

University Hospitals of Leicester NHS Trust Glenfield Hospital

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

University Hospitals of Leicester NHS Trust is one of the biggest acute trusts in England. Formed in April 2000, it is a teaching trust which provides specialist and acute services to a population of around 1,000,000 patients throughout Leicester, Leicestershire and Rutland. The Trust's nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, cancer and renal disorders reach a further two to three million patients nationally.

The trust operates acute hospital services from three main hospital sites:

- Leicester Royal Infirmary
- Leicester General Hospital
- Glenfield Hospital

Glenfield Hospital is situated on the outskirts of Leicester, approximately three miles from Leicester City Centre. It has approximately 440 beds and offers a range of inpatient and outpatient services including nationally recognised medical care for heart disease, lung cancer and breast care. Glenfield Hospital provides medical care, surgery, critical care, end of life care and outpatients and diagnostic services for children, young people and adults.

We served a warning notice under Section 29A of the Health and Social Care Act 2008 in December 2017. The warning notice was served as we found evidence to suggest the quality of health care in relation to management of insulin for diabetic patients' required significant improvement. We carried out an unannounced focused inspection on 29 May 2018 to follow up actions taken following the issue of the warning notice and to see if significant improvements had been made.

We inspected the safe domain in the core service of Medicine at this location. We did not inspect any other core services or wards at this hospital. This was a focused inspection. Information for the location as a whole can be found in our previous report published in March 2018. This can be accessed at http://www.cqc.org.uk/sites/default/files/new_reports/AAAH1561.pdf.

Our key findings were as follows:

- There had been improvements in the care of patients with diabetes since our last inspection, however, further improvement was required in the monitoring and embedding of the actions taken. Staff did not always ensure trust policy was followed in the administration of insulin. Patients with recorded high blood glucose levels did not always receive their prescribed insulin, the reasons for this were not always clearly documented.
- Staff did not always follow trust policy in regards to control of substances hazardous to health (COSHH). We found chlorine based solutions and tablets in unlocked rooms.
- Safety Thermometer results were not displayed consistently by all wards and departments.
- We saw that 'I am clean' were not always attached to equipment that was clean and ready for use.
- We found nurse pull cords and light pull cords in showers and toilets that could pose a ligature risk.
- We found scalpels and razors were not stored securely and could be accessed easily by patients or a member of the public.
- On two occasions we observed that confidential patient records were not stored securely

However:

Summary of findings

- Incidents were reported and managed effectively and learning was identified and shared.
- Wards and departments were visibly clean, there was good use of personal protective equipment and good hand hygiene practice.
- Risk assessments had been completed for patients with a known or suspected infectious disease.
- There was sufficient equipment to deliver safe care. Equipment was services regularly and well maintained.
- Medicines were stored safely and staff understood their responsibilities around medicines management.
- Nursing assessments and care plans were fully completed, up to date and regularly reviewed.
- Systems and processes were in place to assess and respond to patient risk including escalation of the deteriorating patient and management of patients with sepsis.
- There were sufficient nursing and medical staff to deliver safe care and on call systems in place when advice or support was required.

There were areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that all staff follow the prescription and trust guidance when monitoring patients blood glucose levels and administering as required insulin.
- Ensure staff are up to date with mandatory training.

In addition the trust should:

- Ensure scalpels and razors are stored securely so that they can not be accessed by patients or the public.
- Ensure confidential patient records were are stored securely

Professor Ted Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

**Medical care
(including
older
people's
care)**

Requires improvement

Rating



Why have we given this rating?

We rated safe as requires improvement because:

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Summary of findings

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 - There were sufficient nursing and medical staff to deliver safe care and on call systems in place when advice or support was required.
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Glenfield Hospital

Detailed findings

Services we looked at

Medical care (including older people's care)

Detailed findings

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Background to Glenfield Hospital

University Hospitals of Leicester NHS Trust is one of the biggest acute trusts in England. Formed in April 2000, it is a teaching trust which provides specialist and acute services to a population of around 1,000,000 patients throughout Leicester, Leicestershire and Rutland. The Trust's nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, cancer and renal disorders reach a further two to three million patients nationally.

The trust operates acute hospital services from three main hospital sites:

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- Glenfield Hospital

Glenfield Hospital is situated on the outskirts of Leicester, approximately three miles from Leicester City Centre. It has approximately 440 beds and offers a range of inpatient and outpatient services including nationally recognised medical care for heart disease, lung cancer and breast care. Glenfield Hospital provides medical care, surgery, critical care, end of life care and outpatients and diagnostic services for children, young people and adults.

The trust also provides services from 15 other locations and community hospitals; this includes maternity services at St Marys Birth Centre.

The trust employs around 15,000 staff

The trust has 90 wards across the three hospital sites; 1820 inpatient beds and 181 day-case beds including 149 maternity beds. Each week the trust runs 1155 outpatient clinics.

The health of people living within Leicestershire and Rutland is generally better than the England average. Deprivation for both areas is lower than the England average. Deprivation is higher in Leicester and also has a higher percentage of children living in poverty at 26.9%, compared to 11.5% for Leicestershire and 7.8% within Rutland. However the life expectancy for all three areas is higher than the England average.

The trust's main Clinical Commissioning Groups (CCG) are Leicester City CCG, West Leicestershire CCG and East Leicestershire and Rutland CCG

Our inspection team

Our inspection team was led by:

Inspection Manager: Simon Brown, Care Quality Commission.

The team included two additional CQC inspectors and two assistant inspectors.

Detailed findings

How we carried out this inspection

We served a warning notice under Section 29A of the Health and Social Care Act 2008 in December 2017. The warning notice was served as we found evidence to suggest the quality of health care in relation to management of insulin for diabetic patients' required significant improvement. We carried out an unannounced focused inspection on 29 May 2018 to follow up actions taken following the issue of the warning notice and to see if significant improvements had been made.

During the inspection, we carried out a number of activities to gather evidence, including a review of patient records, medicine prescription, observations charts and speaking with a wide variety of trust staff in a number of roles. We also requested specific information from the trust at the time of our inspection visit.

Facts and data about Glenfield Hospital

Glenfield Hospital is one of three hospitals that make up the University Hospitals of Leicester NHS Trust. The hospital is located approximately three miles north west of Leicester city centre. At Glenfield Hospital, there are 275 beds across 16 wards.

The trust had 123,333 medical admissions from July 2016 to June 2017. Emergency admissions accounted for 50,953 admissions (40.6%), 3,535 (2.8%) were elective, and the remaining 70,845 (56.5%) were day case.

Admissions for the top three medical specialties were:

- Gastroenterology: 29,363
- General medicine: 17,224
- Cardiology: 16,217

(Source: HES)

Notes

This was a focused inspection of Medicine at this location. We only looked at the safe domain. We have rated the safe domain at this inspection only. Our previous ratings across the remaining domains in our published report (March 2018) remain the same.

Medical care (including older people's care)

Safe

Requires improvement



Overall

Requires improvement



Information about the service

Glenfield Hospital is one of three hospitals that make up the University Hospitals of Leicester NHS Trust. The hospital is located approximately three miles north west of Leicester city centre. At Glenfield Hospital, there are 275 beds across 16 wards.

This inspection was a focused inspection of the Care Quality Commission 'Safe' domain.

During our inspection we visited the angio-catheter suite, Cardiology wards (F27 and F33), Respiratory Medicine including HDU, TB and Long-Term Ventilation (F15, F16, F17 and F17H), Cardio Respiratory Short Stay Unit (F20) and the Endoscopy Suite.

During the inspection:

- We spoke with 11 patients
- We spoke with 12 staff
- reviewed 19 sets of patient records including nursing records and medication records.

Summary of findings

We rated safe as requires improvement because:

- There had been improvements in the care of patients with diabetes since our last inspection, however, further improvement was required in the monitoring and embedding of the actions taken. Staff did not always ensure trust policy was followed in the administration of insulin. Patients with recorded high blood glucose levels did not always receive their prescribed insulin.
- Staff did not always follow trust policy in regards to control of substances hazardous to health (COSHH). We found chlorine based solutions and tablets in unlocked rooms.
- We saw that 'I am clean' were not always attached to equipment that was clean and ready for use.
- We found nurse pull cords and light pull cords in showers and toilets that could pose a ligature risk.
- We found scalpels and razors were not stored securely and could be accessed easily by patients or a member of the public.
- On two occasions we observed that confidential patient records were not stored securely.

However:

- Incidents were reported and managed effectively and learning was identified and shared.
- Wards and departments were visibly clean, there was good use of personal protective equipment and good hand hygiene practice.
- Risk assessments had been completed for patients with a known or suspected infectious disease.
- There was sufficient equipment to deliver safe care. Equipment was serviced regularly and well maintained.
- Medicines were stored safely and staff understood their responsibilities around medicines management.

Medical care (including older people's care)

- Nursing assessments and care plans were fully completed, up to date and regularly reviewed.
- Systems and processes were in place to assess and respond to patient risk including escalation of the deteriorating patient and management of patients with sepsis.
- There were sufficient nursing and medical staff to deliver safe care and on call systems in place when advice or support was required.

Are medical care services safe?

Requires improvement



Incidents

- The Trust had a robust incident management policy in place and we saw evidence that lessons were learnt and improvements made following incident investigation. Staff were familiar with the incident management policy and aware of their responsibilities to raise and report incidents. One department told us of action they had taken following an incident involving a patient fall. Extra supervision had been put in place to prevent elderly frail patients from being left alone in cubicles.
- National Patient Safety Alerts were disseminated throughout the wards and departments and included in staff briefing communications. We saw safety alerts displayed on staff notice boards.
- There were 633 incidents reported between February and April 2018 of these 552 were classified as no harm, 77 as minor harm, two as moderate harm and two as major harm. There had been no incidents reported that had resulted in death.
- There had been one serious incident in April 2018, which was still under investigation at the time of our inspection.
- There had been no never events in this core service during this time period.
- Monthly morbidity and mortality (M&M) meetings were held within the clinical management group. These meetings reviewed patient deaths and treatment complications in order to develop improvements to patient safety and aid professional learning. Doctors we spoke with confirmed they attended these meetings. We reviewed a number of M&M meeting for minutes for April and May across a number of specialities within medicine. We saw that meetings were well attended. Minutes were clear and there were clearly documented actions to improve learning and patient safety, for example in the mortality and morbidity meeting minutes for cardiology an action indicated there was to be further investigation of a case discussed by the patient safety team.
- Staff we spoke with were aware of the duty of candour. Prompts to ensure the duty of candour was applied were included in the incident management policy,

Medical care (including older people's care)

complaints policy and incident reporting system. The duty of candour is a regulatory duty that relates to openness and transparency and requires Providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Safety thermometer

- The trust monitored performance on safety by completing the NHS Safety Thermometer. The Safety Thermometer is a measurement tool for improvement that focuses on the most commonly occurring harms in healthcare: pressure ulcers, falls, bladder infections in patients with catheters and venous thrombo embolism (blood clots in the veins). The Safety thermometer also enables wards, teams and organisations to benchmark against each other.
- We found at this inspection, as we had at the previous two inspections in 2017, that not all wards or departments displayed their Safety Thermometer results.
- As part of an insulin safety action plan, the trust planned to add additional metrics to the safety dashboard. Five key metrics to monitor Insulin Safety had been agreed by the UHL Insulin Safety Task and Finish Group and will be presented in the form of a RAG rated dashboard. These were:
 - Number of instances of severe Hypoglycaemia (<3.0mmol/l)
 - Number of instances of severe hyperglycaemia (> 25.0mmol/L)
 - Prevalence of inappropriate missed doses of insulin
 - Compliance of Medical & dental staff compliance with Insulin Safety training (%)
 - Compliance of Registered Nurses, Midwives compliance with Insulin Safety training (%)

Cleanliness, infection control and hygiene

- The wards and departments we visited had systems in place to prevent and protect people from a healthcare associated infection. Everywhere we visited was visibly clean. We spoke with domestic staff who showed us completed and up to date cleaning schedules, and we saw that cleaning equipment and products followed recommended guidelines. Monthly cleaning audits were carried out and staff told us they received feedback from the audit if there were improvements to be made.

- The trust facilitated Patient Led Assessments of the Care Environment (PLACE). Patient Led Assessments of the Care Environment (PLACE) are a self-assessment of non-clinical services which contribute to health delivered in both the NHS and independent healthcare sector in England. The assessment of cleanliness for the hospital demonstrated a compliance level of 98.7% which was slightly better than the England average of 98.4%.
- 'I am clean' stickers were in use so staff knew which equipment had been cleaned and was ready for use. However, in two of the dirty utility rooms we inspected there were eight pieces of equipment that did not have a sticker in place so staff could not be assured they had been cleaned.
- Hand sanitizers were available at the entrance to wards, departments, side rooms and bays. Personal protective equipment (PPE) such as gloves, aprons and masks were readily available to staff and we observed staff using PPE when caring for a patient with an infectious disease.
- Staff practised good hand hygiene following the World Health Organisations five moments for hand hygiene guidance. The guidance describes the key moments when staff in healthcare settings should perform hand hygiene to minimise the risk of cross contamination.
- On our previous inspection in November 2017 we noted that 'There was inconsistent use of infection prevention and control specific care plans and risk assessments across the hospital. In some areas there was good use of risk assessments and care plans to support the care provided to patients with a known or suspected infection. However, in other areas risk assessments were not accurately completed and there were no care plans.'
- During this inspection we reviewed the notes of four patients who had, or were suspected of having, an infectious disease. We saw that the generic record of infection prevention (GRIP) assessment had been completed in all cases. This meant that staff had clear instructions on how to safely administer care and treatment to those patients including visitor access, discharge and room and equipment cleaning following discharge.
- On two wards we observed that two patients with suspected tuberculosis were being nursed following the source isolation protocol. Source isolation is the term which describes the steps taken to prevent the spread of

Medical care (including older people's care)

an infectious agent from one person to another. Specific instruction for staff and visitors were displayed on the door of the isolation room including what PPE should be worn.

- Staff told us that Cystic Fibrosis patient were nursed in a dedicated area of the ward away from patients with known or suspected infectious diseases. Cystic Fibrosis is a genetic disorder that affects mostly the lungs, but also the pancreas, liver, kidneys, and intestine. Long-term issues include difficulty breathing and coughing up mucus because of frequent lung infections. Cystic fibrosis patients are very prone to chest infections.
- During our inspection we visited the endoscopy unit. Endoscopy is a procedure in which a lighted flexible instrument is introduced into the body to give a view of its internal parts. We observed that the flexible endoscopes were decontaminated following guidance in Health Technical Memorandum 01-06: Decontamination of flexible endoscopes.

Environment and equipment

- Generally, we found that the maintenance and use of facilities kept people safe and protected from avoidable harm. We checked 11 pieces of equipment and saw evidence of completed up to date electrical safety checks.
- We inspected two resuscitation trollies. They were equipped according to Resuscitation Council UK guidelines and daily checks had been completed since 01 March 2018.
- Staff told us they had sufficient equipment to deliver care and pressure relieving equipment used to minimise the risk of pressure ulcers was readily available. Specialist pressure relieving equipment was requested from an external supplier but was available for staff within two hours.
- Decontamination equipment in the endoscopy unit was due for replacement and staff told us this was scheduled for 2019 along with a reconfiguration of the endoscopy decontamination service.
- We observed clinical and domestic waste was correctly segregated and waste bins provided for the wards were compliant with health technical memorandum (HTM) 83 as they were fire retardant as well as being enclosed and foot operated which are requirements under the larger

waste management guidance document HTM 07-01 safe management of healthcare waste. The management and disposal of sharps was completed in accordance with trust policy.

- In the areas we inspected curtain rails round beds and in shower rooms were collapsible. Light pull cords and nurse pull cords were not ligature risk proof apart from on Ward 15.
- We found razors and scalpels in two unlocked store rooms which meant the public and patients could access these and therefore could be a risk to patients with mental health issues.
- At our last inspection we found that staff did not always follow trust policy on the care of substances hazardous to health (COSHH). During this inspection we found bottles of chlorine based solutions on work surfaces in three unlocked rooms and chlorine tablets in an unlocked cupboard in one unlocked room. This meant that these chemicals were not stored safely.

Medicines

- On the previous inspection in November 2017, inspectors found that staff were not always following prescription instructions for the administration of insulin. We served a warning notice under Section 29A of the Health and Social Care Act 2008 in December 2017. The warning notice was served as we found evidence to suggest the quality of health care in relation to management of insulin for diabetic patients' required significant improvement. At this inspection we found that prescribing and administering of insulin had improved, although it was not performed in line with guidance on every occasion. Further improvements were required to monitor and embed actions that had been taken to achieve improvements.
- We looked at the prescription charts for 12 patients. The hospital used paper prescription and medication administration record charts for patients. The prescription charts were generally clear and fully completed. The records were clear and fully completed. We saw staff recorded patients' allergies on the prescription chart. In addition to the prescription charts, staff used a green 'adult insulin prescribing and glucose monitoring chart' for patients who were insulin treated patients with diabetes. Staff monitored patients' blood glucose levels at least four times a day and recorded the information on the green chart and on an electronic system, together with the patient's other observations.

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- At our last inspection we found staff did not always follow the trusts policy and prescription instructions for the administration of insulin. We found patients with high blood glucose readings who did not receive insulin to correct this as prescribed. On this inspection we found the same concern. Of the 12 patient insulin administration charts we looked at we saw four patients, across Wards 15, 17 and 29, had not been administered additional insulin on every occasion when the recorded blood glucose readings were above the threshold.
- One patient should have received additional insulin when the blood glucose reading was over 18.0mmols and we saw on three occasions between 14 and 29 May 2018 staff did not administer insulin for blood glucose readings of 19.6mmols, 20.2mmols, and 18.3mmols. However, staff did administer insulin for a blood glucose reading of a 17.2mmols which was below the threshold.
- A second patient was not given insulin on six occasions between 23 and 29 May 2018 following blood glucose readings of 18.8mmols, 20.7mmols, 22.0mmols, 18.8mmols, 19.9mmols, 19.4mmols, and 18.6mmols. The threshold for administration of additional insulin for this patient was 18mmols.
- A third patient was not given insulin on 25 May 2018 following blood glucose reading of 24.9mmols. The threshold for administration of additional insulin for this patient was 18mmols. This reading was not recorded on the green chart but was on the electronic system. We also saw there was a discrepancy between a reading recorded on the green insulin chart and the electronic system. The pre-lunch reading recorded on the green chart for 24 May 2018 was 15.5mmols. The reading recorded on the electronic system was 18.8mmols. No additional insulin was given to the patient following this result.
- Staff had prescribed additional insulin on the fourth patient's insulin chart for blood glucose readings of above 12mmols. Between 23 and 29 May 2018, the blood glucose readings for this patient exceeded this threshold 11 times without additional insulin being given. The readings were 17.1mmols, 14.0mmols, 13.0mmols, 14.8mmols, 17.5mmols, 15.9mmols, 13.4mmols, 17.7mmols, 14.0mmols, 12.9mmols and 16.4mmols. We asked staff why this patient had so many missed doses of insulin and were told the threshold was too low on the prescription however this had not been identified by any of the nursing staff during this period.
- We highlighted these findings to staff but we could not find any evidence in the patient records as to why the insulin was not administered. However, we saw staff followed guidance in the treatment of hypoglycaemic (low blood sugar) episodes.
- Staff told us they believed there had been significant improvements since the last inspection in November 2017. We were told all staff had received one to one training in relation to the management of diabetic patients. Senior nursing staff told us the electronic system gave them better oversight of all the diabetic patients in any area without having to look in individual patient records. We were told the nursing handover now included details of all diabetic patients on the wards.
- The trust had a medicines management policy in place which was accessible to all staff on the trust intranet. The policy covered the obtaining, prescribing, recording, handling, storage, dispensing, administration and disposal of medicines and medical gases.
- On all the wards and departments we visited we observed that drug trolleys were locked and secured to the wall and all other medicines were stored securely in locked cupboards in locked rooms. Medical gases were stored securely in metal crates.
- At our last inspection we found that staff did not always ensure medicines were stored correctly. We found room temperature and refrigeration temperatures above the recommended temperature for safe storage of medicines.
- During this inspection we reviewed four sets of room and fridge temperature logs and found them to be complete and up to date and within the recommended temperature range for the safe storage of medicines. Air cooling fans were kept in the rooms and staff told us they would use these if room temperatures became raised.
- We checked the storage of controlled drugs on two wards. We found these were stored correctly and that the controlled drugs log book was accurate for the drugs we checked. Staff were aware of their additional responsibilities around controlled drugs and referred to the Nursing and Midwifery Council, Standards for Medicines management in respect of controlled drugs which states two members of staff should be present for the checking and administration of controlled drugs.
- Pharmacy staff visited the wards and departments daily to check medicines stocks and review the medicines prescribed for patients along with any other medicines

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they were currently taking (medicines reconciliation). Medicines reconciliation is recommended practice and involves creating an accurate list of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications.

- Medical staff had access to microbiology protocols on the trust intranet this meant that antibiotics were prescribed responsibly according to recommended guidance.
- All but one of the 11 patients we spoke with told us they had been given information about any new medicines prescribed in hospital and were clear about how to take the medicines when they were discharged home. One patient told us he was on four new medicines and did not know what they were for and one patient who had been discharged had waited four hours for his take home medicines. Information about patients' medicines was included in the discharge letter sent to the patients GP.

Records

- Patient records were a mixture of paper based records and electronic records. Nursing, medical and risk assessments were all paper based, the observation charts and referral records were on electronic systems. We reviewed three nursing and medical notes. We found the records were generally legible, contemporaneous, signed and dated and contained specific details about a patient care. However, we occasionally found entries which although signed, had no printed name to accompany the signature, and medical staff did not always enter their GMC number which is not in line with professional standards.
- We saw that nursing assessments were completed as relevant to each patient following risk assessments and updated regularly according to the patient's condition.
- Nursing staff carried with them detailed hand over notes about each patient printed from an electronic record. Staff told us that at the end of the shift this information was disposed of securely.
- Medical notes were stored in trolleys which had a combination lock on the to prevent notes being reviewed by unauthorised persons. On two wards we

visited, we found these trolleys were not locked, out of sight of the nursing station and notes were stored on the top of them which meant that confidential records were not stored securely.

Safeguarding

- Systems were in place to keep people safeguarded from abuse. Safeguarding policies were in place for adults, children and young people and staff we spoke with were familiar with the policies and described how they would manage a safeguarding concern.
- Safeguarding training was mandatory for all staff. At our last inspection we found that nursing and medical staff compliance with level two safeguarding training for children and young people was below the trust target of 95%. Nursing staff were 82% compliant and medical staff were 51% compliant.
- Safeguarding policies and training incorporated the Nursing and Midwifery Council best practice guidance.
- Arrangements are in place to safeguard women and children with or at risk of FGM.

Mandatory training

- An effective mandatory training programme was in place to ensure staff were familiar with safety systems and processes. Mandatory training for all staff groups included; fire safety training, moving and handling, infection prevention, equality and diversity, information governance, safeguarding children (level one), conflict resolution, safeguarding adults, health and safety, basic life support, consent and, mental capacity act (MCA) and deprivation of liberties safeguards.
- The trust had set a target of 95% for the completion of mandatory training. In medicine, in all staff groups, the target was met for six out of the 11 training modules. These were safeguarding adults, safeguarding children level one, PREVENT - Workshop, health and safety, equality and diversity and conflict resolution. Other module compliance was between 62% (fire safety) and 94% (infection prevention and control).
- Sepsis training was also included in the mandatory training programme. Staff we spoke with told us this included awareness of the sepsis management pathways and the sepsis six bundle.

Assessing and responding to patient risk

- Comprehensive risk assessments and care plans were in place to minimise risks to patients and monitor their

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condition during their stay in hospital. We reviewed three sets of nursing notes which contained risk assessments for falls, infection risks, manual handling, skin integrity, malnutrition and bed rails. All risk assessments had been completed within 24 hours of admission and we saw evidence of on-going assessment of the patient.

- Nursing staff used an early warning scoring system (EWS), based on the National Early Warning Score, to record routine physiological observations such as blood pressure, temperature, and heart rate. EWS was used to monitor patients and to prompt support from medical staff when required. There were also clear escalation procedures for nurses to follow depending on the EWS score including sepsis management and implementation of the sepsis six bundle. Sepsis is a life-threatening condition that arises when the body's response to infection injures its own tissue and organs. The sepsis six bundle consists of six basic therapies which if completed within the first hour following recognition of sepsis, the associated mortality has been reported to reduce by as much as 50%.
- Staff used the Situation, Background, Assessment and Recommendation (SBAR) communication tool when referring patients for medical assessment. SBAR empowers staff to hand over in a factual and concise manner and offering their opinion of what they would like to see done, for example, 'Come to see the patient', 'transfer the patient to critical care', 'ask for a consultant to see the patient now'.
- Safety huddles occurred on each ward every morning. During these huddles, staff discussed any issues which may affect or disrupt safe care and treatment and any patient concerns including details about deteriorating patients or patients receiving sepsis management care.
- There was a critical care outreach team available to the wards 24 hours a day, seven days a week. The team supported ward staff in the detection and management of critically ill and deteriorating patients. The aim of the outreach team was to ensure deteriorating patients received appropriate and timely treatment in a suitable area and facilitate movement to a suitable area if required. For patients who deteriorated within the hospital, there was access to level two and three critical care on site (adult intensive care unit with ventilators).
- Patients attending the endoscopy unit completed a general medical questionnaire before the formal admission process. This included questions about

blood problems, heart problems medicines and allergies. This meant that admission staff had the patients' medical history and other relevant information to take into consideration pre- procedure.

- The endoscopy admission checklist included relevant risk assessments such as the Waterlow score for assessing the risk of pressure ulcers, a falls risk assessment and an Entonox checklist.
- At our last inspection Staff in the angio catheter suite told us they did not follow Royal College of Anaesthetist guidance for the provision of conscious sedation. There was no member of staff designated to monitor the patient whilst receiving sedation. This meant that there was a risk that patients who were under or over sedated did not receive prompt treatment.
- At this inspection managers told us that although there was not a member of staff designated to each patient there was a circulating nurse who performed vital signs observations on all patients consciously sedated every 10 to 15 minutes and that patients were never left alone. However, they had acknowledged our feedback from the previous inspection, carried out a thorough risk assessment and were currently recruiting for additional staff to fill the role.

Nursing staffing

- Staffing levels and skill mix were comprehensively reviewed every six months and action taken to address any short falls or discrepancies. One manager told us the most recent review had resulted in recruiting additional nursing staff for medical services.
- The Safer Nursing Care Tool was used daily to ensure wards and departments had the right staff with the right skills in the right place to deliver safe care and treatment. The Safer Nursing Care tool is endorsed by the National Institute for Care Excellence.
- Staffing levels and 'hot spots' were discussed at the daily bed meeting so managers were aware of any unplanned gaps and were able to move staff to cover them.
- Staffing numbers were not consistently displayed on the wards and departments we visited but we observed sufficient staffing levels and skill mix to deliver safe care and treatment. Patients we spoke with told us they felt there were enough staff on duty, that call bells were responded to promptly and patients in single rooms told us that staff checked on them regularly.

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- At the time of our inspection the angio catheter suite were recruiting nursing staff to fulfil the role of scrub nurse and support for patients under conscious sedation as recommended by the Royal College of Anaesthetists.
 - Bank and agency staff were used across medicine services to support staffing levels when necessary. Staff told us that both bank and agency staff completed an induction programme prior to commencing work and agency staff had additional assessments every six months to ensure they were still equipped with the right skills and experience to work at the trust.
- Medical staffing**
- On the wards we visited medical care for patients was provided by a team of junior grade doctors, registrars and a consultant who had overall responsibility.
 - Consultants were on site from Monday to Friday between 8am and 5pm. Out of hours, consultants were on call and could reach the hospital within 30 mins if necessary. Consultants completed twice weekly ward rounds, patients we spoke with knew who their consultant was and most patients had met and spoken with their consultant.
 - Out of hours care was provided by a 'hospital at night' team which comprised of junior doctors, nurses and clinical support workers, with all patient-related tasks managed by a senior nurse who triaged the tasks and assigned each to a member of the team.
 - We observed a handover taking place between medical staff. The health status of each patient was discussed in particular any patient who was deteriorating or being treated for sepsis. This meant doctors knew which patients were at most risk.
 - Junior medical staff told us they were well supported from more senior staff and if they had any concerns about a patient they could easily contact someone for advice.
 - The trust had a process in place which reviewed new submissions by agency or locum medical staff requesting to work at the trust. This process also ensured regular checks continued to ensure the staff member was safe to work at the trust. The checks made for each staff member were in line with the guidance from NHS Employers.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- The trust must ensure that all staff follow the prescription and trust guidance when monitoring patients blood glucose levels and administering as required insulin.
- The trust must ensure staff are up to date with mandatory training.

Action the hospital **SHOULD** take to improve

- The trust should ensure scalpels and razors are stored securely so that they can not be accessed by patients or the public.
- The trust should ensure confidential patient records were are stored securely.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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