Nottingham University Hospitals NHS Trust

# Queen's Medical Centre

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inspected but not rated |
| Are services safe? | **Inspected but not rated** |

# Our findings

# Maternity

**Inspected but not rated**

Queen's Medical Centre is operated by Nottingham University Hospitals NHS Trust. The trust's maternity service sits within the division of family health and provides a range of services from pregnancy, birth and post-natal care and is based across two campuses and Nottinghamshire community. The trust provides inpatient antenatal, intrapartum and postnatal beds on Nottingham University Hospital (NUH) City campus and Queen's Medical Centre (QMC) campus for both high and low risk women. Both labour suites have alongside them midwifery led units and the trust provides a homebirth service. There are inpatient antenatal, intrapartum and postnatal beds available for women.

From October 2019 to September 2020 there were 7,941 deliveries at the trust.

Antenatal clinics are held across the whole of the service including community and the trust has day assessment units on both sites and ABC (triage service).

There is a fetal medicine service based on both sites, but this service is primarily delivered at the QMC campus.

Community services are provided by teams of midwives commissioned by Nottinghamshire CCG. They offer women a homebirth service and postnatal care.

The maternity unit at QMC is located over two floors in East block and includes: Ward B26 – an 18 bed antenatal ward (which includes triage and induction of labour), Ward C29 – a 26 bed postnatal ward (which includes transitional care cots), Labour suite – 10 beds plus two obstetric theatres (with 24-hour anaesthetic cover, a bereavement suite and direct access to the neonatal unit) and the Sanctuary birth centre – 4 beds, a midwife led unit sometimes referred to as an Alongside Midwifery Unit (AMU).

At our October 2020 inspection we rated the maternity service overall as inadequate.

We also served a Warning Notice under Section 29A of the Health and Social Care Act 2008. This warning notice served to notify the trust that the Care Quality Commission had formed the view that the quality of health care provided by Nottingham University Hospitals NHS Trust for maternity and midwifery services required significant improvement. We found significant improvement was required to the documentation for risk assessments and information technology systems. As a result of the Section 29A Warning Notice the trust was given three months to make the significant improvements identified regarding the quality of healthcare.

We carried out this unannounced focused inspection as a follow up to the Section 29A Warning Notice. Following a review of all the evidence from this follow-up inspection and a review of additional information provided by the trust following our inspection, we are satisfied that some improvements have been made and the requirements of the Section 29A Warning Notice have been met.

At this visit we inspected the Safe domain.

We did not rate this service at this inspection. The previous rating of inadequate remains.

See the Maternity section for what we found.

**How we carried out the inspection**

# Maternity

We visited ward B26, ward C29, Labour suite and ABC triage assessment unit. We spoke with 16 staff, including service leads, matrons, midwives, community midwives' medical staff, maternity care support workers and student midwives. We reviewed 10 sets of patient records in paper and electronic format (all belonging to women).

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.

## Is the service safe?

**Inspected but not rated**

**Assessing and responding to patient risk**

At our last inspection we found, documentation for risk assessments carried out for women who used the service and risk management plans were not always carried out or developed in line with national guidance. This meant staff failed to identify and respond appropriately to changing risks to women and babies, including deteriorating health and wellbeing.

At this inspection we found staff mostly completed and updated risk assessments for each patient to reduce and minimise risks. Staff identified and acted quickly upon women at risk of deterioration.

Staff completed some risk assessments for each woman on admission / arrival using a recognised tool, and reviewed this regularly, including after any incident. Staff were required to complete trust generic risk assessments for women who were admitted into the service. This included infection control, falls, manual handling and pressure ulcer risk assessments.

Community midwives described how they were prompted from the new electronic system to undertake a risk assessment every time they saw women. All the midwives were able to advise on how they would follow the correct procedure to escalate women if they identified a new risk. For example, one midwife told us how they referred a lady who was presenting with low platelets during pregnancy and then how they followed this up with a direct e-mail to the consultant involved in the women's care.

Community midwives told us "Since the inspection in October, there has been an increase in reminding midwives to undertake risk assessments for women at every appointment, an increase in training and more meetings with managers, were we feedback as to what needs to improve". However, some hospital midwives did always not feel that increased training and updates had been offered to them.

At this inspection we found some improvement in the documentation of Venous thromboembolism (VTE) risk assessments. VTE is a condition where blood clots develop in a vein. We reviewed 10 sets of notes at the Queens Medical Centre; a general risk assessment was completed for all women in the women's part two document and in the online system. However, the paper document did not hold information relating to all VTE assessments. On paper four out of 10 were missing information relating to VTE. The online system however was 100% complete. This meant there was a disconnect between paper and electronic records and in situations where staff were unable to access online records, they would not be able to identify and respond appropriately to changing risks to women.

# Maternity

Staff were trained to use a nationally recognised tool to identify women at risk of deterioration. During this inspection all observations within labour suite, ante-natal, triage assessment and post-natal wards were completed on an electronic tool. All staff were aware of the modified obstetric early warning score (MEOWS) all staff and completed MEOWS scores on women when observations were taken. The early warning scoring system was designed to enable staff to recognise and respond to acute illness, clinical deterioration and to seek appropriate medical assistance. Observations we reviewed, within the medical records, did not always appear to be documented immediately. Staff we spoke with identified that they were still without a full complement of handheld electronic devices and that staffing on the units sometimes meant observations were uploaded later in a shift. We reviewed two sets of notes where women had a MEOWS score that required immediate action. We noted that appropriate action had taken place in both cases and the MEOWS score and the women subsequently improved. The trust monitored compliance with documentation of patient observations as a monthly metric to improve safety.

Previously, there was poor compliance with the completion of growth charts with this not being done in line with requirements. During this inspection only four out of the 10 paper record sets we checked were complete. This meant that potentially there was a risk that babies that were small for gestational age (a term used to describe babies who are smaller than usual for the number of weeks of pregnancy) may not be identified. Babies that are small for gestational age are at increased risk of fetal demise during pregnancy and delivery. However, we are aware that within the online system plotting is completed electronically and is now being audited by the trust. However, if the women are out of area her handheld record (paper) may not reflect what the online system has recorded. Leading to a risk of incorrect management of the pregnancy.

Staff did not always complete, or arrange, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Mental health risk assessments were an essential part of the maternity pathway women went through from the moment they booked in until delivery and discharge home. We reviewed 10 sets of paper records and found eight had both mental health assessments completed when required.

However, the online system did not correlate with this. Online only three patients had a yes for questions relating to mood throughout the patient record. In some cases, the questions were not available as a short booking form had been used. It appeared staff had a choice of a short or long booking form. It was not clear, from the records we reviewed, the rationale for determining which patients would get a short booking and which a long booking. This meant that staff had two different documents with different information as they were having to duplicate information this identified that information was potentially being missed in one or both systems.

There was a requirement for staff to discuss and document domestic violence risk within the assessment. On the 10 paper records four documented the question had been asked. However, online this was only been documented on three occasions.

As patient handheld notes and online notes did not reflect each other there was a risk staff could fail to identify and respond appropriately to mental health and domestic violence concerns.

We spoke with 16 members of staff during this visit and they were all concerned about the duplication of records and that sometimes things would be in one record not the other. Whilst general risk and VTE had improved mental health and domestic violence recording had shown little change.

**Records**

# Maternity

**At our last inspection we found, information technology systems were not used effectively to monitor and improve the quality of care for women and babies. Use of multiple systems meant information needed to deliver safe care and treatment was not always available to relevant staff in a timely and accessible way.**

At this inspection we found, whilst staff completed mostly detailed records of women's care and treatment. There were multiple systems in place for staff to document in which led to duplication and errors at times.

Women's notes were mostly comprehensive and substantive staff could access most of them easily. However, in all area's agency staff had no access to the computer held records which increased the workload of the trust staff as they were required to input agency notes for all women. We reviewed 10 sets of women's records. The standard of documentation had improved and mostly complied with professional standards. Entries made were dated, timed, signed and printed by staff. However not all staff completed the signature legend at the beginning of the notes.

Community midwives were now able to access the same electronic system used in the acute trust. This had been implemented in January 2020, and although this was more in-depth and much better, it was very slow, and the midwives could not always access it online due to connectivity issues. This meant the midwives had to write paper notes and copy these onto the electronic system once their shift had finished. Some hospital midwives were not aware they could now access information from the community midwives.

The trust were aware of, a risk around the number of systems in place for staff to document and record episodes of care. There were still three separate systems for staff to record care and treatment, which increased the risk of not all the relevant information being recorded, on all three forms, due to time factors to repeat the documentation. Whilst the trust had an action plan in place staff told us they were not aware of the future plans for deployment of an all-electronic system and what this meant for the handheld document for the women.

The problems with the new electronic system had been reported to the I.T. department, who had visited the community, no improvements had been made at the time of our inspection.

All midwives told us the electronic system took an extra 25%to 30% of their time, which detracted from the time spent with women.

The trust informed us post inspection that a number of changes had been implemented immediately to develop the digital pathway this included; a Maternity Digital Programme Board, appointment of a digital midwife to support transition work and IT access for 25 agency midwives.

## Areas for improvement

**Action the trust Must take to improve**

- The trust must ensure risk assessments and risk management plans are completed in accordance with national guidance and local trust policy and documented appropriately. Regulation 12 Safe care and treatment.

- The trust must ensure information technology systems are used effectively to monitor and improve the quality of care provided to women and babies. Regulation 12 Safe care and treatment.

# Our inspection team

The team that inspected the service comprised a CQC inspection manager, and one other CQC inspector. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
| --- | --- |
| Maternity and midwifery services | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |