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: 4 May 2021 and 5 May 2021
Date of publication: 07/07/2021

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 because we had concerns about the quality of services in response to patient safety incidents relating to falls at Kettering General Hospital.

During this inspection we inspected the medical care core service only using our focused inspection methodology. We did not cover all key lines of enquiry; however, we have rated this service in accordance with our enforcement policy.

Our rating of the service went down. We rated them as inadequate and have taken enforcement action as a result of this inspection to promote patient safety. 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.

See the medical care core service section for what we found.

During our inspection on 4 and 5 May 2021, we visited Naseby A and Naseby B ward, Twywell and Lamport ward, Cranford ward, HC Pretty wards, Harrowden C ward and the discharge lounge.

We spoke with 40 members of staff of all levels including health care assistants, registered nurses, ward sisters, matrons, therapy staff, 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.

Due to risks associated with the COVID-19 pandemic, we did not speak with patients and their families about the care and treatment they had received at the trust.

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)

Inadequate 

Our rating of this service went down. We rated it as inadequate because:

- Not all relevant staff had completed mandatory falls training. Training provided did not meet the learning needs of all staff.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe from falling.
- Staff did not always complete and update risk assessments for each patient. They did not always act to remove or minimise risks or update the assessments when risks changed. This impacted upon the safe care patients received.
- The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Whilst there were contingencies in place to manage staffing levels, the ability for staff to effectively implement falls prevention actions were restricted.
- Staff did not always recognise and report incidents relating to falls prevention and management. The service did not always manage patient safety incidents well. Managers investigated incidents; however, the service did not ensure the investigation identified all relevant learning. Implementation of serious incident learning action plans relating to falls was ineffective. Managers did not ensure actions from learning briefings were implemented across the service and monitored.
- The service did not always provide care and treatment based on national guidance and evidence-based practice in relation to falls prevention and management.
- Systems and processes to monitor the effectiveness of care and treatment were not always effective. The service did not use the findings of audits to make improvements to reduce the risk of harm to patients at risk of falls.
- The service did not ensure all staff were competent in assessing and mitigating risks associated with patients falling.
- The service did not always consider the individual needs and preferences of patients.
- Leaders did not operate effective governance processes. The service did not always identify, escalate and mitigate risks associated with falling.
- Risk registers did not always reflect the risks identified during our inspection. Action plans to drive improvements were not always effective.

However:

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

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Medical care (including older people's care)

Mandatory training

Not all relevant staff had completed mandatory falls training. Training provided did not meet the learning needs of all staff.

Not all staff had completed training on falls prevention and management. Falls prevention training was mandated for registered nurses and healthcare assistants from 1 April 2021. Training data provided by the trust following our inspection demonstrated 32.6% of relevant staff had completed it. We were advised there was a planned target to achieve 80% compliance by the end of June 2021 and 95% compliance by September 2021.

The service had not acted within reasonable timescales to address gaps in staff knowledge and competency. Prior to our inspection, we reviewed serious incident investigations which had occurred between December 2019 to March 2021. We found recurrent themes in these reports which led to or contributed to harm such as poor assessment of falls risks and omissions in the implementation of falls preventative actions. Staff training and education was identified as learning. We found three of these incidents that occurred in December 2019, March 2020 and May 2020 identified a need to revisit mandated by role training in falls prevention and management. The action was the same in all three reports and assessed as high risk with a meeting deadline to discuss this in September 2020. Further serious incidents resulting in harm from falls had occurred where staff knowledge and understanding was identified as a theme, yet mandated falls training was not implemented until 1 April 2021.

During our inspection some staff told us they were not provided with time to complete mandatory training. Staff on one ward told us their new manager had provided them with protected time within their working hours to complete training. Prior to this they had to complete it in their own time. In March 2021, the trust facilitated two falls summits to gather feedback from staff about why falls with harm were occurring and what changes in practice needed to be introduced. We reviewed the outcomes of this and staff education around falls was cited as a reason falls with harm was occurring. A practice change recommendation from this was staff are provided with protected training time. We were therefore not assured all staff were given the time to effectively complete their training.

At the time of the inspection, there was a plan to achieve compliance with falls training. We found there was significant inconsistencies in staff knowledge about risks associated with falling and preventative actions to reduce falls. We were concerned the recurring risk related to staff training through serious incidents was assessed as high risk yet not fully acted on and further harm had occurred.

Mandatory falls training did not meet the needs of patients and staff. Managers told us training was mandated for registered and non-registered nursing staff only. This meant staff who were involved in the assessment of risk of falling and implementing measures to reduce risk were not included. For example, doctors and physiotherapists were part of the assessment and planning process yet they were not required to complete any training. The impact of this was observed during the inspection, for example, a lack of clarity about who updates mobility boards and the absence of completing lying and standing blood pressures to inform the clinical management plan.

During the inspection, managers told us there was no training in how staff should complete a falls or bed rails risk assessment. Staff we spoke with, who had completed falls prevention training, were not all confident in telling us how they completed falls and bed rails risks assessments. Furthermore, risk assessments we reviewed did not always demonstrate staff understood how to fully complete these assessments. This meant the risks were not effectively assessed, and we could not be assured the risk of on-going harm was mitigated through effective training.

Medical care (including older people's care)

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe from falling.

Patients could mostly reach call bells and staff responded quickly when called. Call bells were generally within reach, however, we observed occasions where they were out of reach. For example, we saw call bells placed on patient's bedside lockers. We were not always assured all patients knew how to use call bells or that they were physically able to use them. For example, we saw a patient with a call bell within reach, however, the patient had large gloves on which would prevent them from being able to use the call bell. It was unclear from speaking to staff or reviewing the patient records, what was in place to support the patient to call for assistance. The ongoing nurse evaluation record stated the call bell was accessible, however as the patient could not use it, this was not the case.

The design of the environment did not always support the safe management of patients at risk of falling. On HC Pretty and Cranford ward the layout of the ward meant there was limited space within patient bays and in corridors. We found there was limited space to store equipment in bays such as walking frames. For example, we saw three patients who required a frame on HC Pretty ward did not have access to their frames as they were stored away from their bed. This meant should they attempt to get up, they would not have access to their mobility equipment to safely mobilise which could increase their risk of falling.

Ward corridors contained medical record trollies which meant the walkway was narrowed. On Cranford ward there were mobile cupboards on wheels in the corridor outside of the bays. These were easily moveable on light touch which posed a significant risk of harm to a patient if they leant on them. We observed patients' who were deemed at risk of falling leaving a cohort bay unattended and were concerned the hazards in the corridor created a heightened risk for these patients. A cohort bay refers to the practice of grouping together patients at high risk of falls in order to manage their needs more efficiently.

On some wards we found patient bathrooms were used to store equipment such as hoists and linen bins. Where patients were left unattended, we felt this posed a greater risk to patients who may be confused or at risk of falls. We know from reviewing serious incident reports, unwitnessed falls had occurred in toilets.

We noted Naseby A ward and Twywell ward had reduced the numbers of beds which increased the space. These wards were much less cluttered and there were less hazards and more room for patients to move. Staff used space well on Naseby A ward to enable more visibility of patients who were high risk of falls. Mobile notes and computer stands were placed in each bay for staff to complete administrative tasks within the bay rather than at the nurses' station.

Beds and bed rails underwent a recent audit and resulted in some being replaced due to damage. Staff we spoke to had not received any training in how to operate bedrails but knew how to escalate any concerns if they were not working correctly.

We saw posters on most wards we visited to alert patients to call for assistance before getting up. "Call don't fall" signs were in most bathrooms we observed during our inspection.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient when risks changed. They did not always act to remove or minimise risks. This impacted upon the safe care patients received.

Medical care (including older people's care)

Staff did not always fully complete risk assessments for each patient on admission or effectively review them regularly. During our inspection we reviewed 18 patient records and found falls assessments were not fully or accurately completed in 15 records. For example, in these records we found:

- One or more of the risk indicators were not assessed.
- Staff did not always consider the patients' medical history or history of falls recorded elsewhere in the records. This information was not always reflected in the falls risk assessment which meant the risk assessments completed did not always reflect the patients' health and care needs. For example, a patient had been admitted following unexplained falls, however this was not assessed as a risk on the falls risk assessment.
- Preventative actions were not always identified as part of the care plan. Staff did not indicate appropriate interventions as instructed on the falls risk assessment document. This meant the resulting assessment and care plan was not personalised to the patient and did not provide staff with a clear plan for preventing patients' from falling.
- Times were not recorded on the risk assessment; therefore, we could not assess whether they were completed within an hour of admission as instructed in the trust falls prevention and management policy.

We found staff did not always review falls risk assessments in line with the trust falls prevention and management policy. We reviewed 18 patient records and falls risks were not effectively reviewed following admission in 15 of them. For example, we found:

- Falls risk assessment reviews were not fully documented. We were unclear how risk was reassessed as new risk assessment forms were not generally used to reassess the risk. Instead, staff indicated they had reviewed the risk on the original risk assessment with a date and by using their initials. Staff told us they did not complete a separate risk assessment form. Staff did not provide a rationale for their update which meant the reassessment of risk was not fully documented. This is not in line with the trust falls prevention and management policy.
- Falls risk assessments were not always reviewed every seven days as a minimum or where there was a change. Furthermore, the trust falls prevention and management policy states risks should be reassessed within four hours of transfer to a new ward. Staff did not record the time they reviewed the risk; therefore, we could not be assured this was completed in the timescale outlined in the trust policy.
- We did not see evidence falls reviews had been documented in the on-going nurse evaluation forms.

Three records did demonstrate the falls risk assessment had been fully reviewed, however, in all three, this was after a patient had sustained a fall in hospital.

We were not assured staff effectively assessed risks associated with falling or identified personalised plans to prevent patients from falling. Whilst staff knew they had to complete the falls risk assessment and review them regularly; we were not assured all staff understood how to assess the risk of falling. Risk assessments did not always reflect the patients' history which raised concerns staff did not know how to identify the risks to inform the assessment. We identified this as a theme in serious incidents which had occurred prior to the inspection where health conditions, which would increase the risk of falls, were not considered to be a falls risk by staff.

Staff told us they did not always have time to update risk assessments in the timescales outlined in the trust policy due to staffing levels. Managers told us staffing levels were reviewed daily. However, this often resulted in staff being moved around to wards where the staff absence or acuity levels were high and additional staff were required. This impacted their ability to complete all tasks; such as risk assessment reviews.

Medical care (including older people's care)

In March 2021, the trust facilitated two falls summits to gather feedback from staff about why falls with harm were occurring and what changes in practice needed to be introduced. Poor risk assessment was cited as a reason for falls with harm. Individualised care plans and robust risk assessment were suggested as a recommendation to improve practice.

Matrons' told us one of their main concerns when it came to falls was non-compliance with risk assessments. We reviewed several serious incidents relating to falls from December 2019 to May 2021 and identified non-compliance with risk assessment documentation as a common theme contributing to the patient falling. We were not assured systems to monitor compliance were effective at improving the completion and quality of risk assessments to ensure the on-going risk of harm was effectively mitigated.

Staff did not effectively deal with specific risk issues to prevent patients from falling. Lying and standing blood pressures were not always recorded for all patients 65 years of age and over or who had a medical condition that would increase the risk of falling. For example, patients' who had a stroke or parkinson's disease. Lying and standing blood pressures are used to identify a postural drop in blood pressure which causes symptoms of dizziness and fainting which can lead to falls. The lying and standing blood pressure question on the falls risk assessment was the most commonly unanswered. We found 11 out of 18 records we reviewed did not document whether a lying or standing blood pressure had been completed either in the admission documentation or on the electronic patient record. We reviewed the record of a patient who had a previous fall in hospital and found this patient did not have a lying and standing blood pressure recorded before or after having a fall.

Staff did not routinely complete lying and standing blood pressure as part of the assessment of falls risk process. When asked, not all staff could tell us where to find lying and standing blood pressures recorded in the patient records. Lying and standing blood pressure compliance was identified as a concern during our comprehensive inspection of the medical care core service in 2018. We were therefore not assured the service had an effective process for identifying patients at risk of postural drops and implementing appropriate actions to prevent them from falling.

Staff did not always accurately, or fully complete bed rails provision risk assessments. During our inspection we observed bed rails were used to care for patients where they were not indicated for use. Bed rails are used to prevent accidental slipping out of bed. When used inappropriately bed rails can cause harm, serious injury or even death. Bed rails should only be used if the benefit of using them is assessed as outweighing the potential risk to the patient.

During our inspection we found decisions to use bedrails were not fully assessed or reviewed within appropriate timescales as outlined in the bedrail provision policy. This was a repeated pattern observed throughout the inspection. Of the 18 bed rail provision assessments we reviewed, 13 were not fully or accurately completed. For example, staff had not completed the bed rails matrix to assess mobility level and state of confusion to determine whether bedrails were indicated. We also found when bed rails had been ticked as safe to use, the rationale for this decision was not documented.

The rationale for deciding to use or not to use bed rails was unclear. The documentation included a review section where staff were required to record specific information such as; date, time, bedrails yes or no, name, signature, job, estimated review. These were not always completed, and we found eight reviews were not completed weekly within the timescales required in the safe and effective use of bedrails policy. Furthermore, where they were updated and there was a change in the decision to use bed rails, the rationale for this was not documented. We did not see evidence nurse evaluation daily updates referenced use of bedrails. We were not assured the decision to use bed rails was effectively assessed across all wards we visited.

Medical care (including older people's care)

Bedrails were not always used appropriately. In six of the 18 patients we reviewed, bed rails were in use when not indicated for use. There was no rationale provided by staff for the bedrails being used outside of trust policy. The risk of these patients' coming to harm or sustaining an injury as a result of bedrails was not sufficiently mitigated. We were not assured staff understood how to decide about when they should or should not use bedrails.

We saw beds were not always at the lowest possible height to mitigate any harms associated with bedrails use. There was no evidence bed height was considered or documented.

Documentation provided to staff to did not support effective decision making and risk management. There was nowhere for staff to document their rationale or professional judgement for using bedrails or record reasons for a change in decision.

We were aware bed rails have been either a root cause or contributory factor in serious incidents where harm had occurred. The falls summits in March 2021 identified bed rails as a reason for falls with harm. Staff recommended bed rail practice as an area for improvement to reduce the risk of falls. We were not assured risks associated with bedrails use were effectively assessed or mitigated and continued to present a risk of harm to patients.

Preventative actions to reduce the risk of falling were not consistently implemented across the service. Staff did not always identify actions to prevent falls in the falls care plan document. We reviewed 18 records and found 15 did not indicate which falls prevention actions should be taken to reduce the risk of falling. We found the preventative actions were not always identified as instructed on the risk assessment/care plan form. Furthermore, there was nowhere on the form to identify individualised actions to prevent a fall. We found limited evidence falls prevention actions were regularly documented in the on-going nurse evaluation forms.

The trust had a falls prevention and management policy and a falls care bundle which provided staff with actions to be taken to reduce the risk of patients falling. For example, falls signs, falls wristbands, cohort bays and mobility cards. However, we found these measures were inconsistently implemented across wards within the medical care service. For example, we found good practice carried out by staff on Twywell and Lamport wards, who identified patients at risk of falling by using the falls hazard sign above patient beds and using the electronic patient board to identify these patients. In contrast, falls hazard signs were not implemented on Naseby ward or Cranford ward.

Not all patients at risk of falling had a falls hazard sign on the wall above their bed. Of 18 patients we reviewed, who were at risk of falling, twelve did not have these cards in place to alert staff to the patient being at risk of falling. Staff on Cranford ward told us they did not use them as they did not stick to the wall.

Not all patients' who were at risk of falling wore a yellow falls risk wrist band,as required in the trust falls care bundle. Ten out of 18 patients assessed as high risk of falling did not have a falls wrist band.

Mobility cards were not always completed and placed above patients' beds, to identify their level of mobility. We were not assured there was an effective system to update them when a patients' mobility status had changed. Of the 18 patient beds we reviewed, where patients were high risk of falls, eight were either incorrectly updated or not completed to indicate the patient's mobility needs at a glance. We found examples of the patient mobility needs not reflecting the mobility assessment. In one case we found the mobility card stated the patient was bedbound, however the mobility assessment indicated the patient needed assistance to transfer out of bed. We did not see dates to indicate when it had been updated. We also found there to be a lack of understanding from staff about who was responsible for updating the mobility cards. This meant it was unclear what support a patient required to mobilise and therefore the risk of falling was not always effectively mitigated.

Most patients had suitable footwear, however, we found two patients' who were at risk of falling, mobile and confused, did not have anti-slip footwear in place.

We did not see evidence falls and bed rails information leaflets were given to patients or they had been documented as given in the patient records.

We saw evidence medicines were reviewed by medical staff during a ward round and as part of the initial clinical assessment. However, we did not review electronic prescribing systems to review medicine charts.

We observed staff lacked situational awareness of risks. Staff did not always consider the patient needs and impacts of the environment. For example, on Naseby B ward, staff did not effectively supervise a patient who appeared high risk of falling and agitated. He did not have appropriate footwear and staff were not always present to supervise him when trying to get up unattended. The patient had a bedside table in front of him and a frame in front of the table. We felt this posed a high risk to the patient. Despite being in a bed in front of the nurses' station he was not observed. This had previously been identified as a contributory factor in a serious falls incident we reviewed prior to the inspection where a patient had fallen, was confused and at risk of wandering yet did not have a plan for how staff should supervise the patient. We were therefore not assured falls prevention methods were always personalised or effectively implemented.

Effective systems were not in place to ensure staff complied with trust cohort bay and tagging processes. This was an on-going theme identified as learning in previous serious incident investigations. During our inspection we were not assured learning had been effectively implemented. 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. During our inspection, we observed:

- Cohort bays being left unattended by staff leaving the bay. This varied in length of time from less than a minute to 15 minutes. We observed this on multiple wards we visited. This is not in line with the falls care bundle which states optimum observation must be maintained by staff remaining in the bay at all times. We observed good practice on Naseby A ward and in one of the two cohort bays on Twywell ward but noted inconsistent practice on all other wards we visited.
- Cohort bays being left unattended by staff to care for patients within the bay behind the curtain. Staff in a cohort bay often had to care for more than one patient who required supervision.
- On some wards, staff supervised the cohort bay from outside with the door closed. On one occasion, we saw an administrative staff member being used to supervise a cohort bay from outside. We were not assured this staff member had received appropriate training to do so.

On some wards' cohort bays did not have a toilet within the bay. We observed staff leaving the bay to support patients who required assistance to mobilise to take them to the toilet or to get a bedside commode. This meant the other patients being supervised were not always observed. We were not assured the process to cohort patients at the time of the inspection was effectively implemented. We were aware of a patient, who was at a high risk of falls, in a cohort bay having sustained an unwitnessed fall the day before the inspection. This was his second fall in a cohort bay during his admission. This raised concerns the current processes in operation within cohort bays placed patients at risk of falling and potential harm. This did not comply with the trust's own standards. Some staff told us they felt they had no choice but to leave the cohort bay unattended to ensure they could meet all patient's needs. Staff could not always find other staff to supervise the cohort bay so they could assist other patients in the bay, get equipment or go on a break. Staff told us this was particularly challenging when they were short staffed due to absence or staff being moved to another ward leaving them short staffed.

We found there was not always a designated person identified for the cohort bay and on some wards, there was lack of a formalised plan to maintain the tagging system to ensure a staff member was always present. We found there was a lack of oversight of this from the nurse in charge or ward sisters. However, we did see good cohort bay tagging practice on Naseby A ward.

Some staff were not always clear about their responsibilities in relation to the cohort bay. On some wards staff told us it was normal practice to observe the bay from outside. This would delay a staff member to intervene to prevent a patient from falling and is not in line with the trust's cohort bay process.

Not all staff were clear about the role and appropriate use of security staff. Some staff told us security staff were used to supervise a cohort bay, however, this was not in their role. During our inspection we observed security staff, who were assigned to a specific patient on an enhanced care plan, being left to monitor the cohort bay. We escalated this to managers during the inspection who told us more junior staff had not yet developed a robust understanding of the process but agreed to address this immediately.

The falls summits in March 2021 identified 'poor cohort management' and 'reduction and gaps in tagging' as a reason for falls with harm. Recommendations for actions to improve were cited as 'a review of bedwatch', 'a review of tagging process' and 'be more visible'. We reviewed several serious incidents relating to falls from December 2019 to May 2021 and identified non-compliance with the cohort bay system as a common theme contributing to patients falling. We were therefore not assured there had been effective learning from previous falls with harm or serious incidents where unwitnessed falls in cohort bays was identified as a root cause or contributory factor.

Staff did not always share key information to keep patients safe when handing over their care to others. Shift changes and handovers did not always include all necessary key information to keep patients safe. During our inspection, we found falls risks were not always documented on the electronic patient handover. Nursing staff told us they discussed all patients at risk of falls during shift handover, however, when asked staff could not always show us this had been documented on the electronic system. We found little evidence risk of bedrails had been effectively handed over. Staff in the discharge lounge told us the risk of falls was not always handed over to them when receiving patients. This meant they sometimes received patients who were unsuitable for the discharge lounge as they did not review risks as part of their role. The patient handover did not enable effective handover of the risks. Furthermore, the falls summit in March 2021 identified poor handovers as a common theme cited as a reason for falls with harm. Improving handover and auditing handover processes was given as a recommendation to improve. Prior to our inspection we were aware of a recent incident where a patient had transferred to a ward and sustained a fall. We were therefore not assured ward handover processes effectively safeguarded patients at risk of harm from falls.

Nurse staffing

The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Whilst there were contingencies in place to manage staffing levels, the ability for staff to effectively implement falls prevention actions were restricted.

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 Clinical Excellence (NICE) staffing guidance.

Medical care (including older people's care)

The planned levels of staff and the actual levels were displayed on each ward we visited. Nurse staffing levels during the inspection were below planned levels on five out of six wards we visited. For example, on 4 May 2021, Cranford ward was down one registered nurse and one healthcare assistant and Harrowden A ward was down one registered nurse on the early and late shift. Following the inspection, the trust provided us with their vacancy position for May 2021. The service had the following vacancies:

- Band six ward sister – 3.9 whole time equivalent staff.
- Band five registered nurse– 43.8 whole time equivalent staff.
- Band four Nurse associate – 5.1 whole time equivalent.
- Band two health care assistant – 18 whole time equivalent.

Some wards had higher vacancies than others such as Cranford ward which had a 38.2% vacancy rate for health care assistants and Naseby B ward had 21.8%. On Cranford ward the overall vacancy rate for both health care assistant and registered nurses was 1.18% and Twywell ward 17%. All unfilled shifts were mitigated through the twice daily safer staffing cell. The cell was chaired by either a matron or head of nursing where they reviewed staffing capacity and capability across the service. Out of hours clinical duty managers monitored and managed staffing. Staffing absence with short notice or any unfilled shifts were managed internally by moving staff to wards with higher need. During our inspection we observed a registered nurse being moved from a ward that was fully staffed to a ward with unsafe staffing levels. We also saw on some wards; the ward sister supported the ward clinically where there were unfilled shifts.

Staff across most wards told us staffing levels had improved, however, also told us they regularly operated on reduced staffing which impacted on their ability to complete all tasks throughout their shift. Staff told us this included updating and reviewing risk assessments and effectively implementing the cohort bay system. Some staff told us, whilst they understood the cohort bay system responsibilities, there were times when they had to leave the bay unattended as there was not enough staff to support them to manage the number of patients requiring supervision in the bay.

Staff across all wards and different levels described having a significantly high level of junior staff. Whilst staff were positive that new staff had been recruited to fill the vacancies, it was commonly acknowledged more junior staff were not yet fully inducted. For example, staff and some managers we spoke with told us they did not fully understand the ward processes around falls prevention such as cohort bays and the tagging process. Senior managers told us they mitigated the increase in junior staff by creating a two-week supernumerary period in the surgical division to give them time to induct and learn the processes in a less pressured environment.

The service underwent an establishment review in April 2020 and adjusted staffing levels to increase patient safety. For example, the night-time establishment was increased on Cranford ward in line with daytime staffing levels. The review also included splitting Naseby wards into two so each had a ward sister and deputy ward sister. It also included an uplift to the registered nurse and health care assistant establishment. All staff we spoke with on these wards told us they had noticed the impact on patient safety as staffing levels had significantly improved. However, they also told us when their staffing levels were full, they often had to release staff to support other wards where there was greater need.

The trust facilitated two falls summits in March 2021 to gather feedback from staff about the reason's falls were occurring and what changes in practice was needed to reduce falls. Staffing levels was cited as a reason falls with harm were occurring in both sessions. Staff cited improved use of the safe staffing tool to effectively assess staffing requirements and allocation of staff as a practice change required to reduce the risk of falls with harm.

Medical care (including older people's care)

Managers told us staffing levels was a known risk and they had undergone a large and successful international nurse's recruitment campaign. The trust had also rolled out a nurse associate training programme to support safe staffing levels. Daily staffing cell meetings meant the service had oversight of unfilled shifts and acuity.

Whilst there were systems and processes in place to mitigate staffing levels, we were not assured the level of acuity in relation to patients requiring observation was fully considered. For example, matrons told us the number of patients with complex needs and at risk of falls had considerably increased. During our inspection we noted wards with more than one cohort bay. Staff told us they could not always cohort all patients high risk of falls due to the number of at-risk patients on the ward. We were concerned the new and emerging acuity level had not been fully assessed in considering whether there was enough staff to implement falls preventative methods such as tagging in cohort bays, particularly where most, if not all, patients in the bay required observation.

Incidents

Staff did not always recognise and report incidents relating to falls prevention and management. The service did not always manage patient safety incidents well. Managers investigated incidents; however, the service did not ensure the investigation identified all relevant learning. Implementation of serious incident learning action plans relating to falls was ineffective. Managers did not ensure actions from learning briefings were implemented across the service and monitored.

Staff knew how to report incidents but did not always know what incidents to report. Most staff we spoke with were aware of their responsibility to report incidents including falls related incidents. However, we found staff did not identify the safety concerns we identified on inspection as incidents. Therefore, these incidents were not reported. For example, the lack of appropriate risk assessment and management plans or the shortages of staff to provide one to one or effective cohort nursing care for patients at risk of falling were not reported as incidents. This meant learning from these incidents could not take place to improve safety and care.

We were not assured the service effectively identified learning through the incident investigation process. For example, during our inspection staff told us they were not always able to implement a tagging system to ensure cohort bays were always staffed due to staff shortages. This was not identified as learning in the investigation reports as the focus was on educating staff to ensure they understand the cohort bay process. Furthermore, during our inspection we reviewed 18 patient records and found the documentation provided to staff did not support them to effectively assess and review risks of falling and plan personalised care. This was not identified as learning in any of the serious incidents we reviewed. We were therefore not assured the service always robustly investigated incidents to draw out root causes and relevant learning.

Governance processes were in place to investigate and share learning, however, they were not effective at embedding learning from incidents across the medical care core service. Following the inspection, the service sent us learning bulletins in relation to serious incidents that had occurred in relation to falls. The learning bulletins provided an overview of the incident and learning points.

The bulletins were produced by the governance team and sent to head of departments for them to share with their staff. Matrons and ward sisters told us they shared learning from incidents with their teams. During our inspection we spoke with staff, including nursing, medical and therapy staff. Most staff we spoke with could describe incidents that happened on their ward. However, staff were generally unable to tell us about incidents that happened on other wards. At the time of the inspection we were aware of a recent serious incident that had resulted in catastrophic harm which was still under investigation. Staff on the ward the incident happened, could describe the immediate learning. However, we were

not assured the immediate learning from this incident had been shared across other wards as staff we asked across the service were not aware. Ward sisters told us they held regular ward meetings where they shared learning from serious incidents. We reviewed ward meeting minutes and found varied information regarding falls but did not see shared learning from specific incidents was consistently documented.

Medical and therapy staff we spoke with were generally aware of incidents that occurred on the ward they were working on but told us they did not routinely receive feedback. Staff we spoke with were unable to describe serious incidents that had occurred on wards they did not work on. Following the inspection, the trust advised us presentation of these incidents commenced at mortality and morbidity meetings from March 2021 as a standard agenda item to ensure wider learning. We were therefore not assured sharing of information processes to all staff were fully embedded at the time of the inspection.

Learning from falls incidents where harm had occurred had not been fully implemented across the service. This inspection was triggered by several serious incidents where harm had been caused as a result of patients falling in hospital. We reviewed these incident investigation reports prior to our inspection for incidents that had occurred between December 2019 and March 2021. We found there were recurrent themes such as poor completion of risk assessments and care plans, lack of falls preventative actions and leaving cohort bays unattended. During our inspection we reviewed 18 patient records and observed falls prevention practices. We found no evidence the learning from these incidents had been consistently implemented across the service to minimise the risk of ongoing harm to patients at risk of falls.

During our inspection, we did however observe an improvement in practice on Naseby A ward where there had been several serious falls incidents. For example, we noted good practice in tagging the cohort bay and utilising mobile notes/ computer stands in each bay to increase the presence of staff at all times. Whilst this was an example of good practice, we did not see evidence this was shared across the medical care core service.

Systems to monitor implementation of learning from incidents were not effective in ensuring improvements had been made and sustained. We were not assured action plans to improve the quality of care were effective or fully implemented.

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 did not provide care and treatment based on national guidance and evidence-based practice in relation to falls prevention and management.

The trust, 'Falls Prevention and Management Policy' was approved in May 2021 and referenced the most up to date National Institute of Clinical 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.

Medical care (including older people's care)

Documentation did not support staff to effectively assess risk and implement evidence-based actions. The falls risk assessment and care plan along with the bed rails provision assessment was included in the nurse assessment booklet. The documentation provided to staff was ineffective and did not reflect the requirements outlined in the falls prevention and management policy and the safe and effective use of bedrails policy. For example, we found:

- There was nowhere on the falls risk assessment to document the risks had been reviewed in line with trust policy.
- The trust bed rails policy states 'should the professional judgement of the nurse differ from the risk assessment, this must be clearly documented, with rationale and how the decision was formed'. However, the bed rails risk assessment did not provide staff with space to record this.
- There was nowhere on either document to demonstrate the assessment of risk and care planning was personalised.

We found the assessment process did not support an effective multifactorial falls assessment of risk with a clear intervention plan. This meant risks were not 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

Systems and processes to monitor the effectiveness of care and treatment were not always effective. The service did not use the findings of audits to make improvements to reduce the risk of harm to patients at risk of falls.

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. The service had a series of audits to assess compliance with the falls prevention and management policy and the safe and effective use of bed rails policy. Audits included nurse sensitive indicators which ward staff completed themselves to assess compliance with risk assessments and care plans in relation to falls. Following the inspection, the service provided us with audit outcomes from May 2020 to March 2021. We reviewed the audit outcomes for March 2021 as due to the COVID-19 pandemic, we found there were gaps in audits. Data for March 2021 indicated a high level of compliance across the medical care core service. The outcomes were as follows:

- 97% compliance with bed rails assessments and use of bedrails.
- 97% compliance with bed rails care planning.
- 89% compliance with target to complete bedrails assessments within twelve hours of admission to the current ward.
- 95% compliance with falls risk assessment completion on admission.
- 95% compliance with falls care planning.
- 83% compliance with weekly falls risk assessment reviews.

We were concerned the outcomes did not reflect the findings of our inspection, the learning identified in serious incident investigations and what staff during the inspection told us about the standard of risk assessment and care planning. During our inspection we found:

- Fifteen out of 18 falls risk assessments and care plans assessments we reviewed were not fully or accurately completed. Furthermore, 15 were not reviewed in line with trust policy.
- Thirteen out of 18 bed rail provision assessments we reviewed were not fully or accurately completed. Furthermore, 13 were not reviewed in line with trust policy.

Medical care (including older people's care)

Matrons' told us poor compliance with falls and bed rails risk assessments was one of their biggest concerns when it came to the quality of care provided to reduce the risk of harm from falls.

We were not assured the audits checked whether the risk assessments and care plans had been completed correctly. The trust was unable to provide assurance these audits were an accurate reflection of the quality of care provided.

Following the inspection, the trust provided us with their perfect ward board report for April 2021. Perfect ward was a system to collect data to monitor quality standards and identify areas for improvement. The data collected was based on existing audits tools such as nurse sensitive indicators and environmental audits. The outcomes provided ward to board assurance. The report in April 2021 summarised the outcomes were inconsistent in providing assurance because the audits included were self-reported. For example, ward staff generally audited their own records.

We were therefore not assured the audits provided the board with an accurate representation of quality around falls prevention and management.

Following the inspection, the senior leadership team told us they had created a new and more robust audit tool which had been implemented following the inspection. The director of nursing provided assurance staff completing the audits had received training. Furthermore, the audits also addressed not only that risk assessments and care plans were completed but that they were completed correctly.

Competent staff

The service did not ensure all staff were competent for their roles in assessing and mitigating risks associated with patients falling.

We were not assured all staff had completed training in specific areas. For example, most staff we spoke with had not received training in the safe use of bedrails. Records we reviewed during our inspection indicated staff did not understand how to complete the assessment and staff we spoke to were not all able to explain the risks of using bedrails. We also found staff did not understand the reasons a lying and standing blood pressure measurement should be completed or the trust policy for completing them. Records we reviewed during the inspection did not demonstrate lying and standing blood pressures were routinely completed or documented. We were therefore not assured staff had received training in specific competencies to ensure patients who were at risk of falling were appropriately assessed and risks were managed effectively.

Falls prevention training did not meet the needs of all staff. Mandatory falls training commenced on 1 April 2021. Prior to this the service told us training was localised and not part of a programme of training. Attendance was not recorded centrally therefore the service could not provide an overview of the training provided and number of staff having received it. Some staff we spoke with during our inspection told us they had completed falls prevention training. However, most staff who had completed it told us it did not train them in how to complete a falls risk assessment or bed rails risk assessment or support them to plan care to minimise risks. During our inspection, we spoke with the trust's falls lead who also told us the falls training did not teach staff how to assess the risk of falling or how to assess the risk of harm through bedrails. This meant the training did not meet staff learning needs or effectively teach staff how to assess risk and ensure personalised actions were taken to reduce the risk of on-going harm.

The service did not have a falls competency sign off process in place to ensure staff could demonstrate to managers they were competent. For example, there was no competency sign off process for completion of a falls risk assessment and care plan, a bedrails provision assessment and decisions to use bedrails, lying and standing blood pressures and cohort bay practice.

Medical care (including older people's care)

The trust facilitated two falls summits in March 2021 to gather feedback from staff about the reason's falls were occurring and what changes in practice was needed to reduce falls. Staff knowledge was cited as one of the reasons falls with harm occurred in both sessions. Staff provided feedback that in order to change practice they needed education and education in the falls bundle. Staff fed back they felt a training programme was required, engagement teaching, cohort practice teaching and protected training time.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw team meetings were in place on most wards we visited. We reviewed the meeting minutes and found evidence to demonstrate discussions were had regarding falls documentation and falls care bundle compliance. Meeting minutes varied in content and quality and the information appeared to be ward specific information regarding falls.

Processes to identify poor staff performance were ineffective in supporting staff to improve. Practice Improvement Facilitators (PIFs) attended wards to support staff learning needs, however, the impact of this was not measured. Managers told us PIFs' attended the ward on a Friday as part of a 'Falls Friday' initiative that had been started in April 2021. The PIFs' completed informal spot checks of documentation to identify concerns and feedback to staff. Ward sisters told us where there were concerns with documentation, the PIFs' discussed this with staff and the manager. We were not assured there was a clear and consistent approach to spot checks. During our inspection, we did not see evidence this positively impacted on quality improvements being embedded in practice.

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 we spoke with generally 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, considering patients' wishes, culture and traditions. During our inspection we reviewed 18 patient records and found evidence in ten records the service had appropriately assessed a patient's mental capacity with best interest decisions documented. Where a patient had a deprivation of liberty safeguard in place, this was documented. Six records we reviewed did not require a mental capacity assessment. A further two records outlined concerns the patient was confused and we did not see evidence of mental capacity assessment having been completed. These were escalated to staff during the inspection and appropriate actions were taken.

Is the service well-led?

Inadequate ↓

Our rating of well-led went down. We rated it as inadequate.

Medical care (including older people's care)

Governance

Leaders did not operate effective governance processes. The service did not always identify, escalate and mitigate risks associated with falling.

Serious incident investigations were not always effective in identifying the root causes and contributory factors associated with falls. During our inspection we reviewed 18 patient records. We found the risk assessment documentation was not effective in supporting staff to clearly assess and document risks associated with falling and use of bedrails. Documentation did not lend to effective care planning to ensure all risks associated with an individual's needs had clear mitigations in place. This risk was not identified in any of the serious incident reports we reviewed. We were also not assured the investigation reports fully considered the impact of staffing levels. During our inspection, staffing was identified as a concern, particularly in enabling staff to effectively supervise cohort bays where patients required increased levels of supervision. Staff felt reduced staffing levels impacted on their ability to safely supervise cohort bays and update risk assessments and care plans. We were not assured this was fully considered in most of the serious incident reports we reviewed yet was considered a root cause by staff.

Systems and processes for implementing learning following incidents was ineffective. Prior to our inspection we reviewed several serious incidents reported following fall's with harm from December 2019 to March 2021. We found the same issues reported through the incident investigations as had been identified throughout our inspection. This included poor standard of falls documentation, inappropriate use of bedrails, incomplete lying and standing blood pressures and failure to implement falls prevention methods. Lying and standing blood pressures had been identified as an area for improvement in two serious incidents which resulted in harm in December 2019 and May 2020. Both investigations had an action to train staff in lying and standing blood pressures. In November 2020 we identified a further serious incident where lying and standing blood pressure was omitted. During our inspection we observed poor compliance with lying and standing blood pressures. We found 11 out of 18 records we reviewed did not document whether a lying or standing blood pressure had been completed. Furthermore, poor compliance with lying and standing blood pressures was identified as a concern in our 2019 comprehensive medical care core service inspection. We were advised during our inspection that lying and standing blood pressure compliance was not audited on a regular basis. We were therefore not assured the learning had been implemented or that governance processes were effective in monitoring this.

Systems and process for monitoring performance and quality were ineffective. Ward sisters completed a programme of internal audit to monitor quality and operational processes. Audits included, for example, documentation, environment, falls and bedrails. We were told these were reviewed at divisional governance meetings, matrons' meetings and ward sister meetings and that the audits were completed electronically which all staff had access to. However, during our inspection we found the audits had not resulted in improvements to the quality of patient risk assessments, person centred care, documentation, or implementation of falls preventative actions. Issues we had identified in previous inspections and learning from serious incidents had not been rectified.

Clinical audit programmes in place to assess quality and safety of falls practice was ineffective. For example, nurse led documentation audits of falls and bedrails demonstrated a high-level compliance which did not reflect what we saw on inspection or what managers told us about poor compliance with documentation. The audit system in place at the time of the inspection did not enable objectivity as it was completed by staff who worked on the ward, they were auditing. We were not assured there was a standardised approach as the audits we reviewed following the inspection, did not reflect what we saw on inspection. We were not assured the audits assessed the quality of risk assessments completed by staff. For example, whether the assessment was an accurate reflection of the patients risks and needs as opposed to only

checking that they were completed. During our inspection, we reviewed 18 patient records and found staff did not always accurately identify the risks that we identified on review of the complete medical record. We reviewed the falls and bed rails audit criteria and were not assured the audits assessed the quality and accuracy of the risk assessment and decision making.

Following the inspection, the trust provided us with their perfect ward report for April 2021 which was presented to the board. Perfect Ward was a system to collect data to monitor quality standards and identify areas for improvement. The data collected was based on existing audits tools such as nurse sensitive indicators and environmental audits. The outcomes provided ward to board assurance. The report in April 2021 summarised the outcomes were inconsistent in providing assurance because the audits included were self-reported. For example, ward staff generally audited their own records.

We were therefore not assured the audits provided the board with an accurate representation of quality around falls prevention and management. We were advised there were no action plans for improvements at the time of the inspection. Therefore, we could not be assured this system enabled effective improvements in quality.

Managing risks, issues and performance

Risk registers did not always reflect the risks identified during our inspection. Action plans to improve were not always effective in driving improvements.

Falls was recorded as a risk on both the divisional and ward level risk registers. We reviewed the risk registers following the inspection. We found they did not identify issues we observed on inspection such as, there was no reference to gaps in controls around cultural change, staffing levels, skills and experience of staff or quality of trust falls documentation. We were concerned the assurance systems cited, such as nurse sensitive indicator audits, were not effective in providing an accurate picture of quality and performance. Actions required did not provide assurance risk would be mitigated as a result. For example, a ward level action for Lamport and Twywell ward was to ‘review ward compliance with falls prevention video’ and ‘review ward compliance with falls prevention’ for Naseby ward. It was unclear how these actions were intended to mitigate the risks.

We were not assured the trust wide falls improvement plan demonstrated how the trust was going to measure qualitative improvements. For example, the action to implement a standard operating procedure (SOP) for cohort bays did not specify how this was to be effectively communicated to staff in terms of training and development. It did not outline how it would be monitored to ensure compliance, so falls were prevented. We were not assured how the implementation of this SOP would positively affect the change required to safeguard patients from on-going risk of harm that was any different to the already existing cohort bay/tagging procedure outlined in the falls care bundle. In the absence of an effective trust action plan which addresses the root causes of non-compliance, we were not assured on-going risk of harm was effectively mitigated.

Areas for improvement

MUSTS

Core service

Medical care (including older people's care)

- The trust must ensure that all staff involved in the care of patients have received effective training in falls prevention and management. This includes but is not limited to; completing risk assessments, use of bed rails and falls prevention strategies. Regulation 12 (1)(2)(c) and (e): Safe care and treatment.
- The trust must ensure that all staff are competent in their roles and processes are in place to assess staff competency. This includes but is not limited to; effective assessment of falls and bedrail risk, personalised falls and bed rail care planning, use of falls preventative actions, lying and standing blood pressures and quality audits. Regulation 12 (1)(2)(c) and (e): Safe care and treatment.
- The trust must ensure environmental risks are appropriately assessed and mitigated. This includes but is not limited to; environmental hazards, ward-based storage, patient equipment and bed rails. Regulation 12 (1)(2)(d): Safe care and treatment.
- The trust must 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, pre-existing medical conditions and behaviours that challenge. Regulation 12 (1)(2)(a) and (b): Safe care and treatment.
- The trust must ensure effective systems are in place to handover patient safety risks where patients are transferred. This includes, but is not limited to; bed rails, falls, lying and standing blood pressure, pre-existing medical conditions and behaviours that challenge. Regulation 12 (1)(2)(a) and (b): Safe care and treatment.
- The trust must 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 trust must ensure effective systems are in place to effectively identify and share learning from incidents to prevent further incidents from occurring. Regulation 17 (1)(2)(b): Good governance.
- The trust must ensure effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care provided. This includes but is not limited to processes to identify where quality and/or safety are being compromised, quality and safety audits and incident investigation oversight processes including quality improvement oversight. Regulation 17 (1)(2)(a) and (b): Good governance.

SHOULDS

Core service

- The trust should ensure all clinical areas are adequately staffed to ensure safe patient care. Regulation 18 Staffing (1).
- The trust should ensure staff have access to the documentation they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and risks, including needs relevant to the formulation of care plans. Regulation 9 (1)(a)(b)(c) and (3)(a)(b): Person-centred care.
- The service should ensure staff who are responsible for audits are appropriately trained. Regulation 12 (1)(2)(c). Safe care and treatment.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two other CQC inspectors. 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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance