Queens Hospital

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Ratings

Overall rating for this hospital	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Summary of findings

Overall summary of services at Queens Hospital

Requires improvement 

We carried out a short notice announced focused inspection at Queens Hospital Burton on 30 July 2020. During the inspection, we inspected falls assessment and management across both the medicine and surgery core services. This was in response to concerns which were initially raised following serious incidents that had happened at the trust.

We also reviewed discharge processes as a result of concerns raised prior to the inspection about communication upon discharge.

We visited medical wards, ward 4, 5 and 8 as well as the discharge lounge and ward 19, which was a trauma and orthopaedic ward. We chose these locations based upon intelligence received prior to our inspection. We spoke with 18 members of staff, including healthcare support workers, nurses including ward manager grade and therapy staff. We did not speak to any patients. We reviewed 16 patient records and 10 discharge records and observed staff providing direct care to patients.

Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of a regulation and issued a requirement notice or acted under our enforcement powers. in these cases, the ratings will be limited to requires improvement or inadequate.

Previous ratings were not all updated during this inspection. However, the ratings for safe and effective (in medicine and surgery services), and therefore the overall ratings went down. We rated these areas as requires improvement. Please refer to the 'areas for improvement' section for more details.

Our rating of services went down. We rated them as requires improvement because:

- Staff did not always undertake mental capacity assessments in line with the Mental Capacity Act. Staff did not consistently follow the Mental Capacity Act requirements when patients were deprived of their liberty.
- Patients at risk of falls were not always supervised in line with the trust policy. It was not always possible to identify patients who were at a risk of falls without reviewing electronic records. Patients could not always reach their call bells.
- Some nursing notes were not detailed enough. Staff did not always find it easy to locate specific information in the electronic records. Staff did not always keep detailed or contemporaneous records of patients' care and treatment.
- Staff did not always follow risk assessment recommendations when using bedrails.
- Not all staff were trained in relevant mandatory training modules in line with the trust's training target.
- Lessons learned from outside of the direct ward area, were not always shared with all staff. Due to COVID-19, staff had fewer opportunities to meet, discuss and learn from the performance of the service.
- Not all staff were aware of the support systems in place (falls group) to ensure effective care packages were received by patients.
- Some processes related to falls were not yet consistent across the trust. Many actions taken to reduce falls were still in progress at the time of our inspection. The trust gave inconsistent information about how staff should manage some risks.

Summary of findings

- We found inconsistencies in the information that was cascaded to staff from senior leaders about incidents. Some senior staff were not fully aware of their accountabilities in line with managing serious incidents.
- Not all staff were wearing personal protective equipment in line with national guidance.

However, we also found:

- Leaders were using systems to identify and escalate falls risks and review falls performance to reduce their impact. They were working towards implementing and embedding effective governance procedures throughout the service in relation to falls.
- The design of facilities, premises and equipment kept people safe. Staff were trained to use the equipment. Staff completed and updated risk assessments for each patient and removed or minimised risks.
- There was enough rostered staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept records of patients' care and treatment. Electronic records were stored securely and available to staff providing care.
- Staff recognised and reported incidents and near misses. Managers investigated incidents. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Manager supported staff to become competent for their roles. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Where patients had capacity to consent to care and treatment, staff supported patients to make informed decisions about their care and treatment.
- The service was inclusive and took account of patients' individual needs and preferences. Staff mostly made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Medical care (including older people's care)

Requires improvement 

Summary of this service

Our overall rating of this service went down. We rated it as requires improvement because:

- Patients at risk of falls were not always supervised according to the trust policy. It was not always possible to identify patients who were at a risk of falls without reviewing electronic records. Patients could not always reach their call bells.
- Staff did not always undertake mental capacity assessments in line with the Mental Capacity Act. Staff did not consistently follow the Mental Capacity Act requirements when patients were deprived of their liberty.
- Some nursing notes were not detailed enough to show care and treatment undertaken per shift. Staff did not always find it easy to locate specific information in the electronic records. Staff on one ward were not aware of paper-based records.
- Some staff were not wearing personal protective equipment in line with national guidance.
- Not all staff received lessons learned from outside of the direct ward area.
- Not all staff were trained in relevant modules in line with the trust training target.
- Not all staff were aware of the support systems in place (falls group) to ensure effective care packages were received by patients.
- Some processes related to falls were not yet consistent across the trust. Many actions taken to reduce falls were still in progress at the time of our inspection.
- We found inconsistencies in the information that was cascaded to staff from senior leaders about incidents. The trust gave inconsistent information about how staff should manage some risks.
- Leaders identified and escalated relevant risks and identified actions in relation to falls to reduce their impact. However, many of these actions were outstanding at the time of our inspection. The trust gave inconsistent information about how staff should manage some risks. Some senior staff were not fully aware of their accountabilities in line with managing serious incidents.

However, we also found:

- The service controlled infection risk well. Most staff used equipment and control measures to protect patients, themselves and others from infection. They kept the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use the equipment.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Staff mostly completed and updated risk assessments for each patient
- Staff kept records of patients' care and treatment. Electronic records were stored securely and available to staff providing care.
- Staff recognised and reported incidents and near misses. Managers investigated incidents. When things went wrong, staff apologised and gave patients honest information and suitable support.

Medical care (including older people's care)

- The service made sure staff were competent for their roles. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Where patients had capacity to consent to care and treatment, staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Is the service safe?

Requires improvement 

Our rating of safe went down **. We rated it as** requires improvement **because:**

- Patients at risk of falls were not always supervised according to the trust policy. It was not always possible to identify patients who were at a risk of falls without reviewing electronic records.
- Patients could not always reach their call bells.
- Not all staff were trained in relevant modules in line with the trust's training target.
- Some nursing notes were not detailed enough to show care and treatment undertaken per shift. Staff did not always find it easy to locate specific information in the electronic records. Staff on one ward were not aware of paper-based records.
- Staff did not always receive lessons learned from outside of the direct ward area.

However, we also found:

- The service controlled infection risk well. Most staff used equipment and control measures to protect patients, themselves and others from infection. They kept the premises visibly clean. However, we saw that some staff were not wearing masks in line with national guidance.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use the equipment.
- The service had enough staff with the right qualifications, skills and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept records of patients' care and treatment. Electronic records were stored securely and available to staff providing care. Staff completed and updated risk assessments for each patient.
- Staff recognised and reported incidents and near misses. Managers investigated incidents. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Requires improvement 

Our rating of effective went down **. We rated it as** requires improvement **because:**

- Staff did not always undertake mental capacity assessments in line with the Mental Capacity Act.

Medical care (including older people's care)

- Staff did not consistently follow the Mental Capacity Act requirements when patients were deprived of their liberty. Not all staff were aware of the support systems in place (falls group) to ensure effective care packages were received by patients.

However, we also found:

- The service made sure staff were competent for their roles.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Where patients had capacity to consent to care and treatment, staff supported patients to make informed decisions about their care and treatment.

Is the service responsive?

Good 

Our rating of responsive stayed the same.

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Is the service well-led?

Good 

Our rating of responsive stayed the same.

- Leaders were working towards effective governance procedures throughout the service in relation to falls. Processes were not yet consistent across the wards. The trust gave inconsistent information about how staff should manage some risks.
- Leaders used systems to review falls performance. Leaders identified and escalated relevant risks and identified actions in relation to falls to reduce their impact. However, many of these actions were outstanding at the time of our inspection.

However, we also found:

- Not all staff received updates and information. Some senior staff were not fully aware of their accountabilities in line with managing serious incidents. Due to COVID-19, staff had less opportunities to meet, discuss and learn from performance of the service. We could see actions were in place to improve this.

Detailed findings from this inspection

Is the service safe?

Mandatory Training

Medical care (including older people's care)

The service provided mandatory training in key skills to all staff, however not all required staff had completed this.

The trust provided mandatory training data for the three medical wards we inspected as of the time of the inspection. We reviewed the training compliance for the following modules; consent, dementia awareness, falls prevention, patient handling, safeguarding level one and safeguarding level three. The trust data did not specify if the safeguarding training related to adults, children or both. The trust target for mandatory training was 95%. We saw a varied compliance to the trust target across the modules reviewed.

We noticed for all three wards, no staff were identified as being eligible for consent training, except for doctors and advanced clinical practitioners as this module outlines the principles and law of consent. Please see 'Effective' for details about gaining patients consent to care and treatment.

Staff on ward four were 100% compliant on all modules except for safeguarding level three, where 84% of staff were up to date with this training (22 out of 26 staff).

Staff on ward eight were 100% compliant on dementia awareness, falls prevention, and patient handling training. However, both safeguarding modules compliance did not meet the trust target. Safeguarding level one showed 88% compliance (16 out of 18 staff) and safeguarding level two showed 77% compliance (14 out of 18 staff).

Training compliance on ward five met the trust target for one module. The rest of the modules fell below this. Falls prevention training had a compliance rate of 65.7% (25 out of an eligible 38 staff). This was significantly below the trust target of 95%. Patient handling training compliance was 100%. Eighty eight percent of staff had completed dementia awareness (44 out of 50 staff). Staff compliance with safeguarding level one training was 94% and safeguarding level three was 82% compliance.

Data from the trust included a training presentation on falls dated June 2020. This presentation was comprehensive and included relevant information to support staff knowledge. However, we did not have data to confirm how many staff had received this training. Furthermore, some of the information in the training about the use of certain types of equipment (hi-lo beds and crash mats) conflicted with information from the trust which stated the trust do not use them.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Most staff used equipment and control measures to protect patients, themselves and others from infection. They kept the premises visibly clean. However, we saw that some staff were not wearing masks in line with national guidance.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. We observed ward cleaning taking place and saw standard operating procedures about cleaning were in place.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff had access to plentiful supplies of PPE across all areas we visited.

Most staff wore correct PPE on all wards we visited. We saw staff consistently discard PPE such as gloves and aprons after each patient contact and wash their hands before putting on fresh disposable PPE.

We did observe one doctor speak with two patients with their face mask over their mouth but under the nose. However, this was rectified before the doctor left the bay. In addition, we saw some nursing staff pulling masks down to speak and removing their masks and putting the same mask back on.

Staff cleaned equipment after patient contact. Staff wiped patient equipment thoroughly with antibacterial wipes after it had been used with one patient before using it with another. The equipment that we saw staff cleaning included blood pressure cuffs and standing aids.

Patients with infections could be identified by staff as they were flagged on the electronic record system.

Patients were being discharged were only permitted to wait in the discharge lounge if they had tested negative for COVID-19.

Environment and equipment

Patients could not always reach their call bells. However, in general the design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use the equipment.

Not all patients could reach their call bells. We checked how many patients could access their call bells on ward four. We found in two of the three bays, all patients could reach their call bells. In one bay, two patients' call bells (out of a total of four patients) were hanging to the floor and were less accessible to the patient. In one instance, a patient struggled to reach this. However, we saw a health care assistant was present and accessible to support any immediate patient needs.

Staff we asked demonstrated awareness that patients with dementia or other cognitive impairment may not understand the need for, or how to use call bells. Therefore, bay nursing (a nurse or healthcare assistant being located in each bay at all times) was encouraged to ensure these patients could still be attended to promptly.

The service had enough suitable equipment to help them to safely care for patients. Patients had access to suitable equipment to support their mobility needs.

The trust had introduced some red walking aids, such as Zimmer frames, to easily identify patients living with a visual impairment or who may be confused. Other equipment to support walking, standing and sitting had red handles for the same purpose.

The trust used a piece of specialist equipment to safely support patients who had fallen to the ground to enable them to return to bed after assessment. This was an inflatable mattress type piece of equipment which was designed to lift a person from lying on the floor, onto a bed or trolley or couch keeping them in a lying position. It was designed to move a fallen patient whilst preventing further pain or injury. Training of ward staff was underway for this equipment.

Not all required staff who required training to use a specific piece of inflatable equipment designed to support patients back up after a fall had received this. On ward four, one out of 14 eligible staff had received training, on ward five one of two eligible staff had received training and on ward eight, six out of 16 staff had been trained. However, we acknowledge this training is face-to-face and therefore had been halted due to the COVID-19 pandemic. In addition, other staff such as therapy staff were trained to use this.

Staff received training in how to safely use day to day equipment, however some staff we spoke with were not aware that walking aids could be adjusted to individual patient's height. Staff told us most of this training was online. Champions (staff who had received extra training to support other staff) assessed newly trained staff to check their competency.

Staff told us that since the onset of COVID-19, they no longer had access to crash mats to place on the floor beside patient beds where patients were assessed as a high risk of rolling out of bed. Data from the trust after the inspection stated the trust no longer used crash mats as they no longer used hi-lo beds. However, this contradicted our findings on site. For example, we saw one patient on ward eight in a hi-lo bed. In addition, a trust wide training presentation for staff dated June 2020 referenced the use of hi-low beds and using additional mattresses next to the bed if hi-low beds were used at their lowest height. Therefore, equipment used by staff on wards was not in line with what the senior leadership team were expecting them to use.

Staff told us in some areas of the trust, footprints and floor-based lighting had been placed on the ward to help guide patients, particularly at night, to reduce the risk of falls from reduced visibility. However, these were not in place on the wards we inspected.

Staff understood the importance of appropriate footwear. All patients we observed were wearing sturdy slippers or anti-slip socks to minimise the risk of a fall.

Medical care (including older people's care)

We observed anti-falls information displayed above bed areas and around wards.

The discharge lounge was able to accommodate one patient in a bed at any one time in addition to patients who were able to sit. Only patients returning to care homes used the discharge lounge during COVID-19, and ward staff liaised with care home staff to organise this. During our inspection, this environment was being safely managed.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough nursing and support staff scheduled to work on the wards to keep patients safe. During our inspection staffing levels were appropriate for the needs of the patients. However, staff from the medical wards we visited told us they would often be redeployed to support other areas of the hospital which needed support, particularly at night. Staff felt this could compromise patient safety on their usual ward.

Senior nurses reviewed staffing levels daily to ensure wards were staffed appropriately as per patient needs and bed occupancy.

The number of nurses matched or exceeded the planned numbers for the four weeks prior to the inspection. The only slight exception to this was the night shift on ward four.

Ward four planned nursing hours for the day shift was 1617.5 and actual hours was 1638.08 (101%). The planned hours for the night shifts were 1069.5 and the actual fill rate was 1047.5. This meant a fill rate of 97%.

Ward five showed planned nursing day shift hours of 1162 and an actual fill rate of 1790.3 (154%). The planned hours for night shifts was 828 versus an actual fill rate of 1632 (197%).

Ward eight planned day shift hours were 1070 and the actual filled shift hours were 1883 (176%). Night shift planned hours were 713 and actual hours worked were 1012 (142%).

Healthcare assistants, and other unregistered staff such as nursing associates did not meet the planned numbers on some wards but exceeded this on others. Where actual numbers did not meet planned numbers, nursing staff numbers made up for this deficit.

On ward four, day shift planned hours were 1356 and actual hours exceeded this (1393.75, 105%). Night shift planned hours were 713 and actual hours were 701.5 (98% fill rate).

Ward five showed day shift planned hours were 816.5 and the actual filled hours was 1059 (130%). Night shift planned hours were 713 and actual hours were 1081 (151%).

Ward eight planned day shift hours were 1413.5 and the actual hours were 895 which was 63% of the required staff. However, the number of nursing hours planned for were exceeded by 76% which could have made up for this shortfall. Night shift planned hours were 701.5 and actual hours were 747.5 (106%).

Staff, mostly health care assistants, from the trust wide enhanced care team were used to provide one-to-one supervision where patients were assessed as a high risk of falls. Staff told us the enhanced care team, however, was understaffed which meant staff were not always able to provide one-to-one continuous supervision as per the trust enhanced nursing policy. If there were no members of the enhanced care team available to support one-to-one supervision, senior ward staff requested bank or agency staff to provide this cover. When this request was not met, ward staff were used which impacted the overall staffing for the ward. The enhanced nursing policy specified that matrons and divisional nurse directors should audit compliance with the policy in relation to patients who require enhanced supervision. Data from the trust showed this was not formally monitored on the medical wards we visited.

Assessing and responding to patient risk

Medical care (including older people's care)

Patients at risk of falls were not always supervised according to the trust policy. It was not always possible to identify which patients were at a risk of falls without reviewing electronic records. Staff completed and updated risk assessments for each patient and removed or minimised most risks.

Staff completed a multi-factorial risk assessment to identify each patient's risk of falls. This was undertaken on the patients' admission, then weekly thereafter. If the patient moved wards or had a change in presentation, the risk assessment was also reviewed. The assessment considered the patient's falls history, the number of medicines they were taking, the reason for admission and a number of other related factors. This assessment gave only two results; either the patient was at a risk of falling or the patient was not at a risk of falling. The assessment did not differentiate between patients who were at a low, medium or high risk of falls. Therefore, it was not clear at which point specific interventions to manage patients of a high risk of falls, such as one-to-one supervision, would be required. Staff used their own experience and knowledge to make these decisions. This assessment was recorded electronically and linked with the electronic patient care plan. During our inspection we saw this was difficult to navigate and understand which specific interventions should be implemented for each patient depending on their individual risk factors. This meant that staff who were not familiar with the patients, such as bank or agency staff, may work with patients but not be fully aware of their needs in relation to falls prevention based on the electronic record.

The trust provided us with a copy of the enhanced nursing policy approved in December 2016 and due for review in 2018. Although this policy was out of date at the time of inspection, it contained information for staff to follow about patient supervision and monitoring when at risk of harm such as from falls. A draft updated version was in place but had not yet been disseminated to staff. The policy reported that a risk matrix should be completed for all patients and the score recorded on care records to identify what level of supervision each patient required. During our inspection we did not see this assessment score recorded, rather staff used their own judgement to decide whether a patient was a low, moderate, high or extreme risk of harm as discussed above.

All staff we spoke with were aware of risk factors that contributed to falls including low blood pressure, inadequate footwear, mobility, confusion or delirium, medicines intake or substance misuse, long toenails, nutrition or hydration concerns, poor mobility, and vision impairment. Staff told us interventions that could be implemented to manage these risk factors and therefore reduce the risk of a patient having a fall. Examples given were supervising patients more closely, using suitable footwear, referring patients to therapy teams for support, and using mobility aids and equipment.

Staff undertook daily assessments for bed rail suitability when it was considered that bed rails may be useful. We saw bed rails were used following an appropriate assessment which indicated bedrails would support a patient to safely remain in bed rather than rolling out. However, staff did not always follow legal requirements regarding consent when using bed rails. See under 'effective' for more information.

We observed staff of various disciplines ask questions relating to the risk of falls during interactions with patients. For example, therapy staff included questions about sleep patterns, hydration, pain levels when trying to stand, and general mobility.

Medical staff reviewed patients' medicines as part of the ward round; any potential changes were explored and explained to the patient. Staff told us pharmacy review audit had been conducted within the site at the end of 2019 into medicines that increased the risk of falls.

Staff knew about and dealt with any specific risk issues. Staff told us across the medical wards we visited, there should always be at least one member of staff in a patient bay at any time, particularly at night. This was due to most of the patients on the wards we visited being assessed as having a risk of falls.

During our inspection of the medical wards, we observed there was always at least one member of staff in each bay. The nurse and/ or health care assistant allocated to each bay did leave the bay at times for periods of 30 seconds, but we observed there were other staff such as medical staff, therapy staff or domestic staff present. We saw that on occasions, where there was one member of staff in the bay, they would pull the curtains around one bed to aid a patient or attend

to support a patient with a task. This meant the staff member was unable to see the other patients for this period. Therefore, staff were not always compliant with the policy referenced above which specifies they should be able to see patients when supervising them either in cohorts or on a one-to-one basis. In addition, the policy states that one staff member should supervise up to four patients. On some wards, there were more than four patients to a bay which meant that there was a risk that the staff member allocated, if on their own, may not be able to fully supervise every patient.

Staff understanding of supervising patients in a bay where at least one patient was a risk of falls was consistent across all medical wards visited. They reported that generally they were expected to remain in their allocated bay; however, if they were urgently needed in another bay they could leave to assist. This would leave their bay unattended for this time with unsupervised patients who may be at a higher risk of falling.

The trust had a central enhanced care team. Ward staff could submit a request to the team if they had a patient who required one-to-one support and they would provide staff, usually a health care assistant. Staff understanding of one-to-one supervision for patients with a very high risk of falling was varied as the assessment outcome did not give this as a specific category. Some staff saw the staff member undertaking the enhanced supervision as extra support for the whole bay. We were told that if the enhanced care team staffing was short and there were two patients in the same bay requiring one-to-one supervision, one healthcare assistant would be allocated to observe both patients. Therefore, the ratio was reduced to two (patients) to one (staff). This was also the case when two patients both needed one-to-one supervision in individual side rooms.

Ward staff were expected to undertake 'intentional rounding' which was checking on patients to ensure they were comfortable, had a drink, could reach items including the call bell and had no other immediate needs. Staff were expected to complete an entry in a specific form to demonstrate they had undertaken these checks. We saw completed intentional rounding sheets on ward four and eight which showed patients were generally checked on an hourly basis. On ward five, staff did not know where this paperwork was located, and it was not clear if intentional rounding was undertaken.

Ward four had introduced a 'falls pack' to be used if a patient fell. It contained a falls checklist, a sticker to attach to the patient's paper record and a Glasgow Coma Scale assessment tool to assess the patient's level of consciousness.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Medical staff assessed patients' mental health and made recommendations for psychological intervention where appropriate.

Staff shared key information to keep patients safe when handing over their care to others. Nursing and support staff took part in handovers and staff huddles to discuss each patients' needs and where staff needed to be placed in order to support patients.

Staff used a handover sheet to communicate information about each patient. This included a section on risk of falls. Staff recorded the equipment needs of each patient on this form; although it was not always identified if the patient had been assessed as a risk of falls.

Staff told us they knew which patients were at risk of falls in each area, however we saw there was no specific marker or indication either on the overall patient whiteboard, or by any patients' beds about whether each patient was a falls risk. This meant that it was not immediately obvious, particularly to any staff members not familiar with the ward.

Staff in the discharge lounge were aware of which patients had a heightened risk of falls and were familiar with the falls risk assessment. Upon receiving patients into the discharge lounge, staff undertook a brief risk assessment to identify any areas where they needed to support patients to prevent falls.

Records

Medical care (including older people's care)

Staff kept records of patients' care and treatment. Some nursing notes were not detailed enough to show nursing actions taken per shift. Staff did not always find it easy to locate specific information in the electronic records. Electronic records were stored securely and available to staff providing care. Staff on one ward were not aware of paper-based records.

We checked twelve patient records across wards four, five and eight. Records were stored securely. Patient records were mostly electronic but there were paper records on wards four and eight which included mental capacity assessments, respect forms and intentional rounding sheets. There were no paper records on ward five. Instead staff told us the same information was recorded electronically. Data from the trust post inspection reported that these paper records were present on ward five. Therefore, some staff were not aware of these parts of the patient paperwork such as intentional rounding sheets, sepsis pathway paperwork and patient passports.

We also reviewed 10 sets of discharge notes. Each set of notes was complete and showed staff had followed the trust policy to ensure patient safety prior to discharge. For example, all patients had had a pre-discharge COVID-19 test, evidence of conversations with the care home or location the patient was due to be discharged to and a discharge letter indicating the results of the pre-discharge COVID-19 test results.

Patient notes were not always comprehensive. Staff could not always access them easily on the electronic system. All patients eligible had regular falls assessments. Falls care plans were updated on the electronic system; however; care plans were difficult to navigate. Staff had not always documented information in enough detail to explain what care and treatment had been provided during that shift. In addition, some nursing documentation was not detailed enough to describe what elements of the patients' fall care plan had been carried out.

When patients transferred to a new ward, there were no delays in staff accessing their records.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents. Not all staff received lessons learned from outside of the direct ward area. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff on wards told us they were aware of falls incidents that occurred on their own ward, and there was variable knowledge about other serious incidents from other wards. Staff told us they did not always receive shared learning from falls around the trust. Staff told us that most updates about incidents involving falls were shared via email rather than through handovers/ safety huddles.

Staff did not consistently receive feedback from investigation of incidents, both internal and external to the service. Staff did not always meet to discuss the feedback and look at improvements to patient care. However, we acknowledge that at the time of the inspection the wards we inspected had only recently (last four to six weeks) resumed normal activity with permanent staffing since the start of the COVID-19 pandemic.

We requested data from the trust about shared learning. We received one email to staff on ward four about the importance of bay nursing and appropriate use of bedrails to prevent falls. We did not receive any other evidence from the other wards we visited.

Serious incidents and associated learning were not consistently shared within wards or across the trust. Some staff had a very limited knowledge of serious incidents which had happened in the hospital, and on the same ward. In addition, some staff we spoke with had very limited knowledge of any learning following serious incidents involving falls.

Therapy staff and some nursing staff were aware of new initiatives and learning following incidents. Some staff wore 'call don't fall' badges to advertise the importance of patients calling for help rather than trying to mobilise independently.

Medical care (including older people's care)

There was evidence that changes had been made to reduce the risk of falls. For example, a new falls pack had been implemented on ward four. Therapy staff told us of changes to the colour of mobility aids and equipment. More staff were aware of, and becoming trained in, a new inflatable device to support patients back up after a fall.

Is the service effective?

Competent staff

The service made sure staff were competent for their roles.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff told us they had undertaken training on falls management, dementia awareness and mental capacity whilst at the trust. Staff new to the trust completed this as part of induction training whereas longer serving staff undertook refresher training. Staff reported that the majority of this training was electronic; however, some modules were delivered face-to-face.

Staff reported that the training provided the information required to enable them to undertake their role. All staff we spoke with demonstrated knowledge of falls management including risk factors and ways to manage patients.

The clinical educators supported the learning and development needs of staff. Staff told us there was an emphasis on falls training, and that some face-to-face training had been delivered in 2020 in addition to the mandatory e-learning package.

We were not assured managers made sure staff attended team meetings or had access to full notes when they could not attend. We requested copies of team meeting minutes from the trust. We did not receive this data. However, staff told us that information about falls was included in team meeting agendas.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Consultants leading ward rounds took the opportunity to explain their clinical decision making to the junior doctors accompanying them.

Managers made sure staff received any specialist training for their role. A programme of training was underway specifically for staff to learn how to use a new piece of equipment to support patients back up following a fall.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. However, not all staff were aware of the support systems in place (falls group) to ensure effective care packages were received by patients.

Staff worked across health care disciplines and with other agencies when required to care for patients. During our inspection we observed teams of therapists comprised of occupational therapists and physiotherapists working with ward staff to provide treatment and support. The therapists collaborated on falls risk assessments with ward staff. They undertook activities and exercises to support patients, deliver tailored intervention plans and to prevent falls. The therapy staff also contributed to discharge planning for patients.

Due to the impact of COVID-19, staff were unable to refer patients to the chiropodist or podiatrist. This meant many patients, particularly those who had been an inpatient for some time, had long toe nails which could impact upon patients' falls risk. Staff said they managed this by encouraging patients to wear anti-slip socks if their sturdy slippers were becoming uncomfortable.

Upon discharge, staff communicated with care home staff to share information about the pre-discharge COVID-19 test results. Staff also advised care home staff to try to keep the patient isolated for a period of time in case of any incubation.

A trust falls group, which was made up of a multi-disciplinary team, worked across the trust to develop consistency in working practices across the trust, to review falls incidents and provide support and to conduct analysis of falls to promote learning. We saw evidence of minutes from these meetings. Not all staff we spoke with were familiar with the trust falls group or how the group could offer support.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We observed medical staff make arrangements for psychological support where appropriate.

Consent, Mental Capacity Act

Staff did not always undertake mental capacity assessments in line with the Mental Capacity Act. Staff did not consistently follow the Mental Capacity Act requirements when patients were deprived of their liberty. Where patients had capacity to consent to care and treatment, staff supported patients to make informed decisions about their care and treatment.

Where patients had the capacity to consent to decisions, staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw that healthcare assistants, nurses and therapy staff asked consent from patients before undertaking routine activities. This included actions such as taking blood pressure, covering patients with a blanket or piece of clothing, shutting curtains around the bed and supporting with therapy based activities.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, we saw examples where patients' capacity to consent to a specific task or act of care was not appropriately assessed. Not all staff considered Deprivation of Liberty Safeguards (DOLS) in line with best practice guidance.

One example was from the emergency department where staff had assessed a patient on arrival, however had applied a 'blanket approach' to the Mental Capacity Act (MCA) assessment, rather than this being relevant to a specific decision about care and/ or treatment as per the MCA requirements.

A second example demonstrated a lack of awareness about the need to assess mental capacity. Staff had assessed a patient as requiring bed-rails, which although was appropriate for the patient's safety, the patient was unlikely to be able to consent to. During this inpatient stay it had been identified via two separate MCA assessments that the patient did not have capacity to consent to other care and treatment decisions. Therefore, staff should have assessed if the patient had capacity to consent to bedrails, however they did not.

The use of bed-rails can be a deprivation of liberty if the patient lacks capacity to consent to this arrangement if using them would restrict a patient from easily leaving their bed. A DOLS application should be considered following an assessment which shows a patient does not have the capacity to consent to this potentially restrictive measure. Staff did not complete a DOLS application.

This concern was raised with the trust executive team after the inspection. The trust provided a response that stated the use of bedrails or having one-to-one support, in and of themselves, does not necessarily constitute a DOLS in the acute trust setting. However, some staff we spoke did understand that a DOLS application should be considered if a patient was unable to consent to bed rails due to a lack of capacity.

The same patient as the above example had also had a mental capacity assessment completed on the acute assessment unit for the decision of leaving the ward. The assessment decided the patient did not have capacity to consent to this, but no DOLS was considered or applied for despite restricting the patient from leaving the ward.

A further example was found whereby a patient (based upon their patient record entries) required their mental capacity to be assessed in order to consent to care and treatment relating to their risk of falls. This patient was not assessed in line with the MCA. When we asked staff about this, we were told that they had not yet 'got around' to completing this; but had already undertaken the care and treatment. This meant that they may have done so unlawfully as the patient potentially did not have mental capacity in order to consent to care and treatment.

Data from the trust showed results from an audit conducted on the mental capacity assessment conducted on 10 patients on the acute assessment centre from December 2019 to February 2020. This showed all assessment were fully completed and where necessary referrals were made to the enhanced care team.

We saw some good examples when patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. These were evidenced in the completion of 'Respect' forms which indicated decisions about cardio-pulmonary resuscitation or other lifesaving treatment at the end of a patients' life. Where patient's lacked capacity to consent to being allowed to pass away without resuscitation, capacity assessments were completed and involvement of family and the next of kin was sought where possible.

Staff told us medical staff were responsible for completing mental capacity assessments. Senior nurses completed DOLS application forms electronically.

Most staff received and kept up to date with training in the MCA and DOLS, although the trust training target was not always met. See 'mandatory training' for specific details.

Is the service responsive?

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We observed medical staff undertaking ward rounds. Medical staff explored mental health with patients and sought to understand patients' individual needs outside of their immediate physical health condition. However, we did notice that some conversations with or about the patient (such as between doctors at the bed) were loud and could easily be overheard, which may result in sensitive information being heard by other patients, despite curtains being pulled round the bed.

Staff clearly explained the process to patients due to be discharged. A patient we spoke with told us they understood the process and had all the relevant information. We observed a medical team providing discharge instructions to another patient. These were clear and set realistic time scales for what time the patient could leave the hospital. We observed some patients report that they wanted to return home despite not being due to be discharged. Staff working with the patients explained clearly why staying in the hospital a while longer would be more appropriate and ensured patients understood this.

We observed an occupational therapist (OT) and a physiotherapist undertaking an activity with a patient designed to assess mobility and contribute to the understanding of the patient's falls risk and potential needs on discharge. Both staff members demonstrated a person centred approach where the patient was at the heart of the conversation. The OT used a skilful open questioning style, which incorporated motivational interviewing techniques, to fully understand the patient's thoughts and feelings. This enabled the OT and physiotherapist to understand psychological barriers to engaging with therapy as well as the patient's physical needs. The two staff members allowed a suitable amount of time for this intervention; therefore, the patient was not rushed and was not put at more risk of falling as a result.

Medical care (including older people's care)

Staff supported patients with additional needs to be discharged to community inpatient hospitals, care homes or patients' own homes via the track and triage system. This meant delays to patient discharges were reduced, and patients still received appropriate assessments for how support needs could be met.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff had access to an equipment library to support patients with learning disabilities, and patients who communicated in ways other than speaking.

The trust wide enhanced care team who provided staff for one-to-one observation also included activity co-ordinators who could work with patients to provide distraction activities and reduce the risk of falls. However, due to COVID-19, these staff were not available to undertake this role for patients at the time of inspection. Members of the enhanced care team expressed concerns about not being able to make care for patients individualised and patient centred due to COVID-19 and staffing.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff had access to 'this is me'/ 'about me' patient passports which provided information about patients living with dementia, who were not able to communicate their preferences verbally.

Some wards were designed to meet the needs of patients living with dementia. Staff told us of some areas within the medicine core service which had been adapted such as having floor lighting to increase visibility at night and adding footprints to the floor to help patients safely mobilise.

Staff wrote some patient details on a whiteboard behind each patient's bed. This included the patient's preferred name. We saw that for most of the time, staff used the preferred name, but there were some occasions where staff did not do this.

Staff had arrangements for patients in the discharge lounge to be collected within two hours if being collected by patient transport services. However, staff told us that the two hour wait was being breached for some patients. Staff had access to an ambulance liaison worker who supported them to manage patient waits.

Is the service well-led?

Governance

There were governance processes to monitor falls. These had highlighted that some processes were not yet consistent across the trust. Due to COVID-19, staff had less opportunities to meet, discuss and learn from performance of the service. We found inconsistencies in the information that was cascaded to staff from senior leaders about incidents. Some senior staff were not fully aware of their accountabilities in line with managing serious incidents.

The trust monitored falls through mechanisms such as the safety thermometer, monthly audits and through the trust falls group. We saw a report presented at the patient safety committee which monitored falls which had occurred from January to April 2020. This report covered the number of falls and compared these with the past 12 months. The impact of COVID-19 was considered in line with this data. We saw the number of falls per bed days across Queen's Hospital Burton was over the trust target for ten of the months reviewed as of May 2020 (the trust target is 6 falls per month). Conversely, patient falls with harm at Queen's Hospital Burton ranged between 0 and 0.164 for the period from April 2019 to April 2020. This was below the trust target.

The data is further broken down here for total falls per 1000 bed days across the Queens Hospital Burton site. In April 2019, there were 6.38 falls, in May 2019 there were 6.68, in June 2019 there were 5.39 falls, in July 2019 there were 6.86, in August 2019 there were 7.26, in September 2019 there were 6.94, in October 2019 there were 6.75, in November 2019 there were 5.86, in December 2019 there were 7.14. From 2020, in January there were 6.52 falls, in February there were 5.69, in March there were 6.25 and in April there were 7.51.

Falls with harm (category three and over which means the harm was moderate, severe or death) per 1000 bed days at Queens Hospital Burton was as follows: April 2019 was 0.3 falls with harm, May 2019 was 0.15, June 2019 was 0.24, July 2019 was 0.46, August 2019 was 0.37, September 2019 was 0.16, October 2019 was 0.22, November 2019 was 0.22 and December 2019 was 0.07. For 2020 figures were as follows: January was 0, February was 0.075, March was 0.16 and April was 0.13.

The report discussed in paragraph two above and presented to the patient safety group in May 2020 highlighted some prevailing issues with falls with harm. These concerns included most falls being unwitnessed, confusion in two patients, most of the patients that fell were mobilising, therefore did not fall from their beds and the use of the inflatable device used to lift a patient after a fall was inconsistent. Bed rails were not found to be a significant factor.

It is acknowledged that the patient safety committee had not been able to meet as regularly through the height of the COVID-19 pandemic.

Data from the trust showed various areas of continued improvement and development to address inconsistency related to falls. These included a renewed focus on delivering falls training to staff at Queen's Hospital Burton to promote standardisation with Royal Derby Hospital, a twice yearly falls conference, a 'falls week' to be held once a year, the development of the above mentioned trust policy to promote consistency across the trust, and using posters to promote falls awareness in clinical areas.

We found inconsistencies in the information that was cascaded to staff from senior leaders. Staff working on wards told us managers told them about incidents that occurred on the ward; but generally, they did not hear about incidents from other wards or locations unless a very serious incident had occurred. Staff told us information about serious incidents tended to be shared via trust email. Additional sources of information included the trust chair's weekly blog and information cascaded by the matron for the ward.

Senior nurses on one ward told us information from the trust wide falls group was shared during team meetings and on a social media group messenger service. A member of the ward staffing team was on the falls group so shared information regularly. However, on other wards staff were not familiar with the falls group.

Some staff told us they felt that the Royal Derby Hospital had better falls management pathways and were eager to have a consistent approach across the trust which incorporated best practice to help prevent falls.

A trust wide policy about falls was available to all staff. The policy was in date and comprehensive. However, the enhanced nursing policy was out of date as of 2018.

Two senior nurses had a poor understanding of how to grade serious incidents involving falls or which falls would be reportable under The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) despite this being in the trust policy.

Staff had access to policies and procedures about infection prevention and control (IPC) during COVID-19 and were aware of these. Staff told us they were kept well informed of updates and alerts relating to IPC and had access to the site wide IPC team. Staff told us they were aware of discharge policies in relation to COVID-19.

A trust wide discharge team was responsible for the overall management of patient discharges. A policy was in place for discharging patients during COVID-19. Staff working in the discharge lounge were aware of this. The policy outlined requirements about testing for COVID-19 prior to leaving the hospital and ensuring results had been received.

Medical care (including older people's care)

Management of risks, issues and performance

Leaders used systems to review falls performance. Leaders identified and escalated relevant risks and identified actions in relation to falls to reduce their impact. However, many of these actions were outstanding at the time of our inspection. The trust gave inconsistent information about how staff should manage some risks.

We saw a trust wide falls action plan to improve patient safety in relation to falls. This comprised 18 specific actions including staff training and developing a trust wide policy. We saw that several actions had been delayed due to the COVID-19 pandemic. Through the action plan the trust had pinpointed concerns that we also found during our inspection. These included staff understanding of supervising high risk patients. One action was 'to review how staff undertake increased visibility and cohort bay care'. A meeting was organised for October 2019 to discuss this; however, it was unclear if this had gone ahead. The action was still 'red' (outstanding) on the action plan document.

Another action identified was to address bed heights as these had been observed as a contributing factor to some falls with harms. A poster campaign had been due to commence in 2020. However, we received information from the trust in relation with bed heights which was inconsistent with other data sent, and with what we saw on inspection. Therefore, we were not assured that equipment across the trust, or staff understanding around this was consistent at the point of inspection.

One action was to ensure 'falls heroes' were in place on each ward. We found that some wards did have falls champions, or individuals who were part of the falls team during our inspection. Therefore, we could see this action was being addressed.

An area of outstanding concern was that of compliance with falls training. The action plan identified this as requiring a recovery plan in July 2020 to address poor compliance, particularly in areas with a higher rate of falls.

The falls group were undertaking trust wide quality improvement initiatives; we saw evidence to show that medication reviews and lying/ standing blood pressure were being explored. Further data from the trust indicated staff on ward four had received 'on the job' training about standing and lying blood pressure' which was delivered by an advanced care practitioner.

On all medical wards we visited, there was a focus on bay nursing regardless of whether patients had specific falls risk. Staff told us this was to promote a culture of positive risk management.

Senior nurses told us they undertook spot checks of falls assessments, care plans, bed rails and falls checklists. Senior nurses conducted audits to monitor compliance to falls prevention standards.

We saw audits from the acute assessment ward for three weeks in January which showed all patients who required extra supervision were referred to the enhanced care team in line with the relevant trust policy, although on one occasion the patient was supervised by ward staff initially. However, it should be noted that we requested data specifically from wards four, five and eight rather than the acute assessment centre. We also requested data from August 2019 to January 2020 but only received data from January 2020. The trust told us formal monitoring required as per the enhanced nursing policy is not in place on these wards. The trust stated assurance has been received from the matrons that as part of their role they attend each of their wards regularly during the day and will assess all one-to-one supervision as part of their rounds, which included reviewing the patients' conditions, the appropriateness of the enhanced supervision and any other requirements.

Serious incidents involving falls with harm were discussed at the patient safety group meetings via information presented by the falls group. Areas for improvement and ideas to maintain consistency across the trust were also discussed.

Medical care (including older people's care)

Senior nurses told us they had addressed a risk involving the use of bed rails; previously staff tended to use bed rails with almost all patients believing this to be an appropriate way to keep patients safe. The senior nurses reported that time had been spent to promote the use of bed rails in a safe way, rather than as a blanket approach.

Areas for improvement

The trust must:

Ensure that staff adhere to the Mental Capacity Act 2005 and undertake timely assessments of patients' capacity to consent to care and treatment where it is likely a patient may lack capacity. Staff must also ensure they consider a Deprivation of Liberty Safeguard application where they are restricting a patient for non-urgent care or treatment. This is a breach of the Health and Social Care Act (2014) Regulation 11: Need for Consent

Ensure that staff are supervising patients at risk of falls and that learning following incidents is shared with all staff. Health and Social Care Act (2014) Regulation 12: Safe care and treatment

The trust should:

Consider that all staff wear personal protective equipment in line with the trust policy.

Consider that all patients can access their call bell.

Consider that staff receive consistent information regarding falls management.

Consider that it is visually apparent to any staff working on the ward which patients are at risk of falls.

Consider that mandatory training compliance meets the trust target.

Consider that policies and procedures are in date and regularly reviewed.

Consider that all senior nursing staff are supported to manage incident grading and reporting in line with trust policies and legislation.

Surgery

Requires improvement 

Summary of this service

Our overall rating of this service went down. We rated it as requires improvement because:

- Staff did not always undertake mental capacity assessments in line with the Mental Capacity Act. Staff did not consistently follow the Mental Capacity Act requirements when patients were deprived of their liberty.
- Not all patients at risk of falls were supervised according to the trust policy. It was not always obvious which patients were at a risk of falls without reviewing electronic records.
- Staff did not always follow risk assessment recommendations when using bedrails.
- Staff did not always keep detailed or contemporaneous records of patients' care and treatment. Some staff were not aware of paper based records.
- Not all staff were up to date with mandatory training in relation to falls management; although some staff were very new to the trust.
- The trust gave inconsistent information about how staff should manage some risks. There were governance processes to monitor falls, these had highlighted that some processes were not yet consistent across the trust. Due to COVID-19, staff had less opportunities to meet, discuss and learn from performance of the service.

However, we also found:

- The service controlled infection risk well in patient areas. Staff used equipment and control measures to protect patients, themselves and others from infection. The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well. However, we found one non-patient area of the ward was unclean.
- Electronic records were stored securely and available to staff providing care. Staff mostly completed and updated risk assessments for each patient.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team.
- Managers worked with staff to develop competency. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Where patients had capacity to consent to care and treatment, staff supported patients to make informed decisions about their care and treatment.
- The service was inclusive and mostly took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, we noted that staff had delayed a non urgent diagnostic test due to not obtaining an interpreter.
- Leaders used systems to review falls performance and were working towards effective governance procedures throughout the service in relation to falls. However, many actions were outstanding at the time of our inspection.

Is the service safe?

Requires improvement 

Surgery

Our rating of safe went down **. We rated it as** requires improvement **because:**

- Not all patients at risk of falls were supervised according to the trust policy. It was not always obvious which patients were at a risk of falls without reviewing electronic records.
- Not all staff were up to date with mandatory training in relation to falls management; although some staff were very new to the trust.
- Some staff were not wearing personal protective equipment in line with national guidance.
- Staff did not always follow risk assessment recommendations when using bedrails.
- Staff did not always keep detailed or contemporaneous records of patients' care and treatment. Some staff were not aware of paper based records.

However, we also found:

- The service controlled infection risk well in patient areas. Staff mostly used equipment and control measures to protect patients, themselves and others from infection.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, we found that one non-patient area of the ward was unclean.
- The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Electronic records were stored securely and available to staff providing care.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team.

Is the service effective?

Requires improvement 

Our rating of effective went down **. We rated it as** requires improvement **because:**

- Staff did not always undertake mental capacity assessments in line with the Mental Capacity Act.
- Staff did not consistently follow the Mental Capacity Act requirements when patients were deprived of their liberty.

However, we also found:

- Managers worked with staff to develop competency. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Where patients had capacity to consent to care and treatment, staff supported patients to make informed decisions about their care and treatment.

Is the service responsive?

Good 

Our rating of responsive stayed the same.

Surgery

- The service was inclusive and mostly took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, we noted that staff had delayed a non urgent diagnostic test due to not obtaining an interpreter.

Is the service well-led?

Good  

Our rating of well-led stayed the same.

- The trust gave inconsistent information about how staff should manage some risks. Processes were not yet consistent across the wards. Due to COVID-19, staff had less opportunities to meet, discuss and learn from performance of the service. We could see actions were in place to improve this.
- Leaders used systems to review falls performance. Leaders identified and escalated relevant risks and identified actions in relation to falls to reduce their impact. However, many of these actions were outstanding at the time of our inspection.
- Leaders were working towards effective governance procedures throughout the service in relation to falls.

Detailed findings from this inspection

Is the service safe?

Mandatory training

Not all staff were up to date with mandatory training in relation to falls management; although some staff were very new to the trust.

The trust provided mandatory training data for Ward 19, the surgical ward we inspected at the time of the inspection. We reviewed the training compliance for the following modules; consent, dementia awareness, falls prevention, patient handling, safeguarding level one and safeguarding level three. The trust data did not specify if the safeguarding training related to adults, children or both.

We noticed for ward 19, no staff were identified as being eligible for consent training, except for doctors and advanced clinical practitioners as this module outlines the principles and law of consent. Please see 'Effective' for details about gaining patients consent to care and treatment.

Staff compliance to training was above the trust target of 95% for patient handling (100% compliance) but below the trust target for dementia awareness, safeguarding level one and safeguarding level two (all 88%, 22 out of 25 staff) and falls prevention training (72%, 18 out of 25 staff). However, we acknowledged that some staff on this ward had started with the trust in June 2020.

Cleanliness, infection control and hygiene

One non-patient area of the ward was unclean. The service controlled infection risk well in patient areas.

The ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. However, the store room for equipment was not clean. We found this room was dirty, with a discarded wipe, debris on the floor, and

dust on some surfaces. One 'I am clean' sticker was in place on one piece of equipment, but no other stickers were noted. Therefore, it was not obvious if the other pieces of equipment, such as hoists, were ready for patient use. Part of the floor near the door was damaged which meant that this could not be cleaned effectively in line with infection prevention and control standards.

Staff cleaned equipment after patient contact. We observed one piece of equipment used by staff to support a patient to stand had paint peeling off. This meant that cleaning this piece of equipment would be less effective.

The remaining ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. We observed ward cleaning to take place and saw standard operating procedures about cleaning were in place.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff wore correct PPE on all wards we visited. We saw staff consistently discard PPE such as gloves and aprons after each patient contact and wash their hands before putting on fresh disposable PPE.

Staff had access to supplies of PPE which was plentiful across all areas we visited.

A patient told us they were impressed with the cleanliness and the environment of the ward.

Environment and equipment

The design and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

Ward 19, which was the only surgical ward we visited, was split with male patients at one end, and female patients at the other. Each end consisted of three bays. The male end had two side rooms and the female end had four side rooms. The layout of the ward was clutter free, spacious and open which enabled patients to walk around easily and more safely. Each end of the ward had a bay designated for patients at a high risk of falls, or who needed additional staff supervision. These were called the high visibility bays.

Most patients could reach call bells. We observed one patient whose call bell was out of reach; however, while we were present, the patient attracted the attention of staff who were nearby, was supported back into bed and the call bell relocated to be within reach. We sample checked one further bay and found all patients could reach their call bell.

Patients had access to suitable equipment to support their mobility needs. We spoke to a patient who told us they had been fitted for a walking aid to use on the ward to prepare for discharge. The occupational therapy team had organised suitable furniture to use at home to prevent future falls.

The trust had introduced some red walking aids, such as Zimmer frames, to enable patients with visual impairment or who may be confused to easily identify them. Other equipment to support walking, standing and sitting had red handles for the same purpose.

The trust used a piece of equipment to safely support patients who had fallen to the ground to enable them to return to bed after assessment. This was an inflatable mattress type piece of equipment which was designed to lift a person from lying on the floor, onto a bed or trolley or couch keeping them in a flat lying position. It was designed to move a fallen patient whilst preventing further pain or injury. Staff told us they had received information about a new protocol setting out that this was to be used with every patient who had a fall on the ward.

Staff told us they used pillows and/ or wedges to support patients to lie comfortably and safely in bed as appropriate.

Staff received training in how to safely use equipment. Staff told us much of this training was online. Champions (staff who had received extra training to support other staff) then assessed newly trained staff to check their competency. We observed staff support a patient transfer from the bedside chair to the bed using a specific piece of equipment. This was used as designed and enabled a safe transfer which reduced the risk of a fall.

Staff told us that since the onset of COVID-19, they no longer had access to crash mats to place on the floor beside patient beds where patients were assessed as a high risk of rolling out of bed. from the trust after the inspection stated that the trust no longer used crash mats as they no longer used hi-lo beds. However, this contradicted our findings on site. For example, we saw one patient on ward eight in a hi-lo bed. For example, we saw one patient on the ward in a hi-lo bed which was lowered to the floor. In addition, a trust wide training presentation for staff dated June 2020 referenced the use of hi-low beds and using additional mattresses next to the bed if hi-low beds were used at their lowest height. This indicated that the senior leadership team were not familiar with the equipment being used by staff on the wards.

A store room for equipment such as hoists, walking aids, and trolleys was cluttered. We saw two hoists, one had stickers in place showing it was in date for servicing. The other was due to be serviced in March 2020. An electric standing and transferring aid was in date for servicing.

Staff understood the importance of appropriate footwear. All patients we observed were wearing sturdy slippers or anti-slip socks to minimise the risk of a fall.

Staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough nursing and support staff to keep patients safe during the day of our inspection. Throughout our visit to the ward staffing levels were appropriate for the needs of the patients. Staff told us that on occasions, they would have to wait to deliver patient care if two staff were required, as their colleagues may have had to leave the ward to collect patients from theatre. Staff said the nurse in charge was available to support with this where possible to ensure patients received care and treatment more quickly.

Staff told us that the ward could be understaffed at night, and this was consistent with the rest of the hospital which was also short staffed. However, data from the trust showed the number of nurses exceeded the planned numbers for the four weeks prior to inspection.

Data showed that the planned day time shift hours for nurses were 2029 versus 2141.25 actual hours worked (105%). Planned hours for night time shifts were 1069.5 and actual hours were 1080.92 (101%).

However, the number of healthcare assistants did not meet the planned numbers.

For healthcare assistants and nursing associates, planned hours for daytime shifts were 1095.25 and actual hours were 956.5 (87%). For night shifts, planned hours were 701.5 versus actual hours of 688 (98%).

Staff, mostly health care assistants, from the trust wide enhanced care team were used to provide one-to-one supervision where patients were assessed as a high risk of falls. Staff told us that the enhanced care team was understaffed which meant staff were not always able to provide one-to-one continuous supervision as per the trust enhanced nursing policy. If there were no members of the enhanced care team available to support one-to-one supervision, senior ward staff requested bank or agency staff to provide this cover. When this request was not met, ward staff were used which staff told us impacted the overall staffing for the ward.

Assessing and responding to patient risk

Not all patients at risk of falls were supervised in line with the trust policy. It was not always obvious which patients were at a risk of falls without reviewing electronic records. Staff mostly completed and updated risk assessments for each patient and removed or minimised risks. However, staff did not always follow risk assessment recommendations when using bedrails.

Staff completed a multi-factorial risk assessment to identify each patient's risk of falls. This was undertaken on the patients' admission, then weekly thereafter. If the patient moved wards or had a change in presentation, the risk assessment was also re-completed. The assessment considered the patient's falls history, the number of medicines they were taking, the reason for admission and several other related factors. This assessment gave only two results; either the patient was at a risk of falling or the patient was not at a risk of falling. The assessment did not differentiate between patients who were at a low, medium or high risk of falls. Therefore, it was not clear at which point specific interventions to manage patients of a high risk of falls, such as one-to-one supervision, would be required. This assessment was recorded electronically and linked with the electronic patient care plan. During our inspection we saw this was difficult to navigate and understand which specific interventions should be in place for each patient depending on their individual risk factors. This meant that staff who were not familiar with the patients, such as bank or agency staff, may work with patients but not be fully aware of their needs in relation to falls prevention based on the electronic record.

Of the four patient records checked on the ward, one falls risk assessment was not completed fully as one risk factor was not reported upon. The other three were fully completed.

All staff we spoke with were aware of risk factors that contributed to falls including low blood pressure, inadequate footwear, mobility, confusion or delirium, medicines intake or substance misuse, long toenails, nutrition or hydration concerns, poor mobility, and vision impairment. Staff told us interventions that could be put in place to manage these risk factors and therefore reduce the risk of a patient having a fall. Examples given were supervising patients more closely, using suitable footwear, referring patients to therapy teams for support, and using mobility aids and equipment. Staff talked through how they would support patients who became dizzy or experienced a drop in blood pressure when standing. Our observations of patient care were consistent with this understanding.

Staff knew about and dealt with most risk issues. Staff undertook daily assessments for bed rail suitability where it was considered that bed rails may be useful. On the surgical ward we visited during the inspection, we saw that with one exception, bed rails were used following an appropriate assessment which indicated bedrails would support a patient to safely remain in bed rather than rolling out.

We observed one patient had bed rails up, but the latest assessment (completed on the 29 July, the day before our inspection) showed that bed rails were not appropriate. We asked why bed rails were in use given this assessment outcome and were told that staff had undertaken an assessment mentally but not recorded it in the patient record. This was despite other staff working supernumerary on the ward who could have supported whilst the assessment was re-completed. An email sent from the trust the day after the inspection (31 July) stated, 'a bedrail assessment was completed earlier today, and states bedrails not required'. This indicated that the bedrails were still not recommended. The email also reported that based on the latest Mental Capacity Act assessment, the patient did not have the mental capacity to consent to having bedrails up. The trust enhanced nursing policy clearly states that bedrails can be unsafe, particularly for patients who do not have the capacity to understand why the bed rails are there. Therefore, if staff were using these despite the assessment indicating they should not be used, the patient was put at risk of harm. In addition, no supplementary assessments had been completed to identify whether the patient had consented to the bed rails such as the Mental Capacity Act assessment.

The trust provided us with a copy of the enhanced nursing policy approved in December 2016 and due for review in 2018. Although this policy was out of date at the time of inspection, it contained information for staff to follow at this time about patient supervision and monitoring when at risk of harm such as from falls. A draft updated version was in place but had not yet been disseminated to staff. The policy reported that a risk matrix should be completed for all patients and the score recorded on care records to identify what level of supervision each patient required. During our inspection we did not see this assessment score recorded, rather staff used their own judgement to decide whether a patient was a low, moderate, high or extreme risk of harm.

During our inspection of the surgical ward, we observed there was always at least one member of staff in each bay. The nurse and/ or health care assistant allocated to the bays did leave the bay at times, but we observed that there was

other staff such as medical staff, therapy staff or domestic staff present. We saw that on two occasion staff working in the high visibility bays pulled the curtains around one bed to support a patient with a task. This meant the staff were unable to see the other patients for this period. Therefore, staff were not always compliant with the policy referenced above which specifies they should be able to see patients when supervising them either in cohorts or one a one-to-one basis. In addition, the policy states that one staff member should supervise up to four patients. On ward 19, there were more than four patient beds to some bays which meant that there was a risk that the staff member allocated, if on their own, may not be able to fully supervise every patient. In addition, the open plan layout of the bays meant that if staff were in a certain part of bay one, they could not physically see patients in bay two or three.

Staff understanding of supervising patients in a bay where at least one patient was a risk of falls was consistent across the surgical ward we visited. They reported that generally they were expected to remain in their allocated bay; however, if they were urgently needed in another bay they could leave to assist. This would leave their bay unattended for this time with unsupervised patients who may be at a higher risk of falling.

Ward staff were expected to undertake 'intentional rounding' which was checking on patients to ensure they were comfortable, had a drink, could reach items including the call bell and had no other immediate needs. Staff were expected to complete an entry in a specific form to demonstrate they had undertaken these checks. On ward 19, staff we asked did not know where this paperwork was located. We spoke with staff who told us they did check on patients for this purpose when they had time to do so. However, we did not see supporting documentation.

The trust had a central enhanced care team. Ward staff could submit a request to this team if they had a patient who required one-to-one support and they would provide staff, usually a health care assistant. Ward staff completed an enhanced care bundle when making referrals to this team. Staff understanding of one-to-one supervision for patients with a very high risk of falling was varied. Some staff saw the staff member undertaking the enhanced supervision as extra support for the whole bay. We were told that if the enhanced care team staffing was short and there were two patients in the same bay requiring one-to-one supervision, one healthcare assistant would be allocated to observe both patients. Therefore, the ratio was reduced to two (patients) to one (staff).

Staff shared key information to keep patients safe when handing over their care to others. Nursing and support staff took part in handovers and staff huddles to discuss each patients' needs and where staff needed to be placed in order to support patients. Staff told us they discussed which patients were at risk of falls and ensured that bank or agency staff were familiar with this information.

Shift changes and handovers included some necessary key information to keep patients safe. Staff used a handover sheet to communicate information about each patient. This included a section on risk of falls.

Therapy staff took part in board rounds held each weekday morning to share information with consultants, ward staff and other relevant professionals.

Records

Staff did not always keep detailed or contemporaneous records of patients' care and treatment. Electronic records were stored securely and available to staff providing care. Some staff were not aware of paper based records available on the ward.

Patient records were mostly stored in secure electronic form. We checked four electronic patient records on ward 19. Staff we asked told us there were no paper records available on ward 19 (as seen on other wards such as mental capacity assessments, respect forms or intentional rounding sheets). Instead staff told us the same information was recorded electronically. Data from the trust post inspection reported that these paper records were present on ward 19. Therefore, some staff were not aware of these parts of the patient paperwork.

Electronic patient notes were not always comprehensive or contemporaneous. All patients eligible had regular falls assessments, although one we reviewed was not complete. Care plans were updated; however, care plans were difficult

to navigate and did not always contain detailed information. Some nursing documentation was not detailed enough to describe what elements of the patients care plan had been carried out. Furthermore, as described above, staff told us that assessments were undertaken mentally, such as bed rails assessments, but not recorded until the end of the shift. This meant that if for some reason the nurse was unable to complete the record at the end of the shift, this information and decision making would not be recorded nor be shared with other staff.

Medical decisions and surgical treatment plans were clearly documented.

When patients transferred to a new ward, there were no delays in staff accessing their records.

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff told us of recent incidents including a fall, and an occasion where a patient had slipped trying to reach their call bell.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff working on wards told us that managers told them about incidents that occurred on the ward; and received email updates about incidents that had occurred on other wards in the trust.

Managers and senior nurses cascaded information and updates, including about falls, via email, through print outs kept in a folder and via a social media messenger group. We requested data to affirm this. The trust sent through information that had been disseminated to staff. We noted some of this was from over, or about, 12 months prior to our inspection which indicated the trust did not have more recent evidence to show us.

There was evidence that changes had been made as a result of feedback. Data from the trust showed various areas of continued improvement and development. See the well-led section for more detail.

Is the service effective?

Competent staff

Managers worked with staff to develop competency.

Staff were qualified and had the right skills to meet the needs of patients. Staff told us they had undertaken training on falls management, manual handling, dementia awareness and mental capacity whilst at the trust. Staff new to the trust completed this as part of induction training whereas longer serving staff undertook refresher training. Staff reported that the majority of this training was electronic; however, some modules were delivered face-to-face.

A nurse on the ward had completed ‘train the trainer’ training and was able to deliver ward based training to other staff.

Staff reported that the training provided the information required to enable them to undertake their role. All staff we spoke with demonstrated knowledge of falls management including risk factors and ways to manage patients.

We were not assured that managers made sure staff attended team meetings or had access to full notes when they could not attend. We requested copies of team meeting minutes from the trust. We did not receive this data.

Not all required staff who required training to use a specific piece of inflatable equipment designed to support patients back up after a fall had received this. On ward 19, four of 21 eligible staff had received the training. However, we acknowledge this training is face-to-face and therefore had been halted due to the COVID-19 pandemic. In addition, other staff such as therapy staff were trained to use this.

Surgery

Data from the trust included a training presentation dated June 2020. This presentation was comprehensive and included relevant information to support staff knowledge. However, we did not have data to confirm how many staff had received this training. Furthermore, some of the information in the training about the use of certain types of equipment (hi-lo beds and crash mats) conflicted with information from the trust which stated the trust do not use these.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Senior nurses told us that they had forged links with the educational service at the trust to develop an orthopaedic specific competency framework which was linked to national standards.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. During our inspection we observed teams of therapists comprised of occupational therapists and physiotherapists working with ward staff to provide treatment and support. The therapists collaborated on falls risk assessments with ward staff. They undertook activities and exercises to support patients, deliver tailored intervention plans and to prevent falls. The therapy staff also contributed to discharge planning for patients.

Staff told us that they worked well with therapy staff, and regularly shared information such as at board rounds or when the therapy teams attended the ward to work with patients.

Due to the impact of COVID-19, staff were unable to refer patients to the chiropodist or podiatrist. This meant that many patients, particularly those who had been an inpatient for some time, had long toe nails which could impact upon patients' falls risk. Staff said they managed this by encouraging patients to wear anti-slip socks if their sturdy slippers were becoming uncomfortable.

A trust falls group which was made up of a multi-disciplinary team worked across the trust to develop consistency in working practices across the trust, to review falls incidents and provide support and to conduct analysis of falls to promote learning.

Upon discharge, staff communicated with care home staff to share information about the pre-discharge COVID-19 test results. Staff also advised care home staff to try to keep the patient isolated for a period of time in case of any incubation.

Consent, Mental Capacity Act

Staff did not always undertake mental capacity assessments in line with the Mental Capacity Act. Staff did not consistently follow the Mental Capacity Act requirements when patients were deprived of their liberty. Where patients had capacity to consent to care and treatment, staff supported patients to make informed decisions about their care and treatment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Consent to surgical treatment was clearly documented in the four patient records we checked. Where appropriate consultants had completed a mental capacity assessment to identify if the patients had the capacity to consent to surgery.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, when patients could not give consent, staff did not always assess patients' capacity in line with the MCA. Staff did not always consider Deprivation of Liberty Safeguards in line with the MCA. We saw an example where patients' capacity to consent to a specific task or act of care was not appropriately assessed.

Staff had raised the bedrails for a patient despite the most recent recorded assessment (completed on the 29th July) not recommending these. We asked staff who said the staff would have done the assessment mentally but had not yet documented it, despite their being other staff working supernumerary on the ward who could have supported whilst the assessment was re-completed. This patient had been assessed as not having capacity to consent to other decisions about care and treatment, therefore it is reasonable to expect staff to undertake an assessment for capacity to consent to having bedrails if these were indicated. There was no evidence of a capacity assessment having been undertaken. Furthermore, there was no consideration of whether the bed rails were in the best interest for the patient, and whether they would deprive the patient of their liberty and restrict them. There was no evidence of a Deprivation of Liberty Safeguards (DOLS) application. However, senior nurses were aware that this should have been considered.

This concern was raised with the trust executive team after the inspection. The trust provided a response that stated the use of bedrails or having one-to-one support, in and of themselves, does not necessarily constitute a DOLS in the acute trust setting. However, we did not see that DOLS were considered on an individual case basis.

Is the service responsive?

Meeting people's individual needs

The service was inclusive and mostly took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, staff had delayed a non urgent diagnostic test due to not obtaining an interpreter.

Staff wrote some patient details on a whiteboard behind each patient's bed. This included the patient's preferred name.

Staff gave us examples of how they worked with patients as individuals and considered different patients' needs and preferences. During our inspection we saw staff help patients to either return to bed or sit in their chair depending on the patients' preference, rather than leave the patient in the same place for the day.

Staff supported patients with additional needs to be discharged to community inpatient hospitals, care homes or patients' own homes via the track and triage system. This meant delays to patient discharges were reduced, and patients still received appropriate assessments for how support needs could be met.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to an equipment library to support patients with learning disabilities, and patients who communicated in ways other than speaking.

The trust wide enhanced care team who provided staff for one-to-one observation also included activity co-ordinators who could work with patients to provide distraction activities and reduce the risk of falls. However, due to COVID-19, these staff were not available to undertake this role for patients at the time of inspection.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff had access to 'this is me'/ 'about me' patient passports which provided information about patients with dementia who were not able to communicate their preferences verbally.

Staff told us the trust had introduced a new screening tool to identify signs of dementia. Staff were awaiting training for this at the time of inspection.

The ward had some design features to meet the needs of patients living with dementia. It was spacious and light.

Managers did not always ensure interpreters were available at key times. Staff had access to interpreters to support patients who did not speak English but did not always use these. During COVID-19, routine visits from family and friends had been stopped. Staff identified one patient who did not speak English, and as a result staff found it difficult to have routine conversations about care, and to assess mental capacity after surgery to consent to routine care and treatment.

As a result, staff arranged that a family member who provided care outside of hospital could attend the ward each day as a carer to provide support to the patient. While this was helpful to the patient, on the day of our inspection we found that staff chose to delay a scan because the carer had gone home. Staff re-arranged the scan for the following day when the carer was due to return. Following our inspection, the trust informed us that the scan was non urgent. However, use of family members in place of interpreters is not considered best practice; particularly to ensure that medical information is explained accurately, and informed consent is therefore obtained.

Is the service well-led?

Governance

There were governance processes to monitor falls. These had highlighted that some processes were not yet consistent across the trust. Due to COVID-19, staff had less opportunities to meet, discuss and learn from performance of the service.

The trust monitored falls through mechanisms such as the safety thermometer, monthly audits and through the trust falls group. We saw a report presented at the patient safety committee which monitored falls date from January to April 2020. This report covered the number of falls and compared these with the past 12 months. The impact of COVID-19 was considered in line with this data. We saw the number of falls per bed days across Queen's Hospital Burton was over the trust target for ten of the months reviewed as of May 2020 (the trust target is 6 falls per month). Conversely, patient falls with harm at Queen's Hospital Burton ranged between 0 and 0.164 for the period from April 2019 to May 2020. This was below the trust target.

The data is further broken down here for total falls per 1000 bed days across the Queens Hospital Burton site. In April 2019, there were 6.38 falls, in May 2019 there were 6.68, in June 2019 there were 5.39 falls, in July 2019 there were 6.86, in August 2019 there were 7.26, in September 2019 there were 6.94, in October 2019 there were 6.75, in November 2019 there were 5.86, in December 2019 there were 7.14. From 2020, in January there were 6.52 falls, in February there were 5.69, in March there were 6.25 and in April there were 7.51.

Falls with harm (category three and over which means the harm was moderate, severe or death) per 1000 bed days at Queens Hospital Burton was as follows: April 2019 was 0.3 falls with harm, May 2019 was 0.15, June 2019 was 0.24, July 2019 was 0.46, August 2019 was 0.37, September 2019 was 0.16, October 2019 was 0.22, November 2019 was 0.22 and December 2019 was 0.07. For 2020 figures were as follows: January was 0, February was 0.075, March was 0.16 and April was 0.13.

The report discussed in paragraph two above and presented to the patient safety group in May 2020 highlighted some prevailing issues with falls with harm. These concerns included most falls being unwitnessed, confusion in two patients, most of the patients that fell were mobilising, therefore did not fall from their beds and the use of the inflatable device used to lift a patient after a fall was inconsistent with trust guidance. Bed rails were not found to be a significant factor.

We acknowledged that the patient safety committee had not been able to meet as regularly through the height of the COVID-19 pandemic.

Data from the trust showed various areas of continued improvement and development to address inconsistency related to falls. These included a renewed focus on delivering falls training to staff at Queen's Hospital Burton to promote standardisation with Royal Derby Hospital, a twice yearly falls conference, a 'falls week' to be held once a year, the development of the above mentioned trust policy to promote consistency across the trust, and using posters to promote falls awareness in clinical areas.

Staff working on wards told us that managers told them about incidents that occurred on the ward; and received email updates about incidents that had occurred on other wards in the trust.

Managers and senior nurses cascaded information and updates, including about falls, via email, through print outs kept in a folder and via a social media messenger group.

Staff told us they felt supported by their colleagues and senior staff on the ward.

A trust wide policy about falls was available to all staff. The policy was in date and comprehensive. However, the enhanced nursing policy was out of date as of 2018.

Staff had access to policies and procedures about infection prevention and control (IPC) during COVID-19 and were aware of these. Staff told us they were kept well informed of updates and alerts relating to IPC and had access to the site wide IPC team. Staff told us they were aware of discharge policies in relation to COVID-19.

A trust wide discharge team was responsible for the overall management of patient discharges. A policy was in place for discharging patients during COVID-19. The discharge co-ordinator working on ward 19 was aware of this. The policy outlined requirements about testing for COVID-19 prior to leaving the hospital and ensuring results had been received.

Management of risks, issues and performance

Leaders used systems to review falls performance. Leaders identified and escalated relevant risks and identified actions in relation to falls to reduce their impact. However, many of these actions were outstanding at the time of our inspection. The trust gave inconsistent information about how staff should manage some risks.

We saw a trust wide falls action plan to improve patient safety in relation to falls. This comprised 18 specific actions including staff training, developing a trust wide policy. We saw that several actions had been delayed due the COVID-19 pandemic. Through the action plan the trust had pinpointed concerns that we also found during our inspection. These included staff understanding of supervising high risk patients. One action was 'to review how staff undertake increased visibility and cohort bay care'. A meeting was organised for October 2019 to discuss this; however, it was unclear if this had gone ahead. The action was still 'red' (outstanding) on the action plan document.

Another action identified was to address bed heights as these had been observed as a contributing factor to some falls with harms. A poster campaign had been due to commence in 2020. However, we received information from the trust in relation with bed heights which was inconsistent with other data sent, and with what we saw on inspection. Therefore, we were not assured that equipment across the trust, or staff understanding around this was consistent at the point of inspection.

One action was to ensure 'falls heroes' were in place on each ward. We found that some wards did have falls champions, or individuals who were part of the falls team during our inspection. Therefore, we could see this action was being addressed.

An area identified by the trust as a concern was that of compliance with falls training. The action plan identified this as requiring a recovery plan in July 2020 to address poor compliance, particularly in areas with a higher rate of falls.

The enhanced nursing policy stated that matrons or divisional nurse directors should audit compliance with the policy in relation to patients who require enhanced supervision. We requested copies of audits for ward 19 from the trust. The trust told us that formal monitoring required was not in place on these wards. The trust stated assurance has been received from the matrons that as part of their role they attend each of their wards regularly during the day and will assess all one-to-one supervision as part of their rounds, which included reviewing the patients' conditions, the appropriateness of the enhanced supervision and any other requirements.

Serious incidents involving falls with harm were discussed at the patient safety group meetings via information presented by the falls group. Areas for improvement and ideas to maintain consistency across the trust were also discussed.

Surgery

The falls group were undertaking trust wide quality improvement initiatives; we saw evidence to show that medication reviews and lying/ standing blood pressure were being explored.

Senior nurses told us they were undertaking training in root cause analysis to support investigations into incidents.

Areas for improvement

The trust must:

Ensure that staff are supervising patients at risk of falls. Health and Social Care Act (2014) Regulation 12: Safe care and treatment

Ensure that staff adhere to the Mental Capacity Act 2005 and undertake timely assessments of patients' capacity to consent to care and treatment where it is likely a patient may lack capacity. Staff must also ensure they consider a Deprivation of Liberty Safeguard application where they are restricting a patient for non-urgent care or treatment. This is a breach of the Health and Social Care Act (2014) Regulation 11: Need for Consent

The trust should:

Consider that that staff adhere to recommendations following bedrail assessments for patients that are not able to consent.

Consider that the store room area, and any identified equipment, is cleaned and repaired in line with infection prevention and control principles.

Consider that all falls risk assessments are fully completed.

Consider that staff receive consistent information regarding falls management.

Consider that it is visually apparent to any staff working on the ward which patients are at risk of falls.

Consider that mandatory training compliance meets the trust target.

Consider that all policies and procedures are in date and regularly reviewed.

Consider that assessment decisions are recorded contemporaneously.

Our inspection team

The CQC inspection team at Queens Hospital Burton comprised of two CQC Inspectors and a specialist advisor with experience in falls investigations. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

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