Kettering General Hospital NHS Foundation Trust

Kettering General Hospital

Inspection report

Rothwell Road
Kettering
NN16 8UZ
Tel: 01536492000
www.kgh.nhs.uk

Date of inspection visit: 15 March 2022
Date of publication: 06/05/2022

Ratings

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

Our findings

Overall summary of services at Kettering General Hospital

Requires Improvement 

We carried out this unannounced focused inspection to check the quality of services in response to a warning notice we issued in May 2021. Following our previous inspection, we served a warning notice to the trust requiring them to make improvements in the assessment and management of risk, implementation of falls prevention actions and improvements in learning from serious incidents. As a result of these findings we rated the medicine service as inadequate and took enforcement action as a result of the inspection to promote patient safety in relation to falls prevention and management.

During this inspection we inspected the medical care core service using our focused inspection methodology. We did not cover all key lines of enquiry; however, we have rerated this service as the issues that lead to the serving of the warning notice had mainly been addressed therefore the rating limiters no longer applied.

Our ratings of the service went up based on the improvements we identified during our inspection, in relation to falls prevention and management only. We have rated them as requires improvement.

During our inspection on 15 and 16 March 2022, we visited Naseby B ward, Cranford ward and HC Pretty B ward.

We spoke with 29 members of staff of all levels including health care assistants, registered nurses, ward sisters, matrons, doctors and service leads. We also reviewed 18 sets of patient records and looked at other documentation including incident records, quality audits and trust policies and procedures.

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 improved. We rated it as requires improvement because:

- Not all medical and therapy staff had completed mandatory falls training. The design of the wards we visited occasionally impacted staff ability to keep patients safe from falling. Ward bay tagging processes were not always consistently implemented. The service did not always have enough nursing and support staff with the right skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers did not always ensure actions from learning briefings were implemented across all areas in the service.

However:

- Most registered and non-registered nursing staff had completed mandatory falls training. The training met the needs of all staff. Systems were in place to maintain a safe environment to prevent patients from falling. Staff generally completed and updated falls risk assessments for each patient. Improvements had been made in the completion and quality of falls care plans. Staff acted to remove and minimise risks of falling. Systems and processes were in place to enable the supervision of patients at risk of falling. Mitigation was in place to manage staffing levels. The service managed patient safety incidents in relation to falls prevention and management well. The number of falls with moderate and above harm had reduced.
- The service provided care and treatment based on national guidance and evidence-based practice in relation to falls prevention and management. Managers checked to make sure staff followed guidance. Staff monitored the effectiveness of care and treatment in relation to falls prevention and management. The service used the findings of falls audits to make improvements to reduce the risk of harm to patients at risk of falling. The service made sure staff were competent for their roles. They knew how to support patients who lacked capacity to make their own decisions. They used measures that limit patients' liberty appropriately.
- Leaders operated effective governance processes in relation to falls prevention and management. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. The service identified, escalated and mitigated risks associated with falling.

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 falls prevention to all staff and most staff had completed it. Training provided met the learning needs of all staff.

Most staff completed falls prevention training. Compliance data provided by the service following our inspection showed 87% of staff had completed falls prevention training, against a target of 85%. This was a significant improvement since our inspection in May 2021 where only 32.6% of staff had completed it. Data showed only 51% of medical staff and 71% of allied health professionals had completed the training but we saw no evidence that their practice was unsafe.

A plan was in place to improve training compliance. For example, there was an action on the trust wide falls action plan for all medical staff to receive falls prevention training by the end of April 2022. The service offered varied opportunities to complete the training. For example, the service introduced 'training tuesdays' which included falls prevention training that staff could book onto. The service also offered on-line training and practice facilitator led training sessions in clinical settings. Most staff we spoke with told us they were given protected time to complete this training.

The mandatory training was comprehensive and met the needs of patients and staff. Staff understood how to assess the risk of a patient falling, when to use bedrails and how to complete a lying and standing blood pressure. Staff demonstrated good knowledge of falls prevention methods and we saw these were generally in place.

During our focused inspection in May 2021, we found there was no training in how staff should complete a falls or bed rails risk assessment. Following our inspection, the service implemented new documentation and provided training to staff in how to complete it. This was also included in the fall's prevention training module.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Environment and equipment

The design of the wards we visited occasionally impacted staff ability to keep patients safe from falling. However, systems were in place to maintain a safe environment to prevent patients from falling.

Improvements in the environment to keep patients safe had been made across all wards we visited. During our previous inspection in May 2021, we found the use of the environment did not always support the safe management of patients at risk of falling. Improvements were noted on all three wards we visited. For example, corridors were generally free from unnecessary clutter on Naseby B and Cranford Ward. Whilst we saw equipment stored in corridors, this was limited to items such as patient records trolleys. These were generally against a wall and did not restrict access or mobility. HC Pretty B ward was particularly challenged with space and we saw several notes trollies as well as a large domestic drinks trolley stored in the corridor. However, this had improved since our previous inspection, as there was less equipment stored in the corridor. Managers told us HC Pretty ward was a priority for refurbishment although no timescales had been confirmed.

Patient bays and side rooms were generally tidy and clutter free on the wards we visited. Only frequently used or required equipment such as patient mobility aids were stored in bays. This had improved since our previous inspection and we observed patient walkways were as clear as possible.

Patients bed spaces were generally tidy and clear of hazards. Staff were more aware of trip hazards and equipment in the patient bed space was limited to their bedside table and where required, mobility aids. This meant if a patient got up, there was less equipment in their way, reducing their risk of accidental trips or falls.

During our last inspection in May 2021, we found patient mobility frames were not always in close proximity to the patient to support them when getting up. During this inspection, mobility frames were generally at the patient's bedside or close by. Where the mobility frame was not in immediate reach, this was due to limited space which posed a risk of accidental trips. However, all patients at risk of falls, were placed in tagged bays which provided some mitigation as staff were on hand to assist the patient when required. Tagged bays are where a staff member is assigned to a bay to provide continuous and optimal observation of patients at risk of falling. Staff were expected to remain in the bay at all times.

Medical care (including older people's care)

During our previous inspection we found some bathrooms were used to store equipment which posed a risk of falling to patients if left unattended. During this inspection toilets and bathrooms across all three wards we visited were generally free from clutter. However, one bathroom on Naseby B ward had been used to store a hoist and mobility equipment. Staff told us this bathroom was generally not used by patients and if it was, a staff member was always present with the patient.

Patients could reach call bells and staff responded quickly when called. Call bells were generally within reach. We visited three wards and did not hear many calls bells during our visit. However, patients at risk of falling were generally cared for in a tagged bay, where staff were available to assist patients when needed.

The design of the wards we visited occasionally impacted on staff ability to keep patients safe from falling. Tagging of bays was more challenging on Cranford ward and HC Pretty Wards due to the lack of toilet facilities within the bay. Staff told us this meant at times they had to wait for someone to cover before getting equipment or supporting a patient to the toilet. Both wards also had doors on bays due to infection control and the COVID-19 pandemic. This made visibility and tagging more challenging. This was on the risk register. However, we observed good teamwork and staff were responsive to calls for assistance. We observed improvements following our last inspection in staff presence in bays, however we did see staff leave a bay on Cranford ward for short periods and the closed doors meant there was a risk of falling for those who were not supervised.

Systems were in place to ensure the environment was well maintained to reduce the risk of patients falling. Managers carried out monthly audits of the environment. For example, matrons undertook a monthly '100 step' audit to identify environmental risks. The audits looked at all areas of the ward including corridors and patient bays. The audit assessed cleanliness and environmental risks including flooring, clutter and storage of equipment. We reviewed the 100 steps audits for all three wards we visited in the month prior to our inspection and found the audits were between 90.4% to 98.9% compliant with audit measures. All audits had clear actions and tracked progress against previous areas of non-compliance.

Assessing and responding to patient risk

Staff generally completed and updated falls risk assessments for each patient on admission and reviewed them in line with trust policy. Improvements had been made in the completion and quality of falls care plans. Staff acted to remove and minimise risks of falling. Systems and processes were in place to enable the supervision of patients at risk of falling; however, the processes were not always consistently implemented.

Improved practice was observed across all three wards we visited in relation to completion and review of falls risk assessments. During our last inspection in May 2021, we found staff did not always fully complete risk assessments for each patient on admission or effectively review them thereafter. Following our inspection, a falls improvement programme was implemented across the service and wider trust. The falls risk assessment document was redesigned and effectively implemented. We reviewed falls risk assessments in 18 patient records and found all patients had a falls risk assessment completed. This demonstrated patients were routinely assessed on admission to the ward for their risk of falling.

Of those 18 patients records we found 14 had been fully and accurately completed on admission to the ward and reviewed, if required, in line with trust policy. One patient sustained a fall whilst in hospital and we saw evidence of timely review of the patients' risk. However, we also found:

- One patient was assessed on admission to the ward but not reviewed in-line with timescales outlined in the trust policy.

- In two records the patients' medical history had not been fully identified as a risk on the assessment which meant both patients were assessed as 'high risk' but should have been 'very high risk'.
- In one record the score was incorrectly selected as 'high risk' when it should have been 'very high risk' based on the risk score.

Whilst there were some inaccuracies, this did not impact on patient safety as the outcome did not change which was to implement a falls prevention care plan. All three patients had a completed care plan and preventative actions were in place.

During our previous inspection, we were not assured staff understood how to assess the risk of falling. During this inspection, we saw an improvement in the overall quality of risk assessments and staff we spoke with could articulate how to complete the risk assessment.

Documentation audits provided to us following the inspection showed the service exceeded the 90% compliance target for falls risk assessments being completed on admission in January (98.3%) and February (91.3%) 2022. Furthermore, the service exceeded targets for weekly risk assessment reviews with 96.5% compliance in January and 97.5% in February.

Staff knew about but did not always deal with specific risk issues to prevent patients from falling. However, we saw significant improvements had been made. During our previous inspection in May 2021, we found patients were at risk of ongoing harm through falls due to postural drops in blood pressure which were not being effectively identified or mitigated. During this inspection we found staff had more awareness of the requirements to complete lying and standing blood pressures. The service has a visible awareness campaign on all wards we visited. Lying and standing blood pressures were added onto the electronic patient record along with other observations. We observed a ward round on Naseby B ward, and we found this was discussed when reviewing the patients' care and treatment. The re-designed risk assessment included a question on history of postural hypotension and a section to prompt staff to record lying and standing blood pressures. We reviewed 18 risk assessments and found staff had effectively completed lying and standing blood pressures in nine records. One of these patients had fallen whilst in hospital and had a lying and standing blood pressure completed following the fall. A further five records, whilst not completed, had a documented reason for this not being completed. However, we found no evidence in four records that a lying and standing blood pressure had been completed or a reason why it could not be.

Of those patents who had a lying and standing blood pressure completed, only one patient was found to have a postural drop. This was escalated to doctors but was not continually monitored.

Whilst there were still some gaps in practice, this was a significant improvement since our last inspection in May 2021. By comparison, in May 2021 only 39% of the 18 records we reviewed had a lying and standing blood pressure recorded or documented rationale for it not being completed. During this inspection it had increased to 75% of the 18 records we reviewed.

Monthly audits provided to us following our inspection demonstrated the service did not meet the 90% compliance standard for lying and standing blood pressure in January (80.4%) or February 2022 (68.4%). We saw this was shared with staff in ward meetings to promote completion.

Staff fed back they found it difficult to identify whether a lying and standing blood pressure had been completed in urgent and emergency care before transferring to the ward. We saw some records had a yellow sticker where the outcome was recorded and actions taken, however, this was not fully in place across the service. Managers told us this initiative had recently been rolled out and wards were awaiting the stickers, however it was expected to positively impact compliance.

During our previous inspection in May 2021, we found decisions to use bedrails were not fully assessed or reviewed within appropriate timescales as outlined in the bedrail provision policy. During this inspection we observed improvements had been made. The bed rail provision assessment document had been re-designed, and we saw this was fully implemented across the service. The document supported staff to effectively assess and re-assess risk and record whether bed rails were recommended. This meant the rationale for deciding to use or not to use bed rails was much clearer. Staff we spoke with generally understood how to undertake an assessment and could articulate the risks of bedrails to certain patients.

Bedrail use assessments were generally completed in line with trust policy in most records we reviewed. During our previous inspection we found safe use of bedrails were fully assessed in 28% of the 18 records we reviewed. During this inspection we reviewed 18 bed rail provision assessments and found significant improvements had been made. Fourteen out of 18 (78%) were fully and accurately completed. We saw evidence of regular risk assessment review and some good practice in reassessments for patients with fluctuating capacity to ensure bedrails were being used safely and this was monitored. Of the four records not completed in line with trust policy we found:

- Staff did not fully complete the assessment in two records.
- The risk score was incorrectly calculated in one record we reviewed.
- The mental state score did not reflect information in the patient record or handover tool in one patient record.

Whilst there were some gaps in practice, where the risk assessment was not accurately completed, we did not see any evidence this impacted patient safety.

During our last inspection we also found bedrails were not always used appropriately. During this inspection we found bedrails were used in line with the outcome of the risk assessment. We saw most beds were at the lowest possible height to mitigate any harms associated with bedrails use.

Ward sisters and matrons undertook weekly random spot checks of bed rail usage. For example, the ward sister on Naseby B ward spot checked a patient with bedrails in place, by reviewing the assessment to check whether the assessment was accurately completed, and bedrails were used safely in line with policy. Furthermore, a staff member told us they cared for a patient who had bedrails in place, but the assessment stated not recommended. The staff member told us the sister provided them with a coaching session at the time on how to assess the risks and how to check whether bedrails can be used.

Monthly audits from January to February 2022, showed the service exceeded the 90% compliance standard for bedrail risk assessment completion and appropriate use. This also included beds being at their lowest level.

Medical care (including older people's care)

Improvements had been made in the completion and quality of falls care plans. During our last inspection in May 2021, we found falls care plans were not fully completed. The service implemented a new care plan which included a list of preventative actions for staff to select based on the patients' risk. Staff indicated whether the preventive action was required or not. There was also a section to document 'not applicable' or any personalised actions not already listed. The revised care plan included a section so staff could review it in line with trust policy.

During this inspection we found improvements had been made. Of the 17 patients identified through the risk assessment as requiring a care plan, 16 had a falls care plan completed. In one record there was no evidence it had been completed within four hours of admission, but staff were aware they needed to do it.

Actions to prevent a patient from falling were implemented across all wards we visited. The falls care bundle was included in falls training. It provided guidance for staff on all preventative actions they could use to mitigate the risk of a patient falling. For example, falls symbols on the electronic patient record, falls wristbands, appropriate footwear, tagging and mobility cards. Staff were always expected to remain in the bay. We reviewed 17 falls care plans and our observation of patients confirmed preventative actions were in place as outlined in the care plan.

Managers completed monthly audits to assess compliance with falls prevention actions and we saw they shared the learning with staff, with actions for improvement. Falls practice improvement facilitators supported the manager to improve practice where performance was below the expected standard. The service scored over 94% for seven out of the audit requirements and less than 90% in two. These were yellow wrist bands being in place (79.4%) and mobility equipment in reach (89.4%). However, overall, what we saw on inspection and on-going audits demonstrated improvements had been made in preventing patients from falling.

Systems and processes were in place to enable the supervision of patients at risk of falling. We found improvements in practice; however, the processes were not always consistently implemented. During our previous inspection in May 2021, we found effective systems were not in place to ensure staff complied with the cohort bay and tagging process. We found inconsistent practice in the cohort bay tagging system which raised concerns patients in those bays were not always safely supervised to reduce their risk of falling. Following our inspection, the service took action by revising their processes for tagging and implementing a new standard operating procedure (SOP). Tagging was included in falls prevention training and staff inductions. We also saw tagging was included in the shift handover. Staff we spoke with during our inspection understood the tagging process, their role and responsibilities.

During our inspection we saw tagging of bays was in place most of the time so patients at risk were always supervised. However, we observed four occasions on Cranford ward where a staff member left the bay for short periods. We also observed a staff member on HC Pretty ward go behind a curtain momentarily to care for a patient, this meant they did not have sight of the whole bay for a short time. Whilst there were some lapses in practice, we observed this had improved since our previous inspection. Staff generally stayed in a bay and called for assistance when they needed to leave the bay or care for a patient behind curtains. We observed ward sisters and matrons tagging a bay to relieve the staff member. Naseby B ward had implemented a tagging bay sign-in process to improve practice following a serious incident, which we saw worked well during our inspection.

Systems were in place to ensure 'very high risk' patients were in high visibility bays. These were bays in line of sight of the nurses' station. For example, Naseby B ward had two high visibility bays and used these to care for those at highest risk. Managers told us this sometimes led to patients being moved bays if a risk assessment was reviewed and the risk increased to ensure they were in the safest location. We saw there were always staff present in these bays during our inspection.

We saw a patient on Naseby B ward who required closer supervision than observation, always had one to one supervision.

'Patient at risk of harm' signs were visible on most tagged bays we observed on Cranford and HC Pretty wards. The signs contained a circle representing a bed number and staff were required to indicate the level of supervision the patient required. These were generally up to date where in place. However, these were not being used on Naseby B ward at the time of the inspection.

The tagging SOP states side rooms should not be used for patients' high risk of falls. We found most side rooms were compliant with the SOP. However, there was a patient in a side room on Naseby B ward assessed as high risk of falls due to their medical condition. A staff member was assigned to supervise the room; however, it was not tagged in line with the SOP. Whilst the room was not tagged, the patient was aware of the risk of falling and was able to ask for assistance when they needed to move.

Shift changes and handovers included all necessary key information to keep patients safe. We saw handover included oversight of patients at risk of falling. Electronic handovers were in place which included all relevant information such as falls risks and bedrails risks. Handovers included discussions about tagged bays and the nurse in charge assigned bays to specific staff to ensure tagging was effectively implemented. During our inspection, staff were able to tell us who their high risk of falls patients were.

Following our previous inspection, the service implemented a revised nurse evaluation form which included a section on falls prevention. Staff had a series of check boxes, so they knew what tasks were required such as reassessment of risk or lying and standing blood pressures. We saw falls prevention and management was included in on-going nurse evaluation sheets. An audit in January 2022 demonstrated falls had been considered in daily nursing evaluation sheets in 98.3% of records reviewed.

Staff shared key information to keep patients safe when handing over their care to others. Ward transfer documents included prompts around falls risks and actions taken. We saw these were routinely completed on transfer. Staff had to indicate whether the verbal handover corresponded with the documented handover. We observed falls risks being discussed on board rounds. For example, we observed a board round on Naseby B ward. Patient risks such as falls were discussed as well as factors increasing the risk of falls such as postural hypotension. The matron ensured falls was discussed as part of this process.

Nurse staffing

The service did not always have enough nursing and support staff with the right skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed staffing levels and skill mix. Contingencies were in place to manage staffing levels.

There were systems and processes to assess, plan and review staffing levels, including staff skill mix. A staffing tool was used to calculate the number of nurses and health care assistants required for each shift based on the acuity (level of care a patient requires) and needs of the patients. The staffing tool was in line with National Institute of Health and Care Excellence (NICE) staffing guidance. At the time of the inspection, a nursing establishment review was being undertaken. Prior to this, the service had made improvements to staffing structures on medical wards to increase the staff to patient ratio and improve the overall management of the wards. For example, Naseby wards were split into two, reducing the ratio from one nurse to 10 patients to one to five. In December 2021, Lamport and Twywell wards were split into two

with one nurse to six patients. Following the inspection, the service provided us with their vacancy position for March 2022. The service was over established by 5% across the medical division for registered nurses. However, there was an average 10.5% vacancy rate for health care assistants. The service had a plan to improve recruitment and retention of health care assistants.

The planned and actual levels of staff did not match on all wards we visited. Staffing levels were displayed on each ward we visited. Nurse staffing levels during the inspection were below planned levels on two out of three wards we visited. For example, on 15 March 2022, Cranford ward was down one registered nurse and two healthcare assistants. Naseby B ward was down one registered nurse but filled with a nurse associate and one health care assistant. Managers told us unfilled shifts were impacted by vacancies and short-term sickness absence. Data provided to us following the inspection showed from September 2021 to February 2022, the average sickness rate for health care assistants was 8.3% and 6% for registered nurses, both of which were above the trust target.

Fill rates for both health care assistants and registered nurses combined from September 2021 to February 2022 ranged from 82.58% to 90.72% in February 2022. All unfilled shifts were mitigated through a morning staffing huddle led by the matrons and the head of nursing. The nurse in charge and ward managers updated the safe staffing tool to identify staffing gaps and acuity to enable the matrons to ensure all areas were safe. This meant where a ward was fully staffed, they may have staff moved to a ward which was at risk due to low staffing numbers.

Processes were in place to assess daily staffing requirements which considered patients at risk of falling. However, these were not fully in line with trust policy. During our previous inspection we were not assured the level of acuity in relation to patients requiring observation was fully considered. The service revised its process and introduced a bay tagging system. The falls prevention policy stated that at the beginning of each shift the staffing risk assessment template should be completed and uploaded onto the ward electronic system called care flow connect (CFC). This supported the nurse in charge to assess staffing levels, acuity and numbers of bays requiring tagging to determine whether all bays could be tagged. During our inspection, we did not see this being used by managers or uploaded onto CFC. Whilst this was not used, managers told us the information required was put into the safe staffing tool, escalated to the matron or bleep holder and discussed at the morning staffing huddle to find a resolution. Decisions were made at the huddle to move staff to areas with higher acuity to ensure all bays could be tagged if required.

Most staff felt staffing levels continued to improve and staff generally understood the need to ensure all areas were covered so patients were safe. Staff told us short term absence and unfilled shifts impacted on their ability to maintain the tagging system, however, a plan was discussed at the beginning of the shift to ensure tagging was maintained. We also saw ward sisters and a matron support the tagging process.

Systems were also in place to request enhanced care where a patient was very high risk of falling and the bay tagging system could not sufficiently reduce the risk of falling. We saw a patient on Naseby B ward had one-to-one enhanced care in place.

Incidents

The number of falls with moderate and above harm had reduced. The service managed patient safety incidents in relation to falls prevention and management well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the team. Managers ensured actions from serious incident learning were implemented and monitored. However, managers did not ensure actions from learning briefings were implemented across all areas in the service.

Medical care (including older people's care)

The falls improvement action plan implemented by the trust in May 2021 following our inspection, had a positive impact on reducing harms associated with falling within the medical care core service. Data provided to us by the service demonstrated a reduction in falls categorised as moderate or above harm reducing from 10 between January to March 2021 to three between January to March 2022. All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents. Most staff we spoke with were aware of their responsibility to report falls related incidents and felt confident to do this. Following our inspection there was an overall reduction in falls reported, although there was an increase over the winter period.

Staff reported near misses in line with trust policy. From September 2021 to February 2022, the service reported 23 near misses in relation to falls. Some staff we spoke with had reported falls incidents and incidents where staffing levels impacted their ability to implement tasks such as tagging.

Staff reported serious incidents clearly and in line with trust policy. All falls with moderate or above harm were presented to the serious incident review group (SIRG) by the ward manager. The incidents were discussed to assess whether they met the serious incident criteria. From April 2021 to February 2022, the service declared three serious incidents relating to falls. This was significantly lower than in the previous 12 months.

Governance processes were in place to investigate and identify learning. Following our inspection in May 2021, the service revised its serious incident investigation report scrutiny process. An improved falls investigation template was implemented. The investigation specifically identified care delivery problems and linked them with the root cause. This enabled the investigator to immediately identify any root causes and learning. This meant learning could be acted on quickly rather than waiting for the outcome of the final report. The immediate learning was presented to the SIRG and actions agreed.

Managers investigated incidents thoroughly. They were supported through the investigation process by the patient safety team and less experienced managers had a 'buddy' to support them. Where there had been a rise in falls incidents in a specific area, the falls lead, and managers undertook a swarm to identify whether there were any root causes. A swarm provides a rapid response to patient safety incidents, allowing immediate action. For example, there had been a recent increase in falls on Lamport and Twywell wards. A swarm was undertaken to determine whether there were any concerns. On this occasion the swarm did not identify any specific root causes and there was a reduction in the number of falls.

If an incident with moderate or above harm did not meet the serious incident threshold, the service undertook an internal root cause analysis investigation. This resulted in a learning briefing being produced by the patient safety team and shared with staff. Following our inspection, the service provided us with learning briefings, and we saw learning from this had been implemented. For example, a learning briefing was shared following an incident on Naseby ward in August 2021. We saw learning to ensure risk assessments were reviewed on admission to the ward, had been implemented. We also saw the ward had a system for assigning bays based on level of falls risk. This meant the most high-risk patients were placed in the most visible bay, which was tagged.

Staff received feedback from investigation of incidents. During our previous inspection in May 2021, we were not assured the service effectively identified learning through the incident investigation process. During this inspection, we found examples where the service had identified learning from incidents and acted to reduce the risk of a reoccurrence. For example, on HC Pretty B ward, all staff were aware patients at risk of falling should not be cared for in a side room due to the inability to effectively tag the side room. This was learning identified in a recent serious incident.

There was evidence that changes had been made as a result of feedback. For example, on Naseby B ward, learning had been identified following a serious incident where a staff member left a bay unattended and a patient subsequently fell. The manager implemented a process for staff to sign in and out of a tagged bay. We saw this in practice during our inspection. Overall staff felt the process improved teamwork and reduced the number of unwitnessed falls on the ward.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed and learning identified through senior nurse meetings, ward meetings and daily handovers. Falls was a standard agenda item. Learning briefings were stored in meeting folders to share with staff. These were in place on wards where there had been a recent fall such as HC Pretty ward and Naseby B ward. Staff we spoke with could clearly describe the incident, learning and how their practice had changed.

Each ward we visited had a practice improvement facilitator (PIF) for falls prevention. PIF's supported team training and development needs around falls, with support from the falls prevention lead. We saw evidence of falls PIF's teaching sessions in ward meetings where there had been an incident.

Whilst we saw effective processes to improve practice on wards where a fall had occurred, we were not assured learning was shared across the medicine division. For example, staff could not tell us about incidents that had occurred on other wards. However, the service had recently implemented a digital newsletter with key learning from incidents to be shared across the division. Senior nurse meetings took place weekly and discussed incidents that had occurred across the division. Managers acknowledged sharing of wider incidents was an area for improvement.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice in relation to falls prevention and management. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The trust, 'Falls Prevention and Management Policy' was approved in May 2021. The policy referenced the most up to date National Institute of Health and Care Excellence (NICE) falls guidance for older people 2013. The guidance recommends all patients aged 65 and over received a multifactorial falls assessment and intervention plan. The policy was amended in June 2021 following our previous inspection and a trust wide falls quality improvement programme was implemented. A workstream falls group was set up to improve the quality relating to falls and amendments to the policy. These included bed rails risk assessments, falls risk assessments, falls care plans, tagging, lying and standing blood pressure, clinical handover and ward board magnets on the electronic record.

During our previous inspection we found documentation did not support staff to effectively assess risk and implement evidence-based actions. During this inspection we found the falls assessment process included a multifactorial falls assessment of risk with a clear intervention plan. The document enabled staff to effectively review risk in line with trust policy. The bed rails assessment provided staff with more clarity about how to assess the risk and there was space to document reviews and rationale for changes. The revised risk assessments had been fully implemented on all wards we visited and there were improvements in the completion of them.

This meant risks were effectively identified, assessed and documented so all staff involved in the patient's care knew what to do to reduce the risk of patients falling and coming to harm.

Patient outcomes

Staff monitored the effectiveness of care and treatment in relation to falls prevention and management. The service used the findings of falls audits to make improvements to reduce the risk of harm to patients at risk of falls.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. During our previous inspection, we found documentation audits were ineffective in monitoring the quality of care and treatment in relation to falls. We found processes to monitor effectiveness provided the service with false assurance. Following our inspection in May 2021, the service implemented a falls quality improvement programme.

The service provided us with weekly progress reports which demonstrated improvements in compliance over time and that learning had been identified and shared with staff. Managers used information from the audits to improve care and treatment. Learning was identified and actions recorded. Managers had access to a dashboard to enable them to review progress against actions. The improvements reflected the incident data showing a downward trend in incidents, particularly those with moderate and above harm.

Audit data provided to us following our inspection demonstrated improvements made had been sustained. We reviewed the January 2022 harm free care report which demonstrated a good level of compliance with audit standards. Seven scored above 93% and two under. Tagging compliance at 83% and lying and standing blood pressure compliance at 80.4%.

These measures were generally consistent with what we found during our inspection. We identified some non-compliance with tagging and completion of lying and standing blood pressure. Managers shared results from audits and made sure staff understood information from the audits. The harm free care report identified learning each month which was shared with staff. We saw discussions took place at ward meetings and handovers. We observed an awareness campaign of lying and standing blood pressures in all three wards we visited.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to reduce the risk of patient's falling. Most staff we spoke with had completed falls prevention training. Falls prevention training met the needs of all staff. This included safe use of bedrails, tagging processes and lying and standing blood pressures. Staff were able to articulate their role in preventing falls and describe how to undertake an assessment. This was a significant improvement from our inspection in May 2021. Records demonstrated an overall improvement in staff ability to assess risk of falling and to identify which preventative measures should be in place.

In addition to falls prevention training, the service provided training to nursing staff following the implementation of new falls and bedrails risk assessments and care plans. The training was aimed at teaching staff to complete the risk assessment and associated care plan. Most staff we spoke with had received this training.

Medical care (including older people's care)

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We reviewed ward meeting minutes which demonstrated a good level of attendance. Most wards had folders with relevant information and shared information through electronic messaging systems so staff who were unable to attend could see the minutes.

Managers identified poor staff performance promptly and supported staff to improve. For example, managers undertook spot checks and where there were areas of non-compliance, managers addressed this with staff. Falls practice improvement facilitators supported staff to improve practice by offering coaching and education sessions on the ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff knew how to support patients who lacked capacity to make their own decisions. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood the requirement to assess a patient's capacity. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We saw where patients were on an enhanced care plan and had one to one supervision to prevent them from harm, staff ensured deprivation of liberty safeguards were in place. For example, where one to one supervision was in place to prevent a patient from falling, we saw deprivation of liberty safeguards were in place.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. During our inspection we found mental capacity assessments and best interests were completed appropriately. A capacity assessment and best interests had been completed in seven records we reviewed. Appropriate use of mental capacity assessments and deprivation of liberty safeguard were included in monthly audits. Audits in January 2022 showed 100% compliance.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Governance

Leaders operated effective governance processes in relation to falls prevention and management. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. The service identified, escalated and mitigated risks associated with falling.

There were effective structures, processes and systems of accountability to support the delivery of the falls improvement plan. During our previous inspection in May 2021, we found the serious incident investigation process was not always effective in identifying root causes and contributory factors associated with falling. During this inspection, we found improvements had been made. The service revised its serious incident investigation report scrutiny process, so the investigation specifically identified care delivery problems and linked them with the root cause. An improved falls investigation template had been implemented. This enabled the investigator to immediately identify any root causes and learning.

Medical care (including older people's care)

During our previous inspection we found systems and processes for implementing learning following incidents, was ineffective in relation to falls. During this inspection, we found significant improvements had been made. The service had implemented a falls training programme which met the learning needs of staff and compliance had significantly improved. The training programme was made accessible in varied formats to increase completion. Leaders had reviewed the management of wards and staffing establishment to improve lines of accountability and planned staffing levels. Improvements in the oversight of high risk of falls patients, acuity and safe staffing had been made when making decisions about daily staffing levels. Furthermore, we also found managers took ownership of immediate learning from serious incidents and considered local improvements required. The immediate learning was presented to the serious incident review group (SIRG) and actions agreed. For example, piloting a tagging sign in and sign out process on Naseby B ward. This meant learning could be acted on quickly rather than waiting for the outcome of the final report.

Oversight of serious incident (SI) action plans had improved. A standard operating procedure (SOP) for the governance of SI action plans was produced so that learning was shared with the wider service. The local manager and falls lead presented incidents, categorised as moderate harm or above, to the panel and a decision was made whether it met the serious incident threshold. The SIRG panel had improved oversight of serious incident actions through a dashboard to monitor progress. If an incident did not meet the SI criteria, a local investigation and improvement plan was implemented. Any additional learning was added to the Trust wide falls action plan. Progress against action plans were monitored in divisional governance meetings.

We saw learning briefings were produced with the patient safety team to capture learning and actions. These were also disseminated through the 'patient safety lessons learnt' forum.

The SOP stated outcomes and progress against local improvement plans were monitored at the falls multidisciplinary team meeting (MDT). However, these meetings were infrequent. Following the inspection, the service sent us the previous two meeting minutes for 26 May 2021 and 17 January 2022. We reviewed the meeting minutes and did not see evidence that monitoring of local action plans took place at these meetings.

Systems and process for monitoring falls performance and quality were effective. Following our inspection in May 2021, the service revised its audit programme to improve quality. The programme was aligned to the falls prevention management policy and falls improvement programme. The audits were initially completed weekly and moved to monthly once performance had improved. The service implemented a performance dashboard to track performance over time, identify poor performance quickly and set actions for improvement. This was visible locally at ward level for nursing staff to see their performance and at divisional and board level. Themes from the audits reflected what we saw on inspection. For example, we found lying and standing blood pressures were not always completed, which was also identified by the service as an issue through audits. Where there were gaps in performance, we saw appropriate action being taken to address it and there was evidence of escalation of concerns through to board reporting.

A falls reduction group was in place which met weekly at the time of the inspection. The group had oversight of performance, incidents, risk and themes associated with falling. This was chaired by the director of nursing and enabled quick action where there were any areas of concern. For example, where there had been a significant increase in falls on a ward, quick action was taken to do a deep dive to understand the concerns. This group was also flexible in increasing its surveillance of performance where they saw increases of incidents or drops in performance. For example, the group increased its frequency to address reduced performance in tagging of bays during the peak of the omicron variant during the COVID-19 pandemic. This allowed the service to identify any learning or improvements required, which led to a revision of the bay tagging standard operating procedure.

A falls action plan was in place. The falls reduction group fed into the wider trust falls action plan where there were areas of concern. For example, we saw a new action added in relation to a specific ward where there had been an incident and concerns with falls compliance. The action was to provide support to the ward and carry out focused quality improvement work by the practice development team by June 2022. This was to support the ward in improving clinical practice. The action plan was live and added to following learning from audits or incidents. We saw actions had been completed, revised and new ones added since our inspection in May 2021.

Managers held regular ward meetings with staff which were well attended. Weekly senior nurse meetings took place where performance and quality in relation to falls was shared with ward sisters and matrons. Falls was a standard agenda item and we saw key messages in relation to performance and quality being shared with staff.

Staff were clear about their roles and understood what they were accountable for in relation to falls prevention and management. All staff understood their role in preventing patients from falling. The falls lead was visible, and staff knew who they were and how to contact them. Falls practice improvement facilitators were in place for each ward which enabled the falls lead and quality matrons to ensure key messages, risks and quality improvements in relation to falls was consistently shared with staff at ward level.

Management of risk, issues and performance

The falls quality improvement programme implemented following our inspection in May 2021 was effective in driving improvements. Risk registers reflected the risks identified during our inspection.

The falls quality improvement plan implemented following our inspection in May 2021 was effective. The service implemented an immediate action plan in response to the warning notice issued requiring significant improvement. The service undertook a series of listening events with staff to understand what impacted effective falls prevention and management. Feedback was used to inform quality improvements such as the implementation of the tagging standard operating procedure. Six workstreams were in place including:

- Bedrails.
- Falls risk assessments.
- Tagging.
- Lying and standing blood pressure.
- Handover.
- Serious incidents.

A group of dedicated staff were identified to lead on each workstream. They were tasked to identify areas for improvements and implement them. For example, the falls risk assessment workstream identified the need to revise its documentation to support staff, train staff and roll out the new documentation. Each workstream had an action plan with timescales and clarity about how it will improve practice. Staff training was included in action plans across all workstreams. The service also set key performance indicators so managers could drive improvement and measure progress. The work streams provided weekly progress updates to the executive team and this was monitored by the trust board.

A systematic programme of audit to monitor quality was in place with systems to identify where action should be taken. During our previous inspection we found audits were not effective in improving quality. During this inspection we found significant improvements had been made to the audit process, including measures which reflected policy. The service

also implemented a monthly peer audit which provided objectivity in the assessment of compliance and quality. We saw the audits identified areas for improvements and actions for improvement were in place. Local managers were given objectives to improve compliance with areas outlined in the improvement plan. In relation to falls, performance and patient outcomes were fed back to the board.

Risk registers reflected the risks identified during our inspection. The service had one risk in relation to falls and had amalgamated all local risks into a divisional risk. During our previous inspection we found risk registers did not identify issues we observed on inspection. During this inspection we saw the risks we found had been identified and where appropriate cited in the divisional risk register, which was regularly reviewed. We found improvements in the overall management of risk which reflected the service and trust wide falls improvements plans.

Areas for improvement

Action the service SHOULD take to improve:

Core service

- The service should ensure all staff involved in the care of patients have received effective training in falls prevention and management. Regulation 12 (1)(2)(c) and (e): Safe care and treatment.
- The service should ensure effective systems are in place to assess and mitigate individual patient safety risks. This includes, but is not limited to; bed rails, falls, lying and standing blood pressure, supervision of high risk of falls patients, pre-existing medical conditions and behaviours that challenge. Regulation 12 (1)(2)(a) and (b): Safe care and treatment.
- The service should ensure all clinical areas are adequately staffed to ensure safe patient care. Regulation 18 Staffing (1).
- The service should ensure complete and accurate records are maintained that support effective risk management and describe the care and treatment delivered to individual patients. Regulation 17 (1)(2)(c): Good governance.
- The service should ensure effective systems are in place to effectively identify and share learning from incidents across the service to prevent further incidents from occurring. Regulation 17 (1)(2)(b): Good governance.
- The service should consider reviewing the falls multidisciplinary team meeting (MDT) to ensure it is aligned with the standard operating procedure (SOP) for the governance of serious incident (SI) action plans and trust falls action plan.

Our inspection team

The team who inspected the service comprised a CQC lead inspector, an assistant inspector and a specialist advisor. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.