Burton Hospitals NHS Foundation Trust

Samuel Johnson Community Hospital

Quality Report

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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	Good
Minor injuries unit	Good
Medical care	Requires improvement
Maternity and family planning	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Samuel Johnson Community Hospital is one of the three locations that Burton Hospitals NHS Foundation Trust provides services from. The other locations are Queen's Hospital and Sir Robert Peel Community Hospital. We inspected the hospital between 24 and 25 April 2014.

Samuel Johnson Community Hospital provides a range of services including rehabilitation, care of older people, general medical care, outpatients, minor injuries service, diagnostics and midwifery-led maternity services. The inspection team inspected the minor injuries unit (MIU), medical care (including older people's care); and maternity services during this inspection.

In the last 12 months 30,000 patients attended the minor injuries unit. Before and during our inspection we heard from patients, relatives, senior managers and other staff about some key issues that were having an impact on the service provided at this trust. We also held a listening event in Burton where patients and members of the public were given an opportunity to share their views and experiences.

Why we carried out this inspection

Burton Hospitals NHS Foundation Trust had a significantly higher than expected mortality rate from April 2012 to March 2013. As a result, the trust was included in Professor Sir Bruce Keogh's review of trusts in 2013. The overview report Review into the Quality of Care and Treatment provided by 14 Hospital Trusts in England is available on the NHS Choices website. The Keogh review identified a number of areas of good practice. However, the report identified a number of areas of concern, such as no systematic approach to ensure the collection, reporting and action on information about the quality of services. It also found that there was a lack of support for junior doctors, and that medical staffing levels and skills mix were not appropriate and equipment safety checks had not been carried out.

We inspected this hospital as part of our in-depth hospital inspection programme. When we inspected the trust in April 2014, 14 of the 61 recommended actions following the Keogh inspection had still to be completed.

Overall, Samuel Johnson Community Hospital was rated as good. This hospital was rated as good for providing services that are effective, caring, responsive and well-led. However, it requires improvement in providing safe services.

Our key findings were as follows:

- Ward staff were committed to delivering high quality care and saw patient experience as a priority.
- Recruitment is a recognised challenge for the trust, with some wards below establishment. Bank, agency and locum staff were used to fill vacant posts and some staff worked additional hours. In some areas there was a high dependency on temporary nursing staff.
- There were procedures in place for staff to learn from incidents and implement changes.
- There were systems in place for monitoring the safety of the environment and equipment.
- Staff had access to and attended mandatory training.
- Clinical areas were clean and there were policies and procedures in place detailing cleaning schedules.
- Documentation for children attending the MIU lacked specific prompts and did not include evidence such as the names of parents/guardians accompanying children or if the child or family had contact with social services.
- Translation services were available on request.
- There was a trust complaints policy and procedure for managing complaints. Staff were made aware of the outcome of complaints. However, the trust set a timeframe of 35 working days to respond and this was not always met.
- The hospital does not always meet the needs of all patients living with dementia.
- Some specific equipment, such as adjustable beds for people who were at a high risk of falls, was not always available.

We saw areas of outstanding practice including:

Summary of findings

- The arrangements to cover unexpected midwife absences. A system alerted staff by a text message to inform as many midwives as possible that replacement staff were required. Staff were very positive about the efficiency of this system.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the hospital must:

- Take action to ensure documentation for children attending the MIU records appropriate information.
- Take action to ensure the care for people living with dementia is embedded throughout the hospital.
- Review the systems and processes for responding to complaints within the agreed timescales.

In addition the hospital should:

- Consider reviewing the availability of equipment such as adjustable beds.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Minor injuries unit	Good 	The service provided effective care and treatment to the local population, which was tailored to their needs. There were appropriate facilities, staffing and equipment to deliver care, and systems were in place to monitor the quality and safety. People using the service praised the staff and the way in which care and treatment was provided. There was a good flow through the department and people were seen in a timely manner. Relationships between junior and senior staff were positive. However, it was noted that some of the standard assessments for children, to ensure that they were safe, were not built into the children's documentation and at times were not checked, which could put children at risk.
Medical care	Requires improvement 	We visited two elderly care wards at the Samuel Johnson Community Hospital. The Anna Seward ward and Erasmus Darwin ward. Local risks were managed effectively, but we highlighted concerns with hand hygiene practice and nurse staffing levels at night time. There was seven day access to therapies and allied healthcare professionals who provided appropriate input as required. Patients told us that they felt informed and included in decisions about their care and treatment. The trust does not always respond appropriately to the needs of all patients with dementia. The lead dementia nursing team consists of two staff, who are not resourced to support all patients with a diagnosis of dementia at the community hospital. We observed good local leadership on the wards with senior nurses demonstrating a commitment to patient safety and the management of risk. One senior nurse on Erasmus Darwin ward had been nominated for a national award upon completion of a project which reduced the risk of falls to the ward's patients.
Maternity and family planning	Good 	There were systems in place to ensure that women and their babies were treated in a safe, well equipped environment by suitably qualified staff. Feedback from women, commissioners and third

Summary of findings

party organisations had been used to inform the service's development strategy. We found evidence that incidents were reported, investigated and learning was shared through a variety of forums. Staff felt engaged and were supported to be innovative in order to constantly improve the service.

Good

Samuel Johnson Community Hospital

Detailed findings

Services we looked at
Minor injuries unit; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning

Contents

Detailed findings from this inspection	Page
Background to Samuel Johnson Community Hospital	7
Our inspection team	7
How we carried out this inspection	7
Facts and data about Samuel Johnson Community Hospital	9
Findings by main service	10
Areas for improvement	27

Detailed findings

Background to Samuel Johnson Community Hospital

Samuel Johnson Community Hospital provides a range of services including two inpatient wards, Anna and Darwin providing rehabilitation, care of older people, general medical care, outpatient, minor injuries service, diagnostics and midwifery-led maternity services and antenatal clinics for people living in and around Lichfield and Burntwood. It is one of three of Burton Hospital NHS Foundation Trust locations. The trust also provides services from Sir Robert Peel Community Hospital and Queen's Hospital.

Our inspection team

Our inspection team was led by:

Chair: Brigid Stacey, Director of Nursing and Quality NHS England (Central)

Head of Hospital Inspections: Siobhan Jordan, Care Quality Commission

Inspection Lead: Fiona Wray, Inspection Manager, Care Quality Commission

The team included CQC inspectors, analysts, doctors, nurses, midwives, patients and public representatives, experts by experience and senior NHS managers.

How we carried out this inspection

How we carried out this inspection

In planning for this inspection we identified information from local and national data sources. Some of these are widely available in the public domain. We developed 117 pages of detailed data analysis which informed the inspection team. The trust had the opportunity to review this data for factual accuracy, and corrections were made to the data pack from their input.

We requested information in advance of the inspection from national and professional bodies for example the Royal Colleges and central NHS organisations. We also sought views locally from commissioners and Healthwatch.

The CQC inspection model focuses on putting the service user at the heart of our thinking. We held a well-publicised listening event on 23 April 2014. This was held before the inspection began and helped inform the thinking of the inspection team. More than 32 local residents and service users attended the listening event, and each had the opportunity to tell their story, either in small groups or privately with a member of the inspection team.

We received information and supporting data from staff and stakeholders both before and during the inspection.

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

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

The inspection team inspected the following core services:

- Minor injuries unit (MIU)
- Medical care (including older people's care);
- Maternity & family planning

During our inspection we spoke with patients and staff from all areas of the hospital, including the wards and the MIU. We observed how people were being cared for and spoke with carers and/or family members and reviewed personal care or treatment records of patients.

What patients say

We received 83 comments cards across the three trust locations. The majority of these were positive and related to the good or excellent care that patients or relatives received while having treatments at the trust. Many

comments related to the fact that the trust was always found to be clean. However, the negative comments were about poor communication between staff and patients/ relatives.

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Detailed findings

Facts and data about Samuel Johnson Community Hospital

The trust employs about 3,000 staff over three sites; The trust carries out more than 47,000 planned and emergency operations and carries out around 13,000 day case procedures annually. In the last 12 months the trust had more than 60,000 A&E attendances and 70,000 minor injuries unit attendances.

On average, 97% of the trust's population are registered with a GP. The life expectancy is worse than average for men and better than average for women in East Staffordshire. This is similar to the England average for Lichfield and Tamworth.

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Minor injuries unit	Requires improvement	Not rated	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Maternity and family planning	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Minor injuries unit

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The minor injuries unit at Samuel Johnson Community Hospital is open 24 hours a day, seven days a week. They see approximately 30,000 patients annually for minor injuries and illnesses. Approximately 40% of attendances were children. This is a nurse-led service, though GPs attend for planned sessions Mondays to Fridays. Staff have access to onsite x-ray facilities 9am to 5pm Monday to Friday, and 9am to 12pm on Saturdays.

Much of the data we received related to the trust's Accident & Emergency (A&E) department and their Minor Injury Units (MIU) combined, therefore combined data we will refer to as the Emergency Department data. Where we have unit specific data we will make this clear.

We visited this service unannounced within ten working days of the main, announced inspection.

Summary of findings

The service provided effective care and treatment to the local population and was tailored to their needs. There were appropriate facilities, staffing and equipment to deliver care and systems in place to monitor the quality and safety. People using the service praised the staff and the way in which care and treatment was provided. There was a good flow through the department and people were seen in a timely manner. Relationships between junior and senior staff were positive.

However, it was noted that some of the standard assessments for children, to ensure that they were safe, were not built into the children's documentation and at times were not checked, which could put children at risk.

Minor injuries unit

Are minor injuries unit services safe?

Requires improvement

There were procedures in place for learning from accidents and incidents, as well as procedures for monitoring the safety of the environment and equipment. Staff undertook appropriate training in topics such as safeguarding and the mental capacity act and knew what to do if a patient started to deteriorate. Both nursing numbers and medical cover were appropriate.

However, it was noted that documentation in children's medical records did not feature specific prompts such as whether they were known to social services or what their immunisation history was. In addition, a review conducted by the Trust indicated that these details, as well as other relevant details such as who the child attended with, were frequently not included in the free text. This meant that staff may not always make appropriate safety considerations for children, which puts them at risk.

Incidents

- No never events had taken place in the unit in the last 12, months events that are largely preventable if the right actions are taken.
- Staff in the unit kept records of accidents and incidents that occurred. There was a process in place for these to be reviewed and for changes to be made to departmental policies and procedures as appropriate.
- Staff we spoke with were able to describe the most recent incident where a patient had waited over 4 hours to be seen and treated, and how this had been reported and acted on.

Cleanliness, infection control and hygiene

- Infection control audits were conducted on a quarterly basis. These included compliance with the hand hygiene policy and the cleanliness of the environment. A review against the trust's infection control standards in March 2014 reported a 97% level of compliance for the Emergency Department as a whole.
- There was a policy and procedure in place detailing what needed to be cleaned by staff on the unit, this included frequency of cleaning and we saw evidence of this.
- For the unit specifically the last available audit in February 2014 indicated a 95% compliance rate with hand hygiene requirements and that there had been no known infections in the unit that month.

Environment and equipment

- All the sterile equipment and supplies we reviewed were in date and fit for use.
- Emergency drugs and equipment were available and these were regularly checked to ensure that they were in date and fit for purpose.

Medicines

- Medications in the unit were stored securely and the actual stock of medications matched the records held.
- Patient Group Directions (PGDs), protocols that had been developed so that nurses who were not independent prescribers could provide some medications without direct authorisation from a doctor, were in use and facilitated patients receiving medication in a timely manner.

Records

- We reviewed a selection of records and looked at recent audits. These indicated some gaps in record keeping such as immunisation history of children, names of parents/guardians and clear records of who was the Next of Kin. At the time of the inspection it was not clear what the outcome of this audit had been, though staff were aware of where improvements needed to be made.
- It was noted that documentation for children lacked specific prompts. Factors specifically relevant to children, such as immunisation history or whether they were known to social services were not always requested or documented by staff.

Mandatory training

- There was a programme of mandatory training, which staff said they were able to complete. This included topics such as safeguarding.
- Staff had been trained in what to do in emergency and received regular update training.
- The staff that we spoke with reported that they could easily access mandatory training.
- At the end of March 2014 88% of nursing staff had completed their mandatory training.

Minor injuries unit

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of the Mental Capacity Act and how it related to the protection of vulnerable adults.

Safeguarding

- Staff we spoke with were aware of the signs of possible abuse and how to report their concerns.
- Staff told us they had attended training in safeguarding adults and children, and that they were expected to attend refresher training on a regular basis.
- Staff reported that a health visitor would visit the unit twice a week and would check all attendances against the child protection register.
- However, it was noted that the names of parents/ guardians accompanying children on attendance were not always recorded, and there was not consistent recording if the child or family had contact with social services.

Management of deteriorating patients

- There was a policy in place for unwell patients who were likely to deteriorate to be referred to local A&E department.
- At the minor injury unit reception staff were trained to identify the signs of serious illness which they would flag to clinical staff immediately.
- Prior to transfer patients would be cared for in the resuscitation bay where their ongoing condition could be monitored until they are transferred by ambulance.
- During our inspection we observed one instance where a patient with a potentially serious condition was referred directly to A&E at Queen's Hospital, the patient was taken to the resuscitation room for continued monitoring.

Nursing staffing

- The minor injuries unit was open 24 hours a day and was staffed by between one and four nurses, depending on the time of day and the predicted activity. We were told that the skill mix was appropriate to meet the needs of the patients who attended.
- The nursing rota included nurses with a range of skills and experience it also included Emergency Nurse Practitioners.
- We reviewed recent rotas and could confirm that staffing levels were sustained over the previous month.

Medical staffing

- Staff reported that they could easily access medical colleagues within the main hospital (Samuel Johnston Hospital) if they needed their support. This included access to the paediatric service and the crisis team.
- General Practitioners (GP's) attended the MIU for one hour each day in the week.

Are minor injuries unit services effective?
(for example, treatment is effective)

Not sufficient evidence to rate

The service conducted appropriate audits and reviews of the quality of the outcomes of their care and treatment. Staff received an appropriate induction to the service and were positive about the learning they undertook. They worked well with other services within the hospital. However we noted that some of the resuscitation guidelines displayed were out of date.

Evidence-based care and treatment

- It was noted that in the resuscitation bay, there were some guidelines and procedures on the walls which were out of date and did not reflect current best practice. This included the guidance on paediatric resuscitation.

Patient outcomes

- The unit monitored specific areas of the service and participated in audits to ensure it was providing effective care and treatment. This monitoring included the number of emergency readmissions; the findings of this monitoring did not highlight any particular risks within the trust.
- The unit conducted its own audits into aspects of their work such as record keeping, as well as national audits such as the assessment of feverish children.

Competent staff

- When staff commenced employment within the MIU they received an induction to the working environment and this included an induction to the local policies and procedures.

Minor injuries unit

- Staff we spoke with were positive about the training and supervision they received. At the time of our inspection the annual appraisal process was underway, but we were not provided with figures about how many staff had been appraised.
- All staff in the unit received some training in paediatric care. A paediatric nurse was employed in the unit. Staff noted that a paediatric nurse made scheduled attendances to the unit each day, but that they had access to the main paediatric team in the hospital if they needed them (Samuel Johnston Hospital).

Multidisciplinary working

- The unit had access to a broad range of other departments in the main hospital including physiotherapy and imaging services.
- Staff reported that there could be delays in accessing patient transport facilities and in waiting for psychiatric assessments.

Seven-day services

- The unit was open 24 hours a day seven days a week, 365 days of the year.
- The radiology services were only open 9am to 5pm weekdays and 9am to 12pm at weekends.
- Staff reported that they could transfer patients with potentially serious fractures to Queen's Hospital or other A&E facilities, or they could stabilise them and ask them to return when the imaging services were available.

Are minor injuries unit services caring?

Good

The service provided care, support and treatment that met people's needs. The written feedback that they received from patients was positive about both the way they were treated and how they were kept informed. The people that we spoke with and their families confirmed this.

Compassionate care

- The unit reported that they had various ways of getting feedback from patients including information from the PALs service, from complaints, and they also got comments from grateful patients.
- Staff also reported that they participated in a patient survey; the last one was completed in March 2014. Staff stated that whilst they did not have the results to hand, no significant concerns had been highlighted.
- We looked at compliments that the unit had received. People mainly complimented the caring nature of staff describing them as kind and patient.
- We spoke to people using the service as well as their friends and family. They also told us that staff were "lovely" and had made them feel "really comfortable."

Patient understanding and involvement

- A wide range of leaflets for patients were available which contained details about minor injuries and illnesses and how people should care for themselves afterwards.
- The people we spoke with and their families said that they had received full explanations of their care and treatment from staff.
- For those people who did not speak English as their first language, translation services were available on request.

Are minor injuries unit services responsive to people's needs?

(for example, to feedback?)

Good

People did not have to wait long to be seen and this performance had been sustained over the past year. There were facilities to cover a broad range of injuries or illnesses, including ophthalmic injuries and minor fractures. We noted learning from complaints.

Access and flow

- At the time of the inspection the unit was meeting its target of seeing and treating, transferring or discharging 95% of patients within four hours.
- The patients that we spoke with in the minor injuries unit said they had not had to wait long to be seen and treated. At the time of the inspection the minor injuries unit itself was meeting the 4 hour target. One patient also praised the access to imaging services which they said had been able to access promptly.

Minor injuries unit

Meeting people's individual needs

- During our inspection it was noted that there was an appropriate amount of seating in the minor injury unit. Some patients did report that it could be very crowded and busy at peak times.
- The unit had a room with specialist ophthalmic equipment for the assessment and treatment of eye injuries.
- There was also a plaster room available for the treatment of minor fractures (which staff had been trained to diagnose and treat).

Learning from complaints and concerns

- There was a trust complaints policy and procedure in place which staff were aware of.
- Staff reported that complaints would be reviewed and they would be made aware of the outcome.

Are minor injuries unit services well-led?

Good

Staff that we spoke with were aware of the vision and strategy for the unit. There were appropriate systems in place to monitor the quality of the service and minimise risks. There were good relationships between senior and junior staff. Both junior staff and members of the public were actively involved in the service and consulted about the quality of service being provided.

Vision and strategy for this service

- The staff we spoke with on the unit were broadly aware of the vision and values for the unit and said they would be able to access the detail if they needed to.
- The vision for the unit was displayed on the central corridor.

Governance, risk management and quality measurement

- The unit collected data by a range of mechanisms to monitor their safety and effectiveness. These included information about infection control, safety of the environment, time taken to be seen, as well as audits on compliance with national pathways.
- The unit provided information to be included in a monthly departmental performance report to the directorate board where their performance was discussed with senior staff from across the directorate.
- Staff from the unit attended meetings of all ward Sisters across the Trust where ideas could be shared. They also reported attending departmental wide meetings where feedback from courses as well as departmental issues was discussed.

Leadership of service

- Staff reported that they had good contact with senior staff and the Executive Team who were aware of any difficulties they had. They said they maintained a good understanding of what the unit did and had visited the service.

Culture within the service

- We spoke to staff who described an open culture within the service. Junior staff were satisfied with the general levels of support they received and we observed open and constructive relationships between senior and junior members of the team.

Public and staff engagement

- Senior staff reported that there were numerous ways to receive feedback from patients. These included the complaints process and their responses to it, as well as other written feedback they received and an annual patient satisfaction service.
- The junior staff we spoke with were positive about their working environment. They were aware of the aims of the unit and where senior staff had made changes to working practices to improve services.

Medical care (including older people's care)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Samuel Johnson Community Hospital in Lichfield provides inpatient services for elderly patients requiring rehabilitation. The two wards Erasmus Darwin Ward and Anna Seward ward also provide general medical services.

Summary of findings

We visited two elderly care wards at the Samuel Johnson Community Hospital. The Anna Seward ward and Erasmus Darwin ward.

Local risks were managed effectively, but we highlighted concerns with hand hygiene practice and nurse staffing levels at night time. There was seven day access to therapies and allied healthcare professionals who provided appropriate input as required. Patients told us that they felt informed and included in decisions about their care and treatment.

The trust does not always respond appropriately to the needs of all patients with dementia. The lead dementia nursing team consists of two staff, who are not resourced to support all patients with a diagnosis of dementia at the community hospital.

We observed good local leadership on the wards with senior nurses demonstrating a commitment to patient safety and the management of risk. One senior nurse on Erasmus Darwin ward had been nominated for a national award upon completion of a project which reduced the risk of falls to the ward's patients.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We were told that the majority of equipment was available; however several staff told us that there were not enough adjustable beds for people who were at a high risk of falls. Despite this, the number of falls on the wards had reduced significantly in 2014 the suggested reason for this was the introduction of a new medication review tool.

We noted that risks were being assessed, identified and mitigated. Records were completed accurately and were used appropriately to support the safe delivery of care.

Trust audit results highlighted concerns with hand hygiene practice. We were also made aware of issues with nurse staffing levels at night time. We were also made aware of issues with nurse staffing levels at night time.

Safety thermometer

- On Anna Seward and Erasmus Darwin wards we saw that a ward assurance tool that monitored areas such as falls was being used effectively on a monthly basis and that improvements to care quality were made. This was used in addition to the safety thermometer tool.
- One senior nurse on Erasmus Darwin ward had been nominated for a national award after completing a project on the effect of historically prescribed patient medicines and how the effect of these medications increased the risk to patients of falling, as they affected their balance. This work had significantly reduced the number of falls on the ward from December 2013 to April 2014, and the findings, and a tool devised as a result of the findings, had been shared with other wards in the division.

Cleanliness, infection control and hygiene

- Erasmus Darwin ward reported the lowest compliance rate with hand hygiene audits across medicine, reporting 86% compliance in February and March 2014. The infection prevention and control team carried out their quality assurance audits in February and March 2014 but did not carry out an environment audit of Erasmus Darwin ward, despite the concerns highlighted by that ward on the previous two self-assessments.

Environment and equipment

- The wards had a store of equipment available to them.
- We were told that access to adjustable beds was limited and staff did not feel that there were enough of these beds available to patients. Therefore, there was a potential risk to the safety of patients who were assessed as needing an adjustable bed and couldn't be provided with one.

Records

- We found that the use of records to ensure safe care and treatment were appropriately completed to manage identified risks to patient safety.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The ward manager on Anna Seward ward was able to explain when people had been assessed for mental capacity and talked us through best interest assessments that had been made for patients currently on the ward, as well as considerations around next steps.

Mandatory training

- Over 90 per cent of the staff working on the wards had met mandatory training requirements in January and February 2014.

Nursing staffing

- We were told by the matron that Erasmus Darwin ward had nursing vacancies and was running below its identified establishment. The ward had 12 patients who required two members of staff to help them mobilise.
- The ward manager on Anna Seward ward told us they had 20-plus patients who needed more than two people to help them mobilise at the time of our inspection. Both these wards were staffed at night with two trained nurses and one nursing assistant, which meant that only one patient could be supported to mobilise at any given time at night. During staff break times at night there would be two members of nursing staff for more than 20 patients.

Are medical care services effective?

Good

The wards had seven day access to therapies and involved allied healthcare professionals at appropriate times to make sure that the delivery of care was effective.

Medical care (including older people's care)

Evidence-based care and treatment

- A senior ward sister on Erasmus Darwin Ward had worked with a colleague to introduce a tool for reducing the risk of patient falls after analysing the impact of certain medicines. This was an evidence-based exercise that had been implemented across medicine and had significantly reduced the risk of falls on the ward.

Nutrition and hydration

- We observed a meal time. Blue trays were being used to highlight people who needed extra support to eat and we noted that this was provided as needed.
- Meal time was protected on the wards we visited to allow patients to eat their meal without interruption.

Multidisciplinary working

- Therapies were integrated across medicine and allied healthcare professionals were involved in a range of meetings, including ward rounds. On Erasmus Darwin ward they told us they had involved allied healthcare professionals in their newly introduced 'Ask Me' clinics.

Seven-day services

- There was a seven-day therapy service available from 07.00 to 19.00, with a focus on patient care.

Are medical care services caring?

Good

Patients told us that they felt informed and included in decisions about their care and treatment.

The ward had recently introduced an 'Ask Me' clinic in which it invited the patient, the patient's relatives or carers and allied healthcare professionals to discuss the patient's care and support needs and their rehabilitation goals. Patients had access to counselling services to offer emotional support.

Compassionate care

- Nursing staff on the wards demonstrated a compassionate nature and conveyed that they cared about their patients. Nursing staff shared with us where they felt patient safety might be compromised, and gave examples of when the trust was not responsive to patients' needs.

Patient understanding and involvement

- The trust introduced an 'Ask Me' initiative which meant that staff wore badges encouraging patients and relatives to ask them questions. Across medicine nursing staff felt that this had been a positive initiative and that patient and relative queries had increased.
- Erasmus Darwin ward had recently introduced an 'Ask Me' clinic which invited relatives and patients to attend to discuss any issues or concerns about their inpatient stay or their discharge.
- Feedback received on Anna Seward and Erasmus Darwin wards was that patients felt informed and included in decisions about their care and treatment.

Emotional support

- Senior nurses on Erasmus Darwin and Anna Seward wards told us that the wards had access to counselling services which included neuro counselling, bereavement counselling and counselling for patients after a stroke.

Are medical care services responsive?

Requires improvement

The trust's failure to respond to the needs of all patients with dementia presents a risk to the elderly patients on Erasmus Darwin ward and Anna Seward ward. We saw good practice being carried out by the trust's lead dementia nurses but they were not resourced to support patients living with dementia at the community hospital.

The wards' discharge liaison nurse was on secondment and the rehabilitation wards had no dedicated support to help facilitate discharge.

Meeting people's individual needs

- Coordinated care for patients living with dementia was not embedded across the community hospitals.
- Feedback at one of our focus groups from staff was that the trust met the government target for the number of required dementia champions, but not all wards had a champion. Staff said there was an identified need for more dementia training.
- The dementia leads shared some examples of where their intervention had enabled patients to achieve

positive outcomes. However, they were only resourced to be able to reach a small number of the patients diagnosed with dementia and so their input was not consistently available."

- One patient on Erasmus Darwin ward had no relatives or friends visiting. This patient fed back that they were pleased there was a free cash machine on site; however, as there was no shop at the Samuel Johnson Community Hospital, they were unable to buy items they needed on site during their stay.
- The ward's discharge liaison nurse has been seconded within the trust. We were told several different timeframes for how long this secondment was due to last for, but each person told us it was for several months. We were told that there was no plan to replace the discharge liaison nurse on these rehabilitation wards while they were on secondment.

Learning from complaints and concerns

- The trust sets a target response timeframe of 35 working days for complaints requiring a written response. As of 02 May 2014, the trust had failed to provide a full response within this target to 43% of those complaints.
- In January to March 2014 the trust received seven complaints relating to the Community and Clinical Services Division which required a written response. The trust told us that, as part of the ongoing review of their complaints response times, work is underway to address and respond to the percentage of complaints that have exceeded their target, and that they are liaising with families to ensure they are kept informed of the status of their complaint. The trust told us that this work is being monitored through the director of nursing's office, and the governance, risk and assurance committee.

Are medical care services well-led?

Requires improvement

We observed good local leadership on the two wards we visited with senior nurses demonstrating a commitment to patient safety and the management of risk. However, decisions by senior leaders had presented challenges to these wards as had the failure to implement the trust's dementia strategy.

One senior nurse on Erasmus Darwin ward had been nominated for a national award upon completion of a project which reduced the risk of falls to the ward's patients.

Vision and strategy for this service

- The matrons and senior nurses on the community hospital wards displayed an oversight on the needs of their patients and evidence of promoting appropriate input from others as necessary to deliver effective and coordinate care.
- However, decisions by senior leaders had presented challenges to these wards as had the failure to implement the trust's dementia strategy.
- A recent decision to not backfill the role of a discharge liaison nurse, for two rehabilitation wards, impacted negatively on the time local leaders had available to manage others and the wards they were responsible for.

Leadership of service

- We observed good local leadership on the two wards we visited with senior nurses demonstrating a commitment to patient safety and the management of risk.

Innovation, improvement and sustainability

- One senior nurse on Erasmus Darwin ward had been nominated for a national award after completing a project on the effect of historically prescribed patient medicines and how the effect of these medications increased the risk to patients of falling, as they affected their balance. This work had significantly reduced the number of falls on the ward from December 2013 to April 2014.

Surgery

Information about the service

<Overview here>

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Summary of findings

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Maternity and family planning

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The maternity unit at Samuel Johnson is a midwifery led unit for women who have been assessed as having a "low risk" pregnancy. There are approximately 250 babies born annually in the unit. It has three birthing rooms and a four bedded postnatal ward. Any women or baby with complications are transferred to Queen's Hospital. The birthing unit is part of midwifery services of Burton Hospitals NHS Foundation Trust and is 10 miles from Queen's Hospital where the consultant led maternity unit is situated.

At the time of our inspection there were no women being cared for at the unit.

Summary of findings

There were systems in place to ensure that women and their babies were treated in a safe, well equipped environment by suitably qualified staff. Feedback from women, commissioners and third party organisations had been used to inform the service's development strategy. We found evidence that incidents were reported, investigated and learning was shared through a variety of forums. Staff felt engaged and were supported to be innovative in order to constantly improve the service.

Maternity and family planning

Are maternity and family planning services safe?

Good

There were systems in place to ensure that women and their babies were treated in a safe, well-equipped environment by suitable numbers of qualified staff. Risks to the service had been identified and were monitored regularly. There was a process for reporting incidents and any areas for learning were shared with staff.

Incidents

- There had been no maternal deaths and no Never Events in the year preceding our inspection. Never Events are classified as events that should never happen and are largely preventable if the right actions are taken.
- There was an electronic incident reporting system in place, which staff told us was easy to complete. However, the community midwives told us they could not access the system unless they were using a trust computer. Therefore, if they were working from a GP practice or out in the community, this could lead to a delay in reporting an incident.
- Incidents were reviewed and investigated. Feedback from incidents was disseminated to staff on an individual basis or as a group. For example, the department held "weekly wash" meetings where incidents from the previous week were discussed to share any learning. We were told the incidents were anonymised to encourage an open and supportive culture. Staff told us they were encouraged to report incidents and felt confident in doing so.
- There were a variety of forums and groups in place to discuss particular topics. For example, there was a multidisciplinary stillbirth study group and a perinatal mortality review group where individual cases were examined to determine if there were any areas for learning or improvement.
- Staff at all levels were able to provide examples of where lessons had been learned following incidents. For example, the documentation for postnatal examinations had been reviewed to ensure there was a standardised approach, and that it was recorded when such examinations had been refused by a patient.

Cleanliness, infection control and hygiene

- During our inspection we noted the midwifery-led unit at Samuel Johnson hospital was visibly clean.

Environment and equipment

- The environment in the maternity service was secure. All areas were accessed by entry phone and/or swipe cards. Staff were aware of emergency procedures and practice drills were randomly undertaken to test staff reactions.
- There was sufficient equipment in each area visited to ensure that patient safety was maintained.
- Resuscitation equipment was checked daily in the areas we visited and a record was kept of these checks. However, not all emergency medication was secure. The adult resuscitation trolleys did not have lockable drawers and so items, including adrenalin, were accessible to unauthorised persons. We were told that this was a trust-wide issue and senior management were aware but no action had been taken to address this issue.
- Units were suitably equipped to provide effective care. Staff had received training on the equipment available and this was reviewed and updated routinely.

Medicines

- There were appropriate arrangements in place for the safe storage of medications in clinical areas; these were stored in lockable rooms that could only be accessed via a swipe card.
- Medication fridge temperatures were checked daily and controlled drug checks were completed appropriately.

Records

- There was a maternity dashboard in place which monitored performance against safety-related targets on a monthly basis. This included indicators such as staffing levels, admissions to the neonatal unit, stillbirths and admissions of mothers to intensive care.
- The dashboard was discussed at monthly divisional risk meetings and any variation in performance was investigated.
- All women were given a "red book," also known as the child health record, which provided information on the health of their baby and the immunisations they would be expected to have.

Safeguarding

- There were systems in place to identify and protect vulnerable people from abuse.

Maternity and family planning

- Staff received safeguarding training in line with the trust's mandatory training policy. All doctors, midwives and care assistants working in the maternity department received level 3 child protection training.
- While there were no formal safeguarding supervision arrangements within the trust, we saw evidence that managers within the maternity service monitored the status of alerts raised by staff and provided support where necessary.
- Staff we spoke with were able to describe the process for reporting any concerns to both social services and the lead midwife for safeguarding.

Mandatory training

- All staff were required to complete the trust's mandatory training. As of February 2014, 96% of midwives and 91% of the obstetric consultants had completed their mandatory training. However, only 59% of junior doctors had completed this training. During our inspection we were not provided with evidence to demonstrate what action was being taken to address this issue.

Midwifery staffing

- The midwife led birthing unit is part of the maternity service of Burton Hospitals NHS Foundation Trust. A senior midwife is based at the unit full time and provides day to day line management to staff working in the birthing unit.
- The maternity dashboard showed that the midwife-to-birth ratio was 1:31 (one midwife to 31 mothers), which was higher than nationally recommended ratio of 1:28.
- Women received one-to-one care during established labour and midwives told us they were never asked to care for more than one woman during this time.
- Unexpected midwife absences were filled using in-house staff, working additional hours. The maternity departments did not use agency staff. If there were any unfilled shifts, all staff were alerted via a text message system to inform as many possible replacement staff at one time. Staff were very positive about the efficiency of this system.

Are maternity and family planning services effective?

Good

Mothers' needs were assessed and care was delivered in line with best practice clinical guidelines to ensure that they received safe and effective care.

Care and treatment was based on nationally recommended guidance, including those produced by the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists. These were applied to patients based on their clinical need.

Women had comprehensive antenatal assessment to develop care plans that reflect their choice based on clinical need.

Evidence-based care and treatment

- Mothers' needs were assessed and care was delivered in line with best practice clinical guidelines to ensure that they received safe and effective care.
- Care and treatment was based on nationally recommended guidance, including those produced by the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists. These were applied to patients based on their clinical need.
- All clinical guidelines and protocols were available to staff via the trust's intranet. We noted that a few of these guidelines were due, or had passed the date, for review.
- Senior staff were aware and a log was kept of all guidelines and who was responsible for reviewing them. We were told that guidelines where national changes had been made were prioritised for updating.

Patient outcomes

- Up-to-date performance information was accessible via the maternity dashboard. Delivery of care achieved positive outcomes for patients, which were in line with the expected norms and performance had been sustained over time.
- Woman selected to deliver their babies at the unit were low risk and expected to have "normal deliveries" if complication arose requiring medical intervention the women were transferred to the consultant led unit at Queen's Hospital.
- In 2013, 58 women were transferred from the birthing unit at the Samuel Johnson Community Hospital in

Lichfield to the labour ward at Queen's hospital, a distance of 10 miles, in the second stage of labour. The service sets its target as having no more than four transfers in each month.

- In eight months in 2013 the service exceeded this number and, on two consecutive months, eight mothers were transferred. These eight transfers were reviewed and reported to the October 2013 risk meeting. It was concluded that the transfers had been clinically appropriate.
- The service had achieved level 2 of the UNICEF UK Baby Friendly Initiative which aims to encourage breastfeeding.
- The maternity dashboard showed that, between April 2013 and February 2014, 70% of woman breast fed their babies within 48 hours overall. The rate for the midwifery-led unit at Samuel Johnson was 80%.
- The service participated in national clinical audits to benchmark performance. For example, the service consistently achieved over 90% for the proportion of women who accessed maternity services before 12 weeks and six days of their pregnancy, as recommended by NICE.
- Each year the service was audited by West Midlands Local Supervising Authority who are responsible for ensuring that statutory supervision of midwives is carried out to an acceptable standard. No concerns were raised by the 2012/13 report in relation to the trust's maternity services.
- As part of the ongoing supervision of midwives, supervisors of midwives audited mothers' notes randomly.
- The staff at the birthing unit held sessions for mothers to promote normal birth, these included reflexology, aromatherapy and normal birth classes.

Competent staff

- Midwives and care assistants reported they had development opportunities, including support to complete degree courses.
- The appraisal rate for midwives at Samuel Johnson was 100%.
- All midwives had a named supervisor of midwives to meet statutory obligations and all reported that they had had their annual review.

Multidisciplinary working

- All staff we spoke with described a positive working environment where different staff groups worked as a team. There were a variety of multidisciplinary groups and forums that met on a regular basis to discuss incidents, individual cases and to share learning.
- Staff worked closely with external organisations and there was effective communication, information sharing and decision making.
- Staff at the birthing unit reported good working relationships with health visitor colleagues with joint clinics taking place
- Referrals were made to social services, health visitors or other hospitals where there were individual concerns.
- The management team also engaged with other health and social care partners, including the clinical commissioning group and Healthwatch in order to inform strategic decisions.

Are maternity and family planning services caring?

Good

The CQC maternity survey (2013) demonstrated that women and their families were treated with compassion, dignity and respect.

Staff told us that providing a positive experience for woman and their families was their priority.

Compassionate care

- The 2013 CQC Survey of Women's Experiences of Maternity Care reported that the trust performed better than other trusts in questions around staff during labour and care in hospital after the birth. These indicated that women did not feel staff left them alone at a time when it worried them, and felt they were spoken to in a way they could understand.

Patient understanding and involvement

- Written information was readily available on the unit. Some information was available in other languages and there was a trust-wide translation service.
- There was a virtual tour of the maternity unit on the trust's website. Mothers and their partners could arrange to visit the maternity-led unit at Samuel Johnson and had the opportunity to meet the team.

Maternity and family planning

- Regular open days were held to promote the facility and to give opportunity for previous mothers to meet prospective parents; these were well attended by users of the service, clinical commission groups and the trust executive.

Are maternity and family planning services responsive?

Good

Over 90% of women received an initial antenatal appointment within 12 weeks and six days of their pregnancy. Women who wished to give birth at the unit were assessed to ensure they were suitable for this low risk environment. The unit also accepted women outside the catchment area; a further assessment was carried out by the unit's midwives closer to the birth date to ensure it would still be appropriate for the mother and her baby.

The service used feedback from woman and their families to inform developments.

Service planning and delivery to meet the needs of local people

- Feedback from woman who had used the service was used to inform the service's strategy for development.
- The midwife lead unit had not closed in the two years preceding our inspection. However, there was a contingency plan in place should the unit be required to close.
- The trust worked with commissioners of services, local authorities, GPs, relevant groups and people who used the service to understand the needs of the local population and to promote the maternity services provided at Queen's Hospital, Samuel Johnson mid wife led unit and by the community midwives.

Access and flow

- Women were able to access maternity services at the trust when they needed it. There was a clear booking process in place and over 90% of women received an initial antenatal appointment within 12 weeks and six days of their pregnancy. If mothers required a referral to another clinician or part of the service, such as the maternal fetal assessment unit, this was arranged.
- Before women were discharged, staff checked they knew when their community midwife would be visiting. They were also given information on how to contact the service if they had any concerns.

Meeting people's individual needs

- Women could access the midwifery-led unit at Samuel Johnson via their GP or their midwife.
- Women who wished to give birth at the unit were assessed to ensure they were safe to do so. The unit also accepted women outside the catchment area, but a further assessment was carried out by the unit's midwives closer to the birth date to ensure it would still be appropriate for the mother and her baby.
- Women's choice was respected, dependent on clinical need. If complications arose during labour, there was an escalation procedure in place to transfer them rapidly to the labour ward at Queen's Hospital via ambulance.
- Care assistants and midwives supported women with breastfeeding. Postnatal clinics at Samuel Johnson had been implemented to provide further support to women and their partners following discharge. For example, women could self-refer or be referred by their community midwife to a breastfeeding clinic.

Learning from complaints and concerns

- There was information displayed at Samuel Johnson Hospital on how women and their partners could give feedback on the service they had received and how they could make a complaint.
- Complaints were fed back to all staff as a way of sharing information and learning. Where required action plans developed and monitored by senior managers to ensure delivery.

Are maternity and family planning services well-led?

Good

The maternity services of Burton Hospitals NHS Trust managed the midwife led birthing unit at the Samuel Johnson community hospital. The leadership, management and governance of maternity services ensured staff worked in an environment where the focus was on providing high quality care to women.

Maternity and family planning

There was an open reporting culture and staff were positive about the feedback and learning that was provided from incidents. Staff were engaged and involved in making changes that directly impacted on and improved patient experience.

There was a clear governance structure for the service which ensured that risks were identified and monitored on a regular basis. Performance was monitored and reported to senior managers within the trust.

Vision and strategy for this service

- Staff within the service shared the trust's vision. Their priority was to provide safe, effective care and to ensure families had a positive experience.
- There was a strategy in place to develop maternity services and this was focused on encouraging "normal" births.

Governance, risk management and quality measurement

- Senior staff were aware of the risks that may impact on the safety or effectiveness of the service and these were logged on the trust's risk register and monitored at monthly risk meetings.
- There were governance structures in place that ensured there was reporting arrangements from the ward to the trust board.
- Performance reports were submitted to divisional board meetings monthly and to the trust board every six months. These included information on staffing, incidents, complaints and quality of care. These reports were informed using the maternity performance dashboard and ward assurance reports which measured quality.
- There was a specialist midwife for governance whose role included conducting audits, root cause analysis investigations following incidents and monitoring any identified risks.

Leadership of service

- Staff viewed the service's senior management and members of the executive team positively, particularly the chief executive and the director of nursing.
- Staff felt able to raise issues with senior staff and described the team as supportive.
- All staff were aware of the matron's monthly "open clinic" where staff could drop in.
- All midwives had a named supervisor who conducted an annual review. The supervisors also monitored performance on an ongoing basis.
- The maternity dashboard, as of February 2014, showed the ratio of supervisors to midwives was 1:15, as recommended by the local supervisory authority. However, following recent recruitment, we were informed that this ratio was now 1:12.

Culture within the service

- There was a culture of collective responsibility within the maternity services at the trust. All staff felt they had a role to play in providing quality care to women and their families.
- Staff at the midwife focus group described the culture of the service as "open". They felt able to report concerns and if learning or improvements were required this was managed in a supportive way.
- All staff we spoke with demonstrated pride in what they did and told us they felt privileged to work as part of the maternity team.
- Staff had participated in the 2013 NHS Staff Survey, but it was not possible to break this down to service area. The trust performed in the top 20% of trusts nationally for the number of staff who had received an appraisal in the last 12 months.
- Areas where the trust performed worse than expected included job satisfaction and percentage of staff reporting good communication between senior management and staff. These negative results did not reflect what we found during our inspection of maternity services.

Public and staff engagement

- Women's experience of care was used to drive improvements in the service. Feedback was collected through a variety of ways.
- There was a patient representative on the monthly labour ward forum, the service engaged with the local Healthwatch and people were encouraged to leave comments or complaints via the NHS Friends and Family Test or comments cards. Changes had been made to the discharge process following feedback from patients.
- There were a variety of forums and groups that staff could attend. Staff told us they felt they had a voice and were actively involved in making improvements to the service.

Maternity and family planning

Innovation, improvement and sustainability

- We were told the service strived to improve the woman's experience and this was the focus of any changes made.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Importantly, the trust must:

- Complete the 16 outstanding actions from the Keogh review that had not been delivered and were overdue.
- Take action to ensure the care for people living with dementia is embedded in all divisions across the trust.
- Review the systems and processes in places for responding to complaints within the trust's agreed timescales.
- Take action to ensure documentation for children attending the MIU records appropriate information.

Action the hospital SHOULD take to improve

- Consider reviewing the availability of equipment such as adjustable beds.