East Kent Hospitals University NHS Foundation Trust

# William Harvey Hospital

**Inspection report**

Kennington Road
Willesborough
Ashford
TN24 0LZ
Tel: 01227886308
www.ekhuft.nhs.uk

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## Ratings

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

# Our findings

## Overall summary of services at William Harvey Hospital

**Requires Improvement** 

We carried out this unannounced, focused inspection because at our last inspection of medical care (including older people's care) at William Harvey Hospital we rated the key question of "Is the service safe?" as inadequate. See the medical care (including older people's care) section of our previous report for our findings and judgements. We had also received information giving us concerns about the safety and quality of the services. The William Harvey Hospital provides; medical care (including older people's care), services for children and young people, critical care, end of life care, outpatients and diagnostic imaging, surgery, and urgent and emergency services. We inspected the key question "Is the service safe?" within the core service of medical care (including older people's care). We did not rerate the hospital at this inspection. The previous rating of requires improvement remains. See the medical care (including older people's care) section in this report for what we found on this inspection. During the inspection, we visited; the acute medical assessment unit, Cambridge M1 ward, Cambridge M2 ward, Cambridge L ward, Cambridge J2 wards and the discharge lounge at the William Harvey Hospital. We spoke with 31 staff including; nurses, doctors, managers, allied health professionals and support staff. During our inspection, we looked at ten sets of patient records. How we carried out the inspection You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

# Medical care (including older people's care)

**Requires Improvement** 

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

- Not all staff had completed their mandatory training.
- Not all staff washed their hands before entering wards and social distancing guidance was not always followed.
- Risk assessments were not always updated. Staff did not consistently monitor patients for risks related to VTE, fluid balance or sepsis.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up to date.
- The service did not always monitor the ambient temperature of areas being used to store medicines.

However:

- The service provided mandatory training in key skills to all staff and there were systems to monitor compliance.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled most infection risks well. Most staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave staff a full induction.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Records were stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines. The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the team. When things went wrong, staff apologised and gave patients honest information and suitable support.

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

# Medical care (including older people's care)

## Is the service safe?

**Requires Improvement** 

Our rating of safe improved. We rated it as requires improvement.

**Mandatory training**

**The service provided mandatory training in key skills to all staff and there were systems to**

**monitor compliance. However, not all staff had completed their mandatory training.**

The mandatory training was comprehensive and met the needs of patients and staff. Nursing and medical staff received and kept up to date with mandatory training.

Statutory training contained: fire safety level 1, health, safety and welfare level 1, data security awareness level 1, equality and diversity and human rights level 1, moving and handling level 1, infection prevention and control level 1, infection prevention and control level 2, safeguarding children level 1, safeguarding children level 2, and safeguarding children level 3.

Mandatory training included: safeguarding adult level 1, safeguarding adult level 2, prevent level 1 and 2, prevent level 3, hand hygiene, dementia, and resuscitation level 2 - adult basic life support.

Online training modules available to all staff were in line with national guidance and regulations. We saw a matrix displayed indicating completion levels and training dates of any booked. We found the information to be up to date. All staff knew about the training matrix.

The overall compliance figures indicated 90% for statutory training and 79% for mandatory training. A breakdown of training contents and compliance levels dated April 2021 showed compliance ranged from 45% for dementia training to 100% for safeguarding adult level 1 at William Harvey Hospital. Eleven out of 17 statutory and mandatory training met the trust's target of 85%.

Not all clinical staff completed training on recognising and responding to patients with dementia. We saw dedicated dementia training was part of the mandatory training modules. However, the compliance levels across sites only reached an average of 49%, which did not meet their target of 85%.

Face to face training were held during the pandemic, but staff told us new sessions were being organised, and they felt able to get up to date after the pandemic. However, staff also told us the online learning platform had been down a few times in the past two months, which caused some issues, but it was being investigated at trust level.

Managers told us new doctors to the trust received a week of time dedicated to completing their mandatory training.

All staff reported feeling supported to complete training and to request any additional training they required, and funding was available to support further training. Staff were not expected to complete training during their own time,

and told us they felt there was a good, supportive culture around training completion and individual needs. Staff we spoke with told us managers supported their team members with protected time for training and held open conversations around additional learning needs. Medical staff gave positive feedback on their weekly "special programs activities", which included eight hours a week of protected study slots.

Managers monitored mandatory training and alerted staff when they needed to update it. Staff and managers were informed about training compliance levels and additional training needs.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Staff received training specific for their role on how to recognise and report abuse. Six members of staff we spoke with told us they felt safeguarding training had been adapted during the pandemic, moving from classroom sessions to webinars and online modules, which staff found helpful. Staff we spoke with also told us classroom sessions were going to restart. They told us they knew where to locate the guidelines for safeguarding referrals on the internal IT platform. We found the equality, diversity and human rights training module, in line with national requirements.

Safeguarding training compliance levels for both children and adults met trust targets except safeguarding children levels 2 and 3. Compliance with safeguarding children level 1 was 100%, but compliance with safeguarding children levels 2 and 3 was 79% and 72%, respectively, which did not meet the trust target of 85%. Compliance with safeguarding adults levels 1 and 2 was 100% and 93% respectively which met the trust target.

Staff knew how to recognise and report abuse. Two members of staff we spoke with gave us examples of recognising abuse in patients in vulnerable circumstances. They described escalating concerns appropriately, which resulted in the patients being protected. Other staff we spoke with knew how to identify and report abuse but had not needed to do so. Staff told us if they were unsure about a concern of abuse they would talk to their manager.

Staff worked together to protect patients from risk of abuse. Staff in various roles reported good collaboration with the dedicated safeguarding team and leads. Staff members also mentioned feeling supported by specialist safeguarding nurses who were readily available on wards when needed. A member of staff told us about a patient with learning and communication difficulties who was well supported due to effective multidisciplinary work to arrange additional support in the community.

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

**Cleanliness, infection control and hygiene**

**The service controlled most infection risks well. Most staff used equipment and control measures to protect patients, themselves and others from infection. However, not all staff washed their hands before entering wards and social distancing guidance was not always followed. They kept equipment and the premises visibly clean.**

Not all staff complied with social distancing to reduce the spread of COVID-19. National guidance recommended "staff adhering to social distancing (2 meters) wherever possible". We saw on most wards we visited social distancing was

being conducted well and signs were present to indicate to 2021 staff how many people could enter each room without compromising social distancing. On Cambridge L Ward we saw the corridor, nurse station and handover room were crowded and did not display these signs. This meant staff did not know when there were too many people in the room to safely enter while maintaining social distancing. Maintaining social distancing reduces the risk of spreading COVID-19.

The service had processes to identify and treat people with infection and reduce the risk of these people transmitting these infections to other people. The trust swabbed patients on admission to hospital for COVID-19 and MRSA. Staff had access to COVID-19 testing kits they were advised to use twice a week to identify infected members of staff that had no symptoms. Patients with infectious diseases were isolated from uninfected patients. Patients with a negative result for COVID-19 from their first swab were re-swabbed after three and five to seven days of being admitted. The service audited their compliance with their swabbing policy monthly and in May 2021 their compliance for medical care at William Harvey Hospital was 98% for day one, 54% on day three and 82% on day five to seven. Leaders told us they were working to improve compliance and since our last inspection there had been an improvement. Patient which had symptoms of COVID-19 were isolated and tested. Patients which had no symptoms were tested to check for asymptomatic COVID-19 patients. Patients that had a positive COVID-19 result were placed in isolation rooms. During our visit there was low number of patients with COVID-19 in the hospital however the hospital had plans for patient cohorts in preparation for higher numbers of patients with COVID-19.

The service had enough sinks and alcohol hand rub dispensers to support compliance with hand hygiene. We saw no queues for sinks and saw alcohol hand rub was available at all entrances to wards. All patient bed spaces had an alcohol hand rub dispenser in line with trust policy. All sinks had soap, disposable hand towels and posters displaying the correct hand washing technique.

Staff did not always complete hand hygiene when needed to reduce the risk of transmission of infections. We saw 11 staff did not decontaminate their hands when entering wards. However, we also saw 15 staff did use alcohol hand rub to clean their hands when entering wards. All staff cleaned their hands before, during and after patient care in line with the World Health Organisation guidance on the “five moments for hand hygiene”. We saw posters reminding staff of these five moments.

We noted compliance levels for hand hygiene training across the trust were 57%, worse than the trust target of 85%. Leaders told us this training involved staff taking equipment to wards which had been more difficult during the global pandemic as they had restricted staff moment between different wards.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service had a clear policy for staff to follow on the use of PPE. PPE was available in all areas we visited. All staff were wearing PPE correctly for the care being provided. All staff in corridors were wearing a mask in line with national and local guidance. Staff took off and put on PPE in line with Public Health England guidance. Leaders of the service had a strategy to monitor the supply and ensure staff always had access to the PPE they need.

The service monitored their compliance with hand hygiene policy and PPE policy. The ward staff completed daily combined audits which for the medical wards at William Harvey hospital showed compliance of 99% in March 2021, April 2021, and May 2021. The trust also monitored the number of audits being completed in each area. Across the medical care service at William Harvey hospital in March, April and May 2021 there had completed 2772, 2528, and 2559 audits respectively.

The trust had produced a training video showing staff the correct personal protective equipment to wear and how to use this. The medical care group staff compliance with watching this was 87% in May 2021.

# Medical care (including older people's care)

The wards had been designed to reduce the spread of infections. All wards we visited had doors on the bays. Doors help to prevent the spread of infection by providing a physical barrier between the patient area and the rest of the ward. All wards had clear plastic curtains used to separate each bed space without limiting visibility of patients. We saw these plastic curtains were carefully cleaned by the domestic staff. All bed spaces also had privacy curtains made of material and these had been changed in line with the trust's policy.

Ward areas were visibly clean and tidy and had suitable furnishings which were visibly clean and well-maintained. All furniture was wipeable and were not ripped or torn.

The service generally performed well for cleanliness. The hospital achieved 99.1% for cleanliness in the latest Patient-Led Assessments of Care Environment Audit, 2019.

The trust was conducting environmental audits using their existing tool while they designed a new version. We looked at three ward environmental audits which looked at each area within the ward with a list of aspects to check. This list included checking if the area looked tidy/clean, if surfaces were clutter free, and if wall mounted soap and towel dispensers were available. We saw each of these audits had identified areas for improvement and the proforma had an area to record an action plan. However, two audits had not had an action plan completed. The audit with a

completed action plan was clearly laid out with updates showing which actions had been

completed and progress made on other actions. Leaders reviewed these and found they needed to be improved; at the time of this inspection, this work was in progress.

Staff managed sharp clinical waste in a way that reduced the risk of spreading infections. Wards had sharps bins assembled correctly and these had not been overfilled. Staff used temporary closure lids to reduce the risk of accidental sharps injuries.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment looked visibly clean and had green stickers on equipment allowing staff to identify the equipment had been recently cleaned.

The domestic staff carried out twice daily cleaning of the wards to reduce the spread of infection. Staff told us the nurse in charge of the ward would check cleaning had been completed each time the domestics had finished their cleaning. We saw cleaning being conducted before a new patient was moved into a bed space on the ward.

The service monitored infection rates and targeted improvement on areas of concern. The trust reported their rates of six types of hospital associated infections which were compared against other trusts across England. Over the past 12 months the trust had performed in the bottom 25% for three and in the middle 50% for the remaining three. Over the last 3 months their performance had improved with one indicator in the top 25%, three in the middle 50% and two in the bottom 25%.

The trust improvement plan included learning from the recent *Clostridium difficile* outbreak. *Clostridium difficile* is an infectious bacterial infection primarily spread by healthcare staff from infected patients with diarrhoea. Improvements identified included strengthening the support for their antimicrobial stewardship team and ribotyping all *Clostridium difficile* samples. Ribotyping is a process to identify more detailed information on the type of a bacterial infection which is used to indicate the likelihood infections were spread between patients. Learning was discussed at the infection prevention and control committee and the infection prevention and control improvement group.

# Medical care (including older people's care)

**Environment and equipment**

**The design, maintenance and use of facilities, premises and equipment kept people safe.**

**Staff were trained to use them. Staff managed clinical waste well.**

The service had enough suitable equipment to help them safely care for patients. We saw staff had access to equipment when needed. Equipment had been serviced and had stickers displaying when servicing was next due. Staff were trained to use equipment they needed including syringe drivers and manager monitored compliance with this training.

Equipment stored on resuscitation trollies was quickly accessible to staff in all wards and departments. Resuscitation trollies were checked daily and all equipment we checked was sealed, in date, and stored in the correct place. Storing equipment in the correct place on resuscitation trollies ensures staff can find lifesaving equipment quickly when needed.

Sterile equipment was stored in a way that prevented contamination. We looked at 17 items of sterile equipment all of which were; in date, sealed and dust free.

The environment and facilities were well maintained to keep people safe. Staff told us they had seen improvements with the décor being modernised on wards. Staff told us they reported maintenance needs to estates. We saw estates staff repairing a ward entrance door.

Staff disposed of clinical waste safely. Staff segregated waste into clinical and non-clinical waste. All wards had clinical waste bins with clear indication about what should be disposed of in them. They also had domestic waste bins for non-clinical waste which had signs on to remind people what could and could not be put into these bins. Staff segregated waste correctly between clinical and non-clinical waste.

The design of facilities kept people safe. We saw the environment had been designed to followed national guidance. The environment was kept clutter free and most areas had dedicated storage rooms with shelfing to store equipment off the floor.

**Assessing and responding to patient risk**

**Staff completed risk assessments for each patient and removed or minimised risks. However, risk assessments were not always updated. Staff identified and quickly acted upon patients at risk of deterioration. Staff did not consistently monitor patients for risks related to fluid balance or sepsis.**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. All patients were monitored with the National Early Warning Score 2 (NEWS2) tool. This tool calculates a score for each patient which alerts staff to deteriorating patients as their score rises. We saw staff had escalated concerns about a patient with a high NEWS2 score and their medical team had reviewed the patient. In March 79.6%, April 81.4% and May 2021 81.4% of observations had been completed in line with the trust's frequency guidelines set out in their policy.

Staff did not consistently record screening of patients for sepsis or the escalation of concerns about sepsis to medical staff. Managers showed us a screening tool produced by the trust that clearly laid out the triggers for sepsis and what

action staff should take. This included a large bright red sticker to be placed into patient records to indicate what actions had been taken. We looked at records of three patients that had been suspected of having sepsis and none had these stickers present. However, these records showed staff had identified concerns about sepsis and escalated these to medical staff and treatment had been given.

The trust completed a deteriorating patient audit monthly for William Harvey Hospital medical care services. This showed compliance with patients receiving a sepsis screen was 80% in March 2021, 75% in April 2021, and 70% in May 2021. This audit also reported compliance of concerns about sepsis being escalated to medical staff was 80% in March 2021, 88% in April 2021, and 70% in May 2021. However, staff could describe the process for the management of sepsis and the service used their quality improvement methodology to look at ways to improve patient care by increasing the percentage of patients receiving screening and escalation for sepsis.

Staff completed risk assessments for each patient on admission, using a recognised tool, however they were not always completed in full or within the required time period. We looked at 10 patient records and all had an initial nursing assessment to assess a range of risks. These risk assessments included an assessment of patient's pressure area risk using a nationally recognised and validated tool used to provide a risk score for each patient. The National Institute for Health and Care Excellence in Quality Standard 89 recommends patients receive a pressure area assessment within six hours of admission to hospital. Five of the ten patients had waited longer than six hours to have their pressure area risk assessment completed with two of these having waited longer than 12 hours. Quickly identifying patients at high risk of developing pressure ulcers allows staff to put in mitigation sooner reducing the number of patients developing pressure ulcers.

Risk assessments had not always been updated with the mitigations taken by staff. Of the ten sets of records reviewed, eight patients had received a falls risk assessment documented and two did not need a falls risk assessment. The risk assessments had space for actions taken to reduce the risks to be recorded. Six care records did not fully record the mitigations taken by staff with some records having no actions recorded at all. We asked staff about the lack of mitigation recorded and they showed us additional mitigations had been taken but not documented, including using anti-slip socks, falls risk signs, and sensor alarms.

The trust monitored the quality of their fall risk assessment completion. The service's audit of fall risk assessment completion showed compliance of 90.1% in March 2021, 88.4% in April 2021, and 79.2% in May 2021 which met the trust target of 75%. The trust reported 101 falls in April 2021 which demonstrated a reducing trend for the last three months and an improving picture.

Staff did not always reduce the risk of patients developing venous thromboembolism (VTE). A venous thromboembolism is a clot that can form due to reduced activity of patients in hospital. The National Institute for Health and Care Excellence recommends this risk assessment is completed as soon as possible after admission to hospital for all medical patients to identify the risk of VTE and bleeding. Quick assessment allows staff to consider and implement mitigations to reduce the risk of clotting or bleeding for patients. We saw nine patients had received a VTE risk assessment within 24 hours of their admission. However, one patient had not received their VTE risk assessment after 48 hours of admission. We escalated this to the nurse in charge of this area who immediately took action to complete this assessment.

Staff did not consistently reduce risks related to fluid retention or dehydration. We looked at five patient's fluid balance charts and none had been fully completed. Fluid balance charts are completed to track how much fluid goes into a patient and how much comes out. These had the input for patients recorded including intravenous fluids. The output for these patients was not recorded clearly with gaps in records or "OTT" recorded with no volume noted. OTT means out to toilet. Without the output being record it is not possible to record the daily balance change or to monitor a cumulative

total. Both daily and ongoing totals were not recorded for these five patients. Tracking the cumulative total is important as this alerts staff to patients becoming dehydrated or fluid overloaded. Managers were aware they had problems with fluid balance completion and had planned additional training with staff. The service monitored the quality of their fluid balance completion. The service's audit of fluid balance showed compliance of 72.1% in March 2021, 71% in April 2021, and 70% in May 2021 which were worse than the trust's target of 75%. In July 2020 the Coroner told the trust to improve the quality of their fluid balance completion in an aim to prevent future deaths. The trust had carried out improvement work however this had not been effective yet. Leaders told us they would work to urgently improve their fluid balance quality.

Staff shared key information to keep patients safe when handing over their care to others. Staff knew how to plan for complex discharges and told us how they handed over care on discharge. The trust had a "rapid transfer service" which supported with complex discharges and acted as a liaison between hospital staff and community services.

Shift changes and handovers included all necessary key information to keep patients safe. The hospital had a site wide safety huddle in the morning of each day, and these included sharing the pressures on areas across the hospital along with support offered by areas under less pressure. Staff told us these safety huddles were useful to them as a source of information. We saw these site wide safety huddles were used to quickly raise safety concerns to the site leadership. Ward-based safety huddles were held at the start of each shift. The trust had audited their compliance with daily ward safety huddles, reporting 95% for the William Harvey Hospital during February 2021.

The service had 24-hour access to mental health liaison and specialist mental health support. There was service level agreement with the local NHS mental health trust to provide a single point of access for this support 24 hours a day. The risk assessment proforma for patients with mental health conditions included the phone number and guidance on when to access this service.

**Nurse staffing**

**The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.**

The service had enough nursing and support staff to keep patients safe. We saw wards had enough staff to assess and respond to patient's needs.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Leaders were completing an in-depth review of their staffing levels across the trust to identify if the planned numbers of nursing and support staff were sufficient to meet the needs of patient groups. They noted several concerns about the previous safe staffing report. This included concerns that 2021 staffing levels were being monitored against an outdated acuity and dependency review from 2019. The trust 2019 staffing review noted 16 areas with lower than 50% registered nurses to health care assistants. The Royal College of Nursing 2006 recommendation was at least 65% of ward staff should be registered nurses.

The number of nurses and healthcare assistants matched the planned numbers. We saw the safe staffing cross on wards had red boxes indicating unsafe staffing levels. However, managers told us this was if the ward did not have the planned number of staff for the shift but did not account for managers then moving staff from other wards with extra staff.

# Medical care (including older people's care)

Managers and staff told us they had enough staff to meet the needs of their patients. We saw on the day of our inspection Cambridge L Ward had a red box however there had been staff moved from other wards to support them and the staffing level was safe on the ward. Patient buzzers were being answered quickly and staff had time to respond to patient needs.

The service had reducing vacancy rates and had reduced their use bank and agency staffing. The service had improved their substantive registered nursing vacancy rate from 18.3% in February 2020 to 13.5% in May 2021. However, a reduction had not been achieved in vacancies for support staff. Staff told us they had seen staffing levels improve over the last 12 months.

The trust's sickness absence levels from October 2019 to September 2020 followed a similar trend to the England average. However, the trust experienced a much higher peak in staff absence in April 2020 and the trust's sickness absence rate continued to be higher than the England average until July 2020.

The ward manager could adjust staffing levels daily according to the needs of patients. Ward leaders reviewed staffing levels every day against the needs and acuity of patients. Managers told us they reassigned staff from other wards when more staff were needed due to sickness or increased patient acuity. We saw staffing levels were discussed during the ward level safety huddles.

Managers limited their use of bank and agency staff and requested staff familiar with the service, where possible placing them to work on wards they were familiar with.

Substantive staff had an induction to the trust and a 'local' induction to the area they were to work on. These included; orientation to the hospital, fire safety procedures, arranging training for use of equipment, and how to access trust policies.

Agency and bank staff had a local induction to familiarise themselves with the ward or department where they were assigned to work. This included; where to find emergency equipment, information on infection control risks, and how to contact senior nursing staff for support. The trust had an up to date policy for temporary staff that required all new services to complete this local induction with all staff new to their area. When bank staff booked to complete a shift the area manager would be alerted on the booking system if this member of bank staff would need an induction. The manager when authorising the timesheet would need to record if this induction was completed.

**Medical staffing**

**The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.**

2021 The service had enough medical staff to keep patients safe. All staff we spoke to told us there was always enough medical staff to provide safe care for patients. In the acute medical unit, we saw there was a doctor trained to the correct level with advanced life support training immediately available. This was in line with national standards for acute medical units set out by the Society for Acute Medicine. Staff told us there was always a suitable trained consultant available to attend the acute medical unit within 30 minutes. Nursing staff told us doctors were always available to escalate concerns about patient care.

# Medical care (including older people's care)

The medical staff did not always match the planned number. However, managers had access to locums when they needed additional medical staff. Staff told us the acute medical unit should have eight doctors, but they had six substantive doctors in post. These were supported by one locum doctor. Medical staff told us if needed they supported other teams when they needed help due to sickness or patient acuity.

The service had low vacancy rates for medical staff. The service had 4.5% of consultant posts vacant with one locum consultant helping support the medical care group.

All new medical staff received a full induction to familiarise themselves with working in the trust and a period of seven days of buddy working with a senior doctor. We looked at two induction day programmes which included; completing life support training, introduction to clinical information technology systems, and information on infection prevention and control.

All locum medical staff received a full induction to familiarise themselves with the area where they worked. The trust had an up to date policy for locum medical staff that required completion of a local induction checklist with all new locum doctors. The local induction checklist included information on; fire safety procedures, incident reporting, and how to access support.

The service always had enough consultants to provide safe care and teaching for junior doctors. Medical staff told us they were always supported by senior medical staff when needed and that training was provided via taught sessions and ad hoc training during ward rounds. The trust was in the middle 50% of scores for overall trainee satisfaction in the General Medical Council survey in March 2019 to May 2019.

**Records**

**Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up to date. However, records were stored securely and easily**

**available to all staff providing care.**

Patient records were not always comprehensive and up to date. We observed care and treatment and looked at ten sets of patient records. Five records were comprehensive, with detailed information about the patients' care and treatment. However, five of the patient records we looked at contained incomplete fluid balance charts. We saw delays in the completion of four pressure ulcer risk assessments and one venous thromboembolism risk assessment. Three sets of patient records had staff entries with names which were not clearly legible. Having clear staff member names helps staff if they need to clarify or confirm information recorded with the staff member that made the entry. We saw three of the ten patient records had incomplete nursing assessments.

The service completed nursing documentation audits that showed compliance levels of 99.5% for March 2021, 81.2% for April 2021, and 76.7% for May 2021 which all met the trust's target of 75%. Leaders of the service had identified the reducing level of compliance and created an action plan to improve their compliance. This action plan focused on the most common causes of noncompliance in record keeping with targeted actions to address these which included reminders to staff in safety huddles and leaders providing immediate feedback from their reviews of records on wards.

Records were stored securely, and staff could access them easily. We saw records were stored in locked records trollies or in constant sight of hospital staff. Staff told us they always had quick access to records when they needed them.

# Medical care (including older people's care)

When patients transferred to a new team, there were no delays in staff accessing their records. Some patient information was recorded on the trust digital systems including patient observations, and nutritional assessments. This information was instantly accessible to staff on transfer to a new team or ward. We saw a patient transferred to a new ward and their patient records were brought with them allowing immediate access to the new team. Patient records showed multidisciplinary working.

Staff considered the efficacy of attempting cardiopulmonary resuscitation. We looked at three do not attempt cardiopulmonary resuscitation (DNACPR) orders which were all completed in line with national guidance. These showed discussion with the patient and if the order had not been discussed with the patient then the reason was clearly recorded. These all clearly stated the reasoning for implementing the DNACPR order and discussions with the patients' family were recorded for these three patients.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines. However, the service did not always monitor the ambient temperature of areas being used to store medicines.**

Staff followed systems and processes when safely prescribing, administering and recording medicines. Staff followed current national practice to complete medicines reconciliation which is checking patients were prescribed the correct medicines. All medicines charts we reviewed were written legibly, had all the patient's details listed and each page had the patients name recorded, and the patient's allergies were clearly recorded in red ink. All administered medicines were signed for and dated. Medicines that had not been given had a reason recorded.

Staff managed medicines and prescribing documents in line with the trust's policy and there was good antimicrobial stewardship. Most antibiotics had a clinical reason for their use recorded on the patient's medicines chart. All antibiotic usage was reviewed after three days and if required, a doctor had signed to confirm the antibiotics were still needed. The controlled drugs registers were up to date and access was restricted to authorised staff via keys kept with the nursing staff on each ward. All patients being administered oxygen had this prescribed in their medicines chart.

Staff stored medicines in line with the trust's policy. All controlled drugs were stored securely, and most other medicines were stored securely. We saw six medicines trollies secured to the wall when not in use however we also saw one medicine trolley was not secured to the wall while not in use. All these medication trollies had locked lids and all medication cupboards were locked. Secure storage of medicines prevents unauthorised access.

Ambient temperature monitoring was not completed for all areas where medicines were being stored. Two wards had no dedicated clinical room which meant medicines were stored and prepared in an area behind the nurse station. On these wards staff were unable to tell us how the ambient temperature was being monitored for the area medicines were being stored. Medicines stored out of the temperature specified by the manufacture can lead to reduced effectiveness and without monitoring staff do not know if storage areas go outside the indicated temperature.

Pharmacy staff supported ward staff with advice on medicines. We saw pharmacy staff on wards checking medicine charts and saw on medicine charts advice notes from pharmacists. Staff told us they always had access to pharmacy staff to answer their questions about medicines. However, some staff reported delays in getting medications when patients waiting to be discharged.

Staff learned from medicines errors. We saw incident reports of medicine errors which had been investigated and learning identified. These included failed discharge of a patient that needed home oxygen which had not been arranged resulting in the patient's discharge being delayed. Managers had investigated and shared learning with all staff in the medical care group to prevent this happening again.

**Incidents**

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the team. When things went wrong, staff apologised and gave patients honest information and suitable support.**

Staff we spoke with knew about the trust's policy on incident reporting of national regulations and told us there was a positive culture where they were empowered to report incidents. Staff reported feeling confident to report and record incidents. The staff we spoke with told us they had received adequate training and were supported by their managers to complete their training.

Leaders told us they had worked to improve the reporting culture and had seen an increase in reporting. From January 2020 to January 2021, the total number of reported patient safety incidents (all types) at East Kent Hospitals University NHS Foundation Trust increased by 84%, from 1,449 in January 2020 to 2,665 in January 2021. In particular, there were large increases in the numbers of incidents reported as resulting in low harm or no harm during May 2020 and October 2020 respectively which is indicative of a good reporting culture.

From March 2020 to February 2021, the trust's overall reporting rate (reported incidents per 1,000 bed days) was similar to other reporting trusts. In this time period, the proportion of reported

patient safety incidents reported as resulting in harm improved (reducing from 39.0% to 33.3%) compared to the previous 12 months.

The service had no never events in medical care at William Harvey Hospital recorded from May 2020 to April 2021. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.,

Staff reported serious incidents clearly and in line with trust policy. We looked at six incident records which contained enough details and were categorised in line with the trust's policy. The incidents we looked at had all been reviewed by a manager and included immediate mitigatory actions with correct grading of severity. We also noticed, when reviewing the sampled incidents, that they contained the detailed investigation process, as well as the outcome.

Managers investigated incidents thoroughly. The six incidents we reviewed included details of the managers who carried out the investigation, and details of how the patients and their families had 2021 been involved and informed of progress in line with the trust's policy and national regulations. Staff, patients and relevant stakeholders were all involved in the investigation, which was in line with the trust's policy, and national regulations.

Staff understood the duty of candour and followed the trust's policy and associated national requirements. Three of the six incidents we reviewed met the duty of candour criteria. Staff members who carried out duty of candour for these incidents were open, transparent, and gave patients and families a full explanation about the things that went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. The six incidents we reviewed included clear information about how staff members shared learning with their colleagues. Learning was shared through ward meetings, safety huddles, monthly site reports, and care group leadership team meetings. The trust provided minutes of these meetings to staff members who did not attend.

Staff met to discuss the feedback and look at improvements to patient care. The six incidents we reviewed each contained a brief description of how learning was shared, the main aspects in need of improvement, as well as a short-term and long-term plan to improve patient care based on learning from the incidents.

The service made improvements because of reported incidents. Staff had investigated an incident report of a delay in venous thromboembolism risk assessment completion which included actions they had taken to improve compliance. The service had audited their compliance following these incidents and seen improvement.

Managers generally debriefed and supported staff after serious incidents. Most staff told us they told us they felt informed and supported if involved in serious incidents.

**Safety Thermometer**

**The service used monitoring results well to improve safety. Staff collected safety**

**information and shared it with staff, patients and visitors.**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Safety thermometer data was displayed on wards for staff and patients to see. We saw wards displayed their harm free care data in colour coded crosses. They had one cross for each aspect they were monitoring. These included falls, pressure ulcers and safe staffing. Each day the boxes were coloured red or green with red being an incident had occurred and green no incident. These were clear to see the performance of harm free care over the last month.

The safety thermometer showed the service had reduced the incidence of harm within the reporting period. Data from the Patient Safety Thermometer showed the trust reported 14 new pressure ulcers, 11 falls with harm and one new urinary tract infection in a patient with a catheter from February 2019 to February 2020 for medical services. Leaders told us they had focused improvements on falls prevention as this was their leading course of preventable harm to patients. Since starting this focus on Kings C2 ward in March 2021 there had not been any falls to May 2021. Before this improvement Kings C2 was having an average of 15 falls per month.

Staff used the safety thermometer data to further improve services. Leaders told us they had seen a high number of pressure ulcers being acquired or worsen for patients during their stay in their hospitals. Leaders had in May 2021 setup a pressure ulcer steering group to monitor performance

and lead improvements in pressure area care.

# Medical care (including older people's care)

## Areas for improvement

**MUSTS**

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

- The trust must ensure that all staff comply with infection control practices. Regulation 12
- The trust must ensure that whenever possible staff are supported to socially distance. Regulation 12
- The trust must ensure that all rooms display the maximum safe occupancy. Regulation 12
- The trust must ensure that staff fully complete fluid balance chart for all patient that need them. Regulation 12
- The trust must ensure that all patients receive all required risk assessments without delay on their admission to hospital, that these are kept updated and staff record all mitigating actions. Regulation 12
- The trust must ensure they improve the consistence in their approach to managing sepsis. Regulation 12 **SHOULDS**

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

- The trust should ensure that all staff complete their mandatory training.
- The trust should ensure that patient records are comprehensive and kept up to date.
- The trust should ensure that all medicines storage areas have ambient temperature monitoring.

The trust should consider how to improve their compliance with swabbing patients for COVID-19, especially on day three.

# Our inspection team

The team that inspected the service comprised a CQC lead inspector, one additional CQC inspector and one specialist advisor with experience in acute medical care. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection (South East).

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

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