Southport and Ormskirk Hospital NHS Trust

Southport & Formby District General Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Southport & Formby District General Hospital

Inspected but not rated

Southport and Ormskirk NHS Trust provides healthcare to approximately 224,402 people across Southport, Formby and West Lancashire.

Acute inpatient care is provided at Southport and Formby District General Hospital and Ormskirk District General Hospital.

The medical care service at Southport and Formby District General Hospital has 209 inpatient beds. The urgent care clinical business unit manages medical care services.

The medical care service operates from nine wards at Southport and Formby District General Hospital.

This consists of a cardiology ward (7a), a short stay unit (9a), a respiratory ward (14b), a stroke ward (15b with two hyper acute stroke beds), an emergency assessment unit (10a) and three care of older people wards (9b, 15a and 7b).

The trust had 18,293 medical admissions from November 2019 to October 2020. Emergency admissions accounted for 10,037 (54.9%), 168 (0.9%) were elective, and the remaining 8,088 (44.2%) were day cases.

For the reporting period (November 2019 to October 2020) admissions for the top three medical specialties across the trust were:

• General medicine: 12,144

• Clinical Haematology: 4,720

• Pain management: 637

We carried out this unannounced focused inspection following information of concern received from the public. We received information about patients absconding from wards and that patients and their families had not always been involved in decision making regarding the application of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). We inspected safety processes in the trust's medical care services. We also looked at the wider oversight and management of risk, governance and safety of patients across the service.

On the inspection we were limited to the wards we could visit due to the COVID-19 infection risk. We visited five out of the eight medical wards which included the medical emergency assessment unit (EAU), ward 11b the general medical /gastroenterology ward, ward 7a the cardiology including coronary care ward, 14b the respiratory ward and 9a the short stay ward.

We did not inspect all of the key lines of enquiry as our concerns were related to specific risks. We inspected against parts of the safe, effective, caring and well-led key questions.

Our findings

We previously inspected medicine at Southport and Ormskirk NHS Trust in August 2019 as part of our comprehensive methodology where we rated the medical care (including older peoples care) service as requires improvement in safe, effective, caring and responsive and inadequate in well led.

During this inspection on the wards visited there was an improvement across all assessed domains. All the staff we spoke with were friendly and helpful. They spoke positively about the culture and the support and visibility of leadership on the medical wards.

We spoke with 23 members of medical and nursing staff. We reviewed 23 patient records, where we looked at specific documentation including care plans, risk assessments, mental capacity assessments, DNACPR records, patient 'rounding' documentation and patient care charts. Patient 'rounding' is a process of regular nursing checks to ensure patient's fundamental care needs are being met.

We spoke with nine patients during the inspection. We observed patient care using the Short Observational Framework for Inspection method (SOFI 2). The SOFI 2 tool provides a framework to enhance the observations we already make at inspections about the wellbeing of people using the service and staff interaction with them. We also interviewed key members of staff, medical staff and the senior management team who were responsible for the leadership and oversight of the service. We observed a handover/patient safety briefing, bed meetings, and a task force meeting with the local commissioners. We took into account nationally available performance data.

Following the inspection, we requested and reviewed information relating to the concerns raised and the evidence we had gathered following the observations we had made.

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.

See the medical section for what we found.

Medical care (including older people's care)

Inspected but not rated

At this inspection we found that:

- 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 bank and agency staff a full induction. This was an improvement against the requirement notice from the last inspection.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. This was an improvement from the last inspection.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. The leadership of the clinical business unit had been reviewed and expanded. Although the leadership team were relatively new to their posts, they demonstrated clearly defined and visible leadership roles and lines of accountability. This was significantly better than at the last inspection.
- The service managed patient safety incidents well. Managers investigated incidents, shared lessons learned with the whole team and the wider service and ensured that actions were implemented and monitored. There were some incidents relating to poor discharges which the trust was taking action to improve.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where staff could raise concerns without fear.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. The dashboard showed moves for patients were being monitored and were not excessive.
- Whilst we did not inspect infection prevention and control processes as part of this inspection, we did not identify any concerns in relation to the environment and we saw that staff were following appropriate guidance in relation to social distancing and the use of personal protective equipment on the wards we visited. We highlighted a minor observation where we saw staff huddled together around the nurse workstation on Ward 9a as it was unclear if social distancing guidelines were being met.
- We spoke with senior leaders on the day of the inspection for the trust's action regarding one patient's potential significant weight loss and the discharge safety for two patients. The trust identified some immediate learning and training actions in response to the concerns raised, however the management of the patient's nutritional needs and the discharges were satisfactory.

However:

- Staff supported and mostly involved patients, families and carers to understand their condition and make decisions about their care and treatment. However, there were a small number of instances where the family had not been involved in meaningful conversation around the making of important decisions about resuscitation, however, a recent audit demonstrated improvement in this area.
- Staff completed but did not always update risk assessments for each patient. However, falls risk assessments had improved since the last inspection and staff identified and acted upon patients at risk of deterioration.
- The service did not always have enough substantive medical staff. Although, managers regularly reviewed and adjusted staffing levels utilising locum and bank staff and new roles had been introduced to help keep patients safe.

Medical care (including older people's care)

- At the previous inspection we found consultants did not lead daily ward rounds on all wards and consultants were not available on wards at weekends. At this inspection we found that this had improved. Consultant ward rounds varied, being held two or three times a week. In addition, multi disciplinary board rounds were held daily on weekdays. This included medical, nursing, allied health professionals, social worker and a discharge coordinator daily on weekdays. Over the weekends there was a discharge ward round on the ward carried out by a consultant and a junior doctor. We were told there was access to additional consultant reviews as required. Consultants were now present on site at weekends, with on-call consultants available during out of hours periods.
- Staff mostly kept detailed records of patients' care and treatment although there were separate records for nursing, medical and allied health professionals. The lack of an electronic patient record (EPR) system meant it was more difficult to holistically review the care of an individual; the trust had identified this risk which they were monitoring. A digital strategy had been implemented and the next planned programme of work being an Electronic Prescribing System.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' needs. Staff did not always fully and accurately complete patients' fluid charts where needed, although this had improved from the last inspection.
- Staff provided emotional support and understood patients' personal needs and had provided contact to families and carers whilst visiting had ceased due to the COVID-19 pandemic.
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service safe?

Inspected but not rated

Assessing and responding to patient risk

Staff completed and mostly updated risk assessments for each patient to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration. The risk of patients absconding had not always been assessed or acted upon. Falls risk assessments had improved since the last inspection.

Staff completed a patient risk assessment and care planning booklet for all patients on admission. We found initial assessments were completed for patients who used the service however, the reviews of these risks were not always fully completed.

We reviewed the records for 17 patients on wards 11b, 4b, 7a, 9a and emergency assessment unit. We found staff had not updated or reassessed these for two of the records. The guidance for staff stated, 'reassessment as part of ongoing care plan review'. However, we found additional care plans had been introduced for both of these patients where concerns were identified. This included management of patients with breathlessness, those who require deprivation of liberty safeguards (DoLS) assessments and required their vital signs monitoring.

Medical care (including older people's care)

At this inspection we saw that the service continued to use mainly paper based patient records, though observations using the National Early Warning Score (NEWS2) were recorded by nursing staff on an electronic system. NEWS2 is a patient safety tool which improves the detection and response to clinical deterioration in adult patients. Records we reviewed showed scores were correctly calculated and that patients were escalated for medical review following this.

Concerns had been raised regarding patients absconding from inpatient wards. We were told on the inspection that if a patient absconded, the missing person protocol was activated. Patient risks were assessed as part of routine DoLS assessment and would be documented in the patient's care plans.

We reviewed the 'Policy and Protocol for the Missing Patient CLIN CORP 76' provided by the trust. This states that; 'on admission to in-patient areas the patients should have an assessment for an 'Enhanced Level of Supervision' and if the patient is identified as being at risk of absconding the appropriate level of supervision must be provided and 'consideration must be given to the completion of a risk assessment for individual patients'.

The policy appropriately referred to the Mental Capacity Act (2005) and the use of restrictive practice; the Mental Health Act (1983) and clearly defines the procedure for a missing patient including escalation. Learning requirements are also noted for relevant designations of staff. Monitoring is after any incident and there are helpful checklists included in the procedure.

An initial assessment of Enhanced Level of Care (ELOC) assessment should be completed for all patients in inpatient areas. This was comprehensive and resulted in one of three levels of supervision. Within the list of reasons for enhanced level of care it referred to potential for absconding. The assessment was reviewed daily.

We reviewed three records for patients who had absconded and found that the ELOC assessment was only contained within the notes for one patient. The form was either not completed or was absent from the other two records. Therefore, the risk of absconding was only recorded for one of the three patients.

The trust had a behavioural observations chart and there was also a hospital passport document which could be initiated to identify support required for patients who had specific requirements related to behaviour.

The trust had introduced new assessments for falls and cognitive impairment which were embedded in the risk assessment booklet.

There was evidence that mental capacity assessments were being undertaken for patients, particularly for patients who had been subject to deprivation of liberty safeguards. Medical staff completed mental capacity assessments if a patient was identified as lacking capacity.

Capacity assessments were also undertaken during an in-patient stay if the patients' ability to consent had changed, for example post-operative delirium. We saw evidence in patient records that DoLS records were accurately completed and were recorded via the trust's incident reporting system. Staff told us that capacity assessments were discussed at consultant rounds and on ward board rounds.

The consultant was aware of one instance where a patient absconded from the ward. The trust safeguarding team were involved and the missing person's protocol was initiated. We were told of another incident where a patient was identified as a potential absconder. Records showed the patient was spoken with and a care plan was in place for de-escalation of risk through engagement and ongoing monitoring of this patient.

Medical care (including older people's care)

Medical staff we spoke with told us that mental health liaison support was available for psychiatric support, and the mental health liaison responded promptly when referrals were made.

The service had a pathway for patients with acute kidney injury (AKI). We saw training materials were provided on the wards with staff around the risks of acute kidney injury and how to accurately monitor patients to prevent such risks occurring.

We observed a nursing handover meeting on ward 7a and saw it contained all information required to keep patients safe.

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, and gave bank and agency staff a full induction.

This was an improvement against the requirement notice from the last inspection. The inspection team reviewed the nursing staff vacancy rate across the five medical wards and found that although the level of band 5 vacancies ran at an average of 7.13 whole time equivalent (WTE) on each ward, the trust had recently recruited several band 5 nurses who were due to start work, as well as nurses from the International Nurse recruitment programme who were either due to start or were currently completing their induction training.

The vacancy rate did not have an impact on the safety of the services provided, with locum/agency staff and bank staff being utilised to fill shifts and the number of care hours per patient was above the national average during February 2021.

We also reviewed the level of sickness across the wards and found that the average rate of sickness absence across the five wards, in February 2021, was 6.3 WTE nursing and midwifery staff. This was above the trust sickness rate trajectory which was between 3.7-3.9 WTE per month.

The medical care service had introduced the role of staffing matron and each day one matron was assigned that role. This was a rotating role shared across the matrons. In addition, roster performance was monitored as part of the ward performance review meetings on a monthly basis.

The matron for staffing reviewed staffing levels across the wards for that day. Each ward manager completed a daily ward acuity tool, which highlighted the acuity level of patients on that ward and any additional staffing needs (such as for one to one care).

The matron for staffing carried out a walk round of all medical wards at 7:30am to review staffing, including any absences or requests for additional staff (for example, one to one due to increased acuity). This information was then added to a staffing spreadsheet at 8:00am and was then discussed at daily huddle with the urgent care clinical business unit (CBU) head of nursing and medical ward matrons. If any shortfalls were identified, then additional staff were requested, either through transferring staff from other medical wards with surplus staff or by using bank / agency staff.

Medical care (including older people's care)

We were advised of three spreadsheets used for managing staffing all of which were live documents that were updated daily. There was a staffing acuity tool (safe care acuity tool) in which the patient acuity scoring was measured against the safer nursing care evidence-based tool, reportable through “Safecare”, which supported the safe staffing decisions made within the staffing huddles combined with bed occupancy. The patient acuity tool showed the acuity level of patients on that ward using a scale (level 1 to level 3).

There was also a staffing spreadsheet which was a live document that listed actual staffing verses establishment on each ward and was updated daily. The spreadsheet used a RAG rated system; red if below safe staffing standards, amber if staffing below establishment and green if there was sufficient staffing.

The third document was a COVID-19 update spreadsheet, a separate online document that was updated daily and showed how many patients were on a ward and how many times they have been moved.

The medical care senior leadership team informed us that, as part of pandemic and wave preparedness, they had developed a live oxygen dashboard which clearly identified the number of patients with oxygen dependency per ward, this was also used as an additional indicator of acuity.

Allied Health Professional teams attended and reported into the daily staffing huddles during the pandemic and the trust reported local multidisciplinary staffing outcomes to all senior and on call teams three times a day. We were advised that when there was exceptional demand on the wards a medical liaison officer at consultant grade supported the command and control arrangements for the site and was responsible for supporting wards with high acuity.

During the inspection we noted that across the wards there were not always the planned number of trained nurses on duty, however, staff informed us that the staffing level was safe due to the lower occupancy and acuity levels on the ward at those times.

Staff on ward 14b mentioned that on occasions, due to the acuity level of patients and the need to provide one to one care to some patients for example, patients on non-invasive ventilators, this affected the staffing level on the ward. In such cases they could escalate their concerns to the staffing matron and/or bed managers.

Additional cover was often filled by substantive staff covering vacant shifts, bank or agency staff or staff being moved from other areas of the hospital.

Our team of inspectors spoke to patients, across the medical wards, who told us that although they felt there were enough staff, they generally felt that they could do with more, as the staff were always extremely busy.

Some patients felt that due to the staff workload they did not always have time to interact and talk to patients. They did however feel safe because there were always staff around.

On speaking with nursing staff across the wards we were advised that there were days where it was particularly busy and additional staff would be of benefit, however, at no times did the staff feel that there were not enough staff to provide safe care.

The senior leadership team advised us that they have an evolving recruitment strategy for the nursing workforce in place, with a significant amount of proactive work ongoing, including strengthening their engagement with external partners, including local Higher Education Institutions, Health Education England, other local Trusts and NHS Professionals. They also had a positive international nurse recruitment process in place.

Medical care (including older people's care)

Some of the medical care wards had already had some international nurses join their teams, however, until these nurses had successfully completed their six to eight weeks induction training and had been signed off as competent, they remained supernumerary to the staffing count. The trust reported they now had 45 international nurses on-boarded with a further 50 international nurses in the pipeline to date, with interviews still ongoing.

To assist with the facilitation of the induction training for overseas nurses the trust had identified a training lead. The senior management team advised that the induction programme had had excellent feedback.

The trust had also utilised the skills of 82 final year nursing students since September 2020. They had enhanced student placements and experience and were working with several other trusts on a pan-Cheshire and Merseyside placement expansion programme using Health Education England funding. It was hoped that this would increase the number of students and strengthen the recruitment into newly qualified nursing posts.

Additionally, the trust had launched three new apprentice training options from September 2020, Trainee Nursing Associate, Nursing BSc Apprentice and Nursing MSc Apprenticeship to help improve recruitment of nursing staff going forward.

They had been working with educational providers to improve the healthcare assistant supply by reintroducing the ACORN programme, recommencing the Care Support Worker Development programme with NHS Providers and had scoped engagement opportunities with the NHS Cadet scheme.

To maintain continuity of care the trust advised that they had encouraged agency staff migration to bank and continued focus on the block booking of flexible workers.

As the trust had stood down all non-essential activity, to support safe staffing across the trust, this allowed re-deployment of clinical staff groups to support medical wards and critical care units.

We were advised that seven-day administration services had been commenced during the last wave of COVID-19. This had continued and provided further support to clinical areas alongside the deployment of staff groups.

To ensure there was enough senior nurse cover across the wards the clinical business unit had reviewed their use/spend on locums and the number of nursing vacancies and this had allowed them to uplift some of their band 5 nurses to band 6. Additionally, some of the agency nurses had accepted permanent band 6 positions with the trust.

Medical Staffing

The service did not always have enough substantive medical staff. However, managers regularly reviewed and adjusted staffing levels utilising locum and bank and new roles had been introduced to help keep patients safe. We were told patients received medical reviews from consultants and consultants were available out of hours and at weekends.

The leadership team shared with us that the service has had challenges with medical staffing, historically as well as through the pandemic. They had undertaken an urgent medical staffing establishment review to see what staffing was needed to meet the needs of the service and had agreed a plan to include a skill mix of existing vacancies and new posts to include advanced clinical practitioners and physician's associates. The trust had recently developed a tool to assess all staffing needs, based on bed numbers. It looked at real time availability and minimum staffing required versus availability. It was a high priority for the trust to get a sustainable workforce.

Medical care (including older people's care)

The trust had plans in place to increase their recruitment of consultants. The Trust was reviewing opportunities with other Trusts to mitigate vacancies, for example in Cardiology.

They had approached a local University and were looking at a formal partnership with the University. There was currently an advert out for a joint academic/clinical specialist position. They told us they knew where they needed to get to and were working towards that.

At the time of the inspection there were two consultants on maternity leave. Three whole time equivalent consultant posts had been created in November 2020 through a review of skill mix. These posts were in cardiology, gastroenterology and diabetes/endocrine. We were told all three posts were currently being advertised.

Following our inspection, the service provided information that showed in February 2021 the service had 14.55 whole time equivalent (WTE) consultant vacancies within medicine. However, the service employed locum and/or bank doctors to cover the vacancies on the general medical rotas. The trust had many locums who were on long term contracts as they wanted to continue working at the trust.

The current vacancy at consultant level was partially mitigated by the employment of long-term NHS locum and agency locum staff, equivalent to 11 WTE. Despite the filled posts the service continued to run at a deficit, with a gap of 4.68 WTE against funded posts.

Staff we spoke with told us the induction for locum medical staff gave them enough information to be able to work on the wards. A locum middle grade doctor told us they felt medical staffing had improved, particularly as there were additional locum doctors to support medical staffing levels.

Due to the COVID-19 pandemic the service had introduced an additional consultant on site (from 5pm to 9.30pm), who provided cover across the medical wards. On ward 11b we spoke with a specialist consultant who had responsibility that week to oversee all gastroenterology patient referrals from other wards and departments. This was designed to streamline consultant review for patients that required gastroenterology care and treatment. We were told that during out of hours, there was one consultant on-call, no second on-call consultant, and the on-call rota was across all medical wards.

We saw that on ward 7a there were two consultants on site from 9am to 5pm weekdays, again with cover provided by the general medical on-call rota during out of hours and weekends.

The service had three consultant gastroenterologists, one consultant vacancy had been advertised, and the service used a locum consultant as additional cover. Funding had been sought for a fifth consultant post and there was a plan to advertise for this once approved. We were told there should be six consultant posts, in order to fulfil 7-day working rota requirements. At the time of the inspection, the on-call consultant was included in the general medical rota, so the on-call consultant may be a general physician but not a gastroenterology specialist. The consultant stated there were no gaps in the middle grade and junior doctor rotas.

We were told that during the COVID-19 pandemic there had been instances where gastroenterology patients were placed across other medical wards. The medical staff had a list of these patients so were able to review these patients in other wards. Over the last few weeks, the impact of Covid-19 had reduced and all gastroenterology patients were now located on ward 11b. This improved staff being able to manage these patients more effectively.

Medical care (including older people's care)

On ward 14b there were two consultant teams. Ward rounds were carried out three times a week, with a board round each day. The consultant on call was present until 7pm and then on call until 9am. During COVID-19 there were two consultants present during the day plus a third from 5pm9pm who saw the new acute patients. This meant all acute admissions received a senior review in a timely way. We were told this level of consultant cover would be stepped down as business as usual started to resume.

There was a designated manager and an operational manager responsible for the management of the medical rota. Both were supported by a rota co-ordinator for the planning and securing of additional medical staff. Daily updates were held to look for any emerging staffing issues for the day and for any upcoming gaps on the on-call rota. A weekly rota was generated and ward staffing for all medical wards was reviewed to ensure safe cover, reallocating locum and bank doctors where required. We reviewed a rota for March 2021 which confirmed this. In addition, a weekly staffing review meeting was held to discuss staffing in more detail and for any emerging risks that required escalation.

The service was using alternative specialist roles to support the medical staffing team including specialist nurse practitioners and physician associates, specialty trainees and specialty doctors. The senior leadership team told us that with the introduction of physician associates within medicine the service had 10 additional doctors in post.

Information from the risk register showed that all vacant posts were being advertised, shortlisted, and recruited in a timely manner. Vacant posts were clinically assessed to determine whether locum/bank was needed. There was evidence in the risk register that the trust was working with partners to mitigate risks to services.

At the previous inspection we found consultants did not lead daily ward rounds on all wards and consultants were not available on wards at weekends. At this inspection we found consultant ward rounds varied being held two or three times a week. In addition, multi-disciplinary board rounds were held daily on week days. This included medical, nursing, allied health professionals, social worker and discharge coordinator daily on weekdays. Over the weekends there was a discharge ward round on the ward carried out by a consultant and a junior doctor. We were told there was access to additional consultant reviews as required. Consultants were now present on site at weekends, with on-call consultants available during out of hours periods.

Patient records

Staff mostly kept detailed records of patients' care and treatment although there were separate records for nursing and medical and allied health professionals. Records were clear, mostly up-to-date and stored securely. The lack of an electronic patient record (EPR) system meant it was more difficult to holistically review the care of an individual however, the trust had identified this risk. A digital strategy had been implemented with the next planned programme of work being an electronic prescribing system.

At the last inspection we saw patient records were fragmented with doctor and nursing records kept in different files and drawers. At this inspection we saw that this remained the case and that the service continued to use mainly paper based patient records, however, the medical handovers and NEWS2 assessments used an electronic system.

During this inspection, we viewed 17 patient care records. We saw they were legible and clear however; we saw some occasional omissions of signatures on records. For one patient we found that the trust checklist documentation had not been used for a discharge. We saw that there were a lot of different patient records, which must cause some duplication of work. The allied health professionals and the medical staff wrote in the medical notes, but the nurses had their own separate notes.

Medical care (including older people's care)

On ward 11b, we escalated concerns for one patient with deteriorating weight and two sets of patient records where we could not locate the discharge paperwork. We asked for records which could confirm what actions the trust had taken regarding the issues of concern identified with the above patients. The trust identified some immediate learning and training actions in response to the concerns we raised. Whilst the trust acknowledged their own process was not consistently followed, we were given assurance that the patients were discharged safely.

We identified there were some inconsistencies in the discharge checklists. A review of one patient record highlighted that the checklist was completed but did not have a second signature in line with the policy. This was being addressed in the form of supportive education with the individual. The trust confirmed that whilst their own process was not followed, the patient was discharged safely. For another patient we found that the trust checklist documentation had not been used. However, there were no concerns identified relating to the safety of this discharge. Management confirmed that a trial discharge form was in place however we found this not consistently used on the wards we inspected.

During this inspection there were no patients with mental health problems on the acute wards we visited, however we reviewed the records for two patients with Deprivation of Liberty safeguards in place and no issues were found.

On the risk register we saw that the dementia and delirium assessment for find, assess, investigate, refer process (FAIR assessment) was being carried out on paper, whilst the new electronic module was being developed.

Matrons audited compliance with nursing documentation standards every month as part of the matrons' checklist. The results for ward 11b and 14b showed improvement in compliance over the last six months with compliance in January 2021 exceeding the target of 95%.

The senior management team told us that there was a focus on improvement, the quality improvement board were looking at doing a refresh of the end of bed leaflet around fundamental care. This was piloted at the time of the inspection. The trust had plans in place to commence an electronic patient records system by 2022. Funding for this had been received in early 2020 but the move was delayed due to COVID-19.

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 whole team and the wider service. Managers ensured that actions were implemented and monitored. There had been an increase in incidents related to discharges, however, the trust had in part contributed to this by creating a mailbox where issues around patient discharge could be reported by external partners, with the aim of learning and improving.

All the staff we spoke with knew what incidents to report and how to report them. Staff reported incidents through an online reporting system and staff we spoke with could give examples of the types of incidents they had reported.

Managers told us there was a culture of high incident reporting and staff we spoke with confirmed they were encouraged to report incidents by their managers. Trust level NRLS data supported that there was a good reporting culture.

From our review of national reporting and learning system (NRLS) information, we found the medical department had 920 incidents reported between September 2020 and February 2021. There had been no never events reported (a medical mistake that should never happen) related to medical care services during this period.

Medical care (including older people's care)

The hospital had an incident reporting policy in place. Staff had a responsibility to report incidents on the hospital's incident reporting system. The highest incidents reported were patient incidents, mainly slips, trips and falls (306). The next to top group was access, admission, transfer, discharge (125). There were 20 discharge planning failures, 14 discharge delay or failure and 10 inappropriate discharges, nine transfer delay / failure / inappropriate, five discharge self against medical advice. Eighty percent of these were reported as no harm, 15% as low harm and there was one death. In comparison during the same period, 13 discharge failures were reported in surgical specialties, of which most related to take home medication issues.

One of the concerns raised prior to this inspection was that patients were discharged at inappropriate times without the right care and support in place. Staff told us all patient discharges after 5pm were required to be reviewed by a matron on the medical wards as an additional monitoring step to check all discharge checklists were completed and appropriate discharge plans were in place. There was no formal cut-off time for when patient discharges stop but, in most cases, patients were not discharged after 7pm.

We spoke with a consultant who told us that board rounds had been in place for approximately three years and helped to facilitate the discharge process. Some delayed patient discharges were unavoidable due to factors outside of hospital control, for example, waiting for the availability of community beds. On ward 11b staff told us they were not aware of any inappropriate or unsafe discharges.

A further concern raised with the CQC prior to the inspection was that patients were moved from ward to ward and it was not uncommon for a patient to experience up to 10 moves in one hospital stay. Bed moves for individual patients were monitored via the Trust dashboard and minimised wherever possible. A consultant told us that the number of moves for patients overall had improved and settled down over the last few weeks. However, this may not be to optimum levels because patients had required moving wards due to the impact of COVID-19. With the recruitment of additional consultants, there was an aspirational plan to conduct gastroenterology in-reach service, so patients in the emergency department could be reviewed promptly and therefore reduce the number of moves.

Discharge facilitators liaised with the ward and the discharge team. Daily multidisciplinary meetings were held to look at those patients that were medically fit for discharge.

We attended the task force meeting which discussed discharges. This was attended by the ward nurse, discharge facilitators, social services and the patient flow team lead. The task force (in their current format) started a month before the inspection and was being trialed on two wards.

Any fast track patients were identified and complex discharges were discussed with actions to facilitate their discharge once medically fit. The team were knowledgeable about discharge options and placements. The discharge facilitators did a lot of the following up to free up nursing time and to maintain patient flow. There were six discharge facilitators in the team, there was recruitment ongoing for a seventh.

On the day prior to the inspection the discharge team (task force) facilitated 10 discharges. The team told us they did not feel that they would have been able to do this previously without this coordinated approach and joint working.

We attended the high impact action meeting which looked at the impact the discharge team had had. We spoke about a patient incident which was discussed as part of the rationale for inspecting. The matron very much felt it was an isolated incident; we were told that the ward discharges 85-90 patients per month and this issue had not been reported

previously. The team had spoken openly about it and actions have been put in place. A two-person discharge checklist had been put in place to ensure everything was checked prior to a patient leaving the ward, this included a 'stop before you go' visual check. During this inspection we did not see any evidence of this in practice, no posters or information for staff and no staff member referenced it when we spoke with them.

There was a system in place for patient safety alerts to be cascaded and responded to at a central hospital-wide team. The matrons and ward managers in each area were made aware of any alerts or actions required. Departmental managers reviewed all incidents, started investigations, put in place necessary corrective actions, reported externally and escalated any risks as required. The incident reporting system emailed all serious incidents to senior staff (matrons, head of governance) so if an incident was raised it would be actioned immediately.

Learning from incidents was shared in a number of ways. Incidents were discussed at daily safety huddles where any high-risk patients would be identified. Serious incidents were shared with staff through lesson of the week, which required a signature from staff to state they had read this. There was evidence that changes had been made as a result of feedback from incidents. We saw one ward had looked at themes following a number of falls on the ward. They had identified they all happened in one area and had made changes to that area to make it safer for patients.

Lessons from incidents were also shared at the weekly Harm-Free Care Meetings. These included involvement from the Deputy Director of Risk and Governance, the Director of Nursing and risk team. Meetings were recorded and minutes were shared with staff. We saw an example of learning from a patient concern we raised during this inspection. An incorrect height recording had been made on a patient's mid-upper arm circumference (MUAC) recording which had a negative impact on the next MUAC assessment. The ward was now working with the dieticians to ensure supportive learning around MUAC recording. In addition, the ward had purchased some weighing patient transport slides which were being rolled out, which meant going forward the MUAC would only be used in very exceptional circumstances.

There had also been learning from previous incidents relating to discharge concerns. For example; patients may not have appropriate clothing at the time of discharge. There was a plan to purchase clothing (fleece jackets, jumpers) so patients that did not have their own clothing could be provided with clothing if needed on discharge.

Also, a diabetic patient was discharged to a care home, but the home did not have the required blood sugar monitoring machine. Learning was taken from this and it was agreed that the required blood sugar testing machine would be provided by the hospital on discharge, where required, going forward.

We saw patient safety boards displayed on the wards. On ward 14b it showed it had been five days since the last patient fall and seven days since the last pressure ulcer. Themes of incidents identified on this board were, falls, pressure ulcers and discharges. Pressure ulcers and discharges were identified as a key area of focus.

Is the service effective?

Inspected but not rated

Nutrition and hydration

Medical care (including older people's care)

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' needs. However, whilst staff mostly completed fluid balance records accurately and completely, and the Trust had monitoring arrangements in place to check this, during our visit we noted three charts that were not fully complete. This had improved from the last inspection.

During the inspection we observed patients over the lunch and afternoon tea periods and noted that staff spent time with patients to discuss their lunch preferences on most occasions. On one occasion a patient's comments that they had had the same lunch three days in a row had been ignored by the staff member.

We noted that where patients were unable to feed themselves staff provided assistance with eating and drinking.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs, however we spoke to seven patients in the medical wards several of whom indicated that it was often difficult to get additional drinks outside of the scheduled tea times and that it would be nice to have access to more cups of tea.

Staff informed us that they had missed the dining companions for patients during COVID-19 as often patients did not eat because they lacked stimulation and having a dining companion to sit and chat with them often motivated them to eat their meals. They have, however, trained corporate staff who will come and sit with patients during mealtimes.

Senior leaders advised us that they had recruited catering assistants to some of the medical wards. They would hand out meals and drinks to patients, fill up water jugs and make sure that patients' hands were clean prior to eating. This had proved to be effective as patients were supported and it freed up clinical staff and healthcare assistants to undertake other patient care activities.

The senior management team told us that they had undertaken a quality improvement project for six months, delivered by staff from the critical care unit and critical care outreach team, to look specifically at nutrition and hydration and fluid balance recording. This piece of work commenced in August 2020 and included the development of a fluid balance standard operating procedure, a urinalysis standard operating procedure, a ward fluid balance audit (using a software package) and development of training materials and learning aids to assist staff in the recording and assessment of fluid balance. They were due to introduce the use of a web based application, but this had been delayed due to COVID-19.

We noted from the urgent care risk register that a new e- learning module relating to nutrition was available to all staff. This was essentially introduced as part of a project; however all staff were currently able to access and complete the learning.

We also noted that eight staff had completed the Mouth Care Matters Train the Trainer programme. Staff did not always fully and accurately complete patients' fluid charts where needed. Our inspectors reviewed the records of 22 patients across the four medical wards and found that on three occasions fluid balance charts had not been completed accurately or fully. We were advised that the trust undertakes audits of nutrition and hydration across the medical wards where they randomly reviewed 10 patient records to assess against 11 key criteria.

• Is the date completed?

• Does fluid balance chart contain correct demographics?

• Is the weight documented?

Medical care (including older people's care)

• Is measurable input recorded?

• Is measurable output recorded?

• Are sub totals calculated and correct?

• Is the total calculated?

• Is the total correct?

• Are all signature sections complete?

• Is catheter emptied at the end of every shift?

• Should the patient be on a fluid balance chart?

On reviewing the trust's audit results from June 2020 to February 2021, the Perfect Ward Score for fluid balance recording was between 75% and 95% (across all the medical units).

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. It was noted on reviewing patient records that the trust utilised the Malnutrition Universal Screening Tool (MUST) to identify adults who are malnourished or at risk of malnutrition.

Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it, however, prior to the inspection our inspection team had undertaken a review of incidents relating to nutrition and hydration on the medical wards and found that there had been two incidents where patients were not referred to the dietetic service despite this being required. The senior leadership team advised that actions have been taken to prevent recurrence of this and that the dieticians now have an electronic referral system in place.

They had also invested in aids to assist with eating and drinking, such as bright yellow plates for patients with dementia and two handled mugs to help with drinking.

Nutrition dashboards had been revised and matrons / ward managers provided access to staff while the roll-out of the project got underway.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. This was an improvement from the last inspection.

Medical care (including older people's care)

Prior to the inspection we had received concerns regarding the provision of communication with families whilst visiting was not allowed. During the inspection, however, we spoke with the senior leadership team who told us they had listened to patient feedback around improving patient care during the COVID-19 pandemic and had introduced teleconferencing calls to provide daily updates to family/next of kin. We were told that during the height of the pandemic the medical care wards had set up daily calls with families to keep them up to date with the patient's progress, however, as the acuity of the patients had reduced, patients who were able to make contact with their families themselves were encouraged to do so.

On speaking with the matron, she told us that she had spoken with every patient on the ward the day prior the inspection.

During the inspection we saw that staff interacted with patients in a respectful and considerate way and ensured that their dignity and privacy was maintained. Members of staff were observed spending time with a patient to discuss their forthcoming discharge, conversing positively with a patient whilst undertaking routine observations, assisting a patient to eat and drink, escorting a patient on a walk around the ward and assisting a patient who required the use of the bathroom.

As part of the inspection, we carried out observations using the Short Observational Framework for Inspection (SOFI) method during our inspections on wards 7a, 9a, 11b and14b. The SOFI tool is used to review services for people who have conditions that mean they cannot reliably give their verbal opinions on the services they receive. We continually observed what happened to patients over a chosen observation period, making recordings at set intervals. In each time period, we recorded the general mood of the patients, the type of activity or non-activity they were engaged with and the style and number of staff interactions with patients. In each time frame there may be more than one type of engagement and multiple interactions with staff. Staff interactions are categorised as positive, neutral or poor. Some examples of positive interactions would include displaying respect, warmth and providing enablement for patients. Negative interactions may include withholding behaviour, such as refusing to give asked for attention, or not meeting an evident need; or failing to acknowledge the reality of a patient.

The observations were noted in five-minute intervals over a period of half an hour. We observed a total of 18 patients across the four wards.

Four, 30-minute observation periods were undertaken, one on each ward.

The general mood state for the group of patients throughout the observations was on average neutral for 68.5% of the period, positive for 21.75% and negative for 11.5%.

There was staff interaction with patients on an average of 39.5% of the time frames. These interactions with staff were noted to be positive on average 65.5% of the time and neutral for 26% of the interactions, however on ward 14b we observed that 29% of those interactions recorded were negative.

Staff interacted with individual patients between zero and nine times over the 30-minute timeframes. One patient was asleep throughout the observation and was left undisturbed. Where the observations occurred over a mealtime staff interacted with every patient being observed. Patients said staff treated them well and with kindness, with some patients advising that the staff were well-mannered, efficient and cheery, despite being very busy.

One of the concerns raised was that patients were moved from ward to ward and being left on corridors. We did not find evidence of any inappropriate patient moves around the hospital during the inspection.

Emotional support

Staff provided emotional support to patients, families and carers whilst visiting had ceased due to COVID-19. They understood patients' personal needs.

During conversations with staff we noted that they understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them and had made sure that plans were in place to provide emotional support.

From November 2020, volunteers from the local hospice, supported with patient communications (Video-conferencing calls and the hospital passports). Between November 2020 and the end of February 2021 the team had facilitated approximately 645 video-conferencing calls for patients and their families.

We found on inspection that there was some communication with families, and this was recorded and monitored but in a variety of ways. On Ward 9a, we noted that a communication sheet was used to record when conversations had taken place with family members. On other wards we observed in patient records that a record of communication with their family had been noted in the patient's nursing record.

During discussions with staff on ward 9a, we were advised that the band 7 nurses reviewed each patient's record daily to check if family have been in touch, or if an update was needed for the family. Other wards used different methods of checking that communications had taken place.

We were advised by the senior leadership team that although video-conferencing calls were arranged for patients to keep in touch with families, it had been noted that a higher number of elderly patients were unable to manage these calls using video technology, so staff had reverted to using a telephone to keep them in touch. Additional telephones had been ordered for the medical wards to increase the capacity for patient calls.

Staff supported and mostly involved patients, families and carers to understand their condition and make decisions about their care and treatment. There were a small number of instances where the family had not been involved in the making of important decisions about resuscitation, however, a recent audit demonstrated improvement in this area.

Prior to the inspection, concern had been raised that the involvement of the patient and family in the decision-making process for Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) had not happened. Therefore, on inspection we reviewed three patient records where this decision was in place and found them to be completed appropriately and noted that conversations were documented as having taken place with patients and/or their family regarding their decision as to whether they should be resuscitated in the event of a cardiac arrest.

We also reviewed incidents reported regarding DNACPR between 1 January 2020 and 16 March 2021, we found only one reported incident within the medical services. However, shortly after the inspection we had a further two instances raised with us regarding the lack of involvement of the patient and family in these decisions. These were raised with the trust as a concern and they were being investigated.

We reviewed additional information from the trust including their DNACPR policy, improvement plan and an audit which demonstrated improved compliance in most areas since changes had been made.

Medical care (including older people's care)

Is the service responsive?

Inspected but not rated

Managing and Learning from Complaints

The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff. The service included patients in the investigation of their complaint. Response times had been slightly longer than the trust target but had improved since the last inspection.

The service received 39 complaints between 01 September 2020 and 28 February 2021. The highest number (8) were for ward 11b but there was a spread across all the wards within the medical service ranging from two to five.

The trust had a target of 40 days turnaround for complaints. In the August 2020 integrated performance report to Board, complaints average timescale for closure remained under the target with the month's average at 35.1 days. Thirteen complaints had been received at the trust in month with four in general medicine, one in cardiology, and one related to rehabilitation. In the December 2020 integrated performance report the complaints average turnaround had significantly improved to 42.5 days following issues caused by staff absence in November 2020 when the average was 67 days. A weekly complaints clinic had been established and had contributed to the improvements in this area. The January 2021 the integrated performance report stated average turnaround time of 49 days. The February 2021 position was much improved with a reported average turnaround time of 24 days.

The trust identified an important need to introduce a trust wide Patient Liaison and Advise Service (PALS) and this was implemented in September 2020. Since implementation there had been over 2000 contacts with patients across the trust, to achieve resolution. Only three of these had resulted in a formal complaint. The number of concerns managed through the trusts PALS service between September 2020 and February 2021 was 140.

During an interview with the local leaders we were informed that all complaints were reviewed by the Head of Nursing and that they were conducting a thematic review of complaints and incidents in order to learn from them. The new leadership team had prioritised both prompt response and investigation of outstanding incidents/complaints against trust timescales, and were focused on learning from themes as part of quality improvement.

Patient information leaflets were available, we were provided with copies of patient information leaflets relating to dementia and delirium, which were available to patients and family/representatives to provide them with further information relating to the diagnosed condition.

We were advised that the medical wards used a "Hospital Passport" for patients living with dementia. This ensured that important information relating to the patient was available in one place. The document was completed together with the patient and their family/representative. Information including what the patient preferred to be called, what they liked to eat and drink and important details relating to issues such as advanced care plans and medications were recorded.

Medical care (including older people's care)

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. The leadership of the clinical business unit had been reviewed and expanded. Although the leadership team were relatively new to their posts, they demonstrated clearly defined and visible leadership roles and lines of accountability. This was significantly better than at the last inspection.

We saw on the inspection that there were matrons responsible for the wards we visited. There were three matrons in post with a fourth starting in April 2021. The matrons were visible and visited the wards regularly and escalated any concerns. There was a matron present every day, including weekends, up to 8.30pm. Matrons had an open-door policy to support staff if needed. There were regular engagement forums held by the senior management team in order that staff were able to raise concerns.

There had been a nursing structure review which had added a lead nurse to provide oversight of matrons and gave the matrons capacity to work at ward level whereas before that had not been possible. It was also noted that there had been significant changes at ward leadership level, there were new band 7's in post who are enthusiastic. There had also been an increase in band 6 nurses to enable a member of senior staff to be on every shift.

On site we had an interview with the directorate manager and Head of Nursing. They told us that senior leaders had identified leadership in the medical service as a concern and in response had redefined the directorates and had improved the governance structures. These changes included a review of how the leaders were performing and how visible they were. They felt this had enabled them to understand, act on and monitor the improvements required across the directorate. There had been conversations with staff regarding a shift from monitoring performance to reporting on quality and care. They felt that staff had stepped up and were focusing more on quality now. They had received the financial support they required to support the improvements.

The new structure had removed some of the hierarchy and had been very well received by staff as it was starting to address concerns with management and was reassuring clinicians who had previously expressed that they were not happy. The local leaders spoke about implementing a lot of changes, some in response to COVID-19 and others to local concerns. To monitor the improvements, they were repeating staff surveys and had noted that people who were disengaged with senior management in the past are now engaging.

They had facilitated an away day with ward managers and discussed the challenge in the recruitment of band 5 nurses which was a national challenge. It was agreed to extend band 6 roles with individual professional development plans to develop staff with clear conversations about roles and the development of leadership roles.

Culture

Medical care (including older people's care)

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where staff could raise concerns without fear.

During the inspection we saw teams working together, we spoke with members of staff who told us things were improving and that the new executive team in place had made significant improvements and there was more engagement. They told us that the wards were well run and focused on patient care with good learning and support.

One consultant told us that changes made by the executive team were starting to filter down to wards and that there was more structure to medical meetings and there was more involvement from senior leaders (associate medical director and the medical director) in these meetings. Directorate managers were also more involved and there was an improved level of engagement.

They also told us there was impressive support and processes available for medical staff during the COVID-19 pandemic, such as provision of PPE and resolving issues with PPE availability. The trust had made a decision to test staff at an early stage, which helped quickly identify staff that needed isolation, swab testing was also expanded to medical staff family members and this helped optimise the number of self-isolation days taken by staff and helped them get back to work.

Staff told us there were good working relationship between medical and nursing staff and strong team working, everyone was very motivated and there was a feeling that the teams have really moved forward. They also told us that leaders were friendly and approachable. Staff felt that issues from the past had had a line drawn under them and people have moved on.

There was a freedom to speak up / whistle blower policy and a freedom to speak up (FTSU) team was in place across the hospital. The hospital chaplain was the FTSU lead. Staff could access the FTSU team if needed and information was available on the intranet site for staff. The matron we spoke with was not aware of any significant ongoing FTSU concerns.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The clinical risk registers were electronic, there was a departmental (Ward) and urgent care clinical business unit risk register, local risk registers are managed by the ward managers / matrons and there is a weekly risk management and governance meeting where risks are reviewed.

We reviewed the risk register for the urgent care clinical business unit and found that it identified relevant risks, there were six risks that had been identified as extreme: these included requirement to improve older peoples' care; risk due to nurse staff vacancies across the clinical business unit; risk due to the number of consultant vacancies in medicine; risk to business continuity; risk to patient flow and capacity on the Southport site and risk to the provision of coronary care including telemetry. All risks had initial and current risk ratings, all had been reviewed and had a risk lead allocated. All extreme risks had been reduced by mitigating actions taken which were articulated in the register. There was also a target risk level identified.

Medical care (including older people's care)

In response to the risk around the need for improvements in older peoples care the trust reported that there was an 'Older People's Training Programme' in place monthly with a focus on changing culture, ethos, behaviours and increasing awareness of risk and 'basic' care needs in a vulnerable and frail population. There had been an initiative introduced called 'End PJ paralysis Get Up, Get Dressed, Keep Moving'.

A Dementia and Delirium team had been recruited and were providing training, education and advice for staff in relation to concerns for patients, carers/family and staff. The falls risk assessment and care plan are now embedded.

As part of the perfect ward initiative, matrons carried out monthly audits to review records, observe care and speak with patients. The perfect ward audits covered areas including nutrition and hydration, VTE(venous thromboembolism) risk assessments and discharge planning.

Assurances on quality and performance from matrons came via monthly performance reviews and local quality ward audits. Ward 14b had achieved silver status. There was a matron's audit and harm prevention app which gave live reports on Perfect Ward data. There was also a monthly performance review with the head of nursing.

Each Friday was 'quality day' where there was a meeting with the director of nursing, assistant director of nursing, head of nursing and matrons; they had an area of focus and visited clinical areas. This was a clinical day for matrons.

There was a harms prevention meeting every week where the ward managers presented information. They looked at initial incident reviews, root cause analyses or any other incidents of concern.

There was also a serious incident meeting every week and weekly patient safety meetings across the clinical business units.

Engagement

Leaders and staff actively and openly engaged with patients.

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should be given the opportunity to provide feedback on their experience. The investigation team reviewed the FFT data received for wards 9a,11b and 14b.

Patients gave positive feedback about the service. Across the wards, between 1 September 2020 and 28 February 2021, an average of 61% of those who responded rated the service as very good and an average of 22.3% rated the wards as good.

An average of 84% of patients stated that they would recommend the service to friends and family, whereas an average of 10% would not recommend the service.

Outstanding practice

We found the following outstanding practice:

Medical care (including older people's care)

The medical care service had undertaken a quality improvement project in partnership with the local hospice to look at how fundamental care could be improved, based on the ethos of individualised patient centred care as experienced on the Oasis Ward, during wave one of COVID19. The remit of the team was to support staff and develop skills in relation to the delivery of the fundamentals of care and help develop holistic patient centred care as experienced on the Oasis ward. The Oasis Team was also supporting the review and launch of the Care certificate.

Areas for improvement

SHOULDS

• The trust should continue to improve the review of patient risk assessments.

• The trust should continue to improve the involvement of patients and their families in decisions regarding care and treatment where DNACPR is considered.

• The trust should continue towards electronic patient records to promote accuracy of holistic record keeping.

• The trust should continue to improve discharge arrangements to ensure safe patient discharge.

• The trust should continue to act to address the high number of registered and unregistered nursing vacancies.

• The trust should continue to improve the assessment of the nutrition and hydration needs of patients including the accurate completion of fluid and nutrition charts.

• The trust should continue to address the number of medical staffing vacancies across the medical care service.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, a lead inspector and two other CQC inspectors. In addition, the team was supported by a specialist advisor. Specialist advisors are experts in their field who we do not directly employ. The inspection team was overseen by Karen Knapton, Head of Hospital Inspection.