Royal Shrewsbury Hospital

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Ratings

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

Summary of findings

Overall summary of services at Royal Shrewsbury Hospital

Inadequate 

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

During this inspection we used our focused inspection methodology. We did not cover all key lines of enquiry. We have rated the service as inadequate and have taken enforcement action as a result of this inspection to promote patient safety. Our enforcement action included the use of our urgent enforcement powers where we placed conditions on the trust's registration in relation to the assessment and management of risk, care planning, and incident management. We also served two warning notices to the trust requiring them to make improvements in the following areas; end of life care staffing, end of life staff competencies, end of life governance systems and the way the staff support patients in line with their personal preferences and individual needs.

- Staff did not always complete risk assessments for each patient in a prompt manner. Action was not always taken to remove or minimise risks to patient's health and wellbeing. Safety incidents were not always managed well to protect patients from avoidable harm.
- Staff did not always keep detailed records of patients' individual needs, preferences and the care and treatment provided. Person centred care was not always planned for to ensure patient's individual care needs and preferences were met.
- The end of life care service did not ensure that all staff were competent for their roles, placing patients at risk of receiving unsafe and inconsistent care. This had not improved since the last inspection.
- The services did not always provide care and treatment based on national guidance and evidence-based practice.
- Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. At times, patients continued to be unlawfully restricted.
- Leaders did not demonstrate that they had the skills and abilities to run the services. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.
- The culture of the services was not centred on the needs and experience of patients.
- The services did not operate effective governance systems to improve the quality of services. Leaders had not effectively implemented new ways of working to drive improvement and they were not always available to provide day to day support to staff. This had not improved since the last inspection.
- Staff did not keep detailed records of patients' preferences for care and treatment provided at the end of their life. This had not improved since the last inspection.
- The end of life care service did not have the 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. This had not improved since the last inspection and was identified at our inspection in 2018.
- Specialist palliative care services were not available on site seven days a week to support timely patient care. This had not improved since the last inspection.

Summary of findings

- It was possible that palliative and end of life care patients could be missed due to the lack of systems to identify patients. This had not improved since the last inspection.

Medical care (including older people's care)

Inadequate ↓

Summary of this service

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

- Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up-to-date. However, records were stored securely and easily available to all staff providing care.
- The service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.
- The service did not ensure that all staff were competent for their roles.
- The trust's policies and procedures were not always based on the most recent national guidance.
- Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. At times, patients continued to be unlawfully restricted.
- The service did not always consider the individual needs and preferences of patients.
- Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff. The culture of the service was not centred on the needs and experience of patients.
- The service did not operate effective governance systems to improve the quality of services.

However:

- Staff on ward 32, identified and acted upon patients at risk of deterioration.

Is the service safe?

Inadequate ↓

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

- Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed. This impacted upon the safe care patients received. However, staff on ward 32, identified and acted upon patients at risk of deterioration.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up-to-date. This meant that care staff could not easily identify care to be given to individual patients. However, records were stored securely and easily available to all staff providing care.

Medical care (including older people's care)

- Staff did not always report incidents and the service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Inadequate ↓

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

- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- The service did not ensure that all staff were competent for their roles.
- Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. At times, patients continued to be unlawfully restricted.

Is the service responsive?

Inadequate ↓

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

- The service did not always take into account the individual needs and preferences of patients.

Is the service well-led?

Inadequate ↓

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

- Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.
- The culture of the service was not centred on the needs and experience of patients.
- The service did not operate effective governance systems to improve the quality of services.

Detailed findings from this inspection

Is the service safe?

Assessing and responding to patient risk

Medical care (including older people's care)

Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed. This impacted upon the safe care patients received. However, staff on ward 32, identified and acted upon patients at risk of deterioration.

Staff should complete risk assessments for each patient on admission, using a recognised tool, but did not always review or complete these regularly. In all 15 records we looked at we saw incomplete risk assessments. Including, falls risk assessments, use of bed rails and skin assessments.

The service continued not to provide assurance that patients were protected from the risk of developing pressure ulcers. Patients with high or very high Waterlow scores, a nationally recognised practice tool was used to assess the risk of developing pressure damage, did not always have further care plans to show what was in place to prevent pressure damage. We saw evidence of this in 11 out of the 15 patient records we looked at. This meant that patients with pressure damage were not appropriately assessed or afforded the correct level of care to minimise the risk of further damage.

We saw that two of the patient records showed poor nutritional intake. There was no nutritional risk assessment recorded to show the risk of malnutrition had been assessed and planned for. We also did not see any heights or weights recorded for these patients. Malnutrition and obesity are risk factors in developing pressure damage to skin. We did not see any height or weights recorded for these patients.

The service continued not to complete holistic and effective falls assessments and falls mitigation plans in line with national guidance which placed patients at serious risk of harm. We saw in one set of patient records that the falls risk assessment on admission stated 'no history of falls'. However, the same patient had been discharged four days before. We saw from the previous admission the falls risk assessment showed the patient did have a history of falls, and one of the reasons for that admission was a fall at home. In another set of patient records the patient was admitted after a fall and a urinary tract infection. The records stated that the patient had fallen at home, however there was no further information given or mitigating risk factors in place.

In a further eight out of 15 patient records we looked at all falls risk assessments were not fully completed, meaning that patients were at risk of potential harm from falling and this had not been identified.

Staff did not manage the risks associated with bed rails which placed people at risk of serious harm. The trusts' own risk assessment for use of bedrails stated that if a patient was restless or confused, staff should not use bedrails. We saw evidence of unsafe and inappropriate use of bedrails on a confused patient. For example, the risk assessment form stated that the patient was restless, confused and was living with dementia. The patient had bedrails in place and there was nothing documented in the risk assessment saying they needed them, except they were confused. This is not a reason to use bedrails.

On ward 32 we saw that there were stickers in place in patients records to highlight to the medical team that the patient was deteriorating. These stickers were red and enabled the nurses to follow a clear check list of when to alert the medical team to assess the patient. Ward 32 had been a pilot for this alerting system, however, they were not recognised or used on the other two medical wards we visited. The plan was to embed this system across the other inpatient wards.

Nursing staff displayed a lack of accountability with regards to their role in assessing and managing patient risk. For example, when we asked a staff member why a patient was not being nursed on a specialist mattress despite having a high risk of developing pressure damage, they could not answer the question. We reframed this question and ask what would trigger a specialist mattress being requested they told us that if the patient developed a pressure ulcer then they would request a specialist mattress. They did not acknowledge that this was potentially too late for the patient as harm to the patient had already been caused.

Records

Medical care (including older people's care)

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up-to-date. This meant that care staff could not easily identify care to be given to individual patients. However, records were stored securely and easily available to all staff providing care.

The service predominately used paper based recording systems. Patients general nursing and medical notes were paper based, and observations were conducted using an electronic device.

Assessments contained in the nursing documentation were not always completed to ascertain patients' individual needs. From the 15 patient records we reviewed, 11 of the nursing documentations contained significant gaps. The gaps included important areas of care, such as; vision, hearing, bowel and urological patterns and history and social history. All of which is essential to provide safe, effective and responsive care. This meant patients were at risk of receiving care and treatment that did not reflect their needs.

The service continued not to provide assurance that the information needed to guide staff in how to provide safe and consistent care was available. The generic care plan options within the nursing documentation were not highlighted to show the care each patient required. None of the 10 patient generic care plans we reviewed highlighted the care and treatment each of these patients required to meet their needs. This meant patients were at risk of receiving unsafe and inconsistent care that was not in line with their individual needs. We reviewed the patient records for a patient who was nil by mouth (NBM) on ward 32. They had a percutaneous endoscopic gastrostomy (PEG) feeding tube in place. Mouth care was inconsistently recorded. Some days it appeared to be on the fluid balance chart, other days showed no evidence of mouth care recorded.

Fluid balance charts were not accurately completed on all five sets of notes reviewed on ward 32. In one set of records the patient was admitted with dehydration. The patient was then considered to be fluid overloaded and a diuretic was prescribed and given. The medical staff had documented in the records that the 'fluid balance was incorrectly recorded', therefore, was not fluid overloaded.

We could not be assured that patients were being supported to change their position at a frequency that was in line with their individual needs and best practice guidance. Patients with high or very high risk of developing pressure damage did not always have their repositioning chart completed accurately, or comprehensively. Mitigations were not always recorded. There was a risk that patients would develop skin damage while awaiting repositioning. Due to the patients' actual position not being recorded before and after repositioning, for example 'back' or 'right side'. There was a risk that patients spent most of their time in the same position.

Daily top to toe skin assessments should be recorded for all patients who received assistance with personal care from staff. However, these assessments were not completed accurately so did not effectively record the condition of individual patient's skin. We saw inconsistences in how the documentation was completed. Some staff stated 'skin intact' and did not complete the whole record, some staff would not physically assess the skin themselves if the patient told them they had no issues. Where wounds were present, there was no further documentation about the size or depth of wound or if any dressing were being used. This meant that a nurse could not assess if patient's skin was improving or deteriorating.

We reviewed in one patient record that the patient had developed a pressure ulcer. The patient was on standard mattress with a Waterlow score of 21 and three red areas marked on their body map on the top to toe assessment. The following day, four red areas were marked on the body map. However, an air mattress was not provided until three days after. This was reported as an incident as a grade 2 pressure ulcer. This was recorded in the patients nursing assessment booklet. However, there was no reference to the grade 2 pressure ulcer on the patient body map. There was no body map completed for two of the days. Changes of patient position were rarely and irregularly recorded on their repositioning chart.

Medical care (including older people's care)

We reviewed the records of a confused patient on ward 22. The falls risk assessment stated that they were of high risk of falls and not able to mobilise independently. They did not have a top to toe assessment carried out but did have a documented Waterlow score of 19. However, there was no record of what mattress this patient was being nursed on.

A patient was admitted with Waterlow score of 10 to ward 32. However, the same patient had been discharged four days ago, and that assessment showed the patient had a Waterlow score of 23. Furthermore, the notes recorded 'pressure areas intact', but the body map indicated a 'red and blanching' area on the buttocks. This patient was obese, with numerous pre-existing medical conditions and was a high risk for developing a pressure ulcer. We discussed this with the ward manager who was confident the bed and mattress were suitable for the patient. However, they requested that the nurse looking after the patient reassessed the Waterlow score.

We found that where catheters were used, catheter care plans or passports were not in place to record when the catheter should be reviewed or changed. We reviewed the records of one patient on ward 21R and one on 22 who had urinary catheters. The reason for the catheter and the review date were left blank. This meant the information needed to guide staff on how to provide safe catheter care was not always available, placing patients at risk of unsafe care.

We found that there was not always an accurate account of the care that patients had received. Records as highlighted above contradicted each other for example, care plans, Top to Toe records and repositioning patients contradicted care that should be given to individual patients. This meant that patients were at risk of harm due to lack of staff knowledge and understanding of the individual patient's needs. For example, we saw in two patient records where falls assessments had been completed to say that a lying and standing blood pressures had been done. However, when we checked the observations this was not the case.

The staff did not always follow the trust and their professional bodies best practice guidance for record keeping. It was not always clear which nursing or medical staff had assessed and treated patients, as records did not always contain a clear record of the staff members name and role who had completed the written entry. Dates and times of written entries were also not consistently recorded to demonstrate an accurate timeline of patients' care.

Records were stored securely. Patient records were stored in locked trolleys in all the ward areas we visited.

Incidents

Staff did not always report incidents and the service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

This inspection was triggered by a never event that had occurred on a medical ward at the Royal Shrewsbury Hospital (RSH) site. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Following the never event, the trust told us that a patient safety alert had been sent to staff to highlight the never event and share learning to prevent a similar incident from reoccurring. We asked 14 members of staff across wards 21R, 22 and 32, if they were aware of the recent never event. Only four of the 14 members of staff were aware of the incident and the learning from it, two of these were the ward manager and the nurse in charge. This meant that the systems in place to manage safety incidents were not always effective.

At RSH, they held a training session in relation to the incident on a piece of equipment, this took place in the canteen. However, if staff were not on duty that day, they did not receive this training.

Medical care (including older people's care)

We found that staff did not identify the safety concerns we identified as incidents. Therefore, these incidents were not reported. For example, the lack of appropriate risk assessment and management plans, the poor record keeping and shortages of staff to provide one to one care for patients at risk of falling were not reported as incidents. This meant learning from these incidents could not take place to improve safety and care.

Is the service effective?

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

We found that the trust's falls and pressure ulcer policy was not based on the most up to date national guidance. The trust's, 'Slips, Trips and Falls Policy' which was last updated and approved in February 2020 continued to reference the National Institute for Health and Care Excellence (NICE) falls guidance for older people from 2004. This guidance has been replaced and the latest NICE guidance recommends that falls prediction tools are no longer used to identify if older people are at risk of falling. These prediction tools should have been replaced with multifactorial assessments for all patients who are 65 and over. We found that this new guidance was not being followed to ensure all patients aged 65 and over had a multifactorial falls assessment and intervention plan.

The trust's, 'Pressure Ulcer Prevention and Management Policy' which was last updated in February 2019 following the February 2019 NICE update. However, we found that this policy did not reflect the need to consider all pressure ulcers as potential serious incidents dependent upon individual circumstances. The policy referred to only reporting grade three and four pressure ulcers as serious incidents. The policy does not reflect that a grade two pressure ulcer could meet the serious incident reporting criteria under certain circumstances. This meant NHS England serious incident guidance was not accurately incorporated into the policy.

Competent staff

The service did not ensure that all staff were competent for their roles.

We were not assured that all staff had completed training in the use of bariatric beds at the time of the serious incident. Out of the nursing staff we spoke with, three of the 14 nurses and healthcare assistants had received formal training prior to the serious incident. The remaining 11 staff told us they learnt from their colleagues, or just 'learnt when the bed was on the ward'. The trust could not provide training records for the compliance of staff. These were held by the external bed company. After the serious incident the trust had arranged training for staff in the use of bariatric beds and mattresses.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. At times, patients continued to be unlawfully restricted.

Staff did not always follow the requirements of the Mental Capacity Act 2005 (MCA) to ensure decisions about care and treatment were made in patient's best interests when they were unable to make these decisions for themselves. This showed no improvement from the last inspection in 2019.

Managers did not monitor the use of Deprivation of Liberty Safeguards (DoLS). Staff continued to inform us they had not completed training in MCA and DoLS. In all the patient records we checked, staff had not carried out daily reassessments

for patients who lacked capacity. On-going assessment of patients with fluctuating capacity, such as when this was likely to improve with medical treatment was not always carried out. There were additional restrictions using close observations, bedrails, physical and chemical restraint. These patients required the protection of the DoLS and early urgent authorisation should have been made.

Managers did not always monitor how well the service followed the Mental Capacity Act and made changes to practice when necessary. When patients could not give consent, it was not always clear that staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Is the service responsive?

Meeting people's individual needs

The service did not always take into account the individual needs and preferences of patients.

Patients continued to be at risk of receiving care and treatment that was not person centred. Patient assessments to ascertain care preferences and individual needs were not completed. None of the 15 care assessment and care plans we reviewed contained any record of patients care preferences or individual care needs. For example, the care records for five patients who were confused or living with dementia contained no information about their likes, interests, what they liked to be called, or what food or drink they normally ate at home.

We reviewed the records of a patient on ward 22, who was admitted with a urinary tract infection and was living with dementia. There was a form from the residential home outlining what they were and were not able to do for themselves. This was not addressed in their care plans on the ward. The form stated that they wake at night to go to the bathroom, the nursing staff documented in their care plans, that the patient did not have the need to frequently go to the toilet. In the residential home they would mobilise with a frame and one carer. In the nursing care plans, it stated that they were not mobile and there was no frame to use and they had the bed rails in place.

Is the service well-led?

Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.

The medical wards were overseen by a matron and each was led by a ward manager. Ward 32 had three junior sisters who provided support to both the ward manager and to junior staff. The manager delegated some tasks to the junior sisters, for example, auditing, training, and staff appraisals. Each junior sister had areas of responsibility specific to them.

An experienced nurse was appointed each day to be the nurse in charge (NIC). Their responsibilities included allocating the daily work, answering telephone enquiries and assisting with patient admissions, transfers and discharges. We were told that the NIC was not normally allocated a group of patients to look after, however this was dependent upon the number of staff working, and the number of patients on the ward at the time. During our inspection, the NIC did not have any patients allocated.

Leaders did not always manage the priorities and the issues the service faced. For example, we found concerns with incomplete patient care plans and risk assessments. Service leaders had not acted to improve patient care records despite carrying out documentation audits and monthly notes audits. This issue was raised as a concern by CQC during the previous inspection.

We were told documentation audits were carried out monthly and that results were used to improve performance. However, each of the patients' notes we reviewed had omissions on care plans and risk assessments which had not been addressed by leaders in the service. We discussed our findings with senior ward staff, and we were told they had found similar issues previously, particularly with regards to accurate recording of fluid balance charts and patient repositioning charts. Despite this, staff did not accurately record this information and we were not assured that the leaders in the service had the necessary skills to challenge bad practice, or to engage with staff in order to make improvements.

We were told that that Covid-19 had increased the workload for staff on the ward, and that caring for infections was often difficult. However, during our inspection there were as many staff as there was patients on ward 32, there were eight members of staff and six patients. We observed that staff would have had time to complete accurate and comprehensive patient care records.

Culture

The culture of the service was not centred on the needs and experience of patients.

We saw that the lack of appropriate risk assessment and care planning had been normalised on the wards we inspected. Staff at all levels did not recognise that this failure to adequately assess and plan patient care led to practice which was unsafe and uncaring. Staff were unable to articulate the impact of inappropriate care documentation, for example around skin damage from pressure, and how this impacted on patients receiving the correct level of care, staff being able to assess whether any interventions were being given or the impact this was having on a patient's health.

We found that there was a normalisation of poor care and a complacency around professional curiosity and challenge. For example, nursing staff and allied healthcare professionals did not challenge medical staff when decisions were made about care or did not contain evidence of patient's individual preferences. Furthermore, we found that staff did not challenge one another when they witnessed poor care or documentation of that care. For example, where body maps, used to highlight areas of pressure damage, were marked with a simple x on the area affected and there was no documentation as to what this meant staff did not challenge their colleagues to complete the document appropriately so that care give n could be assessed for impact.

We interviewed two professional specialist nursing staff about their area of expertise. When we described the concerns, which included those patients at risk of falling who were being managed within their bed to prevent them from falling, we were told that they accepted this was common practice and they were aware this was happening. They acknowledged this was poor nursing care but there was no plan in place to address this. Furthermore, we discussed our concerns around care given to prevent tissue damage from pressure with a senior nurse. We were told that nursing staff used their professional judgement when planning care to relieve tissue damage. However, we found that there was little professional judgement used by ward staff who solely used the chart on the types of mattress to be used to identify when patients required a specialist mattress. Therefore, for a patient who was mobile within the bed a higher-grade pressure relieving mattress was not required unless they developed a grade 3 pressure ulcer. Our discussions with nursing staff supported this position.

Governance

The service did not operate effective governance systems to improve the quality of services.

We saw that there was a lack of learning from previous incidents. We spoke to a specialist nurse about the trust's improvement plan following a prosecution of the trust by the Health and Safety Executive in 2017 in regards to patient falls. We were told that the trust had already provided different beds and therefore there was no improvement plan. Prior to inspecting the trust we reviewed a number of incident reported about falls and found the same issues reported

as had been highlighted in this summary judgement, i.e. lack of staffing poor care risk assessments, and documentation of care and poor management of patients at risk of falling. On this inspection we found the same issues on the medical wards were still evident in the care that was given to patients at risk of falling. This compounded our concerns that the trust failed to learn from significant incidents.

Ward managers completed a programme of internal audit to monitor quality and operational processes. Audits included, for example, documentation, environment, cleanliness, falls, person centred care, and medicine audits. We were told these were reviewed at clinical speciality meetings and divisional quality boards, and that the audits were completed electronically which all staff had access to. However, the audits had not resulted in improvements to the quality of patient risk assessments for pressure ulcers, person centred care, or documentation, in the records we looked at. Issues we had identified in previous inspections had not been rectified. We were not therefore assured that the leaders in the service had identified these key issues in performance and safety.

The service did not have timely and effective actions in place in their improvement plan to appropriately address all previous inspection findings and concerns. For example, our 2018 and 2019 inspections identified a lack of person-centred care planning. The trusts' 2020 action plan recorded an associated action to address this which stated, 'patients must have their individual needs assessed and planned for'. The action plan recorded that this was to be addressed by, 'implementing new nursing documentation to include individual needs. This action was to be completed by June 2020. Other than introducing new documentation, no other interim action, such as; staff training, care record audits etc had been planned or introduced to address the significant and ongoing shortfalls in patient centred care planning whilst awaiting new documentation to be rolled out. Following our inspection, the trust told us they had reintroduced their exemplar ward reviews (the trust's own quality and safety assessment tool). The use of the exemplar ward reviews had been paused due to inspection activity and the Covid 19 pandemic. We will assess if this has been an effective governance tool at our next inspection

Areas for improvement

The trust must:

Ensure effective systems are in place to assess and mitigate individual patient safety risks. This includes, but is not limited to; bed rails, falls, pressure care, pre-existing medical conditions and behaviours that challenge. Regulation 12 (1)(2)(a) and (b): Safe care and treatment.

Ensure complete and accurate records are maintained that describe the care and treatment delivered to individual patients. Regulation 17 (1)(2)(c): Good governance

Ensure effective systems are in place to share learning from incidents to prevent further incidents from occurring. Regulation 17 (1)(2)(b): Good governance

Ensure staff are competent in their roles. This includes but is not limited to the use of; equipment to meet individual needs and care planning. Regulation 12 (1)(2)(c) and (e): Safe care and treatment.

Ensure that when patients are unable to make decisions about their care and treatment, the requirements of the Mental Capacity Act 2005 are consistently followed. Regulation 11 (1)(2) and (3): Need for consent.

Ensure that people are only deprived of their liberty in a lawful manner, by following the deprivation of Liberty Safeguards. Regulation 13(5) Safeguarding service users from abuse and improper treatment.

Medical care (including older people's care)

Ensure that staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and preferences, including needs relevant to the formulation of care plans and mental health needs where appropriate. Regulation 9 (1)(a)(b)(c) and (3)(a)(b): Person-centred care.

Ensure effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance.

End of life care

Inadequate ↓

Summary of this service

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

- Staff did not keep detailed records of patients' preferences for care and treatment provided at the end of their life. This had not improved since the last inspection.
- The service did not ensure that all staff were competent for their roles, placing patients at risk of receiving unsafe and inconsistent care. This had not improved since the last inspection.
- Staff did not consistently support patients who lacked capacity to make their own decisions.
- The service did not have 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. This had not improved since the last inspection and was identified at our inspection in 2018.
- Specialist palliative care services were not available on site seven days a week to support timely patient care. This had not improved since the last inspection.
- It was possible that palliative and end of life care patients could be missed due to the lack of systems to identify patients. This had not improved since the last inspection.
- Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced.
- The culture of the service was not centred on the needs and experience of patients.
- The service did not operate effective governance systems to improve the quality of services. Leaders had not effectively implemented new ways of working to drive improvement and they were not always available to provide day to day support to staff. This had not improved since the last inspection.

Is the service safe?

Inadequate ↓

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

- Although the service had enough suitable equipment to help them care for patients it was unclear if these were available in a timely manner.
- Staff did not consistently complete and update risk assessments for each patient. The service did not consistently identify patients in the last days or hours of their life.
- The service did not have enough nursing and support staff to keep patients safe.
- The service did not have enough medical 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 did not always have a consultant on call during evenings and weekends. Staff could telephone a local hospice for advice and support. However, there was no formalised agreement for this in place.

End of life care

- Staff did not keep detailed records of patients' care and treatment in respect of resuscitation. Records were not clear or up-to-date.
- Staff did not always report incidents and the service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Inadequate 

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

- Staff did not routinely monitor the effectiveness of care and treatment. They did not use the findings to make improvements and achieve good outcomes for patients. The service had not been accredited under relevant clinical accreditation schemes. The service did not audit pain and symptom control or time taken for fast track audits.
- The service did not ensure that all staff were competent for their roles.
- Key services were not available seven days a week to support timely patient care.
- Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. This had not improved since the last inspection.

Is the service caring?

- Staff did not consistently treat patients with compassion and kindness, respect their privacy and dignity, and take account of their individual needs.
- Staff did not consistently support and involve patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service well-led?

Inadequate 

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

- Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced.
- The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy had not been ratified by the board at the time of our inspection.
- The culture of the service was not centred on the needs and experience of patients.
- The service did not operate effective governance systems to improve the quality of services.
- Leaders and teams did not use systems to manage performance effectively. They had not identified and escalated all relevant risks and issues nor had they identified actions to reduce their impact.

End of life care

Detailed findings from this inspection

Is the service safe?

At the time of our inspection, there was no dedicated end of life care ward at the trust. Patients in receipt of end of life care were cared for throughout the hospital. Prior to 05 June 2020 the trust did have an end of life care ward but this had been closed due to the realignment of the wards to accommodate Covid 19 arrangements.

Environment and equipment

Although the service had enough suitable equipment to help to care for patients it was unclear if these were available in a timely manner.

The service used specialist syringe pumps for patients who required a continuous infusion of medication to help control their symptoms. These met the current requirements of the Medicines and Healthcare Regulatory Agency (MHRA) for end of life care patients who required continuous symptom management. On review of the incidents reported this year, we noted three relating to the delay in providing patents with a syringe pump for medications to be given, resulting in potential delay in pain relieving medication being given.

Assessing and responding to patient risk

Staff did not consistently complete and update risk assessments for each patient. The service did not consistently identify patients in the last days or hours of their life.

The service did not have a system in place to identify where patients at the end of their life were throughout the hospital. This meant those approaching the last hours and days of their life may not be identified by the multidisciplinary or end of life care team.

We discussed how patients wishes were reflected on the end of life care pathway with the specialist team. We were told that this aspect of the ReSPECT form was not well completed and that this information would be captured on the end of life care plan for patients at the end of their life. However, minutes of meetings reviewed demonstrated that the use of this tool was only 30%.

We found that patients end of life care preferences had not always been recorded in accordance with local and national guidance. Two of the five ReSPECT forms we reviewed contained no record of the own patient's end of life care preferences. In the other three the patients lacked capacity, but there was minimal documentation of the conversation with the patient's family.

Nurse staffing

The service did not have enough nursing and support staff to keep patients safe.

End of life care was provided by an end of life care team. The service also had a specialist palliative care team. These teams worked throughout the Princess Royal Hospital and the Royal Shrewsbury Hospital.

The end of life care team consisted of a whole time equivalent (WTE) end of life care facilitator and three end of life care nurses who provided the equivalent of 1.8 (WTE) staff. The end of life team covered across both sites from 8.30am to 4.30pm Monday to Friday. Out of hours cover was provide through an on-call service at a local hospice.

The specialist palliative care team consisted of four clinical nurse specialists (CNS) who provided the equivalent of 3.8 WTE cover for the specialist palliative care team. The four nurses worked across both sites and provided a service Monday to Friday from 9am to 5pm.

End of life care

Nurse staffing levels did not meet the minimum standards of the National Institute of Health and Care Excellence (NICE) which states access to specialist palliative care should be made available seven days per week.

There were no specific handovers from the specialist palliative care team (SPCT) and the end of life care team to the nursing and medical staff.

At our inspection in November 2019 we found breaches in staffing levels in line with guidance from the National Institute of Health and Care Excellence. However, the trust's most recent action plan, received 23 July 2020 did not contain updates on the action the service had taken to improve nursing staff levels within the team.

Medical staffing

The service did not have enough medical 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 did not always have a consultant on call during evenings and weekends.

One palliative medicine consultant was employed by a local hospice who provided the equivalent of 0.8 whole time equivalent (WTE) cover at the trust. This did not meet the minimum standards of the Royal College of Physicians (RCP), which requires 1.4 WTE consultants based on the size of the trust and level of patient activity. At the time of our previous inspection, in November 2019, the trust had started the recruitment process to employ a new consultant to provide an extra 0.5 WTE across both sites. This post had still not been recruited despite this being advertised twice, and last advertised in February 2020 just prior to the National lockdown.

Records

Staff did not keep detailed records of patients' care and treatment in respect of resuscitation. Records were not clear or up-to-date.

Two of five patient records we reviewed showed that the patients were not for resuscitation. This means that the patient was not for cardiopulmonary resuscitation which is an emergency lifesaving procedure which is performed on people whose heart has stopped. There was no documented discussion with the patients regarding their treatment plan if they were to deteriorate and need resuscitation and/or critical care intervention in the notes we reviewed. We showed one of the records to the ward manager on ward 32, to see if it was documented elsewhere, but they agreed, there was no documentation to show discussions had been held with the patient. Therefore, we could not be assured that those patients knew they were not going to be resuscitated if needed.

Incidents

Staff did not always report incidents and the service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring . Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

At our previous inspection in November 2019 we were told that since the 2018 inspection the trust had introduced a category for end of life care incidents. This meant relevant staff could identify, track and analyse incidents relating to end of life and palliative care patients. We asked the trust for incidents relating to end of life care from 01 January 2020 to the present date, as on our review we could not see a category for end of life care. The trust sent us details of 14 incidents which had been reviewed as end of life care incidents. We reviewed the incidents submitted to national databases by the hospital and found between 1 January and 20 July 2020, that there were at least 34 incidents reported involving patients at the end of their life. Eight of these related to poor management of pain, medication or access to syringe drivers. Five incidents related to patients not being transferred to the correct ward and five related to pressure area care. The remaining 16 incidents related to poor care planning.

End of life care

On review of the spreadsheet sent by the trust all but one of the incidents were incidents that we had reviewed. The spreadsheet had a description of the incident, immediate action taken, details of the investigation and lessons learnt. However, the lessons learnt pertained only to the individual member of staff or patient and the wider lessons had not been identified except in one case where the policy for admission to ward 35 had been amended. Four incidents involved delays in transferring the patient and three related to no support being available to staff. All incidents were graded as low or no harm despite the results being recorded as; delay in diagnosis and treatment, ongoing pain, disruption to the service and no injury, harm or adverse outcome.

This meant the hospital was not monitoring all incidents that occurred within this service. The service was also failing to share the lessons learnt in these incidents with the wider hospital team. The end of life care safety meeting minutes from February 2020 demonstrated that an incident had been discussed at the meeting. However, this was not one on the spreadsheet by the trust. The minutes also highlighted there were issues with staff using the end of life care category when reporting incidents.

Is the service effective?

Evidence-based care and treatment

Staff did not routinely monitor the effectiveness of care and treatment. They did not use the findings to make improvements and achieved good outcomes for patients. The service had not been accredited under relevant clinical accreditation schemes. The service did not audit pain and symptom control or time taken for fast track audits.

Managers and staff did not carry out a comprehensive programme of repeated audits to check improvement over time. On reviewing the Quality Improvement Plan sent to the CQC in July 2020 the action to establish an audit plan for this service was rated as being in progress.

At our inspection in November 2019 we found that the service recorded patient information onto an electronic database, including the patients preferred place of death, however, the service did not audit this information. We noted from the results of audits that the trust sampled whether the patients preferred place of death was recorded and how many patients achieved this. However, there was no record of whether all patients achieved their preferred place of care and the time taken to move patients into their preferred place of care. The lack of cohesion between the specialist palliative care team and the end of life care team did not help the movement of patients and information between these two services.

At our inspection in November 2019 we found that the service did not audit pain or symptom control for end of life care patients, this meant the service was unable to tell if pain and symptom control was effective or if improvements could be made for end of life care patients in their care. This had not improved since our last inspection. We received one complaint where a patient had not been prescribed adequate pain relief to meet their needs. The staff did not review the effectiveness of the medication or discuss the medication this patient was on at home and provide this whilst in hospital. This patient was not offered regular analgesia nor was a syringe pump offered to manage their pain. This had not improved since our last inspection.

At our inspection in November 2019 we found that the service did not have a comprehensive audit programme, which meant that care was not improved as a result. This had not improved since our last inspection. We reviewed the minutes of the End of Life Steering Group for February 2020 and saw that the trust planned to audit mouthcare, care after death and use of syringe pumps. We did not receive any data from the trust on these audits despite asking for audits in relation to the end of life care service.

The trust confirmed that they had undertaken a “Spot Check on End of Life Care plan”. This audit was undertaken in June 2020. A previous audit was carried out in January 2020 but this does not appear to have been discussed at the

End of life care

February End of Life Safety and Governance Meeting. The audit reviewed five sets of notes at this location. Due to the way in which the report is collated it was not possible to identify all of the results at this location. The results demonstrated that all patients were on the end of life care plan. Most patients had a ReSPECT form completed prior to being commenced on an End of Life Care Pathway. All patients reviewed did not have a documented conversation around their preferences for end of life care. However, there was a documented discussion with the family or relatives of the patient in all records. Three sets of records did not have a preferred place of care recorded. None of the five records had all sections of the end of life care plan completed. This was worse than the previous audit. The action to be taken following the audit was to improve compliance through training. However, at the point at which this report was written, March 2020, compliance with the eLearning package was 50%.

The latest data from the National Audit for Care at the End of Life (NACEL) was published on 9 July 2020. The audit presents results against seven themes. For six themes, performance is calculated by aggregating scores from a series of questions and converted to a score out of 10 for each theme. In comparison against the national average the Royal Shrewsbury Hospital seem to perform relatively poorly in three of the four measures they have results for. These include communication with the dying patient, communication with family and others and individualised care planning. In the remaining theme workforce/specialist palliative care performance was towards the national average.

We reviewed the minutes of the End of Life Steering Group for February 2020 and found the local audit in the use of the service's end of life care plan had increased from 15% to 30%. A further audit was planned around the time of our inspection. This meant that only three out of ten patients who were receiving end of life care had a plan to follow specifically for them at the end of their life.

Following the inspection, the trust sent us this audit. This showed that 23% of patients there was uncertainty if the patient would die during this admission and active treatment was continued. Of the notes reviewed only 29% had the palliative care team involved in their care and 18% had the end of life care team involved in their care. This was despite 97% of patients being recognised by staff that they may die and only 12% of patients having had a conversation with staff about the fact that they may die. The audit results reflected that conversations about the patients death was more likely to be had with the patients family or relatives (94%). The audit demonstrates that 32% of patients were placed on the end of life care plan. Only one patient was involved in planning their care at the end of their life. 44% of records reviewed demonstrated that neither the patient nor the family were involved in planning the care at the end of a patient's life. This means that the patient was not involved in their care at the end of their life and did not have the support of specialist nurses.

This audit demonstrates that anticipatory medications were prescribed for around 75% of patients to support their potential discomfort. However, a syringe pump, to assist consistent pain management, was only used in 32% of patients. The preferred place of care was discussed with 41% of patients and carers. In most (86%) cases this was discussed with the patients carer. In 58% of patients the preferred place of care was not achieved. The free text of this audit highlights that staff are not recognising patients at the end of their life in a timely manner, once recognised there were delays in an end of life pathway being commenced. We were not sent an action plan following this audit to improve the recognition of patients at the end of their lives or in ensuring that they received appropriate care. It is therefore unclear how the trust is planning to improve the care given to patients at the end of their life.

The trust undertook an audit of the completion of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form in January 2020. This demonstrated that:

- The patients' personal preferences for care were only documented 62% of the time.
- Over 30% of clinicians did not give recommendations for emergency care and most did not provide clinical guidance on appropriate interventions.
- In all cases the clinician identified if cardiopulmonary resuscitation (CPR) was recommended and in all but one case the patients were not recommended for CPR.

End of life care

- Over 90% of ReSPECT forms had section 6 completed but less than half had documented who was involved in the discussion.
- Where a patient was recorded not to have capacity only one patient out of 67 had the appropriate legal documentation to support this decision. .

Whilst this audit made recommendations for improvement this was not presented at the Quality Operational Committee until 16 June 2020. However, in discussion with senior executives the outcomes of this audit were known. This meant that we were not assured that actions and learning from audits were implemented in a timely manner to ensure improvements to practice could be made.

Following our inspection, the trust sent CQC an Clinical Audit action plan, 24 July 2020, which centred on training and raising awareness of the ReSPECT form and the audit. Eight actions were colour coded green but rated as recommendation never actioned. Three actions were marked as amber, action in progress and one action coloured red and rated as recommendation agreed but not yet actioned. It was difficult to see how the trust had implemented this action plan given that some completion dates were marked as the end of July 2020.

The trust told us that training in the use of the ReSPECT form was incorporated into resuscitation training. Current compliance for this training which is a two year rolling compliance figure is 79%. However, the ReSPECT form was only introduced at the end of October 2019. Therefore, this figure would include staff where this training had not included information on the ReSPECT form. The trust introduced an eLearning package which 257 staff had completed. Furthermore, the lead resuscitation officer had trained 29 people. The end of life care team were not involved the provision of this training.

The trust undertook a bereavement survey between April 2019 and March 2020. This demonstrated that relatives had had discussions with staff about the fact that their loved one may die. However, only 45% of relatives were involved in planning the care with the care staff during the last days of their loved ones life. Most relatives (80%) felt that their loved one had received appropriate care. The survey identified some areas requiring improvement, including discussion with the patient about where they wanted to die (45%), use of the end of life plan (57%) and provision of the information leaflet (23%). Relatives of the patients felt that care was appropriate, but this is not reflective of the evidence in the case notes audited by the trust.

Competent staff

The service did not ensure that all staff were competent for their roles.

Staff told us they had not received effective training to enable them to use Recommended Summary Plans for Emergency Care and Treatment (ReSPECT) forms in line with national and local guidance. ReSPECT forms are designed to provide a summary of a patient's end of life care wishes which includes resuscitation decisions. ReSPECT forms had been rolled out at the trust in 2019 but no effective and measurable training programme was in place. This meant the trust could not assure themselves or us of how many staff had been trained and were competent in the use of ReSPECT documentation.

Following our inspection, the trust shared with us the training numbers for use of syringe pumps up to the date of our inspection. A syringe pump is a small infusion device that is used to administer a continuous infusion of medication from a syringe. This demonstrated that only one ward area had a compliance of over 90%. The lowest score was 0% on ward 32R which is a respiratory ward. Most ward areas had a compliance rate of less than 50%. This meant there was a risk that patients may not receive their medication through a syringe driver in a timely manner as not enough staff had been assessed as competent in many of the wards throughout the hospital.

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Following our inspection, the trust sent CQC an action plan for the training of staff in using the syringe pumps. This highlighted that it would be incorporated into further intravenous study days, reports on training would be made available for the ward managers and train the trainer sessions would continue. The action plan stated that the trust were looking in to providing an eLearning package for staff. It was not clear who had approved this plan.

Seven-day services

Key services were not available seven days a week to support timely patient care.

When we inspected the trust in 2018, we told the trust they should ensure it provided and meets the recommendations for a minimum service level for access to specialist palliative care as recommended by the National Institute of Health and Care Excellence (NICE), which is 9am to 5pm, seven-days per week.

We re-inspected the service in November 2019 and found the hours of the service had not increased. This meant the trust was not providing a minimum service level for access to specialist palliative care as recommended by NICE. The trust still only provided nursing staff to offer a specialist palliative care service Monday to Friday from 9am to 5pm. Again, we told the trust it should provide its specialist palliative care services seven days a week in line with NICE guidance.

Following a review of the service in July 2020, we found the service operated between 8.30 and 5pm Monday to Friday with on call support from a local hospice. This lack of seven-day provision was included on the services risk register. The minutes of the end of life care steering group, February 2020, reported that there was no update. However, data was being gathered to support a business case. This had not improved since our previous inspection.

On reviewing the Quality Improvement plan sent to the CQC in July 2020 the action to establish a service level agreement with the hospice was still in progress

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. This had not improved since the last inspection.

We found that mental capacity assessments were not always completed in accordance with the Mental Capacity Act (MCA) when patients were unable to make decisions about their end of life care needs. We reviewed five ReSPECT forms. Two of these forms related to patients who staff documented did not have capacity to make decisions about their care and treatment. However, the records for these two patients contained no evidence to show mental capacity assessments had been completed. This meant that the requirements of the MCA had not been followed to evidence these patients did not have the capacity to make these decisions and that these decisions were made in their best interests.

We discussed how the medical staff assess a patients' mental capacity when completing the ReSPECT form with the specialist nurse. We were told that there was a separate form to complete. We reviewed eight patients, two of which were deemed to lack capacity to make decisions. However, a formal mental capacity assessment had not been undertaken for either of these patients. The specialist nurse told us that even when a patient had capacity to make a decision about their care it was good practice to discuss the proposed care with the family in order to ascertain what the patient was like at home or if they had any concerns about the decision of the patient.

Is the service caring?

Compassionate care

Staff did not consistently treat patients with compassion and kindness, respect their privacy and dignity, and take account of their individual needs.

End of life care

In a recent Healthwatch end of life report January 2020 there were six negative comments about staffing, one neutral comment and four positive comments. Those that were positive included that the staff were kind, showed compassion and dignity to their relatives. Those that were negative highlighted a lack of privacy and dignity to their relatives.

Understanding and involvement of patients and those close to them

Staff did not consistently support and involve patients, families and carers to understand their condition and make decisions about their care and treatment.

In the recent Healthwatch end of life report January 2020 there were five negative comments about communication and three positive comments. Those that were negative highlighted a lack of communication about what to expect during the last days and hours of their relatives lives.

We received a complaint about the care at the Royal Shrewsbury Hospital which highlighted the fact that the patient had not felt listened to and that staff were slow to recognise that they were at the end of their life. The carer also felt that the communication between the hospital and themselves was very poor.

Is the service well-led?

Leadership

Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced.

End of life care and specialist palliative care services sat within the division of scheduled care. Scheduled care was led by a medical director, an assistant chief operating officer and a head of nursing.

At board level, the chief nurse and the chair were the executive leads for the end of life care and specialist palliative care services throughout the trust. However, the chief nurse had only just assumed this responsibility and was not aware that the end of life care strategy was in draft format. The end of life care team was directly managed by the matron for oncology and haematology. On reviewing the most up to date Quality Improvement Plan (QIP) for the trust, the action update in respect of leadership stated that a non-executive director was required to lead this service. Yet this action is marked as completed on the QIP.

The executive lead for end of life care did not attend the steering group meetings prior to June 2020 and end of life care was not discussed at the trust's board meetings.

Leaders did not effectively introduce new ways of working. For example, the roll out and implementation of the ReSPECT form was not robust which led to staff not having an adequate understanding of this process. Staff told us that despite there being an implementation plan and policy, no resource was allocated for education. Doctors we spoke with told us they received some training through their grand rounds where they reflected on clinical cases. Junior doctors also told us that they had received training at induction. However, they were unaware that they had to complete a separate mental capacity assessment form. Nurses told us they had received minimal training and did not feel confident in the use of the ReSPECT forms. We were told of the use of the Chatterbox newsletter to promote its introduction. However, nursing staff stated that the respect form had just appeared in the patients notes one day.

Vision and strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy had not been ratified by the board at the time of our inspection.

End of life care

We were told at our previous inspection that there was an end of life care strategy. We asked the trust for their end of life care strategy and action plan, however, the strategy was still in draft form and there was no action plan. Staff told us the strategy had been developed approximately 18 months prior to our inspection. This had been taken to the Clinical Governance Executive Group in November 2019 to be endorsed. Minutes of the meeting concurred that an end of life care strategy should be implemented in early 2020 and discussed at the next board meeting. However, at the time of our inspection, the strategy had not been discussed at any board meeting, it had not been endorsed, approved by the board or implemented.

There were two teams of specialist staff who were responsible to provide specialist knowledge and experience to general staff. The end of life care team supported people who had days or hours of life left. The specialist palliative care that helped staff in the management of patients who had weeks or months of their life left. It was not clear how information form either team was passed between the teams to improve the patient and carer's experience of a dying patient.

Culture

The culture of the service was not centred on the needs and experience of patients.

We found that there was a deference to medical staff held by nursing staff. We spoke with a specialist lead about how patient wishes were captured in respect of resuscitation. We were told that patients cannot demand treatment and that it was the doctor's decision if a patient should be resuscitated. When discussing the poor completion of ceilings of care area on the ReSPECT form we were told that it was everyone's responsibility to complete this. When asked if there was an action plan to address this failing, we were told that during the COVID pandemic that awareness had been highlighted but that the specialist nursing time is limited. This raised concerns around the culture of service. This highlighted the acceptance of poor care and the poor understanding of the ReSPECT form's purpose.

We saw in the patient records we reviewed and the audits from the trust demonstrated that there was a lack of communication between staff and patient who was dying. Whilst we appreciate that this may not always be possible in the last days and hours of a patients life there was an apparent reluctance to do this. However, most families or carers had been spoken to about the fact that the patient was dying and what their wishes were during this time. When we spoke to the lead nurse we were told that they believed that even when a patient had capacity to make decisions staff should talk to the family to see if they have any concerns or what the patient is usually like. This meant that whilst the family were involved in discussions there was little acknowledgement that the patient may have different wishes to those of their family. There was a culture of not involving the patient in decisions made about their care.

Governance

The service did not operate effective governance systems to improve the quality of services.

Minutes of the Clinical Governance Executive Group in November 2019 highlighted that there was a lack of medical staff compliance to complete the end of life care pathway. Patients had been either late to start on the end of life care pathway or they had not commenced this at all. The minutes state that "End of life care is not consistent across all areas and it is important that everyone delivers. The action pertaining to these comments was to check what training had been delivered and report back. However, in subsequent minutes there was no further update. This was corroborated in the Healthwatch End of Life Report, January 2020, which stated that people had a poor experience until the care staff at the hospital recognised that the patient was at the end of their life when the experience improved.

We reviewed the minutes of the End of Life Steering Group for December 2019 and February 2020 and found that whilst there was some improvement between December 2019 and February 2020 on the training of medical staff to address the medical staff completion of the end of life care pathway and the ReSPECT forms there was little traction on other issues discussed at these meetings.

End of life care

The service continued to not take timely and effective action in response to quality and safety audits where concerns or poor compliance was identified. For example, effective action had not been taken in response to an audit of ReSPECT documentation completed in January 2020. At the time of our inspection, six months had lapsed, and the senior leadership team had been aware of the results of the ReSPECT audit but had taken no action to make improvements in its application.

Action plans sent by the trust following our inspection were not clear as to whether action had been taken or embedded. The Clinical Audit Action plan updated 21 July 2020 had items listed as being complete but had a rating of 4 which meant recommendation never actioned. This document also had actions such as roll out of training which had commenced but had not been fully embedded having only started in June or July. The Quality Improvement Plan, updated in July 2020, stated that there was a requirement for a non-executive end of life care lead but the chair told us it was him at our inspection in June 2020.

The trust told us that they had had nine complaints since January 2020 in respect of the end of life care service of which six related to the Royal Shrewsbury Hospital. The themes from these complaints included poor communication with the family, delays in medication and poor communication around resuscitation

Managing risks, issues and performance

Leaders and teams did not use systems to manage performance effectively. They had not identified and escalated all relevant risks and issues nor had they identified actions to reduce their impact.

The current risk register for end of life care had three risks on it. These were in relation to training around the mental capacity act and deprivation of liberty safeguards, the provision of specialist consultant input and the risk that the end of life care and palliative care team were not sufficient to meet the needs of patients. When we asked for the detail of these risks we were provided with only two risks the sufficiency of the service to meet demand had been on the risk register since April 2019 and had not been updated since November 2019. The shortage of specialist consultant staff had last been updated in November 2019 and interviews were due to take place in January. However, at the time of our inspection there was no new appointee in place. The risk in relation to training around the mental capacity act and deprivation of liberty safeguards was not on this “detailed” information. There were no risks related to auditing or training on specific end of life care issues.

The trust failed to act on the risks following audits. We noted that a number of audit results were available but that these were not acted upon in a timely manner within this service. Examples of this includes the audit of completion of the ReSPECT form and the audit on the completion of the end of life care pathway. This meant that whilst the trust was in receipt of information on the risks held by the service this was not used to improve services in timely manner.

Areas for improvement

The trust must:

- The service must ensure staff are competent in their roles. This includes but is not limited to the use of the completion of ReSPECT forms and the use of syringe pumps. Regulation 12 (1)(2)(c) and (e): Safe care and treatment.
- The service must ensure that staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients’ individual needs and preferences, including those highlighted on the ReSPECT forms. Regulation 9 (1)(a)(b)(c) and (3)(a)(b): Person-centred care.
- The service must ensure effective systems are in place to share learning from incidents to prevent further incidents from occurring. Regulation 17 (1)(2)(b): Good governance

End of life care

- The service must ensure that when patients are unable to make decisions about their care and treatment, the requirements of the Mental Capacity Act 2005 are consistently followed. Regulation 11 (1)(2) and (3): Need for consent.
- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.
- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing
- The trust must ensure it has full oversight of end of life care services and fully embeds the end of life care team into the governance processes. Regulation 17(2)(a): Good Governance.
- The service must have an electronic system which accurately identifies and tracks end of life and palliative care patients. Regulation 12 (2)(a): Safe Care and Treatment.

Our inspection team

The team included a head of inspection, two inspection managers and four inspectors.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing