their clinical needs. The term 'outlier' refers to a patient who has been placed on a non-speciality ward, due to a lack of speciality beds. We requested the risk assessments for all gynaecology outliers from December 2016 to March 2017 but were told that no specific outlier risk assessments had been carried out. This meant we could not be assured that all patients were cared for in environments that were suitable for their needs, such as single sex wards.
- On this inspection, we saw that the trust had produced a flow chart, which advised staff of the assessment process for patients awaiting transfer from EGAU to an inpatient area. According to the flow chart, pregnant patients were only to be admitted to Beech B1 ward, where staff were experienced with pregnancy related problems. If no beds were available on Beech B1 ward, the patient should remain on EGAU with experienced staff. Any non-pregnant gynaecology patients must be discussed with a doctor to assess their suitability for transfer to another inpatient area. If again the patient was not suitable for transfer, the patient should remain in EGAU until a bed was available on Beech B1 ward. A risk assessment would be completed, an incident report submitted, and all decisions made should be documented in the patient notes. The capacity hub would also be made aware of the need for an inpatient bed on Beech B1 ward. If a patient was deemed suitable for transfer to another inpatient area, staff on the admitting ward should confirm they were able to care for the patient and their presenting condition, be made aware of contact numbers for the gynaecology team, and be advised that a member of the gynaecology team would visit the patient daily whilst on the ward. The trust had also produced a flow chart detailing the risk assessment process for patients staying overnight in the

EGAU. Therefore, the trust had put processes in place to ensure patients were cared for in environments that were suitable for their needs. However, we were unable to determine the impact these processes had on care provision as they had not been implemented at the time of our focused inspection.

Meeting people's individual needs

- Following our previous comprehensive inspection, the service had made improvements to meeting individual patients' needs by providing staff on Beech B1 ward with additional training on bereavement care, including early pregnancy loss and the management of miscarriage. Staff spoke positively about the training they had received. The bereavement lead midwife was also available to provide additional support and advice to staff and patients as needed.
- Development plans for the EGAU included the reconfiguration of treatment rooms, so that partners could stay as needed.

Learning from complaints and concerns

- We did not gather evidence for this as part of the inspection.

Are maternity and gynaecology services well-led?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found that:

- Risks identified were reviewed regularly with mitigation and assurances in place. Staff were aware of the risks and the trust board had oversight of the main risks within the service.
- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard (SQuID). The dashboard was being developed to include performance indicators specific to the service. Key performance indicators were reviewed regularly and actions were taken to address patient safety and quality issues.

Leadership of service

- The maternity and gynaecology service was under the women and children division. The leadership structure included a divisional medical director, divisional director of nursing and midwifery, divisional director of operations, and divisional governance and quality lead. A clinical director, medical governance lead for obstetrics and gynaecology, and matrons for gynaecology inpatients and outpatients, community and antenatal clinics, delivery suite and theatres, and maternity inpatients supported the divisional team.

Vision and strategy for this service

- We did not gather evidence for this as part of the inspection.

Governance, risk management and quality measurement

- Following our previous inspection, we reported that not all of the risks we identified, such as gynaecology patients being nursed in other wards or staying overnight in the outpatient emergency gynaecology assessment unit (EGAU), were recorded on the risk register. This meant we were not assured the trust had oversight of all risks affecting the quality and safety of patient care, nor that remedial actions had been identified to mitigate these risks.
- During this inspection, we found improvements had been made. We saw that the trust board had oversight of the main risks within the service. The loss of the gynaecology ward at the hospital, following the emergency reconfiguration of maternity services, was included on the divisional and corporate (trust wide) risk register. The potential impact on the safety and/or quality of patient care provision was detailed against this risk, and included, for example, the use of EGAU for patients overnight when there was a lack of inpatient bed capacity. Actions taken to mitigate risks associated with the loss of the gynaecology ward were also included.
- As of April 2017, the service had identified 15 risks, which included the inability to meet contracted activity within gynaecology due to insufficient medical, nursing and physical capacity, and the use of delivery suite rooms for bereaved families. Actions taken to mitigate risks, review dates, progress and assessment of the risk level were included.
- We saw evidence that the divisional risk register was reviewed regularly at monthly governance meetings. Staff we spoke with were aware of risks within the

service, such as the increased risk of neonatal abduction due to an insufficient number of baby security tags. Staff on the postnatal ward were able to describe actions in place to mitigate this risk.

- Since our previous inspection, the trust had introduced a web based 'ward to board' quality assurance system, known as the safety and quality information dashboard (SQuID). The SQuID dashboard was designed to measure performance against quality and safety metrics, such as number of incidents, medication errors, friends and family test scores, and complaints. Staff we spoke with were aware of SQuID and demonstrated how to access the dashboard on the trust intranet. The trust were in the process of developing the dashboard to include key performance indicators specific to the service, such as the number of women who had booked for antenatal care by 12 weeks and six days gestation, but this work had not been completed at the time of our inspection. The minutes of divisional and directorate governance meetings confirmed that key performance indicators were regularly reviewed, and actions were taken to address performance issues where indicated.

Culture within the service

- We did not gather evidence for this as part of the inspection.

Public engagement

- We did not gather evidence for this as part of the inspection.

Staff engagement

- We did not gather evidence for this as part of the inspection.

Innovation, improvement and sustainability

- Following the Section 29A warning notice, we saw some improvements to service provision had been made since our November 2016 inspection. These included the introduction of robust systems to ensure emergency equipment was checked on a daily basis and improved compliance figures for safeguarding children level three, Mental Capacity Act and Deprivation of Liberty Safeguards training.
- There was also evidence that service provision was being developed in order to meet the needs of people within the local community, such as the setting up of a dedicated emergency gynaecology assessment unit.
- The Meadow birth centre won the MaMa 2017 national birth centre of the year award. The annual MaMa awards recognise outstanding health care environments and midwifery staff, and are accredited by the Royal College of Midwives (RCM).
- The trust was actively fundraising in order to create an additional bereavement suite within the maternity department. The suite would provide a private space for bereaved parents, including a kitchen area and access into the memorial garden.

Services for children and young people

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Services for children and young people at the Worcestershire Royal Hospital (WRH) provides outpatient and inpatient facilities as well as emergency and elective surgery for babies and children up to the age of 18.

The hospital opened in 2002 and provides paediatric services on a paediatric ward which has 35 beds or cots, and a neonatal unit comprising of 18 cots. Inpatient services at one of the trust's other locations closed in September 2016; activity and staff from there have all transferred to the WRH. Due to a lack of specialist doctors, inpatient children's beds were centralised at WRH from 7 September 2016. The Alexandra Hospital was closed to admissions and paediatric staff moved to WRH. No changes were made to outpatient services for paediatric patients at the Alexandra Hospital

The paediatric ward comprises an assessment area with three beds and space for up to three seated patients. There are six single ensuite rooms: three of which are equipped for patients who require high dependency care. There is an adolescent area with two twin rooms and one single room, eight cubicles for babies and a four-bedded bay for babies and children over six months of age. This area, along with a further eight bedded bay, is used predominantly for patients admitted for day case surgery.

Children aged 16 and over have the option of being treated on an adult ward if preferred.

The neonatal service is a level two unit and has two cots for babies who require intensive care. Four cots can be used for babies who require high dependency care: two of which can be flexed up to provide intensive care. There are a further 12 cots for babies who require special care.

During the inspection, we spoke with staff, including medical and nursing staff, as well as support assistants and play therapists. We also spoke with patients and their relatives or visitors. We made observations during the inspection and reviewed a range of documents both during and after the inspection.

Services for children and young people

Summary of findings

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of four of the five key questions (safe, effective, responsive, well-led) but did not rate them. We did not inspect the caring key question. We found significant improvements had not been made in these areas:

- Whilst perinatal mortality and morbidity meetings were minuted and well attended, which was an improvement since the previous inspection, there was no evidence that action was taken to address learning from patient case reviews.
- Paediatric mortality and morbidity meetings were not multidisciplinary and only attended by medical staff.
- Whilst some improvements were observed in completion of Patient Early Warning Scores charts, not all charts had been completed in accordance with trust policy. We also found there was not always evidence of appropriate escalation for medical review when required.
- One to one care for patients with mental health needs was not consistently provided by a member of staff with appropriate training and reliance was, on occasion, placed on parents or carers.

We also found other areas of concern:

- Safeguarding children's level three training was below the trust's target of 85% and future training sessions had been cancelled. Compliance rates for this essential training were no better or worse in April 2017 in some staff teams compared to November 2016.
- The department became busy at times and staff said activity had increased since the service reconfiguration. However, there was limited monitoring of assessment and admission to inpatient areas.
- The risk register had been updated to include two additional risks identified during the November 2016 inspection, but not all risks found on this inspection had been identified, assessed and recorded. For example, the increased activity in the service following the transformation process.
- There was limited oversight and planning with regards to the increased activity in the service. This meant that service leaders were not in a position to understand current and future performance and to be able to drive improvements for better patient outcomes.

However, we observed improvements for the following:

- Paediatric mortality and morbidity meetings for paediatrics were now held and minuted.
- Infection control protocols were followed.
- There were appropriate arrangements in place for management of medicines, which included their safe storage.
- All patients admitted to the ward because of an episode of self-harm or attempted suicide had a risk assessment on file.
- The majority of staff had been competency assessed in medical devices used to help patients breathe more easily.

Services for children and young people

Are services for children and young people safe?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but do not have sufficient information to rate it. We found significant improvements had not been made in these areas:

- Whilst perinatal mortality and morbidity meetings were minuted and well attended, which was an improvement since the previous inspection, there was no evidence that action was taken to address learning from patient case reviews.
- Paediatric mortality and morbidity meetings were not multidisciplinary and only attended by medical staff.
- Whilst some improvements were observed in completion of Patient Early Warning Scores charts, not all charts had been completed in accordance with trust policy. We also found there was not always evidence of appropriate escalation for medical review when required.
- One to one care for patients with mental health needs was not consistently provided by a member of staff with appropriate training and reliance was, on occasion, placed on parents or carers.

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- The majority of staff had been competency assessed in medical devices used to help patients breathe more easily.

Incidents

- In response to our concerns regarding the lack of formal minutes for perinatal mortality and morbidity meetings found on our previous inspection, a member of the governance team had been employed to take the minutes. The meeting minutes for February and March 2017 included a list of attendees and their designation. This was an improvement from our previous inspection. The meetings were attended by members of the multidisciplinary team, including consultants, junior doctors, midwives, and student midwives. Case histories and learning points were documented. However, there was no evidence that any actions were taken as a result of learning points identified. Nor was it evident which member of staff was responsible for ensuring actions were completed, or how any learning would be shared within the division. Therefore, we were not assured that an effective system was in place to ensure that learning from perinatal mortality and morbidity meetings was shared, and actions were taken to improve the safety and quality of patient care. We reported this as an urgent concern following our previous comprehensive inspection.
- The divisional director of nursing and midwifery told us the service was in the process of introducing the standardised clinical outcome review tool (SCOR), developed by the Perinatal Institute. SCOR is a software tool, designed to facilitate the comprehensive review of perinatal deaths. It includes the identification of substandard care factors and system failures, and prompts an action plan to help implement multidisciplinary learning.
- During the November 2016 inspection, we identified that paediatric mortality and morbidity meetings were not held and mortality and morbidity issues were not discussed at other meetings. Once we raised this as a concern, the trust had taken action and in April 2017, we found that a paediatric mortality and morbidity meeting was now in place. Meetings were held quarterly, and minutes of the January 2017 meeting demonstrated that there was a discussion around individual cases,

learning points were noted and actions agreed. However, we saw that meeting attendance was not multidisciplinary, with only medical staff attending the meetings.

Safety Thermometer

- We did not gather evidence for this as part of the inspection.

Cleanliness, infection control and hygiene

- Appropriate standards of cleanliness were maintained on the paediatric ward and improvements had been made following the November 2016 inspection.
- In the November 2016 inspection, we found that staff did not consistently comply with infection control guidance. We observed staff failing to adhere to the correct source isolation protocols for patients with bronchiolitis. Staff left doors open when they should be have been closed, patient records were kept inside the patient's room and staff members sat in the patient's room without wearing the correct personal protective equipment.
- In this inspection, improvements had been made and we saw that all staff followed the correct infection control protocols when caring for a child with an infection.

Environment and equipment

- We did not gather evidence for this as part of the inspection.

Medicines

- There were appropriate arrangements in place for management of medicines, which included their safe storage.
- During the November 2016 inspection, we saw an incident had occurred which related to controlled drugs which had been reported missing. We followed this up as part of the April 2017 inspection and found that the correct processes had been followed to ensure the incident had been investigated and appropriate action taken to address concerns identified.

Records

- We did not gather evidence for this as part of the inspection.

Safeguarding

- Not all staff who worked within paediatrics had completed their safeguarding children level three training.
- In July 2015 and November 2016 inspections, we identified that not all staff had completed the required level of safeguarding children training. Overall, some improvements had been made on this inspection. We found with compliance with safeguarding children level three training was now at 83%: however, this was still below the trust's target of 90%.
- There are four levels of safeguarding children training, levels one, two, three and four. The Intercollegiate Document, Safeguarding Children and Young People: 'Roles and competences for health care staff' (2014) states that, 'all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/ child protection concerns must be trained to level three. Named lead safeguarding professionals must be trained to level four. There is an expectation that level three training is multi-agency and will include scenario-based discussions.
- In November 2016, medical staff had achieved compliance of only 41% compared to nursing staff who had achieved 79%; this was significantly lower for medical and nursing staff who worked in adult outpatients / surgery but treated children at 15% and 6% respectively.
- In April 2017, we saw that completion of level 3 safeguarding training had shown no improvement or declined. Training completion for neonatal nursing and support staff, paediatric ward nursing and support staff as well as paediatric medical staff was, 72%, 75% and 41% respectively. Compliance with training for medical and nursing staff who worked in adult outpatients / surgery but treated children was 6% overall.
- We were informed by the trust that all future training sessions for level 3 safeguarding children had been cancelled due to the lack of trainers available to run the sessions.

Mandatory training

- We did not gather evidence for this as part of the inspection.

Assessing and responding to patient risk

- Some improvements were observed in the completion of Patient Early Warning Scores (PEWS) since the November 2016 inspection. A PEWS chart is used to monitor and manage deteriorating patients on the paediatric ward. During the November 2017 inspection, we identified that PEWS charts were completed inconsistently. Some improvement was observed in the April 2071 inspection: however, information for some patients was still not recorded.
- We reviewed a sample of 13 patients' charts and found that the frequency of observations required had not been recorded for five patients. There was a delay in recording observations for two patient charts and the score for another two patient charts had not been totalled. We also noted that the PEWS score for one child required escalation on eight occasions due to deterioration, but there was no evidence appropriate escalation had taken place on two of the eight occasions. It was noted that the child had been prescribed and administered medication in accordance with protocol, so there was indirect evidence of escalation, however this escalation had not been documented on the patient's file in accordance with trust policy.
- Nursing staff undertook regular audits on the completion of PEWS charts and had observed an improving trend. We reviewed the findings from the November 2016 monthly PEWS audit. The audit results demonstrated that 100% of patients had a PEWS chart. The trust had observed improvements in the completion of PEWS charts through its April 2017 audit, which demonstrated 100% compliance.
- We found that 80% of those patients with a score of higher than three had been escalated, which meant that 20% of patients requiring appropriate escalation for medical review had not.
- Patients who were admitted to the paediatric ward because they had 'self-harmed', taken an overdose or had suicidal intent were admitted to an anti-ligature side-room if available to ensure they were cared for in a safe environment. An anti-ligature room means that points where a cord, rope, or bed sheet could be looped or tied to a fixture in order to create a point of ligature have been eliminated.
- During the November 2016 inspection, we found that there was a lack of detailed assessment and provision of one to one care of children and young people who presented with mental health issues. Risk assessments were not always completed and on occasions, a risk assessment form for an adult was placed on file. Forms did not include a section to clearly record the degree of risk, and on only some occasions was this recorded in the patient notes.
- During this inspection, we found that the service had taken a series of actions to improve the safety and quality of care and treatment provided for the children on the ward. These actions included revising the mental health risk assessment so that staff could record the patient's level of risk to themselves and others on admission. A further update had been made to the form so that multiple assessments could be recorded for the duration of the patient's admission; however, the most recent version had not been circulated for use but was due back from the printers imminently staff told us.
- There was evidence that some improvements had been made. We reviewed ten sets of patients' records from the paediatric ward at WRH. All 10 patients had a mental health risk assessment on file and the category of risk identified. However, this was recorded inconsistently within patient records. Some categories of risk were recorded in nursing records and others within the risk assessment document. This meant it was not always clear how staff had reached their decision as to which criteria were met as the standard risk assessment form had not always been used.
- A new form had also been devised to record the level and frequency of therapeutic observations required. These were mostly completed in line with trust policy and the patients' mood was also assessed. There were some inconsistencies in recording the outcomes of the assessments as some staff were using historic categorisations with others referring to the new terminology which meant it was confusing to follow, particularly for temporary staff who may not be familiar with both.
- One nurse we spoke with told us the revised assessment helped easily identify when a patient should be escalated for one to one observation by a registered mental health nurse (RMN). Of the ten files we reviewed, there were no patients assessed as requiring this level of observation. We extended the sample of ten to 15 but there were no additional patients who required one to one care.
- One patient received one to one care periodically during their admission. The risk assessment had not determined this as a requirement, however, staff had

documented in the notes that one to one care was needed. The ward manager informed us this was precautionary. We noted that an RMN was not available consistently to observe the patient. To mitigate this factor the patient was accommodated in a ligature free ward close to the nurse's station. Childcare assistants, registered nurses, or members of the family undertook the one to one observation overseen by the nurse in charge.

- The ward manager informed us there were difficulties in obtaining RMN's. The fill rate (percentage of nursing staff who were able to provide cover) for the one to one observations was 70% for March 2017: this meant 21 out of 30 shifts had had appropriate RMN cover. There was no requirement for an RMN in January or February 2017. Paediatric nursing staff had not yet completed training on mental health but it was expected to be achieved by all ward nursing staff by June 2017.

Nursing staffing

- We did not gather evidence for this as part of the inspection.

Medical staffing

- We did not gather evidence for this as part of the inspection.

Major incident awareness and training

- We did not gather evidence for this as part of the inspection.

Are services for children and young people effective?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found:

- The majority of staff had been competency assessed in medical devices used to help patients breathe more easily.

Competent staff

- During the November 2016 inspection, we identified some staffs' competency assessment was overdue and some staff had not been competency assessed on the use of continuous positive airway pressure (CPAP). This is a piece of equipment that is used to help patients breathe more easily. Significant improvements had been made and in our April 2017 inspection, we saw that 91% of staff had completed training and been assessed on the use of CPAP. This was above the trust target of 90% We also confirmed that a specific code was used on staffing rotas to ensure each shift had at least one member of staff trained and competent in its use.
- In the November 2016 inspection, we found staff had not received training on caring for patients with mental health needs. One of the ward managers had developed training for staff, which had been rolled out to childcare assistants. All qualified nursing staff were expected to have completed the caring for patients with mental health needs training by June 2017.

Are services for children and young people caring?

We have not rated the service for caring. As this was a focused inspection, we did not inspect all elements of this key question.

Compassionate care

- Interactions between staff and patients and their carers were caring and compassionate.
- We observed staff respecting the privacy and dignity of patients during our inspection.

Are services for children and young people responsive?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found:

- The department became busy at times and staff said activity had increased since the service reconfiguration. However, there was limited monitoring of assessment and admission to inpatient areas.

Service planning and delivery to meet the needs of local people

- We did not gather evidence for this as part of the inspection.

Services for children and young people

Access and flow

- During the November 2016 inspection, we found the department became busy at times and activity had increased since the service reconfiguration, although data was not available. This had affected the paediatric ward in particular. Flow through the department did not always work well and the assessment area often exceeded capacity. Staff told us there had been little detailed planning as to how this would be managed following the service reconfiguration. After the inspection, the trust provided us with evidence of paediatric activity used for planning by the Emergency Paediatric Reconfiguration group during July to September 2016. The data demonstrated the consideration for the patient flows between emergency departments and the wards (Ward 1, Alexandra Hospital and Riverbank ward, WRH) and the overall paediatric admissions based on practice at the time.
- Admissions to the paediatric ward were either via a planned admission process or through an emergency admission from a direct GP referral or through the emergency department (ED). The bay consisted of three assessment beds and three seated areas. We were told capacity was regularly exceeded and patients frequently waited in the corridor and assessments regularly took place in the treatment room, intended for inpatients only. After the inspection, the trust provided us with the service's analysis of paediatric activity (in January 2017) that was being used to further develop appropriate pathways with primary care and commissioners.
- During the November 2016 inspection, we observed the assessment area was often very busy. We did not observe this in our April 2017. However, staff we spoke with, told us although there were days when the service saw less patients in the assessment area, it could still become busy and that the concerns found at the last inspection remained. We were told by staff as an example that the assessment area had been extremely busy on Sunday 9 April 2017. We reviewed the assessment records for that day, of which only a small number had been completed. We discussed this with staff who informed us that these forms were not completed consistently. Therefore, it was not possible for us to verify the extent of the concerns raised with us.
- Managers at the service had undertaken an audit of the activity of the assessment unit however, staff said the ward could become overcrowded at times, which also could affect the admission process to inpatient areas. Effective monitoring of assessment and inpatient activity was limited, so the service was not be in a position to use this data to make effective future plans and to drive improvements in the service.

Meeting people's individual needs

- We did not gather evidence for this as part of the inspection.

Learning from complaints and concerns

- We did not gather evidence for this as part of the inspection.

Are services for children and young people well-led?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found:

- The risk register had been updated to include two additional risks identified during the November 2016 inspection, but not all risks found on this inspection had been identified, assessed and recorded. For example, the changes in activity in the service following the transformation process.
- There was limited oversight and planning with regards to the changes in activity in the service. This meant that service leaders were not in a position to understand current and future performance and to be able to drive improvements for better patient outcomes.

Leadership of service

- There was an accountability structure in place; nursing staff on the wards reported to the ward manager who in turn reported to the matron for paediatric inpatients.
- We observed the wards and departments were managed on a day to day basis with good leadership at a local level, staff allocations were made appropriately. However, staff told us and we observed that the paediatric ward in particular became very busy at times and the assessment area frequently exceeded capacity. Medical staff reported to the clinical director. More junior staff were supported and supervised by the consultants.

- The outpatient service was overseen by a paediatric outpatient manager who had responsibility for management of outpatients at each of the trust's three locations, although they were based only at Worcestershire Royal Hospital (WRH). We were informed that although the outpatient manager was responsible for the entire paediatric outpatient service, they had not been allocated protected time for their managerial duties and worked clinically all of the time.

Vision and strategy for this service

- We did not gather evidence for this as part of the inspection.

Governance, risk management and quality measurement

- The service had a risk register in place. Identified risks included appropriate level of detail and had been scored according to their likelihood and impact. During the November 2016 inspection, we saw that not all significant risks had been identified or recorded on the register. In our April 2017 inspection, we observed that service leaders had included two additional risks which related to paediatric early warning scores and patients who attended the ward with identified mental health concerns. There was a risk lead for the Women and Children's directorate. The risk register was presented and discussed at the Women and Children's Governance.
- However, the service still failed to fully consider other significant risks, for example, the changes in demand from the recent service reconfiguration including the pressures this placed on staff as well as full consideration of the potential risks to patients. This demonstrated a lack of structure for identifying and recording new or emerging risks. There was limited oversight and effective planning with regards to increased activity in the service. This meant that service leaders were not in a position to understand performance and to be able to drive improvements for better patient outcomes.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that all patients' conditions are monitored effectively to enable any deterioration to be quickly identified and care and treatment is provided in a timely way.
- Ensure that staff complete all of the risk assessments and documentation required to assess the condition of patients and record their care and treatment.
- Ensure all patients have a venous thromboembolism (VTE) assessment and are reassessed 24 hours after admission in accordance with national guidance.
- Ensure that the privacy and dignity of all patients in the ED is supported at all times, including when care is provided in corridor areas.
- Ensure mental health assessment room in the emergency department is appropriate to meet needs of patients.
- Ensure the children's ED area is consistently monitored by staff.
- Ensure that systems or processes are fully established and operated effectively to assess, monitor and improve the quality and safety of the services provided within the ED.
- Ensure that systems or processes are fully established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients while using the ED.
- Ensure that patients in the ED receive medication prescribed for them at the correct time and interval.
- Ensure patient weights are recorded on drug charts.
- Ensure there are processes in place to ensure that any medicine omissions are escalated appropriately to the medical team.
- Ensure all anticoagulation medication is administered as prescribed. All non-administrations must have a valid reason code.
- Ensure all medicines are stored at the correct temperature. Systems must be in place to ensure medication, which has been stored outside of manufactures recommended ranges, remains safe or is discarded.
- Ensure when patients refuse to take prescribed medication, this is escalated to the medical team for a review.
- Ensure patient identifiable information is stored securely and not kept on display.
- Ensure all staff comply with hand hygiene and the use of personal protective equipment policies.
- Ensure all staff are up-to-date on medicines' management training.
- Ensure all staff have completed their Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training.
- Ensure all staff have completed the required level of safeguarding training.
- Ensure all patients in the children and young people's service with mental health needs have the appropriate level of staff one to one care in accordance with their risk assessments.
- Ensure paediatric assessment area activity is monitored effectively so the service can drive improvements in patient flow.
- Ensure the risk registers reflects all significant risks in the children and young people's service and effective mitigating actions are in place to reduce potential risks to patients.
- Ensure safeguarding referrals are made when required for patients seen in the ED.
- Ensure the sepsis pathway is fully embedded in inpatient wards.

Action the hospital SHOULD take to improve

- Achieve the required numbers of consultants in the ED on duty to meet national guidelines.
- Continue to monitor the effectiveness of the sepsis pathway in the ED.
- Review systems in place so food is served using either gloves or tong in accordance with trust policy.
- Review processes for maintaining patient confidentiality during nursing handovers.
- Review systems in place to manage the safe and effective use of controlled drugs within the discharge lounge.
- Consider displaying actual and planned staff numbers in all clinical areas.

Outstanding practice and areas for improvement

- Consider using a standard risk assessment to assess and identify the needs of patients admitted to the paediatric ward with mental health needs. All forms should be kept updated as required for the duration of the patient's stay.
- Review how pain relief given to children in the emergency department is evaluated for its effectiveness for all patients.
- Consider possible changes in streaming for self-presenting patients with an operating model based on urgent care GP streaming.
- Review the waiting room, bathroom and toilet facilities for patients attending the emergency gynaecology assessment unit were mixed sex, as these were shared with the respiratory outpatient clinic.
- Review systems in place for the monitoring of assessment and admission to inpatient areas in the children and young people's service.

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
Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The service was not meeting this regulation because:** • Patients' privacy and dignity was not respected whilst being cared for in the corridor area of the emergency department. • Some medical care wards did not ensure that patient privacy, dignity, and confidentiality were maintained at all times because other patients and relatives could hear handovers. • Patient identifiable information was stored securely and kept on display in some medical care and surgical wards

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The service was not meeting this regulation because:** • Essential risk assessments and documentation required to assess the condition of patients and record their care and treatment was not being consistently carried out. • Patients' conditions in the emergency department were not being monitored effectively to enable any deterioration to be quickly identified and care and treatment is provided in a timely way. • The mental health assessment room in the emergency department was not appropriate to meet needs of patients. • Medicines were not stored or administered in a timely was when required. • Patient weights were not recorded on drug charts.

This section is primarily information for the provider

Requirement notices

- Anticoagulation medication was not always administered as prescribed.
- Not all staff complied with hand hygiene and the use of personal protective equipment policies.
- Risk assessments were not undertaken for young patients with mental health needs and one to one care from a suitably trained professional was not always provided.
- The sepsis pathway was not embedded in inpatient wards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The service was not meeting this regulation because:** • Not all staff were trained to the required level of for adults and children safeguarding. • Safeguarding referrals were not always made when required for patients seen in the ED.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The service was not meeting this regulation because:** • Not all staff were compliant with medicines' management and mental capacity act/deprivation of liberty safeguards (MCA/DOLS) training. • The children's area in the emergency department was not consistently attended by staff except via CCTV surveillance to the nurses/doctors station in the major's area. Patients and their parents/carers were left alone after assessment and while they waited to see a doctor.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The service was not meeting this regulation because:

- The risk registers failed to identify all risks faced by the service in the children and young people's service.
- There was a lack of oversight and understanding of activity in paediatric assessment area to fully identify potential issues with flow and capacity in the hospital.
- To ensure that systems or processes were not fully established and operated effectively to assess, monitor, and improve the quality and safety of the services provided within the emergency department.
- Systems or processes were not fully established and operated effectively to assess, monitor, and mitigate the risks relating to the health, safety, and welfare of patients within the emergency department, medical care and the children and young people's service.