

Northern Lincolnshire and Goole NHS Foundation
Trust

Diana Princess of Wales Hospital

Quality Report

Scartho Road
Grimsby
Lincolnshire
DN33 2BA
Tel: 01472 874111
Website: www.nlg.nhs.uk

Date of inspection visit: 15 June 2017
Date of publication: 12/10/2017

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Urgent and emergency services	
Maternity and gynaecology	

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) undertook an announced inspection of Northern Lincolnshire and Goole NHS Foundation Trust between the 22 and 25 November 2016 and an unannounced inspection on the 8 December 2016. Following these inspections, the CQC issued the trust with a Section 29A warning notice which stated that the quality of health care provided by the trust required significant improvement.

We had significant concerns relating to:

- Staffing shortages and a lack of escalation processes about the shortages was putting patients at risk.
- The lack of patient assessment and/or escalation of patients identified as being at risk was causing patients' safety to be compromised.
- There was insufficient management oversight and governance of the identified risks.

We undertook an unannounced inspection on 15 June 2017. The purpose of this was to follow up on the actions the trust had told us they had taken in relation to the Section 29A warning notice issued in January 2017. At this inspection we found the trust had not taken sufficient, timely action to address all our concerns.

CQC will not be providing a rating to Diana Princess of Wales Hospital for this inspection. The reason for not providing a rating is because this was a very focused inspection carried out to assess whether the trust had made significant improvement to services within the required time frame. Therefore not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

At this inspection we found:

- There were still gaps in resuscitation equipment and cleaning checklists in the emergency department (ED).
- The completion of patient records in the ED remained variable. We saw gaps in pain, nutrition and hydration, falls and pressure damage risk assessments.
- We saw limited evidence that staff in the ED performed comfort rounds.
- Staff in the ED recorded clinical observations for patients; however, the completion of National Early Warning Scores (NEWS) remained inconsistent.
- We had security concerns regarding the electronic medicine key system for controlled drugs.
- Actual staffing levels did not always match the planned staffing levels in maternity and the ED.
- We were not assured that changes in practice had been fully embedded in maternity following a further never event relating to a retained swab.
- We saw that new processes had been implemented to allow oversight of risks and governance including a nursing dashboard. However, the evidence we found was not always consistent with the information recorded on the nursing dashboard.
- The trust had improved its capacity and demand planning, however, this had not been embedded across all specialties.
- The trust had some significant challenges to deliver against the referral to treatment standards.

However;

- We found that the medicines used by the streaming nurse in the ED were now securely stored in a locked cupboard.
- Emergency equipment in maternity was now checked in line with trust policies.
- Patient records in maternity were now completed to a high standard and had evidence of appropriate risk assessment and escalation when required.
- The maternity service had completed a review of staffing levels using the Birthrate Plus® midwifery workforce-planning tool.
- The trust had developed a maternity services escalation policy.

Summary of findings

Professor Ted Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating Why have we given this rating?

- We found gaps in resuscitation equipment checklists.
- We found gaps in the cleaning checklists. However, the department appeared visibly clean and well maintained.
- We found that the completion of patient records was variable. We saw gaps in pain, nutrition and hydration, falls and pressure damage risk assessments.
- Staff recorded clinical observations for patients; however, the completion of National Early Warning Scores (NEWS) was inconsistent.
- We saw limited evidence that staff performed comfort rounds.
- We found that 22% of shifts were not filled by substantive staff.
- We also had security concerns regarding the electronic medicine key system for controlled drugs.

However;

- We found that the medicines used by the streaming nurse were now securely stored in a locked cupboard.
- We saw that new processes had been implemented to allow oversight of risks and governance including a nursing dashboard. The evidence we found was not always consistent with the information recorded on the nursing dashboard.

Maternity and gynaecology

- Emergency equipment was checked in line with trust policies.
- Patient records were completed to a high standard and had evidence of appropriate risk assessment and escalation when required.
- Risk registers were displayed in clinical areas and were visible to staff on the unit.
- The service had completed a review of staffing levels using the Birthrate Plus® midwifery workforce-planning tool.
- The trust had developed a maternity services escalation policy.

Summary of findings

- The service had developed a pathway to outline how to contact an anaesthetist if women required an epidural.

However;

- Actual midwifery staffing levels did not always match the planned midwifery staffing levels.
 - Staff told us that sharing information and learning from incidents had improved on the unit. We were not assured that changes in practice had been fully embedded following a further never event relating to a retained swab.
-

Diana Princess of Wales Hospital

Detailed findings

Services we looked at

Urgent & emergency services; maternity and gynaecology.

Detailed findings

Contents

Detailed findings from this inspection

	Page
Background to Diana Princess of Wales Hospital	7
Our inspection team	7
How we carried out this inspection	7
Facts and data about Diana Princess of Wales Hospital	8
Findings by main service	9

Background to Diana Princess of Wales Hospital

Northern Lincolnshire and Goole NHS Foundation Trust provides acute hospital and community services to a population of over 361,850 people. The trust serves a population across North and North East Lincolnshire and the East Riding of Yorkshire. The trust's annual budget is around £330 million and it employs around 5,166 members of staff.

This trust has three hospital locations:

- Diana, Princess of Wales Hospital (DPoW)
- Scunthorpe General Hospital (SGH)

- Goole and District Hospital (GDH)

The trust provides community services in North Lincolnshire.

There are approximately 877 beds at the trust including 762 general and acute care, 72 maternity and 43 critical care beds.

The trust's main Clinical Commissioning Groups (CCGs) are North Lincolnshire CCG, North East Lincolnshire CCG and East Riding of Yorkshire CCG.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included one CQC inspection manager, five CQC inspectors, one CQC assistant inspector and three specialist advisors; two midwives and an ED nurse.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We undertook an announced inspection of Northern Lincolnshire and Goole NHS Foundation Trust between the 22 and 25 November 2016 and an unannounced inspection on the 8 December 2016. Following these inspections, the CQC issued the trust with a Section 29A warning notice which stated that the quality of health care provided by the trust required significant improvement.

Detailed findings

We undertook an unannounced inspection on 15 June 2017. The purpose of this was to follow up on the actions the trust had told us they had taken in relation to the Section 29A warning notice.

CQC will not be providing a rating to Diana Princess of Wales Hospital for this inspection. The reason for not providing a rating is because this was a very focused inspection carried out to assess whether the trust had made significant improvement to services within the required time frame. Therefore not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

The inspection team inspected the following core services at Diana Princess of Wales Hospital:

- Urgent and emergency care
- Maternity and gynaecology

We reviewed evidence provided by the trust and interviewed staff about the process, management and oversight of the outpatient waiting list backlog.

We also spoke with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, administrative and clerical staff and managers. We observed how people were cared for, and reviewed patients' personal care and treatment records.

Facts and data about Diana Princess of Wales Hospital

- From February 2016 to January 2017 the trust had 152,623 ED attendances, 431,351 outpatient appointments, 95,455 inpatient admissions, 4,344 births, and 1,641 deaths.
- The catchment area of the trust includes people in North Lincolnshire and North East Lincolnshire. These localities span the area south of the Humber River, bordering the East Riding area, South and Central Lincolnshire and South Yorkshire. The health of people in North Lincolnshire is similar to the England average. Deprivation is similar to average and about 5,490 children live in poverty. Life expectancy for men is lower than the England average, and for women is similar to the England average. The health of people in North East Lincolnshire is generally worse than the England average. Deprivation is higher than average and about 28.5% (8,500) of children live in poverty. Life expectancy for both men and women is lower than the England average.
- From May 2016 to April 2017, the trust had one never event (in maternity) and 75 serious incidents.
- From March 2016 to February 2017 the trust reported 12,392 incidents with 98% categorised as low or no harm.
- Mortality data for the trust showed that from January to December 2016, the hospital standardised mortality ratio (HSMR) was within the expected range of 107.6 compared to an England average of 100. The summary hospital-level mortality indicator (SHMI) was higher than expected at 1.12. This was worse than the England average of 1.0.
- In the NHS Staff Survey (2016), the trust performed better than other trusts in one question, about the same as other trusts in 18 questions and worse than other trusts in 14 questions. Overall staff engagement ranges from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score was 3.68 which was in the bottom 20% of trusts.

Urgent and emergency services

Safe

Well-led

Overall

Information about the service

Urgent and emergency care services are delivered by the emergency departments (ED) at the Diana Princess of Wales Hospital (DPoW) and Scunthorpe General Hospital which provide a 24-hour, seven-day a week service to the local populations. In 2016/17, the trust had 151,765 attendances at its urgent and emergency care services.

The emergency department is a designated trauma unit. However, the most severely injured trauma patients are taken by ambulance or helicopter to the nearest major trauma centre, if their condition allows them to travel directly. If not, they are stabilised within the emergency department and either treated or transferred as their condition dictates. There is a protocol to inform the medical team which patient injuries require treatment at a major trauma centre. The department has a nearby open grassed area where the helicopter can land and a protocol is in place for the transfer of the patient into and out of the emergency department.

Summary of findings

CQC conducted an announced inspection of Northern Lincolnshire and Goole NHS Foundation Trust between the 22 and 25 November 2016 and an unannounced inspection on the 8 December 2016. Following these inspections, the CQC issued the trust with a Section 29A warning notice. This was because we had significant concerns relating to:

- An unsupervised bag containing medicines used by the streaming nurse was left unattended.
- There was a lack of comfort rounds completed by staff for patients.
- Patients were not monitored and escalated appropriately.
- The planned staffing levels were not always met.
- Nationally reported data, relating to the time to initial assessment of patients was not being reported accurately.
- The leadership team had limited oversight of the departmental risks and governance processes.

We conducted this unannounced inspection on 15 June 2017 to specifically look at the concerns we highlighted within the Section 29A warning notice.

At this inspection we found:

- There were gaps in resuscitation equipment checklists.
- The completion of documentation was variable, we saw gaps in pain, nutrition and hydration, falls and pressure damage risk assessments.
- Limited evidence that staff performed comfort rounds.
- Patient records we reviewed showed that a set of clinical observations had been recorded however the completion of National Early Warning Scores (NEWS) was inconsistent.
- Twenty two percent of shifts were not filled by substantive staff.

Urgent and emergency services

- Gaps in the cleaning checklists. However the department appeared visibly clean and well maintained and we saw stickers attached to equipment to indicate when it had last been cleaned.
- Security concerns regarding the electronic medicine key system for controlled drugs.

However we also found some improvements during this inspection including:

- The medicines used by the streaming nurse were now securely stored in a locked cupboard.
- The system for recording the time to initial assessment had been changed and this was now being recorded accurately.
- New processes had been implemented to allow oversight of risks and governance including a nursing dashboard. However, the evidence we found was not always consistent with the information recorded on the nursing dashboard.

Are urgent and emergency services safe?

We have not rated this key question because this was undertaken as a focused inspection to assess whether improvements had been made since we issued the trust with a Section 29A warning notice following our comprehensive inspection in November 2016.

At this inspection we found:

- Gaps in the cleaning checklists, however, the department appeared visibly clean and well maintained and we saw stickers attached to equipment to indicate when it had last been cleaned.
- Gaps in resuscitation equipment checklists.
- Completion of patient records was variable; we saw gaps in pain, falls and pressure damage risk assessment.
- Limited evidence of comfort rounds being performed.
- Patient care records showed that a set of clinical observations had been recorded however National Early Warning Scores (NEWS) were inconsistent.
- Nurse staffing did not meet the planned levels for 23% of shifts.

However we also found:

- The medicines used by the streaming nurse were now stored in a locked cupboard.

Cleanliness, infection control and hygiene

- Staff we spoke with were aware of the cleaning schedules for equipment within the department. Each area of the department, for example minors, majors etc had a designated staff member who had overall responsibility to ensure that equipment was cleaned in line with guidelines.
- The department appeared visibly clean and well maintained and we saw stickers attached to equipment to indicate when they had last been cleaned. However, we saw gaps in the cleaning checklists; for example, we looked at the daily checklists for the 13 major's area cubicles and found gaps in all of the sheets we reviewed.
- We spoke with a member of staff who told us that each patient trolley had a 'deep clean' every day, in between patients staff cleaned the trolleys using detergent wipes.

Urgent and emergency services

- We looked at 26 cleaning sheets, these did not show evidence that each trolley had been deep cleaned each day. Only one of the 26 sheets showed that all trolleys had been deep cleaned.
- We looked at the 'twice daily cleaning rotas'. These sheets listed 14 items of equipment to be cleaned twice each day. We looked at seven sheets and found gaps in cleaning on every sheet. For example, we saw that during the week commencing 20 March 2017 there were 74 gaps on the cleaning schedule.

Environment and equipment

- Resuscitation trolleys were labelled and matched with an equipment checklist. We looked at the equipment checklists and saw that these were predominantly completed daily. We asked a member of staff about the gaps we found and were told that the policy is for the trolleys to be checked weekly or immediately after use. The trolleys were sealed with a numbered security tag that was removed when the trolley was used. We saw that the tag number was not logged which meant that there was no assurance that the tag had been removed and reapplied.
- We were told that defibrillators were checked daily. We looked at the checklists and found some gaps in the checklists. For example, the defibrillator on resuscitation trolley three had four gaps in December 2016, six gaps in February 2017, two gaps in March 2017, three gaps in April 2017 and one gap in May 2017. It had been fully completed in January 2017 and June 2017.

Medicines

- At our previous inspection we observed an unsupervised bag containing medicines used by the streaming nurse in the ED at DPoW.
- At this inspection, we found that the medicines used by the streaming nurse were stored in a locked cupboard in a room behind reception.
- We looked at the medication fridge temperature checklists and found that these were checked daily.
- We looked at the record keeping and balance checks of controlled drugs (CDs – medicines that require extra checks and special storage arrangements because of their potential for misuse). The trust policy states that these should be completed weekly. We saw that in the ED at DPoW these were completed daily. We saw that

there were some gaps in daily checks, for example, there were five gaps in May 2017 and five gaps in June 2017. However, staff were completing checks over and above trust policy.

- We spoke with a member of staff about access to the controlled drug cupboard and were told that all registered nurses held a key for the cupboard. We were also told by this member of staff that they had lost their key and was waiting for a replacement. Staff also told us that they are responsible for the key at all times. The keys were an electronic system. This system recorded the date, time and name of the person accessing the cupboard.
- We looked at the 'the medicines code: policies and procedures for the use of medicines in Northern Lincolnshire & Goole NHS Foundation Trust. Part 5 of 6. Controlled drugs'.
- In section 5.4.2 Key Holding and Access to CDs, the policy states:
 - There must be only **ONE set of keys** to the controlled drugs cupboard(s) in the ward or department etc. The controlled drug keys must be on a separate key ring to other medicines cupboard (or other) keys, although for practical use, they may be connected with a detachable link
 - The appointed registered nurse or midwife in charge can delegate control of access (i.e. key holding) to the CD cupboard cabinet to another, such as a registered nurse or midwife or Registered Operating Department Practitioner (ODP). However, legal responsibility remains with the appointed registered nurse or midwife in charge. Whilst the task can be delegated, the responsibility cannot
 - The controlled drug key should be returned to the nurse or midwife in charge as soon as possible after use by another registered member of staff.
- This meant that the staff in the ED were failing to adhere to the trust's medicine policy. We raised this with the trust at the time of the inspection.
- The controlled drug cupboard was located in the resuscitation area of the department. This area was not locked when it was not in use.

Records

- During our previous inspection we found limited evidence that staff performed comfort rounds for patients.

Urgent and emergency services

- At this inspection, we reviewed nineteen sets of patient records and found completion of documentation was variable. For example:
 - Pain assessment was applicable in 17 of the records. We found that pain scores were not recorded in 53% (nine) of the records.
 - We saw comfort round sheets in 14 (74%) of the records we reviewed. However, completion of these was variable; one of the records had no timings, one showed approximately two hourly assessment whilst others the review was less consistent and the documentation was poor with no evidence of assessment of pressure damage. Three of the sheets had only one entry and no reviews.
 - Four sets of records had omissions of timings.
- One set of notes was incomplete. The notes ended with 'security informed'. This related to a patient who was undergoing a mental health assessment who had absconded whilst they were being taken to x-ray. We did not see any evidence that staff had referred to or acted on the policy for patients who have absconded, or that the incident had been reported on the electronic reporting system or escalated.
- This meant that staff were not completing records in line with professional standards and trust policies.
- There was no formal procedure or criteria in place to support moving a patient from a trolley to a hospital bed. A senior member of staff informed us they used clinical judgment and considered risk factors such as age, mobility status and skin integrity when making this assessment. We did not see evidence of pressure damage risk assessment in any of the records we looked at.
- Staff did not consistently complete falls risk assessments. We saw one example where a falls risk assessment stated that the patient was 'intoxicated' and the corresponding comfort round sheet stated the patient 'independent'.
- The unit provided a 'hydration station' where patients could access hot and cold drinks.

Nursing staffing

Assessing and responding to patient risk

- At our previous inspection we found that national early warning scores (NEWS) charts were not always completed. This meant that we were not assured that patients were having the appropriate level of monitoring and escalation whilst in the ED.
- At this inspection we looked at 19 sets of patients records, each set showed that a set of clinical observations had been recorded however there were no NEWS recorded in 58% (11) of the records. There were no NEWS charts in 32% (six) of the records. In 21% (four) sets of records, there was a failure to record the NEWS score and a failure to respond to a NEWS trigger in one. Fully and accurately completed charts were seen in 42% (eight) of the records.
- We found staff followed specific care pathways in four records (chest pain, thrombolysis, sepsis and foot/ankle injury) which were relevant for the patient presentation. There was one other record (presentation of chest pain) where the specific care pathway was not within the patient record. The remaining fourteen records used standard documentation.
- At our previous inspection we found that the planned staffing levels were not always met.
- At this inspection, we reviewed eight weeks of historic nurse rotas covering the period 24 April to 11 June 2017. We found that nurse staffing did not meet the planned levels on 51 (23%) of 224 shifts. Of those 51 shifts, 61% (31) of shifts were covered using bank/agency staff. There were 20 (9%) of 224 shifts where the unit worked below planned staffing levels. The unit was fully staffed on the day of the inspection.
- The ward manager reported that there were no registered nurse (RN) vacancies but that two members of staff were off on long term sick. Senior staff we spoke with were able to describe the escalation procedure for staffing shortages.
- The action plan, created following the trust being issued with a Section 29A warning notice stated that a review of the staffing establishment had taken place and this was due to be presented at the resource committee. The outcome of this was not known at the time of the inspection.
- Figures provided by the trust showed that on 31 May 2017 the department had a budget for 10.9 whole time equivalent (wte) band 6 and 7 RNs and a current establishment of 13.6 wte, therefore the department was over established by 2.8 wte band 6 and 7 RNs.
- The band 5 RN budget was 34.8 wte, the current establishment was 31.6 wte, this meant the department had 3.1 wte band 5 vacancies however, the overall total RN staffing, taking in to account the over establishment of band 6 and band 7 RNs, was under budget by 0.4wte.

Urgent and emergency services

Are urgent and emergency services well-led?

We have not rated this key question because this was undertaken as a focused inspection to assess whether improvements had been made since we issued the trust with a Section 29A warning notice following our comprehensive inspection in November 2016.

At this inspection we found:

- The trust had implemented processes to allow oversight of risks and governance including a nursing dashboard. The evidence we found was not always consistent with the information recorded on the nursing dashboard.

However:

- The ED leadership team had set up an ED working group to monitor and progress actions that flowed from the previous inspection.

Governance, risk management and quality measurement

- During our previous inspection, we had concerns that the nationally reported data, relating to the time to initial assessment of patients was not being reported accurately.
- At the time of this inspection, we found that the system for the recording of the time to initial assessment had been reviewed and changed to ensure that nationally reported data was being recorded accurately.

- We reviewed the nursing dashboard and found that the data was inconsistent with our findings on this inspection. For example during a four week period in March 2017, the dashboard showed 100% compliance in NEWS recordings however we found that NEWS charts were not being completed, which meant that patients were at risk of not being appropriately escalated.
- We found that record keeping was variable, we found gaps in the recording of pain scores, pressure risk and falls assessments. The dashboard indicated that in March 2017 between 80-100% of patients were assessed for pressure area risk and care rounds were performed consistently for 100% of patients. This meant that we were not assured about the accuracy of the trust's audits.
- We also saw gaps in the equipment and medication fridge checks.

Leadership of service

- The ED leadership team reviewed nurse staffing establishment three months prior to the inspection and compiled a business case.
- We found that staff were aware of the ED improvement plan created following the Section 29A warning notice.
- The ED leadership team had set up an ED working group to monitor and progress actions that flowed from the previous inspection; progress on the actions was discussed at departmental meetings and elements were highlighted during staff huddles.

Maternity and gynaecology

Safe

Well-led

Overall

Information about the service

The maternity service at Diana Princes of Wales Hospital (DPoW) has 33 beds. The service offers a labour, delivery, recovery and postnatal (LDRP) model of care. This means that women's care through labour, delivery, recovery and the postnatal period is delivered in the same room for their whole stay in hospital unless they need to go to the obstetric theatre.

Women with low-risk pregnancies are cared for by the community midwives. There are three teams of community midwives who deliver antenatal and postnatal care in women's homes, clinics, GP practices and children's centres.

During our inspection, we visited the maternity unit and spoke with seven members of staff including matrons, ward managers and midwives. We reviewed ten sets of maternity records. We also spoke with members of the management team who are responsible for the leadership and oversight of the service at DPoW, Scunthorpe General Hospital and Goole District Hospital.

Summary of findings

CQC conducted an announced inspection of Northern Lincolnshire and Goole NHS Foundation Trust between the 22 and 25 November 2016 and an unannounced inspection on 8 December 2016. Following these inspections, the CQC issued the trust with a Section 29A warning notice. This was because we had significant concerns relating to:

- The sharing of lessons learnt following serious incidents.
- Gaps in the emergency equipment checklists.
- There was no dedicated anaesthetic cover for the service and staff did not have a formal process to follow to access anaesthetic support out of hours. This had led to delays in care for women in labour.
- Record keeping was inconsistent in relation to the completion of the world health organisation (WHO) safety checklist, cardiotocography (CTG) reviews and 'fresh eyes' resulting in a failure to recognise the need for patient escalation.
- Staffing levels did not always meet the planned levels and the midwife to birth ratio was worse than national guidelines.
- The risk and governance processes in maternity services.

We conducted this unannounced inspection on 15 June 2017 to specifically look at the concerns we highlighted within the Section 29A warning notice.

At this inspection we found:

- Emergency equipment was checked in line with trust policies.
- Patient records were completed to a high standard and had evidence of appropriate risk assessment and escalation when required.
- Risk registers were displayed in clinical areas and were visible to staff on the unit.

Maternity and gynaecology

- The service had completed a review of staffing levels using the Birthrate Plus® midwifery workforce planning tool.
- The trust had developed a maternity services escalation policy for staffing shortages and a pathway to outline how to contact an anaesthetist if women required an epidural.
- The service had developed a pathway to outline how to contact an anaesthetist if women required an epidural.
- The service had implemented processes to allow oversight of risks and governance. The evidence we found was not always consistent with the trust findings.
- The service had commenced submitting data to the maternity safety thermometer

However we also found;

- Actual midwifery staffing levels did not always match the planned midwifery staffing levels.
- Whilst staff told us that sharing information and learning from incidents had improved on the unit, we were not assured that changes in practice had been fully embedded following a further never event relating to a retained swab.

Are maternity and gynaecology services safe?

We have not rated this key question because this inspection was undertaken as a focused inspection to assess whether improvements had been made since we issued the trust with a Section 29A warning notice following our comprehensive inspection in November 2016.

At this inspection we found:

- Processes were in place to ensure staff had checked emergency equipment. We found adult and neonatal emergency equipment was checked in line with the trust policy.
- Modified early obstetric warning scores (MEOWS) were recorded using an electronic system and were audited. We found MEOWS were complete and appropriately escalated for the patients we reviewed during the inspection.
- Clinical records were completed to a high standard. We saw evidence of 'fresh eyes' and hourly assessment of cardiotocography (CTG) in line with the trust policy.
- We saw evidence of appropriate escalation of women to the coordinator and plans were clearly documented using the situation, background, assessment and recommendation response (SBAR) tool.
- The service had commenced submitting data to the maternity safety thermometer.
- The service had introduced patient safety midwives. Their role was to audit maternity records and undertake safety checks on aspects of women's care.

However we also found:

- Whilst staff told us that sharing information and learning from incidents had improved on the unit, we were not assured that changes in practice had been fully embedded following a further never event relating to a retained swab.
- Actual midwifery staffing levels did not always match the planned midwifery staffing levels.

Incidents

- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. From May

Maternity and gynaecology

2016 to May 2017 there was one never event reported at DPoW which had occurred in May 2017 and related to a retained swab. At the time of the inspection, the investigation into the incident was ongoing. Immediate actions taken by the team included the introduction of plastic trays and reminding staff to ensure that second swab counts were completed. Staff told us they were aware of the immediate actions taken following the never event.

- During our inspection in November 2016 we were not assured that:
 - Lessons learnt following a never event of a retained vaginal swab in February 2016 had been fully embedded.
 - A live drill completed in October 2016 had identified that although policies and procedures had changed they were not fully embedded. For example, the use of white boards and clear trays was not consistently adhered to and despite swab counts being observed, documentation did not support this.
- During this inspection we found that:
 - Staff we spoke with felt that sharing information and learning from incidents had improved. We heard an example of a staff member returning from annual leave and being updated on any incidents and lessons learnt.
 - Staff said they were up dated on any lessons learnt during handover at each shift. The patient safety midwives had produced a patient safety newsletter which included information about lessons learnt.
 - One of the responsibilities of the patient safety midwives was to ensure that any lessons learnt from incidents were communicated to all staff.
 - The service completed monthly audits to assess if swab checks were being carried out following delivery, fetal blood sampling or suturing. The results demonstrated an improvement and in May 2017 DPoW was 100% compliant. However the service had reported a further never event in May 2017. This meant we were not assured about the trust's audit processes.
 - The service had introduced patient safety midwives. Their role was to review records and complete safety checks to provide assurance. One of their checks included reviewing swab checks and documentation. If non-compliance was identified, they would discuss it with the individual and escalate any concerns to the leadership team.

- The service had implemented a zero tolerance approach to any non-compliance with swab checks and had produced a policy to support this approach.
- The unit used ward safety briefings that were displayed in each office and used to disseminate information to staff.
- Each team office had a folder which contained information on lessons learnt.
- A quarterly newsletter from the women's and children's group included summaries of lessons learnt from incidents.

Safety thermometer

- The maternity safety thermometer allows maternity teams to monitor and record the proportion of mothers who have experienced harm free care. At the previous inspection in 2016 we found the service did not submit information to the maternity safety thermometer.
- The service had commenced collating and submitting data to the maternity safety thermometer in January 2017. We saw this was displayed in staff offices and included on the safety improvement bulletin. However, this information was not visible to members of the public.

Environment and equipment

- During our inspection in 2016, we found gaps in the daily checking of advanced resuscitation equipment on the inpatient areas.
- At this inspection, we checked adult resuscitation equipment, neonatal resuscitation equipment and resuscitaires and found daily and weekly checks were completed in line with the trust policy.
- We inspected the infant resuscitaire equipment cabinets in three patient rooms and found the equipment cupboards had been checked, restocked following use and the cupboards were sealed with a tag to indicate they were ready to use.
- The service had revised the daily checklist to include the checking of resuscitaires including portable resuscitaires.
- The patient safety midwife completed checks to ensure that daily and weekly checks of emergency equipment had been completed.
- The service had conducted an audit of adult resuscitation trolleys. Results from April 2017 demonstrated 100% compliance with weekly checks.

Maternity and gynaecology

- The matrons completed random 'spot checks' of emergency equipment to give assurance that checks had been completed in line with the trust policy.

Records

- During our inspection in 2016, we found that a lack of patient assessment, and escalation of patients identified as being at risk had compromised patient safety. We found 55% of records had no evidence of hourly cardiotocography (CTG) reviews or 'fresh eyes'. This was not in line with the service's policy which stated that an hourly systematic assessment of the CTG trace must be recorded and that every two hours the practitioner providing care must seek the assistance of a colleague to systematically review the CTG trace.
- During this inspection, we found that the standard of record keeping had significantly improved.
- We reviewed ten sets of records and found that there was evidence of 'fresh eyes' and hourly assessment of CTGs. We saw evidence of appropriate escalation of patients to the coordinator and plans clearly formulated and documented.
- The patient safety midwife was responsible for reviewing patient records and ensuring that CTG reviews and 'fresh eyes' were completed. Any areas of non-compliance were escalated to the leadership team.
- The service had completed an audit of antenatal and intrapartum CTG monitoring. In April 2017 they found 100% of records had evidence of 'fresh eyes' reviews. This had improved from 58% in August 2016.
- The service had relaunched situation, background, assessment and recommendation (SBAR) stickers. We saw evidence of these being effectively used in patient records.
- Staff we spoke with said that the standard of record keeping had improved and the role of the patient safety midwives had helped to drive that improvement.

Assessing and responding to patient risk

- Within maternity services staff used the modified early obstetric warning score (MEOWS) to assess the health and wellbeing of women. These assessment tools enabled staff to identify if a patient's clinical condition was changing and prompted staff to get medical support if a patient's condition deteriorated.
- At the previous inspection the service's audit of MEOWS identified that when escalation was required, only 58% of records had evidence of appropriate escalation, referral and a management plan.

- In May 2017 the service introduced an electronic system for recording MEOWS. We reviewed ten patients and found MEOWS scores were correctly calculated and where appropriate women had been escalated in a timely manner. Staff had used SBAR stickers to document the actions they had taken.
- The service completed spot checks on the completion of MEOWS. Results from December 2016 and January 2017 at DPoW showed 70% of MEOWS charts were fully completed.
- The World Health Organisation (WHO) surgical safety checklist is a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications.
- In February 2017 the service completed an audit of the WHO surgical safety checklist within obstetrics. At DPoW, the audit reviewed 27 sets of records and found limited assurance. Compliance with the sign in ranged from 93% to 100%, compliance with the time out ranged from 89% to 96% and compliance with the sign out ranged from 85% to 96%. This was worse than the trust target of 100% compliance.
- In March and April 2017, spot check audits of the WHO surgical safety checklists conducted by the patient safety midwife showed a compliance rate of 96%.
- We reviewed ten sets of records and found 100% compliance with the completion of the WHO surgical safety checklist.
- Staff completed annual K2 training (an interactive computer based training system that covered CTG interpretation and fetal monitoring). At the time of the inspection, 85% of midwives (60 of 70) and 86% medical staff (12 of 14) had completed the K2 training.
- The service had implemented a fetal monitoring workbook to support the services CTG mandatory training. The workbook was based on national guidance. In April 2017, 95% of staff were compliant with CTG mandatory training. This had increased from 69% in November 2016.
- The service had introduced CTG champions. At the time of the inspection there were no CTG champions on duty, however staff said the patient safety midwife or coordinator would take on this role.
- In January 2017 the service had introduced patient safety midwives. Their role was to audit maternity records and undertake safety checks on aspects of women's care. They reviewed the following:
 - Was a CTG commenced within thirty minutes?

Maternity and gynaecology

- Was there evidence of CTG review and ‘fresh eyes’?
- Was there evidence of clinical escalation?
- Was there a clinical management plan in place?
- Had women received responsive and appropriate analgesia?
- Was there evidence of proactive communication with the obstetric and anaesthetic team?
- Had the WHO checklist and swab counts been completed?
- Had the service’s escalation policy been followed?
- Had emergency equipment been checked?
- Had any lessons learnt been communicated to all staff?

Midwifery staffing

- The Royal College of Obstetricians and Gynaecologists (RCOG) standards for The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour recommend a ratio of one midwife to 28 births (1:28). In May 2017, the midwife to birth ratio at DPoW was 1:29. This had improved since our previous inspection where the ratio was 1:30.
- Staffing levels were displayed on the entrance to all wards.
- Any delays in patient care were reported on the trust’s electronic reporting system using a red flagging system. We reviewed incident data and found from January to June 2017, 47 incidents were reported that related to staffing levels. The service reported 18 delays in induction of labour due to midwifery staffing levels in line with the service’s escalation policy. None of these delays resulted in patient harm.
- We reviewed planned and actual midwifery staffing levels from 24 April to the 18 June 2017. On Honeysuckle and Jasmine ward, we found 41% of day shifts and 25% of night shifts where the actual midwifery staffing levels fell below the planned staffing levels. On Blueberry and Holly ward, we found 17% of day shifts and 22% of night shifts where the actual midwifery staffing levels fell below the planned staffing levels.
- The trust had developed a maternity services escalation policy. We saw evidence of this been ratified during a clinical governance meeting in February 2017. The policy included a risk assessment tool that was completed during times when concerns were raised regarding patient safety being compromised and if there was a potential for patient harm.

- The trust reported that there were no midwife vacancies at the hospital; however, there were two whole time equivalent vacancies in community services.
- RCOG guidelines state that co-ordinators should be supernumerary. The coordinators at DPoW were supernumerary and not included in the staffing numbers.
- At DPoW there was one whole time equivalent supernumerary patient safety midwife post. This post was filled by three midwives and on average a patient safety midwife was rostered to work three times a week.

Medical staffing

- At the previous inspection in November 2016 it was identified that the maternity unit did not have a dedicated anaesthetist, out of hours the anaesthetist was based on the critical care unit and provided cover to the unit.
- At this inspection, we found dedicated anaesthetic cover was available on the labour ward during the day. From 6pm to 8:30am, anaesthetic cover was available with the anaesthetist also providing a service to the critical care unit and theatres. There was an additional on-call anaesthetist if required.
- The service had introduced a twice daily multidisciplinary handover that discussed any potential needs for epidurals. We observed a medical handover which was well attended by a number of professions including the consultant anaesthetist, labour ward coordinator and advanced midwifery practitioner.
- We reviewed incident data between December 2016 and May 2017 and found one incident reported in April 2017 when there was a delay in providing an epidural because the anaesthetist was busy.
- The patient safety midwife reviewed the time to epidural as part of their review of patient records.
- The service had developed a pathway to outline how to contact an anaesthetist if women required an epidural. The trust provided a copy of this and showed the processes for midwives to follow during normal working hours and outside these times. It also showed the expected response times however it did not give any guidance of the process to follow if an anaesthetist failed to respond.

Maternity and gynaecology

Are maternity and gynaecology services well-led?

We have not rated this key question because this was undertaken as a focused inspection to assess whether improvements had been made since we issued the trust with a Section 29A warning notice following our comprehensive inspection in November 2016.

At this inspection we found:

- Risk registers were displayed in clinical areas and were visible to staff on the unit.
- The service had completed a review of staffing levels using the Birthrate Plus® midwifery workforce planning tool.
- The trust had developed a maternity services escalation policy.
- The service had developed a pathway to outline how to contact an anaesthetist if women required an epidural.
- We were not assured about the trust's audit processes. For example, the trust reporting 100% compliance with swab checks in May 2017; however, there was a never event of a retained vaginal swab reported in the same month.

Governance, risk management and quality measurement

- At our inspection in November 2016, we were not assured that the governance processes were sufficiently in place and implemented in maternity services.
- The action plan, created following the trust being issued with a Section 29A warning notice, stated that risk registers would be displayed in clinical areas. At this inspection, we saw that risk registers were displayed in clinical areas and were visible to staff on the unit.
- Since our inspection in November 2016, the service had completed a review of staffing levels using the Birthrate Plus® midwifery workforce planning tool. The review indicated that DPoW required an increase in the midwifery establishment by 2.7 whole time equivalents,

and the antenatal day unit required an increase of 0.3 whole time equivalent. In June 2017, the service had submitted a business case to implement the recommendations from Birthrate Plus®.

- The service had introduced patient safety midwives. Their role was to review records and complete safety checks to provide assurance. One of their checks included reviewing swab checks and documentation. If none compliance was identified they would discuss it with the individual and escalate any concerns to the leadership team. The service had implemented a zero tolerance approach and produced a policy to support this approach.
- The trust's audit of compliance with swab checks showed 100% compliance in May 2017 however the service reported a never event of a retained vaginal swab in the same month.
- The service had revised the daily checklist to include the checking of resuscitaires including portable resuscitaires.
- The patient safety midwife completed checks to ensure that daily and weekly checks of emergency equipment had been completed.
- The matrons completed random 'spot checks' of emergency equipment to give assurance that checks had been completed in line with the trust's policy.
- The trust had developed a maternity services staffing concerns escalation policy. We saw evidence of this been ratified during a clinical governance meeting in February 2017. The policy included a risk assessment tool that was completed during times when concerns were raised regarding patient safety being compromised and if there was a potential for patient harm.
- The service had developed a pathway to outline how to contact an anaesthetist if women required an epidural. The trust provided a copy of this and showed the processes for midwives to follow during normal working hours and outside these times. It also showed the expected response times however, it did not give any guidance of the process to follow if an anaesthetist failed to respond. At the time of the inspection, the trust had not audited compliance with the pathway.