

Lewisham and Greenwich NHS Trust

Queen Elizabeth Hospital

Inspection report

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Ratings

Overall rating for this service

Inspected but not rated ●

Are services safe?

Inspected but not rated ●

Are services effective?

Inspected but not rated ●

Are services well-led?

Inspected but not rated ●

Our findings

Overall summary of services at Queen Elizabeth Hospital

Inspected but not rated



Queen Elizabeth Hospital (QEH) is one of two hospital locations operated by Lewisham and Greenwich NHS Trust. The trust provides acute and community healthcare services to people living in the London boroughs of Lewisham, Greenwich and Bexley.

The hospital has 521 beds and services include accident and emergency, medical, surgery, critical care, maternity and gynaecology, services for children and young people, outpatients and diagnostic imaging.

We carried out an unannounced, focussed inspection because we received information from a national CQC review that gave us concerns about the safety and quality of the services. These related to 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders and the way they were completed and recorded. These orders were recorded within patient treatment escalation plans (TEP) in the trust's electronic patient records system. We focussed on medical wards as this patient population was more likely to include people on DNACPR orders.

Our inspection team analysed 31 orders from a random selection of four wards. We also interviewed the medical director and three members of the senior management team and spoke with two doctors and three nurses. In addition, we examined 14 documents; including trust policies, risk papers, audit reports and training summaries.

The patient treatment escalation plans (TEP) we reviewed did not always contain easily accessible and relevant information to the DNACPR order. We noted the completion of free text fields in the TEP were sometimes inconsistent and did not follow the trust's TEP policy guidance.

However, all the orders we checked were authorised or endorsed by a senior clinician and were easily visible for healthcare professionals who may have needed to use them.

You can find further information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Medical care (including older people's care)

Inspected but not rated



- We found that patient treatment and escalation plans (TEP) did not always contain easily accessible or relevant information that supported the 'do not attempt cardiopulmonary resuscitation' (DNACPR) order. We saw free text fields in the TEPs were completed inconsistently and not in compliance with trust policy. Examples included the lack of records detailing discussions with family; ceilings of care and clinical decisions. Although we heard that discussions were recorded in the medical notes, we were also told these were not easily accessible to inexperienced users.
- We saw three examples where “Community DNACPR” was given as the sole reason for the new DNACPR order. It was unclear from the narrative in the TEP if these were reviewed after the patient had been admitted.
- Managers and leaders we spoke with acknowledged the need to change the perception among practitioners that “one word sentences” were not acceptable evidence of the key clinical rationale and discussion undertaken as part for the DNACPR decision.
- The TEP policy was dated 24 July 2018 and due for review in July 2021, which meant it was in place during the transition from paper to electronic records. The policy did not fully support current practice as everything was now reported and recorded on the electronic system.

However,

- Senior managers described how the division supported best interest meetings and mental capacity training, which were key aspects of the TEP policy. This was done as part of annual safeguarding training and the trust had worked hard to improve safeguarding training compliance. We saw divisional compliance results that exceeded the trust target of 90%. We acknowledge this represents a significant improvement compared to the rates we found when we last inspected.
- All of the DNACPR orders we reviewed were easily visible for healthcare professionals who may have needed to use them. These were displayed on the start screen of the electronic record by an alert symbol against the name of the patient.
- Of the 31 orders we analysed, we found all had been electronically dated and signed by a doctor. Orders signed by a more junior doctor were endorsed by a senior grade, such as a consultant, in line with trust policy.
- We saw how the trust had identified issues with the electronic record software and has plans in place to make changes where needed.

Is the service safe?

Inspected but not rated



As a focussed inspection, we did not inspect all aspects of this service.

- DNACPR stands for ‘do not attempt cardiopulmonary resuscitation’. It means that if a person has a cardiac arrest or dies suddenly, there will be guidance on what action should or shouldn’t be taken by a healthcare staff, including not performing CPR on the person. Decisions about DNACPR are subject to review based on a person’s individual assessments.
- The DNACPR only specifies whether a person will receive CPR or not. Patients will still receive appropriate treatment for their health issues and all personal care needs will be attended to.

Medical care (including older people's care)

- National guidance states that records of decisions about CPR must be accurate and up to date. Systems (whether paper-based or electronic) for recording these decisions must be reliable and responsive, in particular, to any change in the decision about CPR. Recorded decisions about CPR should accompany a patient when they move from one setting to another.
- The trust had fully-implemented an electronic patient recording system since our last inspection and we saw that all the orders were contained in the treatment escalation plan (TEP) section of each patient's record. TEPs recorded the DNACPR decision with clinical reasoning; mental capacity and consent, ceilings of treatment and discussions with patients and their relatives or advocates.
- During the site visit we analysed 31 DNACPR decisions using an assessment tool developed by the CQC. The records we checked represented active DNACPR orders obtained from a selection of medical wards. Our choice included two admission wards, an elderly care ward and a designated COVID-19 ward.
- The DNACPR orders were easily accessible and available immediately to healthcare professionals who may have needed to use them. We were able to view each ward's electronic patient record using a secure terminal set up for us by a senior manager.
- Staff we spoke with said they felt adequately trained and supported to use the electronic system and had sufficient computer terminals provided to access the software. We saw terminals located in ward offices and stations. We also saw staff using mobile terminals on purpose-built trolleys.
- All of the orders were electronically dated and signed. Orders signed by a doctor in training were endorsed by a senior doctor, such as a consultant, in line with trust policy. Staff we spoke with confirmed it was not possible to progress a record until it was signed and endorsed.
- We observed that orders for patients in the admission wards had been completed within the first four hours and we saw other examples documented on the system that had been completed within 90 minutes of admission.
- Although all DNACPR orders contained comments in the text fields, 23 were completed inconsistently and did not follow the trust's TEP policy. Activities such as discussions with family; ceilings of care and clinical decisions were not always documented on the TEP. A consultant explained these details were often recorded in post ward rounds and could be difficult to find for inexperienced users. We were shown an example of this.
- However, eight orders included clear and concise summaries of the clinical reasons supporting the DNACPR decision.
- We saw six examples where a patient was identified as potentially lacking mental capacity to help make a DNACPR decision. In each of these cases, a mental capacity assessment had been undertaken and recorded. Doctors told us that if a person was deemed unable to make a decision, the system prompted the completion of a mental capacity assessment.
- We saw one example where a relative had protected characteristics and this was correctly acknowledged in the text field. However, it was unclear if the relative had been included in the discussion about the DNACPR decision.
- We noted three examples where "Community DNACPR" was identified as the sole reason for the new order. It was not clear in the TEP if these were reviewed, in line with national guidance, after the patient had been admitted. This is important because decisions about starting or continuing with a treatment may be needed in the light of changes in the patient's condition and circumstances.

Is the service effective?

Inspected but not rated



Medical care (including older people's care)

- The last audit of 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders was completed by the trust in March 2020. This represented the end of a transition period from paper-based records to electronic records. The trust examined 149 patient records, including DNACPR orders. The audit found that 92% of DNACPR status was recorded in the main text of the doctor's notes. In 100% of the records we reviewed we found the patient's DNACPR status was recorded.
- We asked a senior manager how the system ensured that decisions relating to CPR were available as soon as they were required. We were told that the system was "live" and that any changes made or decisions taken could be seen immediately by any user reading the file. The system contained audit trail features when meant that it was possible to see who made changes to the record and when this was done. This is in line with national guidance from the British Medical Association, Royal College of Nursing and UK Resuscitation Council in 'Decisions relating to cardiopulmonary resuscitation, 2016'.
- When we spoke to staff, we found that the nurses had a good understanding of the DNACPR policy and felt confident to escalate any concerns about unclear orders to the consultant via their matron or ward manager.

Is the service well-led?

Inspected but not rated



- Prior to inspection, we wrote to the trust to express our concerns about the information we had received. The trust responded by sharing their assurance processes that patients were being safeguarded. Assurance and governance processes included the resuscitation committee, mortality review group and the trust quality and safety committee. The trust also shared evidence of do not attempt cardiopulmonary resuscitation (DNACPR) audits as well as safeguarding training compliance, along with the DNACPR and treatment escalation plan (TEP) policies for the trust.
- We also requested records of incidents linked to DNACPR and were told there were no serious incidents or internal 'red incidents' from 1st March to 30th November, 2020.
- The trust acknowledged challenges with the transition from paper records to the electronic system. For example, the trust's last DNACPR audit (March 2020) identified that 100% of paper records showed senior medical oversight of the orders, but this was less in the electronic records (89%). However, senior managers explained that the trust now only used electronic records and continued to work with the software providers to have the process streamlined for clinicians. The trust explained that the resolution to this was delayed by the pandemic and the system changes were scheduled for implementation by the end of December 2020.
- Senior managers stated that an ongoing review of deaths demonstrated that correct DNACPR processes were being followed. The trust had been an early adopter of the medical examiner initiative (ME), which involved independent medical reviews of all cases resulting in death. The medical director told us that the medical examiner review of deaths and trust complaints feedback helped to pick up points where discussions were had and that feedback to the respective consultant lead was provided where needed. The medical director told us that there had been no cases where the issuing of a DNACPR order was done incorrectly.
- The trust's DNACPR audit in March 2020 recognised that consultants were not always endorsing DNACPR decisions recorded by doctors and made recommendations in this regard. Senior managers we spoke with described the response from the trust to the audits and we saw evidence of the governance processes supporting these actions, which included communication with consultants and planned changes to the patient record software.

Medical care (including older people's care)

- We reviewed the governance structures and saw meeting agendas and minutes from quality, safeguarding and resuscitation committees that kept the board informed. The safeguarding committee, for example, was assisted by the independent medical examiners in helping the medical director and board maintain clinical oversight of DNACPR decisions, including those who were vulnerable due to a lack of mental capacity.
- The TEP policy was dated 24 July 2018 and due for review in July 2021, which meant it was in place during the transition from paper to electronic records. The policy did not fully support current practice as everything now was reported and recorded on the electronic system.
- Managers and leaders we spoke with recognised that “one word sentences” were not acceptable evidence of the key clinical rationale and discussion undertaken as part for the DNACPR decision. The safeguarding and learning disabilities lead was aware of the challenges of accurately reflecting conversations with patients and families.
- Senior managers described how the division supported best interest meetings and mental capacity training as part of the safeguarding training and said the medical division had worked to improve safeguarding training compliance. We saw evidence that divisional compliance results were now above 90%, the target for the trust. We acknowledge that this represents a significant improvement on the rates we found at our last inspection.

Areas for improvement

We told the trust that it must take action to bring services into line with one legal requirement.

- The trust must ensure that do not attempt cardiopulmonary resuscitation (DNACPR) orders are supported by treatment escalation plans (TEP) that contain easily accessible and relevant information in line with trust policies. (Regulations 17(1)(2));
- The trust must update the TEP policy to reflect changes made to the electronic patient recording system. (Regulations 17(1)(2)).

We told the service that it should take action because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall.

- The trust should ensure that senior clinicians responsible for endorsing the DNACPR document check the treatment escalation plans (TEP) is completed in accordance with the trust TEP policy.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and one other CQC inspector. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

To help maintain patient and staff safety during the coronavirus pandemic, the team followed all relevant infection prevention guidance and visited selected areas of the hospital only. Some of the discussions had with senior staff were conducted after our visit using secure teleconference facilities.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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