University Hospitals Sussex NHS Foundation Trust

St Richard's Hospital

Inspection report

St Richards Hospital
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Date of inspection visit: 26 and 27 April 2022
Date of publication: 29/07/2022

Ratings

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

Our findings

Overall summary of services at St Richard's Hospital

Inspected but not rated

We carried out this unannounced focused safety inspection of maternity services provided by University Hospitals Sussex on the 28 September 2021 because we received information of concern about the safety and quality of the service. Following this inspection, we issued a warning notice because of our concerns around the safety of the service.

On the 26 of April 2022 we re-visited St. Richards Hospital to see what improvements had been made.

Maternity (inpatient services)

Inspected but not rated

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities in maternity services. We carried out a focused inspection related to the concerns raised at the previous inspection. This did not include all of our key lines of enquiry (KLOEs). We looked at KLOEs specific to the domains: safe, effective and well-led.

We visited clinical areas including the delivery suite, the postnatal and antenatal ward (Tangmere ward), and the co-located midwifery led unit.

We spoke with 26 staff, including service leads, midwives (bands 5-7) obstetric staff, maternity care support workers, student midwives, governance lead, practice educators and the patient safety lead.

We observed the morning multidisciplinary handover on the delivery suite and morning handover on the postnatal and Tangmere ward. We also attended the morning safety huddle on Tangmere ward the daily cross site staffing meeting and the patient safety meeting.

We reviewed five sets of maternity records and 5 prescription charts. We also looked at a wide range of documents including the trust action plan, standard operating procedures, meeting minutes, risk assessments, recently reported incidents and audit results.

After the inspection we requested further documentary evidence to support our judgements.

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Previously staff were unable to complete mandatory training and there was not clear governance around this. The department had made several improvements to ensure completion of mandatory training since our last inspection. This included reminders at four and two weeks. If staff had not completed the training at this point the interim head of midwifery would email them directly to understand why. All staff had received an email outlining the importance of completing training. Training dates were displayed in ward areas with a spreadsheet indicating when staff training was needed.

Maternity (inpatient services)

In August 2021 only 53% of midwifes had completed specific training on fetal monitoring which was much worse than the trust target of 90%. This training included the key skill of cardiotocography (CTG) interpretation. CTG is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. During our re-inspection we saw training figures had greatly improved to above 90% for all staff groups. This was due in part to a staff member being tasked with ensuring compliance and organising further training.

A recent CTG audit showed that 100% of cases had appropriate escalation and 83% had reviewed the women hourly, when the women had not been reviewed a reason was clearly documented. The results of this audit were displayed on the delivery ward for staff and the public to see.

Environment and equipment

The design, maintenance and use of facilities and premises kept people safe. Staff managed clinical waste well. However, regular checks on lifesaving equipment had not always been completed.

During our last inspection we found staff did not always complete daily safety checks of specialist equipment. All resuscitaires had gaps in the recording of important daily checks. In total 104 checks had been missed from three resuscitaires from June to September 2021. In two of these records, more than a week had passed without a check. Staff should check resuscitaires daily to ensure they are working correctly. A resuscitaire combines warming therapy along with the components you need for clinical emergency and resuscitation. On re-inspection we saw resuscitaires still had gaps in the recording of important daily checks. In total 54 checks had been missed from four resuscitaires from February to April 2022.

The department provided audit results relating the to resuscitaires. They showed that with the exception of Bramber ward the audits had only been completed in November and December 2021. In these months the audit showed that checks had not been fully completed. From January 2022 to April there had been no further audits to check for compliance.

Although there was an improvement in checks there was still no reliable system to ensure these vital checks were carried out.

The unit had two resuscitation trollies, one on labour ward and one on Tangmere ward. Previously the resuscitation trolley on Tangmere ward included out of date equipment. During this inspection we saw that checks had been completed and there were no out of date items across all areas of the unit. However, the resuscitation trolley on labour ward had gaps in the daily external checks of the equipment on top of the trolley. In total there were 14 gaps from 27 February 2022 to 11 April 2022, on one occasion the trolley was not checked for 6 days in a row. Equipment held inside the trolley was checked weekly and a security tag fitted to evidence the trolley had not been used since the last check". This meant that lifesaving equipment could have been faulty or missing when it was needed. Staff did not have assurance that checks were being completed.

A cupboard in neonatal emergency room contained sharps and cannulas and was not locked. The cupboard was not locked as equipment may be needed in an emergency. The department had risk assessed this and felt a key and padlock was not appropriate, as too many clinicians may need access the cupboard. Post inspection we saw evidence they had ordered a keypad lock to secure the cupboard.

Previously equipment did not always indicate when the last service was undertaken, or when the next was due. We checked 14 pieces of equipment and found all indicated when they were last serviced.

Previously staff did not always dispose of clinical waste safely. On re-inspection we found this had improved. Although, we saw several sharps bins that were not closed, all other waste was managed in line with national guidance. This included locked clinical waste rooms and bin stores that could be accessed with a code.

Equipment was provided to assist staff with the safe removal of a woman from the birthing pool in an emergency. There was a flow chart and protocol on the wall behind the birthing pool. During our last inspection the pool evacuation equipment was obstructed by an air conditioning unit and equipment. This had been removed and there was clear access to all evacuation nets.

However, as a result of COVID-19 and national guidance on social distancing, pool evacuation training had been paused. We were told this was due to commence in 2022. There was no specific date provided for this vital training. Staff did however undertake skill drills in pool evacuation.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration

On our last inspection there was an effective triage system that was monitored by midwives. Previously we found staff did not use a nationally recognised tool to ensure risks were rated consistently. The department now used a nationally recognised triage tool which was audited for completion. Recent audit results showed the tool had been used effectively 100% of the time.

Every woman that contacted the department was documented in the patient records and a template was used to identify women who called multiple times. If a woman had called four times then a consultant saw them to ensure that there were no underlying issues.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff used the modified early obstetric warning score (MEOWS) to identify women at risk of deterioration. These were accurate and care escalated in line with guidance. Recent audits showed that they were correctly completed 100% of the time.

Midwifery staffing

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

Previously the service did not have enough nursing and midwifery staff to keep women and babies safe. The unit had introduced a number of new measures and employed new midwives to ensure the unit was adequately staffed. However; we saw actual verses planned numbers of staff were not always achieved.

There had been improvements. For example, the unit was fully staffed for both band seven and five midwives. They had employed seven nursery nurses and with a further four planned. The unit had new registered nurses helping on the wards. Although they were not midwives they could alleviate the pressure on midwives by undertaking specific roles such as monitoring, taking blood, and routine care.

There was a new governance lead and a matron post had been advertised to allow one matron per site.

The department also had a rolling advertisement for midwifery staff which allowed more flexibility if existing staff members left.

The department now had twice as many student midwives and agreement to interview them pre-qualification so they could start straight away if they were successful.

The interim head of midwifery for the West, head of midwifery for the East, and other members of the leadership team including the transformation lead, director of midwifery, governance lead, and the assistant director of nursing held a daily staffing call. They identified staffing issues and could quickly resolve them if needed. The call followed a template which identified staffing risk through several metrics. These included whether supernumerary staff had to work clinically, whether one to one midwifery had been achieved and patient acuity. Staff reported this had been working well to identify areas of need quickly and resolve them.

Recently a woman had to be transferred to the Royal Sussex County Hospital (RSCH) as she was labouring at 27 weeks. The RSCH did not have the right staffing numbers so the unit sent a midwife with the woman to ensure that the right staffing mix could be achieved. This showed the units were working together for the safety of their patients.

The number of midwives and healthcare assistants did not match the planned numbers. Although we saw an improving picture from February 2022 to April 2022. One to one care was achieved 100% of the time. The interim head of midwifery monitored red flags, staffing and acuity and Red, amber and green (RAG) rated the unit monthly in a safer staffing report. On average from February to April 2022 the unit rated itself as green 74% of the time, amber (up to two midwives short) around 24% and red (two or more midwives short) 2% of the time.

Average turnover rates for St. Richards and Worthing Hospital had were 9.6% for midwives and 9.9% for maternity support workers over the past 12 months.

On our last inspection the service had high vacancy rates of 25%. Previously at St. Richards there were 36 vacant midwifery posts in August 2021. Staffing numbers had significantly improved with a vacancy of 3.8 whole time equivalent (WTE) for core midwives and 3.2 WTE for community midwives.

Previously the service had a high sickness rate of 9.4% at St. Richards in August 2021. The sickness rate had improved in the core maternity staff to 1.8% in March 2022, however the community sickness rate was slightly higher at 4.5% (non-COVID-19 sickness).

The unit used a nationally recognised tool to identify safe staffing numbers. However, this was still not being consistently used. The department had commissioned a staffing review which was due to be completed in the next two months which would enable the unit to calculate staffing more accurately. The interim head of midwifery collated current staffing information which was presented to a patient safety meeting and reviewed by the board through the director of midwifery.

Records

Staff kept detailed records of women's care and treatment but there were several systems in place to records patient records. Records were stored securely.

Maternity (inpatient services)

Previously women's notes did not contain the maternity early obstetric warning system (MEOWS) charts. These were stored separately at the nurses' station as the midwife care assistants undertook this monitoring. Not keeping the MEOWS charts within the women's' record could mean there was a delay in recognising a deteriorating patient. During the re-inspection we found women's notes were stored correctly and the MEOWS chats were now stored with women's notes.

Women's notes were comprehensive, however, there was several different systems to record patient information. Some records were electronic and others were paper based. This could mean that information was hard to find as several systems were in place. The service had funding to move to an online system due for completion by March 2023.

Prescription charts were accurate and accessed online.

Records were stored securely. Women's records were stored for six weeks on the midwife led unit and for a further three months on site. The clerical team maintained the notes and uploaded information to various systems postnatally.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The maternity service used an online prescribing and administration system for maternal prescriptions. Prescriptions were legible, named, dated, allergies and weight were clearly documented, time and route of administration were clearly recorded.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were checked were all stored securely, were in-date and ordered to ensure the oldest medication was used first.

Controlled drugs were stored in locked rooms within a locked cupboard and the checklists and records associated with these were completed correctly.

Medical gases were checked and stored safely. They were stored securely to prevent them from falling. This was in well ventilated areas, away from heat and light sources, in an area that was not used to store any other flammable materials.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the team and wider service.

Previously staff reported feeling to report incidents as they were so busy and although they received feedback from investigation of incidents that they reported staff did not have regular formal meetings to discuss the feedback and look at improvements to patient care. On re-inspection we saw that staff knew what incidents to report and how to report them and that there was a focus on reporting and sharing learning from incidents.

There was a patient safety lead who reviewed and allocated all incident reports. Once triaged, any moderate or higher incidents were reviewed at a weekly multidisciplinary incident review meeting. The patient safety office was located on the labour ward which meant staff had easy access to talk to the leads if they had any concerns.

Maternity (inpatient services)

We attended the incident review meeting and saw active participation from several staff groups including consultants and maternity support workers. Discussions included the grading of incidents and any immediate learning could be shared via safety huddles.

Staff participation in the incident review panel meeting formed part of mandatory training for all staff. This highlighted to staff the importance of these meetings and promoted a positive culture around incident reporting and learning from incidents.

On labour ward and Tangmere ward we saw several information boards, one of which was a 'learning board'. These were up to date and could be seen by patients and staff.

Staff received feedback from investigation of incidents that they reported. Feedback and learning was shared through departmental meetings huddles and newsletters contained information on incidents and shared learning.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver care according to best practice and national guidance. We reviewed 10 guidelines, all followed national guidance and had clear indications at the start of the document referenced recent changes. Policies were dated when reviewed and there was an indication of the next review date. A recent audit showed 100% of guidelines were up to date.

There was a central risk assessment which included the updating of policies.

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 meet the needs of women.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal rates across maternity were 95% for midwives and 89% for medical staff.

The clinical educators supported the learning and development needs of staff. Staff had completed train the trainer workshops to enable inhouse training and increase opportunities for staff to complete training.

Staff undertook face to face skills drills. These included simulation and debriefing incorporating the trust guidelines for shoulder dystocia, postpartum haemorrhage and new-born resuscitation. The department had recently added breach birth to the skills drills training following a recommendation from the Ockenden report.

Maternity (inpatient services)

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 interim head of midwifery was visible and approachable in the service and staff spoke of improvement in visibility of the leadership team.

The senior leadership team formed a triumvirate that included the interim head of midwifery, chief of service and acting divisional director of operations. The interim head of midwifery had been in post since March 2021. The interim head of midwifery was line managed by the chief nurse.

They were supported in their role by two matrons. One matron was based at Worthing Hospital and one at St. Richards Hospital; currently the department were advertising one of these roles.

The current structure had filled many of the previous gaps in management and day to day running of the maternity services. This included support from the governance lead, the introduction of a director of midwifery and a non-executive director (NED) safety champion for maternity.

There were seven band seven midwifes and a ward manager who supported the interim head of midwifery. A band seven midwife was in charge of a shift and supposed to be supernumerary to provide leadership and oversight of the maternity services. We reviewed staffing information and saw this was achieved most of the time and formed one of the metrics discussed in the daily leadership staffing huddle.

The leaders recognised that there was a significant pressure on the staff in the unit and had been making changes to start to address them. Staff were now aware of these and updates were cascaded formally.

There was a practice development nurse who had made a positive impact over the past six months in assuring staff had access to training.

Culture

Staff felt respected, supported and valued.

Previously staff felt demotivated and overworked. During our re-inspection staff were more positive about working in the department and were able to describe improvements in communication and support.

The department had held listening events to allow staff to talk through the challenges in the unit and allow the leadership to address these and communicate what was happening across the trust in relation to the maternity services.

Maternity (inpatient services)

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. 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.

Previously we identified gaps in the governance of the department. Since our last inspection there had been several changes to the governance of the unit. These included the introduction of more formalised huddles, staff meetings, listening events and monthly newsletters meant staff had several opportunities to give and receive information and updates about the department.

There was a series of meetings and access to the trust board. A new non-executive director (NED) safety champion for maternity and a director of midwifery had meant there was a direct link to the board and reporting lines to the chief operating officer.

Staff reported they felt listened to and things had improved since our last inspection.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The governance lead had recently asked midwives for feedback on which metrics were helpful for them to see included in a monthly newsletter. These were displayed in an accessible way and individual metrics would be updated based on feedback from staff.

The full maternity dashboard was reviewed monthly at the maternity quality and safety meeting and quarterly at the divisional governance review and by the trust board. The monthly governance report also included information on women from minority ethnic groups to monitor outcomes in relation to COVID-19 complications and increased morbidity and mortality rates overall.

Metrics and information from the dashboard were displayed across the unit. This included information on the top three risks and actions relating to them.

The daily safety huddle included any alerts relating to incidents. These were presented using a situation-background-assessment-recommendation-situation (SBAR) method which allowed staff to understand why they were being asked to do certain things.

A rolling audit programme including local and national requirements was now being used. This ensured audits were regularly used to identify issues and drive improvement.

The department recently commissioned another NHS hospital to undertake a peer review in relation to governance. This showed an open culture and willingness to learn and share learning.

However, there were still missing checks on lifesaving equipment. A new band seven midwife has been employed on a six month role to take on a management role on labour ward to support the matron with the day to day running of the unit. The role included off duty management, management of staffing, equipment checks, and appraisals.

Maternity (inpatient services)

Areas for improvement

Action the trust MUST take to improve:

St. Richards Hospital Maternity Services

Action the trust MUST take is necessary to comply with its legal obligations

The trust must ensure regular checks on lifesaving equipment are undertaken. (Regulation 12: (2) (b, e)).

Action the trust SHOULD take to improve:

St. Richards Hospital Maternity services.

The trust should ensure that training for emergency evacuation from birthing pools is booked for staff to ensure they are up to date a soon as possible. (Regulation 12)

The trust should ensure consistency with the use of the birth-rate plus tool and escalation policies to ensure safe staffing numbers. (Regulation 17)

The trust should continue to embed the new triage tool and ensure all records are updated when women contact the service.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor. The inspection team was overseen by Carolyn Jenkinson 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