

The Rotherham NHS Foundation Trust

# Rotherham General Hospital

## Quality Report

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

We carried out a focused follow-up inspection between 27 and 30 September 2016 to confirm whether The Rotherham NHS Foundation Trust had made improvements to its services since our last comprehensive inspection in February 2015. We also undertook an unannounced inspection on 12 October 2016.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so, we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

When we last inspected the hospital in February 2015, we rated the service as requires improvement. We rated safe, effective, responsive and well-led as requires improvement. We rated caring as good,

There were fourteen breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. These were in relation to the safety and suitability of premises, staffing, supporting staff, records, consent to care and treatment, complaints, care and welfare of people who use services, dignity and respect, need for consent, cleanliness and infection control, management of medicines, safeguarding people who use services from abuse and assessing and monitoring the quality of service provision.

The trust sent us an action plan telling us how it would ensure that it had made the improvements required in relation to these breaches of regulation. At this inspection, we checked whether these actions had been completed.

We found that, although the trust had made considerable improvements, there remained areas that required further improvement.

Our key findings were as follows:

- The trust had not taken sufficient action raised in the 2015 inspection to ensure DNACPR forms and mental capacity decisions were documented in line with trust policy, national guidance and legislation. We wrote to the trust immediately following our inspection to ensure that action was taken promptly regarding the DNACPR forms and mental capacity decisions. The trust initiated a number of actions, which we will continue to monitor.
- Staff understanding and application of the Mental Capacity Act 2015 was inconsistent across most of the services inspected.
- There were concerns about the current pharmacy service and the impact on patient care. We wrote to the trust immediately following our inspection to ensure that action was taken promptly regarding the management of discharge medications and service provision. The trust initiated a number of actions, which we will continue to monitor.
- Staffing levels in the children's ward and maternity had improved since the previous inspection. However, there remained staffing shortages most notably in the emergency department, school nursing and medical wards. There was a high use of medical locum staff in some specialties.
- Some policies and guidelines were out of date and there was a backlog of incidents in maternity services that had not been reviewed.
- Access to safeguarding supervision was a concern and was in the process of being addressed.
- Audit plans were behind schedule within children's services.
- There were some environmental concerns at the time of inspection; the fire escape on critical care was not appropriate and there were some remaining ligature risks on the children's ward. The trust took immediate action to address these following our inspection.
- Risk registers were in place, but did not always reflect the risks identified on inspection.

# Summary of findings

- The hospital reported no cases of hospital acquired MRSA bacteraemia, 16 cases of C.difficile and nine of MSSA bacteraemia between July 2015 and June 2016. The number of cases of C.difficile and MSSA per 10,000 beds has been mostly below the England average. However, on medical wards, there were concerns about infection control practices and facilities in the refurbished areas.
- There were areas of notable improvement since the previous inspection. These included safeguarding training and awareness, achieving no mixed sex breaches, improvements to the short-break service, access to sexual health records and improvements to training data.
- There had also been improvements in ensuring there were no mixed sex breaches, wherever possible and actions had been implemented to minimise these.
- We saw that patients were assessed using a nutritional screening, had access to a range of dietary options and were supported to eat and drink.
- There were no mortality outliers identified at the trust.

We saw several areas of outstanding practice including:

- Safeguarding and liaison had a daily meeting with the Emergency Department to identify any safeguarding issues and concerns.
- All patients with mental health needs admitted to the children's ward were reviewed by the CAMHS liaison team/nurse within 24 hours of admission and were followed up after seven days.
- Staff had successfully offered the use of acupins for the relief of nausea, particularly in gynaecology services.

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

Importantly, the trust must:

## **Urgent and emergency care**

- Ensure there are sufficient numbers of suitable qualified, competent and skilled staff deployed in the department.
- Ensure that facilities on the clinical decision unit are properly maintained in a good state of repair and able to meet patient needs.
- Ensure all staff are aware of their responsibility to report incidents and ensure learning is shared with all relevant staff.

## **Medicine**

- Continue to take action to ensure there are sufficient numbers of suitably skilled, qualified and experienced staff.
- Ensure all relevant staff have received appropriate training and development. This should include, mental capacity, safeguarding adults and children, resuscitation and dementia awareness.
- Ensure all staff have an annual appraisal.
- Mental capacity assessments and discussions must be clearly documented in patient records.

## **Critical care**

- Ensure risks are assessed, monitored and managed in a timely manner to ensure safety.
- Ensure patients' individual records are held securely on the unit.

## **Maternity**

- Complete the reviews of maternal and neonatal deaths and implement any further identified actions to support safe practice.
- Ensure that identified risks recognised and recorded on the risk register.
- Ensure that incidents are reviewed and investigated in a timely manner.
- Ensure staff have access to safeguarding supervision and support.

# Summary of findings

## Children and young people

- Ensure the policies and procedures for the management of the children's and young people's service are up-to-date, regularly reviewed, document controlled and readily accessible to staff.
- Ensure children and young people's service risk register reflect current risks, contains appropriate mitigating actions, is monitored and reviewed at appropriate intervals and acted upon.

## End of life care

- Ensure all "do not attempt cardio-pulmonary resuscitation" (DNACPR) decisions are always documented in line with national guidance and legislation.
- Ensure there is evidence that patients' capacity has been assessed in line with the requirements of the Mental Capacity Act (2005).

In addition the trust should:

## Medicine

- Improve the recording of fluid balance to ensure appropriate actions are taken when imbalances are present.
- Take action to improve compliance with good infection prevention and control practice and procedures.
- Review provision of hand wash basins in line with relevant guidance e.g. HBN 00-09 IC in the Built Environment and HBN 04-01 Adult inpatient facilities (when wards are being refurbished)

## Surgery

- Continue to review and implement on-site support to junior doctors and advanced nurse practitioners at night.

## Critical Care

- Ensure the Guidelines for the Provision of Intensive Care Services (GPICS) 2015 guidance are implemented.

## Maternity

- The divisional risk management strategy should be reviewed.
- Review equipment on the delivery suite to ensure it is suitable for use.
- Review information governance arrangements.
- Review the use of staff, out of hours, on delivery suite to be the scrub nurse in theatres.
- Review information systems to ensure they are fit for purpose.
- Continue to improve mandatory training compliance.
- Improve the referral to treatment time for gynaecology patients admitted to hospital.

## Children and young people

- Children should be seen in an appropriate environment by staff who are suitably skilled, qualified, and experienced. In particular, in the adult outpatient clinics, on the high dependency unit, on the children's ward, and in the paediatric dental unit.
- Children's and young people's service should carry out appropriate and timely clinical and nursing audits
- There should be call buzzers available in all rooms, including the sensory room on the children's ward.
- Consider employing a nursing co-ordinator on the neonatal unit, which is recommended as good practice by the Department of Health's Toolkit for High-quality neonatal services (2009)
- Staff signatures in care record documentation should be completed and legible/traceable.
- Review noticeboards in clinical areas to ensure they meet infection control standards.
- The outside play areas for the children's ward and children's OP clinic should be well maintained and fit for children to use.

# Summary of findings

- The numbers of SCBU nursing staff that are qualified in speciality should meet the government recommendation of 70%.
- All staff with direct responsibilities for involvement in reporting and contributing to the assessment of safeguarding concerns should be trained to safeguarding level 3.

## **Outpatients and diagnostics**

- Continue to review the challenges the environment poses in all departments, particularly orthotics.

## **Professor Sir Mike Richards**

Chief Inspector of Hospitals

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

Requires improvement

### Rating



### Why have we given this rating?

There were insufficient medical and nursing staff employed by the department and staffing levels were often below assessed and planned levels. Nursing and medical shifts frequently went uncovered. There was a heavy reliance on bank, agency and locum staff in the department. Mandatory training levels and appraisals were worse than the trust minimum standard. Staff did not always identify vulnerable patients and follow safeguarding processes to protect them in a timely manner. This had been recognised and the trust's safeguarding team were providing training and additional support. Staff were also unclear about the mechanisms in place to support people living with dementia or a learning disability. Although there was a dementia strategy, this was not embedded in practice. Although the multi-disciplinary staff worked together to ensure the safe treatment of patients, the department did not give the impression of working as a cohesive team. Most staff reported incidents and we saw examples of this, however there was also a culture amongst some staff groups that it was not their responsibility to report patient safety incidents. The department followed national guidance and had recently introduced established assessment processes, however, some documentation was out of date. For example, some standard operating procedures that allowed nurses to give pain relief and other medication to patients was out of date, meaning some nursing staff could no longer give patients this medication. We found that the facilities on the clinical decision unit (CDU) meant that patients on the department did not have access to bathing facilities or a shower. However, there was a clear vision and strategy for the department and staff were aware of planned future developments. Patients who visited the department had their individual needs met. Interpreters were available and there were facilities available to assist disabled patients and those with specific needs.

# Summary of findings

Staff maintained patients' privacy and dignity and worked hard to deliver care to patients. Staff treated patients as individuals. The department had evidence-based policies and procedures relating to care, which were easily accessible to staff.

## Medical care (including older people's care)

Requires improvement



We found that the service had made many improvements since our last inspection but there were still some areas requiring further improvement.

Staff shortages were still evident and planned staffing levels were not being achieved on many wards. However, the trust was taking action to cover shifts wherever possible with bank and agency nurses and most staff felt well supported. Staff reported incidents and learning was disseminated using a variety of methods. Mandatory training levels were improved from last year, but were still poor in some areas. Infection prevention, practices and procedures did not always protect against the risk of spreading infection.

Knowledge of the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards was good, but documentation of mental capacity assessments and discussions was poor. Appraisal rates were below trust target. Fluid balance recording needed to be improved.

Although the discharge lounge was still sometimes used as an inpatient ward, there were processes in place to close to discharges if this happened and the unit was appropriately staffed to care for overnight patients. We found that staff were very caring and there had been no mixed sex breaches for this service in the last 12 months.

Each speciality had a vision and direction for their service and business plans were developed regarding sustainability and future development. Ward managers, matrons and senior managers were aware of their risks and mitigations were in place. Risk registers were comprehensive and up to date.

## Surgery

Good



The trust had taken action on some of the issues raised in the 2015 inspection, for example, staff were confident in reporting incidents and received feedback from incidents. The World Health Organisation (WHO) safer surgery checklist was

# Summary of findings

embedded in practice and additional staff had been recruited. The management of medical outliers was in line with trust policy, there had been no mixed sex accommodation breaches and access and flow had improved in fracture clinic.

Systems and processes for infection control and medicines management were reliable and appropriate.

Senior staff planned and reviewed staffing levels and skill mix to keep people safe from avoidable harm. All wards used an early warning scoring system for the management of deteriorating patients.

Patients' needs were met through the way services were organised and delivered. The trust's referral to treatment performance was better than the England average between June 2015 and May 2016. However, the trust did not have a Hospital at Night team and out of hours senior doctors were not always resident on site to support junior doctors and advanced nurse practitioners.

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## Critical care

Good



We found there was a culture where patients were at the centre of activities. There was a clear process for escalation, investigation and feedback of incidents. Lessons learnt were shared with staff to minimise them reoccurring. Staff received training in vulnerable adult and children protection. They were confident in safeguarding patients. Outcomes for patients using this critical care service were measured against similar services; this unit were better in some areas and similar in others. Staff were appropriately qualified. Staff understood and were able to verbalise the principles of mental capacity act, duty of candour and the unit vision and aims. At our request at the inspection, the trust took immediate action to ensure the fire evacuation arrangement in place for intensive care unit was fit for purpose. We confirmed this during our unannounced inspection. We also wrote to the trust and they confirmed that fire safety advisors were satisfied with the arrangements in place.

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# Summary of findings

However, due to staff shortages, the nurse coordinator on shift was unable to fulfil their duty of managing, supervising and supporting staff to ensure safety. There was also a lack of a designated pharmacist on the unit.

Patients' notes were not stored securely within the units to maintain patient confidentiality.

The governance arrangements including maintenance of a risk register and the review process did not promote effective risk control.

## Maternity and gynaecology

### Requires improvement



We found although action was taken to address most of the areas identified at the previous inspection, there were still some areas that required improvement.

There was a backlog of incidents for review and the rate of safeguarding supervision was low and community midwives reported a lack of support.

The trust had identified a number of poor outcomes since late 2015, which included neonatal deaths, stillbirths and maternal deaths. A multidisciplinary review of all the cases was taking place. Maternal incidents since 2014 were being reviewed and neonatal incidents that had occurred from 2015 onwards were also being reviewed.

However, there had been some improvements since the previous inspection. Staffing levels and training had improved and arrangements for assessing and responding to patient risk were in place and monitored.

The rate of emergency caesarean sections had improved and was similar to expected when compared with national rates. The rate of normal deliveries was better than the England average.

There was evidence of good multidisciplinary working.

## Services for children and young people

### Requires improvement



Compliance with National Institute for Health and Care and Excellence (NICE) standards was variable. The clinical audit schedule was behind schedule and no nursing audits were carried out. More than half (55%) of the policies, procedures and guidelines in use were out of date. Audit data showed most patient outcomes were similar to or better than the England average.

# Summary of findings

There was a lack of evidence to show there was effective risk management within the service and the vision and strategy was not clearly defined or understood.

There was no nursing co-ordinator on the SCBU as recommended by national guidelines and several vacancies for medical staff. However, the nurse staffing establishment had improved significantly since the last inspection and nationally recognised guidelines were being met on the wards.

Action had been taken since the last inspection and the children's ward environment was safe and appropriate for children and young people. Access to psychiatric input for children and young people with a mental health needs (CAMHS patients) using the service had improved since the last inspection. There was good evidence of multidisciplinary working across children's services. Safeguarding procedures were well embedded and understood by staff.

We saw staff treated patients and relatives with kindness and compassion throughout the inspection. Patients and families gave positive feedback about their care and treatment.

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## End of life care

The trust had not taken action on some of the issues raised in the 2015 inspection. DNACPR forms and mental capacity decisions were not documented in line with trust policy, national guidance and legislation. The individualised care plan for adults had been launched in March 2016, however, its use was not yet embedded in practice. Resources within the specialist palliative care team affected their ability to deliver evidence based care and treatment, specifically in relation to seven day working..

However, staff in the specialist palliative care team were skilled and competent and offered training to all staff groups in end of life care. We saw evidence of good multidisciplinary team working in the hospital, across the community and hospice.

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## Outpatients and diagnostic imaging

The trust had taken action on some of the issues raised in the 2015 inspection, for example, procedures around sharps bins had been updated and were followed and records were now stored securely in clinics.

# Summary of findings

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Mandatory and safeguarding training levels were better than the trust target. Staff understood their responsibility to raise concerns and report incidents. They received feedback from incidents. However, although some improvements had been made since 2015, but the environment continued to present significant challenges for most departments.

There was a shortage of consultants employed by the trust. Locum staff were employed, however, this had affected continuity of care for patients.

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# Rotherham General Hospital

## Detailed findings

### **Services we looked at**

Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people; End of life care; Outpatients & Diagnostic Imaging

# Detailed findings

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## Background to Rotherham General Hospital

Acute hospital services are provided at Rotherham General Hospital which serves a population of 259,000.

The hospital has approximately 450 beds.

A total of 3954 staff are employed by the trust (at end April 2016). These were:

- 292 (WTE) Medical & Dental
- 1118 (WTE) Nursing/ Midwifery / Health Visiting
- 2118 (WTE) Other

For the 2015/16 financial year, the trust reported a deficit of £8.8m

We carried out this focused follow-up inspection to confirm whether Rotherham General Hospital had made improvements to its services since our last comprehensive inspection In February 2015. We inspected services focusing on the key questions (safe, effective, caring responsive and well-led) that had previously been identified as requires improvement. We also inspected caring where we were looking at the majority of the key questions within a service.

## Our inspection team

Our inspection team was led by:

Chair: Carole Panteli, Nurse Director

Head of Hospital Inspections: Amanda Stanford, Head of Inspection

The team included CQC inspectors and a variety of specialists: including medical consultants, nurses, midwife and expert by experience.

## How we carried out this inspection

We carried out this focused follow-up inspection between 27 and 30 September 2016 to confirm whether The Rotherham NHS Foundation Trust had made

improvements to its services since our last comprehensive inspection In February 2015. We also undertook an unannounced inspection on 12 October 2016.

# Detailed findings

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

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

When we last inspected the trust in February 2015, we rated the service as requires improvement. We rated safe, effective, responsive and well-led as requires improvement. We rated caring as good.

The trust sent us an action plan telling us how it would ensure that it had made the improvements required in relation to these breaches of regulation. At this inspection, we checked whether these actions had been completed.

Before the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning group (CCG), NHS Improvement, NHS England and the local Healthwatch.

We held a stall at the hospital on 21 September 2016 and spoke with patients and relatives. We also received comments cards. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who provided feedback about the trust.

Focus groups were held with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals, including physiotherapists and occupational therapists. We also spoke with staff individually as requested.

We talked with patients, families and staff from all the ward areas and departments that we visited. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

## Facts and data about Rotherham General Hospital

The hospital activity for period April 2015 to March 2016 was:

- Inpatient admissions: 55,000
- Outpatients: 250,000
- A&E attendances: 75,000

The health of people in Rotherham is varied compared with the England average. Deprivation is higher than average and about 22.8% (11,300) children live in poverty. Life expectancy for both men and women is lower than the England average.

Life expectancy is nine years lower for men and seven years lower for women in the most deprived areas of Rotherham than in the least deprived areas.

For children in Year 6, 23.4% (671) are classified as obese, which is worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 was

29.1, which is better than the average for England. This represents 17 stays per year. Levels of breastfeeding and smoking at time of delivery are worse than the England average.

In 2012, 28.5% of adults are classified as obese, which is worse than the average for England. The rate of alcohol related harm hospital stays was 673. This represents 1,688 stays per year. The rate of self-harm hospital stays was 161.4, better than the average for England. This represents 406 stays per year. The rate of smoking related deaths was 349, which is worse than the average for England. This represents 497 deaths per year. Estimated levels of adult physical activity are worse than the England average.

Black and minority ethnic residents make up 6.5% of the population, within which the largest group are those identifying as Asian / Asian British (4.1%) of total population.

Rotherham is in the most deprived quintile within the Index of Multiple Deprivation.

# Detailed findings

## Our ratings for this hospital

Our ratings for this hospital are:



	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Surgery	Good	N/A	N/A	Good	N/A	Good
Critical care	Good	Good	N/A	N/A	Requires improvement	Good
Maternity and gynaecology	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
End of life care	N/A	Requires improvement	N/A	N/A	N/A	N/A
Outpatients and diagnostic imaging	Good	N/A	N/A	N/A	N/A	N/A

### Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.
2. We previously inspected Rotherham General Hospital in February 2015 and rated it as requires

improvement overall. At this inspection, we rated services that had previously been rated as requires improvement. We did not review the overall ratings for the hospital as the inspection was focused on specific areas only.

# Urgent and emergency services

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

## Information about the service

The Emergency Department (also known as accident and emergency, A&E, or ED) is situated on floor B of the main building at Rotherham General Hospital. It is a trauma unit which means that it can treat patients with a wide range of illnesses and injuries including those who have been involved in accidents and incidents. Although it is not a major trauma centre, patients can arrive by foot, road or ambulance. Within the department, there are three distinct areas where patients can be treated. The minors department can treat patient with minor injuries such as simple fractures, the majors department treats patients with more serious illnesses or injuries and the resuscitation area that treats patients with serious and life threatening conditions. The department also has a clinical decision unit with 12 beds where patients who meet strict criteria can be reviewed.

The department has three resuscitations beds, two isolation cubicles, one interview room suitable for patients with mental health conditions, and four bays each with five beds. One of these bays contains monitoring equipment for patients who do not require a resuscitation bed, but do need continuous monitoring.

As part of the trust's transformation plans, the Emergency Department had moved in December 2015 to its current temporary location on a previous ward. This was to enable the final stages of the Urgent and Emergency Care Centre to be built.

The Emergency Department is staffed by a wide range of experienced consultants, middle grade and junior doctors, GPs, emergency nurse practitioners, nurses and emergency department assistants seven days a week, 24 hours a day.

Between April 2015 and March 2016 the Emergency Department had 77,455 attendances. This means there was an average of 212 attendances a day. The majority of patients who attend the department are over the age of 16 (82%); 18% of patients who attend are aged 16 and under.

During the inspection, we spoke with staff including doctors, receptionists, nursing assistants, nurses of all grades, domestic and housekeeping staff, paramedics, patients and their relatives. We looked at the records of 23 patients and reviewed information about the service provided by external stakeholders and the trust.

We carried out this inspection because when we inspected the department in July 2015 we rated safe, effective, responsive and well-led as Requires Improvement.

At our previous inspection, we identified a number of concerns. These related to staffing levels for both nurses and doctors which had an impact on the ability of staff to attend team meetings, cover shifts and attend or complete mandatory training. The location of the children's waiting room meant that children had to walk through adult areas to reach some sections of the department. Access to the children's department was



# Urgent and emergency services

unrestricted meaning that there were some safeguarding risks. There were concerns about the children's safeguarding processes as well as levels of safeguarding training and supervision.

We found that some guidelines in the department had not been updated to reflect national guidance and best practice. We also had concerns that some inexperienced staff were triaging patients.

We told the department it should review staffing levels, ensure that all staff were able to attend staff meetings and ensure that patients had access to sign language interpreters if they needed them.

At this inspection, we returned to check whether services had improved.

## Summary of findings

We carried out this inspection because when we inspected the department in February 2015, we rated safe, effective, responsive and well-led as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated this service as 'requires improvement' because:

- There were insufficient medical and nursing staff employed by the department and staffing levels were often below assessed and planned levels. Nursing and medical shifts frequently went uncovered. There was a heavy reliance on bank, agency and locum staff in the department. Mandatory training levels and appraisals were worse than the trust minimum standard.
- Staff did not always identify vulnerable patients and follow safeguarding processes to protect them in a timely manner. This had been recognised and the trust's safeguarding team were providing training and additional support. Staff were also unclear about the mechanisms in place to support people living with dementia or a learning disability. Although there was a dementia strategy, this was not embedded in practice.
- Although the multi-disciplinary staff worked together to ensure the safe treatment of patients, the department did not give the impression of working as a cohesive team. Most staff reported incidents and we saw examples of this, however there was also a culture amongst some staff groups that it was not their responsibility to report patient safety incidents.
- The department followed national guidance and had recently introduced established assessment processes, however, some documentation was out of date. For example, some standard operating procedures that allowed nurses to give pain relief and other medication to patients was out of date, meaning some nursing staff could no longer give patients this medication.
- We found that the facilities on the clinical decision unit (CDU) meant that patients on the department did not have access to bathing facilities or a shower.

# Urgent and emergency services

However:

- There was a clear vision and strategy for the department and staff were aware of planned future developments.
- Patients who visited the department had their individual needs met. Interpreters were available and there were facilities available to assist disabled patients and those with specific needs.
- Staff maintained patients' privacy and dignity and worked hard to deliver care to patients. Staff treated patients as individuals.
- The department had evidence-based policies and procedures relating to care, which were easily accessible to staff.
- The department offered services round the clock every day.

## Are urgent and emergency services safe?

Requires improvement 

We carried out this inspection because, when we inspected the department in February 2015, we rated safe as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated safe as 'requires improvement' because:

- The department had not employed enough nursing staff to ensure that rotas were safely covered. There were many times when the number of staff deployed on the ward was less than the planned staffing levels. Agency use was high with shifts sometimes being 30% covered by agency registered nursing staff.
- The department had a shortage of middle grade doctors. This led to the middle grade night shift being covered by a consultant, when needed. Additionally, there were consultant shortages due to vacancy and absence. The department had a high locum doctor use.
- There was a culture amongst medical staff that it was not their responsibility to report patient safety incidents. Incidents had highlighted that staff implementation of safeguarding vulnerable patients procedures were falling short of the policy expectations with some referrals being missed. This had been recognised and the trust's safeguarding team were providing training and additional support. Some nursing staff were unable to give patients pain medication because the standard operating procedure to allow them to do so had expired and had not been updated.
- The department was consistently failing to meet the 15 minute time to assessment and 15 minute ambulance handover targets.
- Department staff of nursing and medical disciplines were not up to date with their mandatory training.

However:

- The department was clean and there was access to personal protective equipment.
- The department environment, although unconventional for an Emergency Department was well maintained.
- Medication was stored safely and securely.

# Urgent and emergency services

- Risk assessments were carried out on patients who were expected to be in the department for any length of time, or transferred to the clinical decision unit.

## Incidents

- There were seven serious incidents or incidents between July 2015 and June 2016. These related to delays in treatment, abuse of vulnerable person, maternity and miscellaneous other.
- There were no never events reported by the department. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Between April 2016 and July 2016, 204 incidents were reported in the department. The information sent to us by the trust did not specify the severity of the incidents.
- The most commonly reported categories of incidents were regarding diagnostic images and specimens, staffing and lack of clinical risk assessment.
- When we spoke with staff about reporting incidents, some medical staff told us that nursing staff reported incidents. One told us they did not know how to use the reporting system and would ask a nurse to do it. Other medical staff told us that they knew how to use the system, but that reporting incidents was time consuming and they rarely made reports.
- We spoke with staff about their responsibilities around duty of candour. Most staff were unsure what the phrase meant although they were more familiar with the phrase, 'being open and honest'. Senior staff in the department took responsibility for the formal duty of candour process. They were able to describe it and give examples of when they had used the process.
- Mortality and Morbidity meetings took place across the trust and staff from the department routinely attended and reported back any findings or lessons learned at departmental meetings. Minutes were also emailed to staff.
- We asked staff if they could give us any examples of changes in the department as a result of incidents, but staff were unaware of any.
- The trust held regular mortality and morbidity (M&M) meetings and staff frequently attended and discussed

relevant cases at team meetings. These had recently been amalgamated across acute medicine to ensure that lessons learned were shared across the two divisions.

## Cleanliness, infection control and hygiene

- When we visited the department, we found it to be visibly clean. Patient rooms were cleaned in between patients and waiting area floors and seating were in good order.
- There were cleaning schedules in place and we found that completed paperwork confirming that cleaning had been carried out. We saw staff completing the required tasks in line with schedules.
- Patient toilets were clean.
- Staff could call cleaners to the department 'out of hours' if required however, health care assistants were responsible for general cleaning and wiping of patient equipment such as blood pressure machines. We witnessed staff carrying out cleaning of equipment between patients.
- There was sufficient personal protective equipment (PPE) such as aprons and masks available to staff. We routinely saw staff using this equipment during our inspection.
- The trust delivered infection control and hand hygiene training. The trust target was 80%. Only 34% of nursing staff, 36% of medical staff, 33% of administrative and clerical staff and 36% of additional clinical services staff had completed the training.
- The trust routinely monitored staff hand hygiene procedures. We looked at the audit dated August 2016. This showed that the department was not fully compliant. Areas of non-compliance were related to staff not being bare below the elbow, wearing inappropriate jewellery and having long finger nails. Shortfalls were discussed with individuals and at team meetings.
- During the inspection we observed staff wearing nail varnish. This was against trust policy that stated that nails should be free of nail polish.
- The department had a policy in place to ensure the safe isolation of patients who needed to be isolated. Patients who attended with potentially contagious conditions could be treated safely in cubicles with solid walls and doors.

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- We looked at the areas where equipment was cleaned and these were visibly clean and there were cleaning schedules in place for all equipment.
- Mattress checks were carried out by staff. We checked 10 mattresses and found that they were clean and intact.

## Environment and equipment

- The department was situated on a ward as an interim measure until a new department build was completed in 2017. This meant that the layout of the department was different to the conventional layout of an emergency department. One bay was dedicated to three resuscitation beds. One bay contained five beds that could be used for monitoring patients and the remaining bays each contained five beds and a nurse station.
- Consulting and treatment cubicles were an acceptable size and contained the necessary patient equipment. As cubicles had curtains rather than doors, it was difficult to maintain privacy. However, the department had two isolation cubicles for patients who required isolation for the prevention and management of actual or potential infection; these cubicles had both doors and curtains to enable isolation and privacy and dignity to be maintained. We found that equipment in the department had been safety checked. All of the equipment we looked at had up to date tests.
- Equipment was serviced and maintained in line with manufacturer's guidelines, as there were maintenance contracts in place. To ensure accuracy equipment was regularly calibrated.
- We saw that there were sufficient supplies of all equipment. This meant that if one suffered a mechanical breakdown, a spare machine was available.
- We checked resuscitation equipment during our inspection. All trolleys were sealed, ready to be used in an emergency. Staff returned used trolleys to the theatres department who were responsible for monitoring and maintaining them. Staff returned any unused trolleys to theatres every three months to make sure that all equipment was still within its use by date. The trust had a policy of having one laryngoscope open but in its packet for use in an emergency on each trolley.
- The waiting area used by patients was quite small and although there were a lot of seats, during busy times it struggled to cope with the volume of patients and relatives attending. It was a very warm area with a desk fan for ventilation. There was an identified additional

seating area situated at the entrance to the department for use during the peak times. It was acknowledged this was a temporary arrangement until the new urgent and emergency care centre opens.

- The clinical decision unit shower was out of order. It was being used as a store room for various items of equipment. We spoke with staff about how long the shower had been broken and were told that it had been broken for approximately two years.
- During the four days of our inspection, we noted that the door on the CDU store room was frequently propped open when nobody was inside the cupboard. A number of times, inspectors entered the room unobserved by staff who were busy elsewhere. The door had a keypad lock and a notice stating it should be locked at all times. The store room contained sharps that patients could access to harm themselves or others with.

## Medicines

- Medication was stored securely in the department. Controlled drugs were stored in line with national and trust policy and stock checks were routinely completed.
- Staff from the pharmacy department completed regular checks of medication stocks held in the department and there was a system in place to make sure that any stock close to expiry was removed.
- Records to show that fridge temperatures were checked were not completed regularly. We looked at records from 25 July to 25 September and found that of the 62 days covered, 48 days had no recorded fridge temperature.
- Patient group directives (PGDs - specific written instructions for the supply and administration of medicines to specific groups of patients) were used in the department. Staff had signed to say that they understood them and were working within their guidance. Some PGDs were out of date and had been withdrawn from use. However, this meant that some staff were unable to administer routine medication without an individual prescription, such as ibuprofen, potentially delaying patients from receiving pain relief.

## Records

- The department used paper records at the time of the inspection however, was due to move to an electronic records system in the near future.

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- We looked at the records of 23 patients. We found that the records showed a clear medical history, action plan and treatment plan.
- Two sets of records we looked at were for patients who had been on the CDU at least overnight. We found that there were risk assessments in place. These had been completed fully and updated where applicable.
- The records we looked at showed that nursing care, such as supporting patients to eat, or take comfort breaks had taken place. The department used intentional rounding and this was recorded in records.
- Records were stored securely and accessible only to appropriate people.
- Administrative and clerical staff and additional clinical services staff were meeting the trust target for information governance training however, medical (36%) and nursing (49%) were not.
- A recently scheduled record keeping audit had been postponed because the department was due to implement a new electronic system.
- We looked at the standard of other records kept in the department such as cleaning logs, medication fridge checks and resuscitation trolley checks. We found that these were not consistently completed.

## Safeguarding

- We looked at the processes and policies the trust had in place for safeguarding vulnerable adults and children. They provided staff with good, detailed information about the action they should take if they had concerns about any patients who attended the department.
- We spoke with a number of staff from all disciplines about the action they would take if they were concerned about the safety and welfare of patients. They demonstrated theoretical knowledge.
- Safeguarding children referrals were discussed at a daily, multiprofessional meeting (Monday to Friday) which was attended by the children's safeguarding lead. All child cases were reviewed to ensure that staff had undertaken the appropriate assessment, management and referrals and that any learning and reflection could take place.
- We saw evidence that referrals for vulnerable adults and children were regularly made and information sent to health visitors about children who attended the department. However, we also noted that there had been a number of incidents reported about poor safeguarding practice by staff in the department,

highlighting missed opportunities to report or obtain further information about potentially vulnerable children. This was an issue that we identified at our last inspection in 2015. This had been recognised and the trust's safeguarding team were providing training and additional support.

- Staff in triage were required to check a second system to ensure that there were no notifications on the system relating to safeguarding. Quality checks and audits had identified that this was not being done consistently. Staff identified that they were not always able to access the second system, which hindered them. The need to carry out secondary checks was reinforced at meetings but continued to be a problem.
- The IT system used by the department routinely displayed the number of attendances patients had made during the previous 12 months. Where there were concerns about patients' welfare, the system also displayed an alert to staff that gave specific details about any risks to the patient or to staff. At our last inspection we identified that staff were not always acting upon alerts. At this inspection, we found no evidence from incidents that pre-existing alerts were being missed.
- Safeguarding training included specific training about safeguarding topics such as sexual exploitation, people trafficking and female genital mutilation (FGM).
- The department was not meeting the trust standard of 80% for safeguarding training. Training figures showed compliance as follows: Safeguarding adults level 53% for nursing staff and less than 30% for other clinical staff, safeguarding children level two, 65% and safeguarding children level three, 59% for nursing staff, 36% for medical staff and 64% for additional clinical staff. At our last inspection we identified that safeguarding training levels were low and informed the department that they must improve and meet the trust standard of 80%.

## Mandatory training

- Staff told us they could access some mandatory training via the intranet. They reported few problems accessing e-learning other than the occasional shortage of free time or computers.
- Staff told us that it was not always easy to attend classroom based training due to staffing pressures on the ward.
- None of the staff groups were fully meeting the target of 80% for all mandatory training. Nursing staff had met

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the target for equality and diversity training, additional clinical staff met the target for equality and diversity, information governance and basic life support. Medical staff had not met the target for any mandatory training.

## Assessing and responding to patient risk

- Over the winter of 2015/2016, the trust reported 50 delays of handovers of more than 30 minutes from ambulance staff to hospital staff. This meant that patients were waiting on ambulance trolleys or in wheelchairs under the care of ambulance staff for more than 30 minutes.
- Between April 2015 and June 2016 there was an increasing trend in handovers taking longer than both 30 minutes and 60 minutes. There were 57 ambulance journeys where handover took longer than 60 minutes.
- The percentage of ambulance handovers taking longer than 30 minutes had risen from 27% in June 2015 to 45% in March 2016.
- Between May 2015 and April 2016, the median time to initial assessment had risen from 10 minutes to 15 minutes, peaking at 25 minutes in March 2016. This was worse than the national target of 15 minutes.
- The department had recently introduced the Manchester Triage system, although not all staff had undergone training at the time of the inspection.
- Patients were triaged on attending the department and staff based their decisions about whether the patient should be treated in the minors or majors area.
- The department had recently introduced the rapid assessment and treatment model, however this was not always able to run and was dependent of having the appropriately experienced staff available.
- We tracked the journeys of seven patients who self-presented at the department. Of these patients, three were seen within 15 minute and four waited more than 15 minutes. Two patients waited more than an hour for an initial assessment with the remaining two waiting 19 minutes and 36 minutes.
- Patients with allergies wore a red wristband to ensure that they were easily identifiable.
- Staff recorded known patient allergies in patient records. Nine of the ten records we checked had documented whether a patient had allergies or not.

- There was evidence in six sets of records that observations had been carried out, however no observations had been carried out on three patients. Observations were not applicable for the remaining 14 patients.
- Patients had their observations taken regularly and the department used a modified early warning score (MEWS) to assist in identifying patients whose condition was deteriorating. Staff were aware of the action they should take if patients deteriorated and there was a process in place for staff to follow.
- There was emergency medical equipment in the department and staff were experienced at dealing with very sick patients. There were senior staff on hand to support less experienced staff 24 hours a day.
- We looked at the records of two patients who had been on the clinical decision unit (CDU) for over 24 hours. We found that risk assessments for falls, nutrition, skin integrity and mobility had been completed and reviewed. Where patients were at high risk, action plans were in place, such as to ensure the prevention of pressure damage.

## Nursing staffing

- At our last inspection, we found that the department did not have sufficient staff to meet the needs of patients. Additionally, the skill mix of staff was not always appropriate. At this inspection, we found that the trust had undergone a significant recruitment process. However, at the time of our inspection, the department still did not have enough staff.
- Nurse actual and expected staffing levels were based on a BEST assessment that was carried out in January 2016. They were displayed in the department and updated on a daily basis.
- Within the children's Emergency Department section of the department there was a shortage of specially trained children's nurses. At the time of the inspection, due to vacancies and sickness, the children's section of the Emergency Department was not always staffed by a registered children's nurse. This meant that children were assessed by registered adult nurses. The department continued to actively recruit to the vacancies for registered children's nurses.
- The department used bank and agency staff to try to fill any gaps. However a recent change to the payment of



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substantive trust staff undertaking additional hours via the nurse bank, above their contracted hours, meant that there was a reduced uptake of substantive staff undertaking additional hours via the nurse bank.

- The department's bank and agency use between July 2015 and June 2016 was just under 10,000 hours.
- There were occasions when there were a significant number of agency staff on duty. For example, in August 2016, of 209 registered nurse shifts, 77 were covered by agency staff. On one particular shift, 50% of staff were agency staff. The information did not show whether these were regular agency staff.
- We looked at the planned and actual staffing levels on the department. The rotas showed that there were still significant shortfalls in staffing levels. The planned registered nurse number for the department was nine. On the four days of our inspection, this was not met. There were also two days, (7 August and 15 August 2016) when there were only four registered nurses on duty and six days when there were only six registered nurses on duty. In August 2016, there were only seven days when actual staff numbers met or exceeded planned staffing numbers. An incident reported on 1 July 2016 also highlighted a shift when there had only been five registered nurses on duty and one reported on 24 June highlighted very low staffing numbers in the department. A further incident reported on 3 June 2016 reported that one nurse had been responsible for two patients in the resuscitation department and that a further patient who needed to be monitored had not been monitored because there were no staff to do so.
- We had concerns that the staffing levels and skill mix within the department were not always appropriate to meet patients' needs. For example, the department had received a complaint about a nurse not being able to catheterise a patient because they were newly qualified and had not yet had their competency assessed. There were no other staff available to assist.
- There were qualified members of the nursing team who worked in advanced roles as emergency nurse practitioners, treating patients with minor injuries and illnesses.
- According to information provided to us by the trust, in August 2016 there was a staff turnover rate of 13% for nursing staff and a vacancy rate of 29%. This equated to 22 vacancies.
- The sickness rate for nursing staff was around 5%.

- The management team told us about the action the department was taking to recruit new staff to the ED, including that a recent recruitment drive had secured a number of new nurses, all awaiting either HR checks or confirmation of qualification before they were able to start work as a registered nurse.
- There was an induction process in place and before agency staff were allocated to the department, they had to provide evidence of competency. The senior nurse in charge had to sign to say they were happy with the competencies of any bank staff used.
- We observed a board round between nurses and saw that staff effectively communicated the presenting symptoms and care needs of patients to colleagues.

## Medical staffing

- The department was staffed by doctors 24 hours per day seven days a week. Emergency Department consultant presence was also on site at least between 8am and midnight with on call access outside of these times.
- The department had a funded consultant establishment of 10.2 whole time equivalent (WTE) consultants, which was in accordance with College of Emergency Medicine guidance, 10.5 WTE middle grade doctors, nine WTE junior doctors and two WTE foundation doctors. Compared to the England average, the department had an establishment with more consultants and registrars and fewer middle grade and junior doctors.
- The senior management team and senior medical staff told us that it was difficult to recruit doctors in to the Emergency Department and that this was a recognised national problem. In order to attract staff to the department, the trust had offered two staff development posts called CESR posts (**Certificate of Eligibility for Specialist Registration**).
- The trust information showed that there were currently five WTE vacancies. This equated to a 26% vacancy rate. Staff turnover rate was 55% and sickness was 1%.
- When we spoke with staff, they told us that there were five consultant vacancies. Three of these were covered by locums and two remained uncovered. Two consultants had been on long term sick and one was due to go on maternity leave in January. They were concerned about how consultant cover would be maintained.
- Locum use in the department was high. Between July 2015 and June 2016, the average rate was 32%, peaking at 40.5% in December 2015.

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- There had been 38 incidents reported between April 2016 and July 2016 where at least one or both of the middle doctor grade shifts had not been covered either by permanent or locum staff.
- Incidents between April and July 2016 highlighted issues about the competency of some staff with one misreading test results and one carrying out a procedure in the department than they were not competent to undertake.
- We observed doctors discussing patients and handing over relevant information to colleagues. We had no concerns about this process.
- The trust had a service level agreement with a primary care provider for GPs to work in the department between 6pm and midnight seven days per week to deal with some children who attended, or patients who had minor illnesses.
- The trust reported to us that medical staff were fully up to date with revalidation requirements.

## Major incident awareness and training

- The Emergency Department did not have any specific policies in place to deal with chemical, biological, radiological or nuclear incidents, however there was a trust wide policy in place for staff to follow.
- The Emergency Department at the Rotherham General Hospital was a trauma unit. This meant that patients who were unwell or had been involved in an accident or incident were brought to the department. Patients classed as being involved in a major trauma were taken to the closest major trauma centre.
- We checked the equipment the department held, to be used in the event of a major incident. We found that this was stored securely, organised and appropriately accessible. We found that the department had an ample supply of high visibility clothing, hard hats, torches and radiation detection equipment.
- Staff in the department were aware of the role they would play, dealing with walking wounded if there was a major incident in the region.
- The department had a policy in place to manage patients presenting with suspected Ebola. There was sufficient equipment and a designated area of the department. Staff were aware of their roles and responsibilities in the event of a possible presentation.
- The department had business continuity plans in place, in the event of system failures.

- Security staff were based outside of the department, but were easily accessible if required.
- The department could be locked down easily to ensure the safety of patients should the need arise. Staff were aware of their roles and responsibilities in such a situation.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement 

We carried out this inspection because, when we inspected the department in February 2015, we rated effective as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection, we rated effective as 'requires improvement' because:

- Recording of pain scores was not consistent and results from the national A&E audit showed that the department performed worse than other similar trust for time waiting for pain control and staff doing as much as they could to control patient pain. Additionally, some PGDs were out of date meaning that there was a risk of delays in patients receiving pain relief.
- Royal College of Emergency Medicine and Trauma Audit and Research Network audit results showed that the department was not meeting some standards.
- The rate of staff appraisal did not meet the trust standard.
- Nursing staff from the children's wards had to cover in the Emergency Department on occasions due to a lack of paediatric nurses in that area. They were not trained in or familiar with this area.

However:

- There was evidence of MDT working with a number of different teams attending the department to see patients with conditions such as dementia, mental health needs, substance misuse or requiring a bed on a ward.



# Urgent and emergency services

- There was an electronic system in place to enable staff to check whether patients were on the caseload of a community provider such as community nurses.

## Evidence-based care and treatment

- There was a wide range of departmental policies and guidelines for the treatment of both children and adults.
- Departmental policies were based upon NICE (national institute for health and clinical excellence) and Royal College guidelines. We looked at a reference tool available to staff and found that guidelines reflected recent updates to NICE guidance.
- We saw evidence that the department followed NICE guidance for a number of conditions such as sepsis, head injury and stroke.
- Care was provided in line with 'Clinical Standards for Emergency Departments' guidelines and there were audits in place to ensure compliance. Staff acknowledged that results to some audits needed to improve and there were action plans in place to achieve this.
- Local audit activity demonstrated that audit and re-audit took place in the department and there was evidence of changes implemented as a result. For example, the introduction of a section on the record to note if a patient is under the influence of alcohol as a result of the mental health RCEM audit and the introduction of simulation scenarios for junior doctors to treat fitting children. The RCEM audits also provided evidence to support the recruitment of further staff to carry out observations in a timely manner for asthma and sepsis. Recruitment was ongoing.

## Pain relief

- Pain scores were not always completed. Of 21 records we looked at, five had a pain score recorded, 12 had no pain score recorded and for four, a recorded pain score was not applicable.
- We saw that patients were being asked if they required pain relief as part of the triage process. It was recorded if patients refused.
- We spoke with nine patients about pain relief, four of whom required pain relief in hospital. Three patients felt that staff did enough to help them control their pain. One patient had only been in the department for 10 minutes and was waiting to see a member of staff.

- We saw nurses giving patients pain relief using PGDs although some PGDs were out of date, meaning that some staff could not administer certain pain killers without an individual prescription.
- CQC's national 'A&E survey 2014' showed that the trust performed worse than other similar trusts for the time patients waited to receive pain medication after requesting it.
- In the same survey, the trust performed worse than other similar trusts when patients were asked whether staff did everything they could to control people's pain.

## Nutrition and hydration

- CQC's national A&E survey 2014 showed that the trust performed 'worse' than other similar trusts for the ability of patients to access food and drinks whilst in the A&E Department.
- Staff told us that sandwiches, and beverages were available to patients. We overheard staff asking patients if they wanted drinks or snacks and we saw patients being offered drinks and being brought cold meals. A housekeeper took a sandwich trolley round the ward at 8am and 12pm.
- On the CDU, patients had access to hot and cold meals and drinks as there were specified meal times. Jugs of water were on each patient's bedside table.

## Patient outcomes

- In 2012/13 RCEM audits were carried out for renal colic, fractured neck of femur, and feverish children. A RCEM audit of severe sepsis and septic shock was undertaken in 2013/14. Performance was in the lower quartile for four questions in the report for severe sepsis and septic shock. Results included 10% of patients being administered antibiotics within one hour, against a national target of 50%. The three other questions concerned capillary blood glucose measurement on arrival, the initiation of high-flow oxygen and obtaining blood glucose.
- The department had undertaken or planned to undertake a number of re-audits in response to RCEM audit results. These included, consultant sign off, severe sepsis and septic shock and asthma care in the Emergency Department. The results of these were not available at the time of the inspection.
- The department took part in the NHS England 2016/2017 CQUIN 'Identification and Early Treatment of Sepsis'. Data collection for this CQUIN was ongoing.

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- According to the TARN website, the trust had not submitted any data for 2016. However, in 2015, information showed that out of every 100 patients, there were 0.6 more patients surviving than were expected to.
- The median time for a patient with a head injury to wait for a CT scan was 1hour 37minutes. The national median time was 55 minutes. This means that most patients waited longer for a scan at this hospital than at others.
- The percentage of patients with a cardiothoracic injury being seen by a consultant was 68.7%. This is better than the national figure of 67.2%.
- TARN data showed that the number of patients being seen by a consultant within 5 minutes of arrival at the department had improved. For trauma patients this had increased from 38% to 100% and for general patients, from 5% to 6%.
- The department had an action plan in place in response to issues raised by TARN audits. It was reviewed regularly and progress was monitored.

## Competent staff

- According to information provided by the trust, between April 2015 and March 2016, 58% of additional clinical staff, 100% of estates and ancillary staff and 66% of nursing staff received an annual appraisal. Between April 2016 and August 2016, 48% of additional clinical staff and 57% of nursing staff had received an appraisal.
- Staff felt able to discuss clinical issues and seek advice from colleagues and managers.
- Recently appointed staff were supported by colleagues. Newly qualified staff had preceptorship in place to support them to gain their competencies.
- Some staff expressed concerns to us that not all staff had the competencies required to work independently in the department, for example, to give intravenous drugs.
- Several staff from the children's department told us children's nurses from the ward were asked to work in the Emergency Department. They said they were not comfortable with doing this, because they were not trained in or familiar with this area. Other staff told us they felt very vulnerable when working in the Emergency Department, as they were not trained and competent in the Emergency Department pathways.

- The department employed emergency nurse practitioners and advanced nurse practitioners to work predominantly in the minors department to treat minor injuries.
- The department had recently introduced a new triage system and not all staff had completed training to be able to triage patients.
- The practice education nurse had been newly appointed and planned to work with staff to ensure that they were competent and able to develop their roles. Senior members of staff informally monitored staff competencies throughout the year as well as through appraisal.
- All staff were part of the revalidation scheme and we identified no concerns about compliance within the department.

## Multidisciplinary working

- The Emergency Department teams worked effectively with other specialty teams within the trust, for example by seeking advice and discussing patients, as well as making joint decisions about where patients should be admitted. There were close links with the ambulatory care department and the assessment suite. Doctors from the assessment suite did ward rounds on the Emergency Department and made decisions about the most appropriate wards for patients. This helped with the flow of patients through the department.
- There was good access to psychiatry clinicians within the department with 24 hour telephone access to psychiatric liaison staff.
- There was a substance and alcohol misuse liaison team available by telephone to support patients and staff treating them.
- Allied health professionals attended the department. This meant that patients who needed therapy input or assessment prior to discharge could be seen quickly and efficiently.

## Seven-day services

- The ED offered a seven-day service staffed 24 hours a day, seven days a week by medical and nursing staff. Staff could access support from consultants throughout the 24 hour period.
- There was 24 hour, seven day access to diagnostic blood tests. Radiology tests such as x-rays and scans were carried out as and when needed.

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## Access to information

- Staff were able to access patient information using an electronic system and paper records. This included information such as previous clinic letters, test results and x-rays.
- Patients transferred to other services or sites took copies of their medical records with them.
- The department had access to an IT system that showed when a patient was under the care of a community team such as district nurses or community matrons. This assisted staff in gathering information about patients and also care planning.
- Clinical guidelines and policies were available on the trust intranet.
- During the inspection we saw that waiting times were displayed in the waiting area, however we noted that this was inaccurate and not regularly updated.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with staff about the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards. Most staff understood the basic principles of the Act and were able to explain how the principles worked in practice in the department.
- The trust had introduced a prompt card for staff to use. We spoke with seven staff and none were able to produce the card.
- Staff we spoke with understood the need to obtain consent from patients to carry out tests and treatments. Staff told us that they implied consent when the patient agreed to a procedure and we saw evidence of staff explaining procedures to patients and patients agreeing to them.
- Staff working in the children's area were aware of Fraser guidelines relating to decisions made by children and young people.
- Mental Capacity Act and consent training was part of safeguarding adults training.

## Are urgent and emergency services caring?

Good



When we inspected the department in February 2015 we rated caring as 'good'.

At this inspection we also rated caring as 'good' because:

- Staff ensured that the privacy and dignity of patients and their families was maintained.
- Patients and their relatives were given information about care and treatment and kept informed about tests and planned treatment.
- The department performed better than the England average in the friends and family test.
- Patients told us the staff were kind, caring and helpful. They answered questions in language that patients could understand.

However:

- Staff sometimes were not able to spend as much time as they wished with patients to reassure or support them.

## Compassionate care

- During our inspection we spoke with 10 patients who were happy with the care they received.
- Patients described to us how staff treated them with dignity and respect.
- Results from the 2014 A&E survey showed that the trust scored about the same as other similar trusts when patients were asked if they felt they were treated with respect and dignity in the department.
- Results of the 2014 A&E survey showed that the department performed about the same as similar trusts in seven of the eight questions relating to care and treatment and worse than other trusts for the remaining one, being given conflicting information by different staff members. .
- When we discussed care of patients with staff, there was a consistent message that staff wanted the patients to feel as though they were being well cared for.

# Urgent and emergency services

- In the patient led assessment of the care environment survey undertaken in October 2015, the trust scored 80% for privacy, dignity and wellbeing. There were no figures specifically for the Emergency Department.
- The trust performed about the same as other trusts in 21 of the 24 compassionate care questions in the '2014 Accident and Emergency survey'. The trust scored worse than other trusts for two questions relating to being given conflicting information from different members of staff and information about danger symptoms post discharge. They scored better than other trusts for staff explaining test results in a way that was easy to understand.
- The friends and family test showed that between April 2015 and May 2016, the department performed better than the England average for percentage of patients recommending the department to friends or family. The national average was around 87% and the trust scored 95%. The response rate, however, was worse than the England average at only 8.7% compared to 13.7%.
- Staff told us about how they would support patients who were distressed, by chatting to them and trying to distract them. However, they sometimes found this difficult when the department was busy, due to staffing levels.
- Staff told us they made sure patients received the support they needed. Patients we spoke with said that they would feel reassured if they needed extra support to know someone was there for them.
- We observed all staff talking with patients and relatives in a calm way and offering reassurance to both concerned patients and their family members.
- Staff offered support and gave information about support services if this was required.
- Staff could refer patients who presented with alcohol or drug problems (regardless of their age) to support services available via the alcohol liaison nurse.
- There was pastoral support available for patients of all or no religious belief.

## Understanding and involvement of patients and those close to them

- According to the 2014 A&E Survey, the department scored about the same as other trusts for questions relating to understanding and involvement apart from being informed of danger signals to look for after going home. The trust performed worse than other trusts for this question.
- Patients were happy with the amount of information they received when visiting the department.
- Patients and relatives told us that staff explained patient literature to them and gave them time to ask questions.
- Staff delivered patient diagnoses in a calm and sensitive manner and in language and terms that patients and their relatives understood.
- Patients and relatives told us that staff answered to their questions about their condition.
- When patients needed to be transferred to another part of the hospital, staff were seen explaining why this needed to happen, how it would happen and what would take place once the patient arrived at their new destination. Staff sought to make sure that patients weren't unduly stressed about their medical condition

## Emotional support

## Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Requires improvement 

We carried out this inspection because, when we inspected the department in February 2015, we rated responsive as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated responsive as 'requires improvement' because:

- The department had consistently failed to meet waiting time targets between May 2015 and June 2016, including the median time to treatment target, the 95% four hour target and the re-attendance target.
- Staff we spoke with were unclear about departmental dementia leads and learning disability leads. Although the trust had a dementia strategy, this was not embedded in the care delivered by the department.
- We found that the facilities on the clinical decision unit (CDU) meant that patients on the department did not have access to a shower.

However:

# Urgent and emergency services

- The trust had consulted widely with the local population and other stakeholders to plan services for the future, including in the building of the new Emergency care centre.
- There were systems in place to support patients with additional needs, such as interpreters, leaflets in other languages and formats such as Braille. Bariatric equipment was also available if required.

## Service planning and delivery to meet the needs of local people

- The Emergency Department was in the process of building a new department that would have sufficient room to accommodate the volume of patients attending. The new building had been designed to incorporate primary care providers such as GPs, independent care providers and staff employed by the Emergency Department. Work on design of the services delivered and the design of the building had involved consultation with local people, trust staff, the clinical commissioning groups (CCGs) and other stakeholders.
- The department was working with the local 111 service, Yorkshire Ambulance service, GPs and community services to look at ways to ensure that patients attended the most appropriate service to manage their conditions, such as specialist community services rather than attend hospital unnecessarily.
- At the time of the inspection however, the department had moved to occupy a ward based area. This meant that the configuration of the department was not the same as most emergency department s are set out. Although the ward based design worked, there were some constraints on space and access for patients and visitors. However, this was just a short term arrangement until the new department was completed.
- GPs worked in the department some evenings and weekends to ease the pressure on the main Emergency Department and ensure that patients were seen quickly by the most appropriate clinician.
- Managers were aware of the type of patients who attended the department and the potential incidents which could occur locally and had ensured that the department had the necessary equipment and trained staff to manage such situations.
- The department had acknowledged the mental health needs of the local population and had access to mental health services.

## Meeting people's individual needs

- The waiting room was quite small. This meant that at busy times, patients sometimes had to wait out in the reception area. We saw people with wheelchairs and mobility scooters attend the department. When these were in the waiting area, it became cramped. There were however, dedicated disabled toilets available.
- There were dedicated paediatric waiting and treatment rooms for children. These were decorated with age appropriate murals and wall art. The waiting area was open 24 hours a day. This meant that young people were away from the adult waiting rooms at all times.
- There were facilities, such as beds and wheelchairs, for bariatric patients either in the department or around the trust for loan.
- The clinical decision unit (CDU) shower was out of order. It was being used as a store room for various items of equipment. We spoke with staff about how long the shower had been broken and were told that it had been broken for approximately two years. Some patients were staying on the clinical decision unit for several days. The broken shower meant that patients did not have ready access to washing facilities other than a bowl of hot water at their bed side. Staff told us that if a patient wanted to have a shower, they would be taken to another ward by a member of staff to use their facilities. The alternative was for the patient to have a bed bath.
- There were vending machines present in the department that relatives and carers could access and the hospital had a number of shops and places to eat.
- The trust had access to interpreting services for people whose first language was not English. Staff told us that, in an emergency situation, they may use a family member in the very first instance, but would try to access an interpreter as quickly as possible. The trust could also access telephone interpreters if necessary.
- The department had access to sign language interpreters for people living with hearing impairment. However, we noted that the department received a complaint in July 2016 relating to the unavailability of a sign language interpreter.
- Most patient information was available in different formats such as large print, audio, CD, braille and languages other than English on request.
- There were private areas for relatives to wait whilst patients were being treated and there was a relatives' room close to the department.



# Urgent and emergency services

- When a patient passed away, whenever possible, they were moved to a side room so that family could have privacy to visit. The trust used large butterfly stickers on dividing doors to make it clear that a patient had died.
- The trust had a dementia strategy. Within the department, there were designated dementia leads for nurses and doctors however when we spoke with staff, they were unclear who led on dementia. The trust also delivered mandatory training to staff about dementia awareness. Neither medical (14%) nor nursing (43%) staff teams had met the trust target of 66%.
- We looked at the records of three patients who had a diagnosis of dementia. None of the records displayed the recognised dementia symbol, nor was there any indication above the patient's bed or on the patient board that the patient was living with dementia. Staff were aware of the 'Forget me not' symbol, but its use was not embedded in to practice.
- The staff we spoke with about patients living with dementia, or a learning disability all told us that they would treat patients as individuals and would try to involve family and carers in discussions about care needs.
- Staff told us that whenever possible, people with dementia or a learning disability were seen as quickly as possible in order to minimise distress for the patient.
- Some patients with learning disabilities had patient passports. When the patient or carer presented this at the department, staff used the information to assist them in making decisions about patient needs and wishes.
- If patients had specific needs, such as a learning disability were living with dementia, or had mental health problems, alerts were meant to be put on to the patient board situated behind the nurse station however this did not always happen.
- Information about expected waiting times was clearly visible however this was not updated regularly. This meant that patients were not always clear about how long they could expect to be in the department.
- For patients and relatives of all faiths or none there was access to chaplaincy services.
- Patients with purely mental health needs were supported to wait in a designated room which had two exits and a panic button. The trust had access to the psychiatric liaison team by telephone.
- Between May 2015 and April 2016 the median time to treatment was worse than the standard of 95% of patients being treated within 60 minutes. The median time for this department was 80-90 minutes between May 2015 and April 2016.
- Between July 2015 and May 2016, the trust failed to meet the national target that 95% of patients be either admitted, transferred or discharged within four hours. The trust was also worse than the England average. In March 2016, only 77% of patients met the target. By May 2016, 91% of patients met the target.
- The department was worse than the England average for patients leaving the department before being seen. The England average between May 2015 and April 2016 was less than 3%. The trust rate varied between zero in May 2015 and 8% in December 2015 and March 2016.
- Between June 2015 and May 2016, 1091 patients waited between 4 and 12 hours from decision to admit, to being admitted on to a ward. One patient waited more than 12 hours. In March 2016, 21% of patients waited between 4-12 hours to be admitted after the decision to admit had been made.
- The unplanned re-attendance rate for the department was 6% average between May 2015 and April 2016. This was better than the England average of 7.5%, but worse than the England standard of 5%.
- From our observations and discussions with patients and staff, patients were triaged and assessed quite quickly. Few people we spoke with expressed concerns about excessive waiting times.
- The department used rapid assessment and treatment to triage patients where a nurse and consultant worked together to assess patients and plan diagnostic needs such as order tests. This was aimed at improving the flow of patients through the department at busy times.
- The departments used GPs at certain times of the day to deal with minor illnesses and injuries to ease the pressure within the department. This also helped ensure that patients were seen by the most appropriate person to treat them.

## Learning from complaints and concerns

- Patients and relatives we spoke with were aware of how to make a complaint to the trust although none of the people we spoke with had made a complaint about the department.

## Access and flow

# Urgent and emergency services

- There was information about how to raise concerns about the department or the trust as a whole on display in the department and there were leaflets available for patients to take away with them.
- Staff were able to describe to us the action they would take if a patient or relative complained to them.
- Between January 2015 and July 2016 the trust received 46 complaints about the Emergency Department.
- The most common cause for complaint was 'Clinical treatment' followed by 'Patient Care' and 'Values and behaviours of staff'.
- Of the complaints made, the trust upheld 18, partially upheld seven and did not uphold 15. The remaining six did not have an outcome recorded.
- It took the trust between three and 305 days to process these complaints.
- Of the 46 complaints, 30 related to medical staff and 16 related to nursing staff.
- There were some themes running through the complaints such as missed fractures and missed stroke diagnosis. It was unclear from the complaints information sent to us what action had been taken.
- Staff and managers told us that feedback was given to staff when they were part of a complaint. Additional training was offered as a way of supporting staff.
- Where applicable, the department generated action plans in response to complaints.

## Are urgent and emergency services well-led?

Requires improvement



We carried out this inspection because, when we inspected the department in February 2015, we rated well-led as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated well-led as 'requires improvement' because:

- Some of the management team and senior staff teams were quite new in post and processes were yet to be embedded in to routine practice.
- Some groups of staff were disengaged and did not feel listened to.
- There were mixed impressions of the culture in the department with some staff feeling supported and

others feeling that some colleagues were overly assertive and unwelcoming. The new leadership team still had work to do to improve the culture in the department.

- Although the multi-disciplinary staff worked together to ensure the safe treatment of patients, the department did not give the impression of always working as a cohesive team.

However:

- There was a clear vision and strategy for the department, including building a new emergency care centre in collaboration with other local health care providers.
- There were governance processes in place to ensure that quality, safety and performance were monitored and managed. There was joint working with other directorates in relation to governance and sharing lessons learned. Some of these were new and were yet to be embedded in to routine practice.
- There had been recent changes to the senior nursing management and structure in order to support staff to develop and improve practice through better dissemination of lessons learned.

### Vision and strategy for this service

- At the time of the inspection, a consultation was occurring with staff as part of refreshing the trust's values. This was with involvement of staff to ensure that the core values reflected the views of staff and patients. The trust had a vision for the service and was working with local clinical commissioning groups, GPs and independent service providers to develop urgent and emergency care services. This included the building of a new emergency care centre, due to be completed in August 2017. Once completed, it was envisaged that this would increase the capacity of the department and ensure that patients saw the most relevant clinician for their condition.
- The trust had developed a local strategy plan for the department with key areas of performance for improvement clearly identified.
- Managers in the department were aware of the changing and increasing demands on the department and the types of patients accessing the department. Work was continually underway to try to manage demand.

# Urgent and emergency services

## Governance, risk management and quality measurement

- A clinical governance system was in place across the department. Staff were invited to attend clinical governance, patient safety and clinical audit meetings. The meeting minutes showed that there were concerns about the lack of staff attending the Clinical Quality Risk Management Governance group. We saw that information was intended to be shared with all staff by those who attended the meetings however there were concerns that this was not happening effectively because of the lack of operational staff attending. Because of this, we had concerns about the effectiveness and robustness of the governance system.
- We were not fully assured that the management team were made aware of all incidents as there was a lack of incident reporting culture amongst the medical staff. Most medical staff we spoke with told us that they rarely or never reported incidents as nursing staff usually reported them. One doctor told us that reporting incidents was the responsibility of the nursing staff.
- There was a process in place to ensure that all relevant NICE guidance and drug alerts were implemented and that staff were aware of any changes.
- The staff we spoke with were clear about the risks the department faced.
- There was a process in place for ensuring that the results of radiology investigations were followed up to ensure that any “missed abnormality” was followed up in a timely manner. Where abnormalities had been missed, staff involved were informed and offered support and training to ensure that the risk of future errors was minimised.
- A departmental risk register was available and was under regular review to ensure that the content of the register was reflective of the real-time risks within the department. These risks correlated with the risks we observed during our time in the department.
- When we spoke with the senior management team, they were able to clearly tell us about the risks posed to the department and how these were being addressed. Most mitigation was effective however some risks such as staffing remained a concern.
- Managers discussed waiting time breaches weekly to identify any themes and were able to take actions to address issues, such as bed shortages across the trust.
- The department was led by a clinical lead, matron and business manager. We met with the clinical, nursing and business managers as part of our inspection. The team appeared to work well together to provide a cohesive management team.
- Staff told us that although some of the senior staff were fairly new in post, they seemed to listen to concerns and where ever possible, take action.
- During our inspection, there were occasions when the department did not have sufficient staff to manage demand, due to staffing shortages. We saw managers work with team leaders to support them and other staff to keep the department running smoothly. Some staff told us this was a usual occurrence however others told us that this rarely happened.
- Staff told us that members of the executive team occasionally visited the department.
- Nursing staff told us that they felt well-led at a local level and that they had no concerns with their line managers. They felt that they could raise concerns and be confident that they would be resolved whenever possible in a timely manner. They told us that the management team was open, approachable and provided good leadership. However, some other staff did not share this opinion and thought that the senior department leadership team were remote and unapproachable.
- The department had recently appointed to a number of senior nursing roles such as clinical educator and matron. The impact of these appointments was yet to be seen however staff were optimistic that any influence would be positive.

## Culture within the service

- We spoke with a number of staff from different disciplines about the culture of the department. We received a number of differing perspectives. Some staff said that the staff were supportive of each other, cross discipline and across seniority. Others felt that the department was fragmented and that some people were overly and unnecessarily assertive in their approach. Some people described the department as friendly. However, others described how some staff ignored them and didn't make them feel like part of the team.

## Leadership of service



# Urgent and emergency services

- From what we observed and were told, the new leadership team had significant work to do to improve the culture in the department to make it a place that staff wanted to come and work.
- The atmosphere in the department showed that staff focus was on treating patients in an efficient way.
- The way we saw staff interact with each other demonstrated that there was professional communication between staff from different disciplines. Staff worked as a team to ensure that patients received good care.
- Staff felt that their hard work was recognised and they felt appreciated by colleagues and line managers but that this was not always the case with senior management who didn't work in the department.
- We spoke with a number of staff who felt that as a group of clinicians, they were not listened to. They felt that their concerns had not been listened to or addressed. They felt disengaged from the departmental management team.
- Staff told us that they were kept informed about changes within the department as well as opportunities to progress.
- The trust undertook a staff survey 'pulse check' in June 2016. On the whole, the results has improved from June 2015 with the exception of staff feeling that the quality of patient care is a priority, staff being able to prioritise patient care over other work and staff feeling that the organisation communicates clearly with staff about its priorities and goals. We did not see specific results for the Emergency Department.

## Public engagement



- The department participated in the Friends and Family Test and CQC surveys but had not carried out any local surveys in relation to urgent and emergency care services.
- The trust had consulted with the public and local stakeholders about the building and configuration of the new Emergency Department. This included a simulation event where over 60 members of the public volunteered to attend to help test the new model of care.

## Staff engagement

## Innovation, improvement and sustainability

- The trust had recently introduced a system which linked the records of community health care staff and hospital staff. The system alerted staff when a patient was on the caseload of another team. The management team told us this had the potential to reduce missed appointment and also improve the discharge process.
- The department had successfully trialled a 'patient champion' role to ensure that patient progress through the department was efficient.
- The department had plans in place to move to a 'Most Appropriate Clinician Available' model once it had moved to the new Emergency Care Centre due to open in July 2017.

# Medical care (including older people's care)

Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Good	
Well-led	Good	
<b>Overall</b>	<b>Requires improvement</b>	

## Information about the service

Medical care for The Rotherham NHS Foundation Trust was managed as part of the division of Integrated Medicine. Care was provided at Rotherham General Hospital.

Integrated medical specialities included inpatient and outpatient facilities in relation to cardio-respiratory, care of the elderly, gastroenterology, diabetes and endocrinology, haematology, oncology, stroke services, and dermatology.

Between March 2015 and February 2016, there were 24,611 medical admissions to The Rotherham NHS Foundation Trust. The majority of these, 23,903, were admissions to Rotherham General Hospital. Around 50% of admissions were for general medicine, 16% elderly medicine, and 16% haematology.

The hospital was last inspected in February 2015 and the service was rated as 'requires improvement' overall. We rated the safe, effective and well-led domains as 'requires improvement', responsive as 'inadequate', and caring as 'good'.

We carried out an announced comprehensive inspection between 27 - 30 September 2016 and an unannounced inspection on 12 October 2016.

We visited a number of medical wards including the acute medical unit (AMU), the stroke unit, the coronary

care unit (CCU), the cardiac catheter suite, the discharge lounge and the wards A1, A2, A4, A5, and A7. We also visited ward B11 a gynaecology ward which was routinely used for medical outliers.

We spoke with 39 patients and carers, and more than 65 staff. We attended a number of focus groups and we observed staff deliver care on the wards. We looked at 12 nursing and 22 medical care records and 22 medicine prescription/administration cards and reviewed the trust's performance data.

# Medical care (including older people's care)

## Summary of findings

We rated the care and treatment of patients receiving medical care as requires improvement overall.

We rated the safe and effective as requires improvement and caring, responsive and well-led as good.

We found that the service had made many improvements since our last inspection, but there were still some areas requiring further improvement.

Staff shortages were still evident and planned staffing levels were not being achieved on many wards. However, the trust was taking action to cover shifts wherever possible with bank and agency nurses and in the main staff felt well supported. Staff reported incidents and learning was disseminated using a variety of methods. Mandatory training levels were improved from last year, but were still poor in some areas. Infection prevention, practices and procedures did not always protect against the risk of spreading infection.

Knowledge of the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards was good, but documentation of mental capacity assessments and discussions was poor. Appraisal rates were below trust target. Fluid balance recording needed to be improved.

Although the discharge lounge was still sometimes being used as an inpatient ward, there were processes in place to close to discharges if this happened and the unit was appropriately staffed to care for overnight patients. We found that staff were very caring and there had been no mixed sex breaches for this service in the last 12 months.

Each speciality had a vision and direction for their service and business plans were developed regarding sustainability and future development. Ward managers, matrons and senior managers were aware of their risks and mitigations were in place. Risk registers were comprehensive and up to date.

## Are medical care services safe?

Requires improvement



We carried out this inspection because, when we inspected the service in February 2015, we rated safe as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated the service as 'requires improvement' for safe because:

- Although staff numbers, morale and support had improved, the trust could still not achieve planned staffing levels.
- Infection control practices did not always protect against the risk of spreading infection. We also found that numbers and positioning of hand wash basins did not facilitate good compliance with hand hygiene and that this was not being fully addressed in line with current buildings regulations and guidance, when wards were being refurbished.
- Although improvements to mandatory training levels had been made and managers were taking action to improve staff compliance, levels of compliance were still poor.

However:

- Staff reported incidents and learning was disseminated through a variety of methods.
- Although the discharge lounge was still used as an overnight stay area on some occasions, this was now managed more effectively and was staffed appropriately.
- We found good practice in relation to medicines management.

### Incidents

- There were 11 serious incidents (STEIS events) reported between 01 July 2015 – 30 June 2016; none of these were Never Events. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

# Medical care (including older people's care)

- Seven of the serious incidents were slips / trips / falls resulting in serious harm and the other four were relating to sub-optimal care of the deteriorating patient.
- There were 1195 incidents across the medical service between February 2016 and July 2016; 1159 low or no harm incidents, 20 were reported as moderate harm, eight severe harm, three deaths and six incidents met the threshold for 'Serious Incidents' (SIs) which were externally reported.
- Ward managers and matrons told us they were involved in the investigation of incidents and they had received root cause analysis (RCA) training. Staff told us they received feedback from incidents via email and the matron visited the ward to discuss any incidents when they triggered a duty of candour response. The duty of candour is a regulatory duty that requires providers of health and social care services to notify patients of safety incidents that reach a threshold of moderate harm and provide reasonable support to that person.
- The ward managers told us they received feedback from the governance committee regarding the outcome of SI investigations. They told us they shared the key points from the investigations with their staff using a variety of methods and forums such as ward meetings, following handover, safety huddles, notice boards and emails. One ward manager recorded the key points shared and the names of staff present at a meeting following afternoon handover.
- If information needed to be shared immediately, ward managers told us this was done at the end of the morning handover.
- Staff confirmed that they received feedback from incidents through a variety of methods as described by the ward managers.
- We saw evidence of sharing of themes and learning from incidents in ward meeting minutes.
- The ward managers and matrons demonstrated a good understanding of duty of candour and explained that a letter was sent from the head of nursing to the patient and or their family following incident investigations. Other staff were aware of duty of candour and had a clear understanding of openness and transparency. We observed posters informing staff about this duty but they told us they had not received specific training regarding this.
- Staff were able to give us examples of learning and improvements from incident investigations. For example, staff on A5 told us that findings from RCA investigations showed they needed to make improvements with documentation / records and to assess tall patients regarding the need for a larger bed.
- Doctors we spoke with told us they been involved in reporting of incidents and they had received feedback when incidents was investigated / closed.
- Staff told us that safety huddles had recently been introduced on A1 and the stroke ward with nursing, medical and therapy staff in attendance. The ward manager on A1 told us that these were used as a forum to discuss incidents and felt that the number of drug errors had reduced since these had been implemented. The sister told us she was planning to develop the huddles to target improvements regarding fluid balance and early warning scores.
- Ward managers looked at all incidents for their ward and were responsible for sharing this information with their staff. The ward manager on A1 told us that they tried to hold monthly meetings where information could be given back to staff.
- Ward managers told us that serious incidents were investigated at a more senior level by a team of people including the governance lead, senior nurse or matron and a consultant.
- Staff on the cardiac catheter suite and CCU told us about recent incidents and how these were reported, dealt with and how staff had been supported and received feedback. CCU staff also told us they had safety huddles every afternoon and recent incidents were discussed then.

## Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring analysing patient harms and 'harm free' care.
- Safety thermometer information reported for medicine July 2015 to June 2016 was that there had been 23 (0.9%) category 2-4 pressure ulcers, 3 falls with harm (0.1%) and 20 (0.9%) reported incidents of new urinary tract infections (UTIs) in patients with a catheter. The ward with the highest rate of catheter acquired UTIs was A1 with 2.1 per 100 patients sampled.
- We saw that all the medical wards recorded the Safety Thermometer information monthly.

# Medical care (including older people's care)

- CCU had one fall in the current month and two the previous month; there were no pressure ulcers (none the previous month) and no medication errors (two the previous month).
- Some wards displayed their safety thermometer information for patients and visitors to see, but some did not.

## Cleanliness, infection control and hygiene

- We saw that most areas we visited, were clean and tidy and were in a good state of repair, however, there were some exceptions. Data from cleanliness audits showed that August 2015 to July 2016 the average scores for wards A4, A5 and A7 were below target. However, this was largely due to a poor score in January 2016, which affected overall figures. The latest score for July 2016 was 100% compliance.
- The cardiac catheter suite and CCU were visibly clean and tidy. However, there were some chairs in CCU that appeared to be a fabric that could not be cleaned by wiping down and looked dirty.
- There were no reported Meticillin Resistant Staphylococcus Aureus (MRSA) cases at the trust, 16 reported cases of Clostridium difficile (C diff) and nine cases of Meticillin Sensitive Staphylococcus Aureus (MSSA) in the period July 2015 to June 2016.
- We saw mixed practice in relation to infection control and prevention. Although we saw some good practice, we also observed some poor practice. For example, on AMU we saw a nurse carrying a jug of ascetic fluid from the patient's bedside to the sluice room uncovered. We saw that the jug used for drainage of ascetic fluid was not disposable and had been manually washed and left to dry next to the sink. The jug was not labelled with patient details or identified in any way for single patient use. There was no electrical washer available for reusable containers.
- We also observed a domestic move from the AMU to the clinical decisions unit with a cleaning trolley and without changing apron and gloves. When we spoke to nursing staff about this, they told us the same domestic staff covered AMU and CDU as one unit, however these were two separate clinical areas and cleaning equipment should not be shared between wards.
- We observed that staff generally washed their hands using the correct technique and at appropriate points of care, however we did see some occasions when staff did not do this. We saw staff handwashing after delivering personal care and after removing PPE, but also saw staff moving between rooms and areas without removing PPE or washing hands. For example, on A4, we observed a registered nurse, doing a drug round, who did not apply hand gel after patient contact and before giving the next patient their medications. We observed a therapy assistant on the stroke unit leave a patient and not wash their hands. On AMU we observed a nurse come out of a single room, where additional precautions were being taken, wearing apron and gloves, the nurse then entered a bay for handover. We saw another member of staff carrying a bedpan to the sluice without wearing any PPE.
- We observed that the ward layout and situation of hand basins and waste bins was not ideal on some of the wards. The basins and bins were situated on the ward corridor outside of the bays and not all bays had a basin immediately outside. This meant that staff needed to leave the bay after delivering care to remove PPE and wash hands before returning to the bay to carry out their next task or move on to the next patient. This did not facilitate good compliance with hand hygiene and use of PPE. Managers informed us the trust had a policy, which stated that clinical areas have a bag to bin system in place to mitigate risk and facilitate compliance.
- Due to risks to patients, point of care gel was not available at bed spaces on wards A2 and A4, this meant staff needed to carry personal use bottles. Point of care gel was available at all bed spaces in the cardiac catheter suite and CCU.
- In most instances staff were compliant with the bare below the elbows policy, however, we observed two consultants on the stroke unit who were not compliant this policy.
- We observed good hand hygiene practice, use of PPE and disposal of sharps in the cardiac catheter suite and CCU.
- On A2, we saw that sharps bins were stored in a locked utility room, which was in line with policy and good practice.
- Staff we spoke with on AMU had a good understanding of communicable diseases such as CPE and Clostridium difficile and told us they made immediate contact with the infection control team when they admitted this type of patient. We saw that patients were risk assessed for

# Medical care (including older people's care)

CPE and this was documented in their medical notes. We also saw good documentation of C difficile status and of early interaction with the infection prevention and control team.

- Staff we spoke with on AMU were aware of all of the infectious patients on the ward and we saw appropriate signage outside of the isolation rooms.
- Staff told us that rooms occupied by an infectious patient were 'terminally cleaned' by the isolation cleaning team, when the rooms were vacated. Staff told us this team was available 8am until 8pm and was easily accessible when needed. Nursing or other domestic staff cleaned rooms outside of these hours; staff we spoke with had a good understanding of the cleaning products and when to use them.
- On Ward A1 there was an outbreak of rotavirus; we noted that there were posters and regarding precautions needed and PPE was available at the entrance to the affected bays. We saw that staff used PPE and carried out handwashing appropriately. Equipment on this ward was clean and labelled as ready for use, the dirty utility was clean and tidy and disposable products were stored correctly.
- However, we saw the hand washbasins were outside of the bays on this ward and that there were only four basins for the 30-bedded ward.
- Staff told us rooms were decontaminated with **hydrogen peroxide vapour (HPV)** following cleaning when a patient had C.difficile. They told us this service was provided by an external contractor and was available Monday to Friday. The staff were unclear what would happen if the HPV treatment was needed at the weekend as this service was only available Monday to Friday. Managers told us the site team would be aware how to manage decontamination at weekends.
- Staff told us there was a mattress cleaning team that removed mattresses from the wards to be cleaned and checked for damage. This team worked Monday to Friday 7am to 8pm and Saturday and Sunday mornings. Nursing staff cleaned and checked mattresses as necessary outside of these hours. Although this was a good service, we were concerned that staff told us the mattresses were not cleaned or bagged prior to removal from the ward.
- On the stroke ward, we saw there were two patients nursed in side rooms for infection control reasons, but it was not obvious from the outside of these rooms that particular measures to prevent the spread of infection were in place.
- We saw that all sharps bins in the corridors on AMU were closed using the temporary closure mechanism. We saw appropriate use of mobile sharps bins at patients' bedsides and observed excellent aseptic technique when a member of staff was cannulating a patient.
- On ward A2, we saw that equipment such as commodes were clean, and labelled as such. We saw that curtains had been changed recently and were labelled with date of change. There were infection control posters outside of all cubicles. However, we noticed that the linen trolley and the domestic trolley were rusty making them difficult to clean and a potential reservoir for microorganisms.
- We observed on most wards that the domestic trolley was dirty.
- We also saw on AMU worn equipment such as commodes with exposed rubber, domestic trolleys with rust and damaged walls and doors that exposed plaster or wood which would make cleaning inadequate. There were also sharp edges from a cracked plastic doorframe leaving a potential risk of injury to staff, patients or visitors. We saw that some items of equipment throughout the ward were dusty, such as drip stands, trolley and keyboard covers and telephones.
- On a number of wards, we saw that the macerator was very dirty and when we asked the domestics about this they told us this was not part of their cleaning schedule. Staff were not aware that the macerator seals had ever been checked for integrity. If seals become worn or damaged, the macerator could disperse microorganisms through splashing and aerosol droplets. Following the inspection managers told us the cleaning of macerators had been added to the domestics cleaning schedule and was to be rolled out by December 2016.
- Domestic staff we spoke with in a number of areas told us they received annual infection prevention and control training that included hand hygiene, PPE and cleaning as part of mandatory training and that additional training regarding cleaning was also given by their supervisors. Domestic staff told us that their supervisors audited cleanliness on a monthly basis.



# Medical care (including older people's care)

- We were told that there were infection control link nurses on the wards and departments. The link nurses on the cardiac catheter suite told us they were involved in carrying out annual workshops with their colleagues regarding topics such as hand washing, cannulation and asepsis. We saw that patients were screened and when found positive for MRSA they received treatment for decolonisation prior to any invasive treatment.
  - We saw documentary evidence of cleaning schedules and their completion and frequent flushing of taps to prevent legionella. We saw that estates staff undertook monthly checking of water temperatures on AMU.
  - Staff we spoke with had a good understanding of waste management and we saw appropriate segregation and disposal of waste in all areas we visited.
  - We observed that clinical site managers were aware of where outbreaks of infection were and considered this when managing patient flow to prevent the spread of infection.
  - Infection prevention and control audit data showed mixed results across a number of audits. For example latest commode audits showed 100% compliance in CCU, A&, A5 and A2 while other areas scored poorly. Some areas showed improvements over time with MRSA audits but CPE assessment audit results were poor. Source isolation audits showed recurring areas of non-compliance particularly in isolation room door not being closed and daily re-assessment for ongoing precautions. Hand hygiene audits also recurrently found issues with nails and compliance with bare below the elbow.
  - Compliance for the medical service with Infection control- hand hygiene training was poor at 52%.
- Environment and equipment**
- Patient-led assessments of the care environment (PLACE), for the trust, February 2016 - June 2016 gave 'dementia care' a score of 70% in comparison to the national average of 75% however, this was a 10% improvement on the previous year's score. 'Facilities' scored 88% in comparison to the England average of 93% but this was a 3% improvement on the previous year's score. 'Cleanliness' scored 1% more than the previous year, to give a score of 98%, which was equal to the England average. The 'food' score had improved by 7% from the previous year's score to 87% which was the same as the England average and an improvement of 7%. The privacy, dignity and well-being score was 2% worse than the previous year 74% in comparison to the England average of 84%.
  - The discharge lounge was light and airy and felt welcoming to patients. It had large bright lettering on the corridor saying welcome to the discharge lounge and the sitting area was decorated with brightly painted walls and some artistically painted quotes. The sitting area was set out like a home lounge and patients appeared comfortable there. Staff told us the area had been decorated in response to patient feedback and that further improvements to the environment and furniture were planned.
  - On ward A2, we observed that the environment was light and airy and stores were well organised and tidy.
  - We saw that CCU had eight bed spaces all of which could be centrally monitored; staff told us they had enough equipment for their needs. We saw that endotracheal tubes and laryngoscopes were open on the resuscitation trolleys. Staff told us that the trolleys were replenished in theatres and that this was how they were supplied. We saw that seals were unbroken and staff checked them daily.
  - Staff in the cardiac catheter suite told us that they needed new X-ray equipment, as it was outdated and kept breaking down. This was on the risk register and had been escalated through the organisation. The managers were currently obtaining quotes for a bid to replace this equipment.
  - The stroke unit had a quiet room and a very large therapy room. The ward manager told us that they will be applying to the Hospital Trust's Charity for funding to create two flats for people approaching discharge and also to provide a working kitchen area within the therapy room for occupational therapy assessment's.
  - There were two toilets out of order on the male side of the stroke ward leaving only one usable toilet for up to 12 patients. The nurse in charge told us the broken toilets had been reported for repair and expected they would be fixed within a few days.
  - We noticed that some wards were open (doors not locked) such as A4. We were concerned as this may mean that patients who were confused could leave the ward unnoticed. We did see a patient leaving A4 in a dishevelled state and staff were unaware. When we asked staff about this, they said the door was open for patients to come and go and this had not previously

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caused them any concerns. When we reviewed the trust incident data, we found there were 40 reported incidents of patients absconding from medical wards between February 2016 and July 2016; all of these incidents were reported as low or no harm.

- We saw on A2 that one of the dirty utilities had a key pad on the door to prevent unauthorised access in accordance with the hazardous waste regulations and that the door that had a lock was not being used.
- We saw that in most areas staff checked resuscitation equipment daily and checks were recorded and up to date. There were three days missed in September 2016 on the stroke ward and there was not a standard recording document for daily resuscitation checks. Checks on other wards were all up to date.
- Theatre staff were responsible for replenishing all resuscitation trolleys across the trust after use, and had a recall process in place for replacing out of date stock. Staff told us that when drugs within the trolleys were due to expire they were recalled to theatre for re-stocking.
- On the stroke ward we saw that the hypoglycaemia bag was checked most days; there were three missing dates in September 2016. All of the contents were in date.
- We saw evidence of electrical testing for equipment such as defibrillators, mattress pumps and beds. However, bed frames had a multiple stickers on them relating to service checks and it was not easy to see which was the most recent and if they were in date. We saw that the electrical testing for one of the mattress pumps on the stroke ward was overdue.

## Medicines

- On most wards, we saw that drugs and intravenous fluids were stored securely and appropriately. We saw that staff made regular checks of controlled drugs, other medicines and fridge temperatures; they kept clear records of when they made checks. We saw that fridge temperatures were maintained within the recommended range to ensure safety and effectiveness of the medicines stored there. Patients own drugs were recorded and stored safely.
- We were concerned that there was no system in place to monitor collection or disposal of patients discharge prescriptions on AMU. We saw and staff told us that these were often left behind or patients did not return to collect them. Although there was a list on the drug

cupboard door, of drugs left with patient's name there was no clear audit trail of what drugs had or had not been collected and these were often in the cupboard for long periods before the pharmacist disposed of them.

- On the stroke ward, we observed that the room where intravenous fluids were stored was not always locked. There was not a standard recording sheet in use for the daily recording of the drug storage fridge and staff were recording single daily temperatures not minimum and maximum temperatures. There were four days in September 2016 and six days in August 2016 where fridge temperature had not been recorded as checked. There were no instructions readily available for staff regarding management of refrigerated drugs and what action to take if temperatures were outside the required range
- We looked at 22 medicine cards across different medical wards and found that they were mostly completed correctly and to a good standard. We saw that the drug allergy box on the three of the medicine cards we looked at was not completed and allergy status was not recorded on two cards.
- We looked at three sets of patients notes on ward A1 including medical, nursing and medicine records. We observed that each of the three drug charts showed one drug omission for each patient. There was no documented rationale for these omissions. When we raised with staff on the ward, we were assured that the omissions would be looked into and reported as incidents if necessary.
- The manager on A2 told us they did not have their own pharmacy support at the moment, but their ward did receive some cover from the generic pharmacy team. On this ward, we saw four patients' drug charts where there were missed doses. One at the doctor's request, two as 'not available' and one had no reason recorded. We were told us that omissions of critical medicines were treated as incidents and the ward pharmacist logged them on the incident reporting system. We saw the incident logs relating to medication errors contained incidents relating to omitted doses.

## Records

- Patient's records were largely paper records. A range of risk assessments were included within the records for



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example; falls, manual handling, Waterlow, nutrition and body mass index (BMI), bed rails, early warning scores and neurological observations to manage the deteriorating patient.

- We looked at 12 nursing care records, 20 sets of medical notes and 22 medicine charts. We found that generally these were completed to a good standard.
- Nursing risk assessments were usually completed in full for every patient with very few gaps or delays in assessment noted. However, we saw that six out of six records on A5 and five out of six records on A4 had gaps in intentional comfort rounds. It is possible that this indicated gaps in care rather than poor record keeping. There were four gaps in recording of skin assessment on the skin bundle documentation on A5 and two gaps on A4. It was difficult to establish if this was a gap in care as there was some duplication of recording regarding pressure areas in different document bundles and parts of the nursing documentation.
- Medical records demonstrated thorough clinical assessments and risk assessment. MEWS were recorded and there was evidence of appropriate escalation. However, we could not find evidence of a mental capacity assessment or discussion for two patients on A4 and two on the stroke unit. Another patient had a DNACPR in place from a previous admission and there was no documentation regarding this on the admission assessment or subsequently during his or her stay.
- We saw that AMU used a standard pack of notes / records for every admission. We reviewed seven sets of notes in this area and found that most of the items were completed and that risk assessments were mostly completed within the time specified. Two patients did not have a VTE assessment completed, one was without a pressure ulcer assessment and another had not had a nutritional assessment.
- We reviewed three sets of notes on CCU and found they were illegible in parts, doctors' name and designation was not always printed and patient details were not on every page.
- We saw that the large number of different documents and bundles made record keeping difficult for staff and that this created significant duplication of recording. The Head of Nursing told us that one of the trust objectives for 2016/17 was to undertake a full review of nursing documentation and to streamline this documentation.

- We observed planned care was communicated verbally at handovers. Some wards but not all used formal handover sheets, which were electronically stored and printed for staff use.
- Notes were secure in most areas, however we saw that notes on A1 were kept outside of bays in unlocked trolleys and, although the office on AMU had a key pad and a notice on the door to keep closed at all times, we saw that notes were kept here and the door was open.

## Safeguarding

- There was a dedicated lead for safeguarding and staff were aware of this. Staff we spoke with were able to give examples of recent safeguarding issues and how they had been dealt with.
- Staff were clear how to escalate safeguarding concerns and demonstrated understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff we spoke with told us they had all had safeguarding training and expressed confidence in dealing with safeguarding issues. Staff could explain the process to make a referral to the safeguarding team and flag patients with the ward manager or matron. They knew who the safeguarding team were and how to contact them when they needed advice or support.
- We spoke to healthcare assistants who told us safeguarding training was carried out annually, they were aware of the safeguarding team and felt confident caring for vulnerable patients and how to raise concerns.
- Compliance with safeguarding training was poor. Compliance with adult safeguarding training for the medical service was 59%
- Compliance with children's' safeguarding training at level two for the medical service was 58%. Compliance with children's' safeguarding training at level three for the medical service was 33%.

## Mandatory training

- Some staff told us that their mandatory training was up to date but others told us they were behind with things like manual handling and life support training. Compliance with basic life support training was 65% for Integrated Medicine, while compliance with manual handling training was 68%.
- Overall, mandatory training compliance for Integrated Medicine was 66%. The trust average was 72%.

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- A member of the isolation cleaning team told us they would have been in post 4 weeks before they received their mandatory training; however, they were receiving on the job training and were supervised during this time.
- The team leader in the transfer of care team said mandatory training was 90 – 100% for staff in their team and that they kept their own records as ESR was not always up to date. We saw that the discharge lounge staff were also all up to date, as were staff in the cardiac catheter suite. We saw there was a schedule on the notice board, in this area, so staff could see what they needed to do and when.
- Ward performance posters for August 2016 showed compliance with mandatory training in other areas was mixed; A5 51%, CCU 70%, stroke unit 50%, A7 72%, A4 47% and A1 51%. All staff we spoke with on AMU told us they were up to date with mandatory training however; we did not see the performance poster in this area.
- The main reason given for low levels of compliance was staffing levels and being unable to release staff for training, there were a small number of comments relating to availability of training and gaps in leadership.
- Mandatory training at the hospital included; basic life support, manual handling, information governance, infection control – hand hygiene, safeguarding adults, prevent and children's safeguarding.
- The ward manager on the stroke unit told us that agency staff received a brief induction using an induction checklist if they had not worked on that ward before. This helped identify the level of competence of the agency nurse.

## Assessing and responding to patient risk

- Staff across the hospital used a Modified Early Warning Score (MEWS) to assess patients' vital signs and identify those patients who were medically deteriorating.
- There was a critical care outreach team available to support ward staff with the recognition and management of acutely unwell and deteriorating patients Monday- Friday 07.30am – 5pm.
- The outreach team reviewed patients on the wards, provided advice and support, facilitated admission to and discharge from HDU and ITU and followed up all MEWS triggering patients within the trust. The outreach team also provided some training at ward level.
- Ward staff told us they received support from the critical care outreach team who visited the wards regularly since the introduction, in September 2016, of a modified early warning score (MEWS) chart. They told us the outreach team visited to discuss patients who had triggered an alert and provide training.
- We observed that the clinical site managers evening hand over covered the patient situation in ED, the assessment areas and all wards across the hospital. The site managers identified areas where the acuity of patients was high, what the staffing levels for the next 24 hours were across the hospital and highlighted areas where there were potential shortfalls in staffing. This meant there was oversight of patient flow and acuity and this enabled the team to provide staff cover to those areas where the need was greatest.
- Staff told us the medical consultants were allocated non-medical speciality wards to review any medical outlying patients on a daily basis Monday to Friday. The ward manager on A2 told us they often had outlying patients elsewhere in the hospital but the consultant knew where they were and reviewed them daily.
- We noticed that there were safety briefings on the wall for staff on A5 highlighting identified issues and areas for improvements, which included risk assessments and care planning.
- We observed a huddle on the stroke ward, which was held at the nurses' station. We saw that it was noisy and difficult to hear what the nurses were saying about the patients. We heard risks identified for each patient related to falls, MEWS and frequency of vital sign observations. We did not hear anything mentioned about patient's pressure sore risk or DoLs, although we were aware that a small number of patients did have these in place.
- Staff told us that the practice development team were working towards a new handover protocol using the SBAR approach to help keep patients safe and ensure all risks were communicated to all staff.
- There was a formal service level agreement in place with another trust in relation to the gastro-intestinal on call service. This meant that Monday to Thursday, the trust had an on-call rota operating at the trust. From Friday evening to Monday morning any patient requiring this emergency service would be stabilised at the trust and transferred to the other trust.
- Staff told us there were some issues with senior gastroenterologist cover being available on the ward when they were in clinic or endoscopy. Junior staff told us this made them feel unsupported at times.

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- During our observation of the gastroenterology board round, some staff appeared to be unfamiliar with Carbapenemase-producing Enterobacteriaceae (CPE) which is a communicable disease that required one of the patients on the ward to be isolated and have infection control precautions in place.
  - Non-invasive ventilation (NIV) was physiotherapy led service. The physiotherapy leads told us that NIV was only initiated in ED and high dependency area such as CCU, HDU or ICU. We were told that patients requiring NIV (unless they were self-caring for this aspect of their treatment) were managed by physiotherapists on AMU at admission and then transferred to A1 the respiratory ward.
  - On ward, A1 physiotherapists carried out interventions and management of NIV with support from a small number of nurses who were trained and could carry out care overnight. In higher dependency, areas such as CCU, nurses were trained to be able to initiate and provide this care. Physiotherapists were available to provide care 24 hours every day but this was on an on-call basis between the hours of 6pm and 8.30am. The physiotherapists told us they worked to a maximum of a 30-minute response time.
  - The physiotherapists told us they handed patients over at night to nursing staff using an SBAR approach. They told us that part of the handover included checking whether the staff nurse was competent to adjust NIV settings and indicating when to escalate to the on-call physiotherapist.
  - Nurses told us that if patients' observations showed any signs of deterioration they would immediately raise this with the physiotherapist and ward doctor. Physiotherapists told us they liaised with the medical team regarding deteriorating patients who required initiation of NIV and to ensure patients needing transfer to HDU or ITU were escalated immediately. The physiotherapists told us they had good support from medical colleagues and could easily escalate to the anaesthetists on call when necessary.
- ## Nursing staffing
- The Division of integrated medicine used the Safer Nursing Care Tool to assess patient acuity and dependency. Safe staffing huddles were held every day to review staffing levels and patient acuity with a view to allocating flexi-staff (bank) and agency staff to those areas most in need.
  - We saw that the majority of wards had a 60:40 or 65:35 RN to HCA ratio. Managers told us that nursing establishments were designed to provide 1:5.7; 1:6 and 1:8 nurse to patient ratios on days and 1:11 on nights depending on the acuity of the patients and that these were reviewed formally every 6 months. The process involved discussion with ward staff; the clinical division managers and a presentation to a panel made up of the chief nurse, finance director and director of workforce.
  - The trust acknowledged that recruitment of nurses was a huge challenge and that there were significant vacancies across the medical wards.
  - The worst affected wards were A1, AMU and A4 with vacancy rates of 32%, 31% and 31% respectively. The stroke unit had a vacancy rate of 26%, A5 20% and A2 12%.
  - The trust had its own nurse bank with a number of staff who worked flexibly to cover wards where shifts had not been filled.
  - Managers were able to request bank and agency staff for unfilled shifts but told us that it was not always possible to fill every shift. They told us that RN night shifts were easier to fill than day shifts.
  - We saw that all medical wards displayed planned and actual staffing levels and that actual numbers were often less than planned. This was particularly the case for numbers of registered nurses. For example, we saw that during the inspection the ratio for RNs to patients on ward A5 was 1:12 early morning, 1:9 afternoon and evening and 1:12 at night. The ward manager on this ward told us that she had three wte RN vacancies but had four more HCAs, than planned, which although helped meet fundamentals of care, resulted in skill mix issues at times.
  - The ward manager on AMU told us there were seven vacancies for RNs in that area. They told us the ideal ratio of qualified staff to patients in that area would be 1:5 however; it was more often 1:7 or 1:8 with an additional supernumerary coordinator. The manager told us the ratio was never worse than 1:8.
  - The ward manager of A4 the gastroenterology ward told us there were 8.7 wte vacancies for RNs in that area. Planned staffing for the area was five RNs on day shifts and three on a night, but we were told there were often unfilled shifts. The day we visited the ward there were four RNs on duty during the morning, giving a ratio of one RN to 8 or 9 patients. Off duties between 12 September and 2 October 2016 showed five out of 21

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days when there were five RNs on duty. They did show that additional HCAs had been on duty to mitigate some of the workload on nine of the days that were short. Night shifts were generally covered with planned numbers of RNs although it was evident that this was achieved through using bank or agency staff every night but one during this time.

- We were told and saw that the matron for the area sometimes worked on A4 to support staff delivering care. A member of staff from the bank / agency told us this was a very difficult ward to work on. They felt there was not enough staff on duty because it was so busy and patients could be very challenging. Because of this, the member of staff felt that flexible staff would choose to work elsewhere in the trust if there were a number of shifts or wards to choose from. The ward manager told us that the ward was about to move to a smaller ward while A4 was being refurbished, the bed base would be from 34 to 22. This would mean staffing ratios would be much improved
- A member of staff on A5 told us “there’s not enough time to do everything because we are short staffed, families are frustrated as we do things eventually but there’s not enough staff and too much work. Today I have 12 patients. There is myself and one HCA to deliver care, medicines, turns and dressings; I don’t have time for a break. I’m not aware of any plans to address this. The reason we have a lot of falls is because there’s not enough staff to watch the patients, I can’t be in 12 places.” We saw from off duties on this ward that between 5 September and 26 September that, actual staffing levels were less than planned for RNs on 10 days and one night and for HCAs on five days and three nights during this time.
- Off duties between 12 September and 2 October 2016 on A1 showed actual staffing levels were less than planned for RNs on eight days and eight nights and that bank or agency RNs were used every night.
- Staff on the discharge lounge told us that they could be very at times busy but there was always a care worker in the lounge and in each of the bays.
- We observed a number of nursing handovers and found that communication was clear, comprehensive, and included information about staff sickness, patient transfers, and ward issues. Some but not all wards were using typed and printed handover sheets, which staff updated throughout the day. Staff and managers told us the trust was in the process of introducing a situation,

background, assessment and recommendation (SBAR) approach to handovers but this had not been implemented in any of the medical areas we visited. We saw good practice on A2, which included a safety huddle following handover and we observed that staff handing over effectively shared information with all oncoming staff. Staff highlighted risks such as deteriorating patients, frequency of observations and infection risks.

- We saw that some areas were using typewritten handover documents, which were updated throughout the day and printed out for shift changes.
- The ward manager on A2 told us that although she had some nursing vacancies, she did not feel this was currently impacting on the standard of nursing care delivered. A RN, who worked on this ward for two years, told us that agency staff were regulars and some of them had worked there longer than she had.
- Staff told us there were some challenges regarding nurses who did not speak English as their first language but the trust was supporting these staff with classroom based language workshops.
- Staff also told us that it sometimes took months for overseas nurses to receive their registration personal identification number (PIN) from the NMC. This meant they had to work as band 4 unqualified nurses until this was received. We saw that mentorship and supervision was in place for these members of staff until their registration with the NMC was complete. This was frustrating for all staff concerned as they felt that staff skills were inevitably underutilised.
- The manager of the AMU told us that the ward was currently staff at a ratio of 1 RN: 8 patients at the time of the inspection but there were plans in place to increase the numbers of qualified staff to be able to provide a ratio of 1:5. A member of staff on this ward was concerned that on occasion ambulatory care spaces were sometimes used as bed spaces and that there were not enough staff to care properly for these extra patients when this happened. Another member of staff in this area told us she often felt it was too busy to care properly for patients on AMU.
- The ward manager told us there were five (band 5) RN vacancies and a lot of long-term sickness that affected the ward but HR actively managed this, with keep in touch contacts. There was also ongoing recruitment to a band 6 vacancy and staff had been interviewed this week for secondment into a further two band 6 posts.

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- Ward managers told us they regularly gave up their management shifts to work on the wards as bank or agency staff were not always available to fill vacant shifts.
- Staff on the cardiac catheter suite told us that they had one vacancy and the band 7 post holder had reduced their hours however, they felt the unit was adequately staffed. Nursing staff opened the unit at 7.45am and stayed until the last patient had left if this was after planned closing time. The ward manager told us there was one vacancy on CCU.
- The ward manager of A7 told us that although there were no actual vacancies on that ward, there were four members of staff on maternity leave and two members of staff on long-term sick leave. Current staff worked extra or longer shifts to provide cover and the ward manager sometimes had to give up management time to work on the ward. There were also two clinical nurse specialists working in this area who supported the ward staff with caring for patients when they could.
- On ward A1, we observed a patient who required 1:1 nursing due to his confusion. The patient was aggressive and kept trying to climb out of bed. We saw that there were not enough staff on the ward to provide this level of care. Staff told us they had a safe observational framework to use if they needed to escalate a request for extra staff from another area. If no additional staff were available, then one member of staff should have been allocated to stay in the bay to monitor the patient's safety as much as possible, while providing care for the other patients in the room. We observed that there were periods of time when there was no staff member in this bay.
- The manager of the stroke unit told us that there was a specialist stroke nurse on duty 24 hours, seven days a week.
- Where ward managers could not get RN cover for unfilled shifts, they told us they would have an extra HCA on duty, if possible, to support provision of fundamental nursing care.
- The ward managers told us they attended a huddle at 2pm every afternoon to discuss any staffing or patient safety issues to identify how cover could best be provided. Other issues or concerns could also be escalated at these meetings if needed and learning from incidents or safety alerts could be cascaded.
- The ward manager told us there were no issues with staffing on the discharge lounge, they told us that if beds were opened on this area then 'allocate on arrival' staff would be sent to provide support to substantive staff if needed.
- Staff working in clinical areas told us if they were short staffed, they knew the process for contacting the bleep holder to arrange cover or provide staff to support from elsewhere in the trust.
- Staffing issues were on the trust risk register and actions were being taken to mitigate risks as far as possible.

## Medical staffing

- Medical staffing skill mix across the medical service was similar to the England average with the exception of consultant grade. Consultants, middle career and registrar groups made up 30%, 9% and 37% of the medical workforce and junior doctors 24%. The England averages were 37%, 6%, 36% and 21% respectively. Although there was 7%, less consultant grade at this trust there was 3% higher middle grade and 3% higher junior grade.
- Consultant cover on the wards and AMU was 9am to 5pm Monday to Friday. On call, consultant cover was from 5pm to 9pm on site and 9pm to 9.30am the following day as non-resident on call. The acute medical consultants on AMU told us they tended to work longer days between 9am and 7pm and that general consultant physicians covered the on-call. Twenty-four hour consultant on-call was provided at weekends with onsite cover between 8am and 8pm. The acute medical consultants were not part of the on-call rota.
- Staff told us the trust did not have a hospital at night team in place, but was in the process of developing this and recruiting staff. The trust hoped the hospital at night team would be in place by November 2016. A 24-hour clinical site management team (senior nurses) liaised with the on call medical teams and the critical care team, at night, regarding sick patients.
- There was an on-site medical team in AMU from 9am to 9.30 pm and an on-call team from 9pm to 9.30am that comprised of one ST3-6, 2 ST1-2, and one F1. These staff provided on call support to the AMU and acute medical wards. Doctors told us there were gaps in the medical rota due to unfilled vacancies however; locums were being used to fill the gaps. One of the locums we spoke with told us they had been working at the trust for 2 years.



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- Junior staff told us if they felt out of their depth when on call there was always a more senior member of the team available to advise, support and to undertake medical assessment.
- We spoke to two advanced nurse practitioners on AMU who told us that the role was well embedded and that they received good support from the medical team. These practitioners did not provide 24-hour cover at the time of the inspection.
- Ambulatory care was nurse managed and there was a registrar on duty for this area Monday to Friday 9am to 5pm. The on-call medical team also supported this area and consultant cover was identified.
- Junior doctors told us they often worked over their hours and it was often difficult to get a break during the day.
- Staff told us there were consultant led ward rounds MDT board rounds at 8am and 11am on AMU.
- Senior managers told us there were consultant vacancies in respiratory, stroke, cardiology, elderly care and gastroenterology. They highlighted that the recruitment of gastroenterologists was particularly difficult and that this was similar elsewhere in the country due to a shortage of consultants in this specialism. The vacancies and the shortfall were being covered by long-term locums with support from another trust. Staff on A4 told us that they were never sure what time the gastroenterologists would be attending to do their board round.
- Senior managers told us the safe care bundle register showed who was attending ward rounds every day.
- Senior managers told us there was work ongoing around right sizing the medical workforce and the implications of a new locality integrated care model with primary care. The clinical director highlighted that if the locality pilot was successful and rolled out then the trust would need to offer some training for GPs who would be working in this way.
- Medical teams covered their own patients if sent to the discharge lounge and had an identified surgical ward where they reviewed all medical outlying patients.

## Major incident awareness and training

- The trust had a major incident plan, which provided guidance on the actions needed when a major incident occurred.

- Staff were aware of the major incident plan and business continuity and knew where to access these online.

## Are medical care services effective?

Requires improvement 

We carried out this inspection because, when we inspected the service in February 2015, we rated effective as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection, we rated the service as 'requires improvement' for effective because:

- We found knowledge of the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) was improved, however documentation of MCA assessments was poor.
- Although the service had adopted a train the trainer approach and was making best use of the practice development team, link nurses and specialists to deliver training in the ward area, access to training was still limited and compliance with dementia awareness was below the trust target.
- We found that appraisal rates had improved over the last 12 months but were still below the trust and were extremely low in some areas.
- Fluid balance charts were not always completed fully or action taken when imbalances were present.

However:

- Patients were given good support with their nutritional needs and fluid intake.
- There was evidence of clinical audit and action plans to support improvements.
- There was strong evidence of effective multidisciplinary team (MDT) working.
- The service was meeting the four priority standards (adopted by the CQC) developed by NHS England around seven day working.

## Evidence-based care and treatment

- Policies and pathways were based on national institute for health and care excellence (NICE) and Royal College of Physicians guidelines and were available to staff and accessible on the trust intranet site.

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- Staff demonstrated awareness of policies, procedures and current guidance. They knew how to access this information on the trust intranet and on the ward.
- All doctors took part in clinical audit and each speciality had an audit lead.
- Ward staff had access to specialist staff for additional support, training and expertise. Specialist nurses included; heart failure nurses, respiratory physiotherapists, diabetes specialists, critical care outreach and others. Staff also had access to a practice development team.
- Matrons audited wards against compliance with a number of quality indicators such as staffing, sickness, appraisals, capacity, friends and family test, patient harm and infection control practice. This helped identify areas where improvements were needed and wards were supported with any action needed.
- Minutes of the clinical effectiveness meetings showed that Integrated Medicine undertook regular clinical audit locally and actions were taken when areas for improvement were identified.
- The trust participated in a peer review visit from the Yorkshire and Humber Strategic Clinical Network in March 2016 to look at Cancer of the Unknown Primary (CUP) measures for hospitals. The peer review visit report found immediate risks and serious concerns that were not resolved, for example, there was no designated CUP clinical nurse specialist and the lead consultant medical oncologist did not have dedicated time in their job plan for the CUP assessment service. The trust had a policy in place for inpatient and outpatient assessment, however, an audit had not been completed to ensure assessments were undertaken within national timescales. A business case was due to be submitted in October 2016 to address some of the issues raised by the review. Senior staff were concerned the business case was not sufficiently resourced to address both the CUP and SPCT seven day services.

## Pain relief

- Relatives of a patient on A7 told us that a nurse had asked for their opinion regarding their parent's pain level as she had difficulty communicating this and she suspected pain relief was inadequate. The result was the patient's pain relief medication was increased.
- We observed nurses identifying patients experiencing pain, giving reassurance, and administering pain-relieving medications promptly.

- We saw that patients were asked about pain during two-hourly comfort rounds.

## Nutrition and hydration

- Nursing staff used a nutritional screening and assessment tool incorporated into the patient admission record to assess patients' nutritional needs and risk factors on admission.
- Nutritional assessments and actions were audited monthly. Results for the integrated medical service showed that the year to date average compliance was 88% and 85% respectively; these results were below the trust target and had been rated as amber (medium risk). Specialist medicine scored 100% compliance for both indicators.
- Fluid balance completion and action was audited monthly. Results for integrated medicine showed compliance of 66% for both indicators and rated as red (high risk). Specialist medicine scored 100% compliance for both indicators.
- Patients could choose from a range of options, which included healthy choices and special diets such as gluten-free or diabetic and soft diets.
- We saw that patients assessed at risk of malnutrition were given food supplements.
- Finger foods were available for those who needed to eat throughout the day and were unable to feed themselves in other ways.
- We saw that drinks were available within reach of patients most of the time and that staff provided patients with assistance to eat and drink when needed.
- On the stroke ward, we observed that individual patients' diet and fluid requirements were written on a white board above the patients' bed. We saw that staff sat patients up in bed or on chairs next to their bed for meal times and all patients received an appetising meal that was hot. We were told that bank and agency staff did not feed patients and saw that substantive ward staff were available to assist with meals and feeding patients. We saw that family members came onto the ward to feed patients and staff encouraged this. We observed a group of patients were served all courses of their meal together on one tray at the request of the nursing staff. We did not know whether this was due to a previous request by these patients or if this was for staff convenience.
- On A2, we saw a member of staff sitting with a patient and feeding them.

# Medical care (including older people's care)

- We saw a number of examples where patient's fluid balance charts were not completed correctly or totalled. On A2, we saw input recorded, but not output.
- On A5, we saw patients were helped with eating and drinking in an appropriate manner and were involved in choices about their food. Drinks were offered regularly in-between mealtimes.
- We had mixed feedback regarding food, some patient told us it was "great" while others told us it was "alright" or "awful".
- We saw that patients in the discharge lounge had access to hot and cold drinks and were provided with a hot meal at lunchtime and soup and sandwiches at teatime.

## Patient outcomes

- The national lung cancer audit 2015 showed the proportion of patients receiving surgery was not significantly different from the national level; however, the proportion of patients receiving chemotherapy was significantly worse than nationally. The trust told us that 'patients receiving chemotherapy' was adversely affected by reliance on another trust for this provision.
- The MINAP 2013/14 audit (nSTEMI) showed improved performance compared to the 2012/13 audit and performance across the three measures is better than the England average.
- The heart failure audit 2013/2014 showed scores worse than the England average for the majority of inpatient and discharge indicators. Input from a specialist was the biggest difference with trust reporting 40% compared to an England average of 78%.
- A consultant told us that, following the audit, new guidelines had been produced and circulated to all consultants to help improve the referral of heart failure patients to a cardiologist. The team hoped that because of improved referral the number of patients on appropriate treatment would also increase. This message was also being reinforced through the 'grand ward rounds'. The cardiologist told us there was a cardiology ward round had also been introduced every day on AMU to assess cardiac patients. Complex patients were discussed at a monthly meeting with all of the cardiologists and specialist nurses present.
- The cardiology service was monitoring device implantation and comparing their rates to national trends.
- A cardiology consultant told us that the most recent quarter's heart failure data had shown a higher than expected mortality, however, when these cases were investigated a number of patients had been coded incorrectly and the figure was found to be lower than the expected figure. The heart failure nurses were working with the coding department to ensure results of future audits were not affected by incorrect coding. We were told that the investigation and action plan had been presented to the trust's Clinical Governance committee.
- The Sentinel Stroke National Audit Programme (SSNAP) in December 2015 scored the trust as a C overall (A being the best and E being the worst). The results in relation to scanning had increased from B to A and no results had decreased for Quarter 2 (July-September 2015) and Quarter 3 (October-December 2015). There was a SSNAP action plan in place. The National Diabetes Audit 2015 had mixed results with seven indicators better than the England average, and 10 indicators worse than the England average. The areas highlighted for improvement were; visit by a specialist team, foot risk assessment and care, insulin and prescription errors, self-management, meal timing and staff awareness. The results were better for staff knowledge, staff answers to questions, visit by MDT in 24 hours, meal choice, management errors, overall satisfaction and admitted with foot disease. action plan
- The 2013 lung cancer audit reports that the trust performed about the same as the England and Wales average except for the percentage of patients receiving CT before bronchoscopy. CT before bronchoscopy was better than the England average.
- The readmission rate for medical care across the trust was higher (worse) than expected for elective admissions overall, and in the specialities of general medicine and haematology. The readmission rate for gastroenterology was lower (better) than expected.
- The readmission rate for medical care at RDGH was higher (worse) than expected for elective admissions overall, and in the specialities of general medicine and haematology. The readmission rate for gastroenterology was lower (better) than expected.
- The readmission rate for medical care across the trust was lower (better) than expected for non-elective admissions overall, and in the specialities of general medicine and geriatric medicine. The readmission rate for respiratory medicine was higher (worse) than expected.



# Medical care (including older people's care)

- The readmission rate for medical care at RDGH was lower (better) than expected for non-elective admissions overall, and in the specialities of general medicine, geriatric medicine and clinical haematology.
  - Summary Hospital-level Mortality Indicator (SHMI) for the 12-month period from January 2015 to December 2015, was as expected with a value of 105 compared to 100 for England. There were 1,484 deaths compared to an expected number of 1,413 deaths; this was not statistically significant.
  - Hospital Standardised Mortality Ratio (HSMR) for the 12-month period from Jan 2015 - Dec 2015, HSMR was as expected with a value of 101.79 compared to 100 for England. There were 914 deaths compared to an expected number of 898 deaths. Weekend HSMR was within expected range for this time.
  - There are currently no active mortality alerts for this trust.
  - Mortality reviews, in Integrated Medicine, involved an initial review of all deceased patient notes by the clinical director. The clinical director scored the cases using defined criteria, depending on identified issues or concerns, and allocated the cases to a formal mortality review meeting. Findings and recommendations were shared with other clinical staff through the audit meetings and was a standard agenda item at divisional meetings.
  - The trust had been identified as an outlier for deaths from pneumonia in the over 75 year-old population. However, following a review of 600 episodes it was found Pneumonia had been incorrectly coded as the cause of death in 300 cases.
  - The trust informed us that since the opening of 'Breathing space', a community facility within the integrated medical service that the mortality associated with smoking had improved. At the time of the inspection, the trust was undertaking a review of mortality associated with cardiac failure.
  - The trust was taking part in the 'National Dementia Audit' 2016.
- Competent staff**
- All staff should receive an annual appraisal to facilitate personal development and maintenance of skills and competence. The target for nursing and medical staff groups was that 80% of staff would have received an appraisal in the last 12 months.
  - We saw that appraisal rates were improving for nursing staff across all areas although some of the wards still had very low rates. The overall compliance rate had improved from 67% in 2015/16 to 77% in 2016/17. The most recent data held by the wards was from August 2016 and showed compliance on CCU was 71%, A1 was 17% but all staff had been given a date, A4 was 79%, A7 was 81%, stroke unit was 45% and A5 was 17%. The ward manager on A5 had an action plan to improve compliance with appraisals and mandatory training in her area.
  - Members of the transfer of care team told us they had all received an appraisal in the last 12 months.
  - On A2, nursing and therapy staff told us they had received an appraisal.
  - A clinical site manager told us their appraisal had been a meaningful experience.
  - Not all staff we spoke with told us that their appraisal had been worthwhile.
  - Staff told us they received training relevant to their role such as; cannulation, catheterisation, venepuncture medicines and wound care. A train the trainer approach was encouraged for clinical skills and staff told us they received face to face training from the practice development team, critical outreach team, link nurses in their own area and nurses or therapists who undertook specialist roles.
  - Staff told us that competency based assessments were carried out following training
  - Some RNs told they had not received SEPSIS training.
  - Online elearning modules were also available for some elements of training.
  - We observed student nurses receiving supervision and teaching from qualified members of staff.
  - Staff told us that newly qualified staff went through a period of preceptorship as did nurses recruited from abroad.
  - Junior doctors told us they had received induction and training, which had included competency assessment. They told us that formal teaching was provided several times in a week in the form of theory sessions, grand board rounds, case presentations and clinical skills training. There were also five away days a year for dedicated teaching for foundation year one (FY1) doctors.
  - Locum staff had the same access to induction and training as employed doctors.

# Medical care (including older people's care)

- Senior managers told us that one of the long-term locum consultants in gastroenterology was GMC accredited and provided the medical supervision for the junior medical gastroenterology team but there were some issues regarding accessing online learning and training for long-term locums.
- Healthcare assistants told us they received training when they started at the trust, which enabled them to complete a care certificate. They told us that there were opportunities for personal development and for them to extend their skills. HCAs in AMU had received additional training in taking blood, cannulation, vital signs, blood glucose monitoring and regarding equipment. There was additional training for RNs in this area regarding syringe drivers, enteral feeding and life support.
- Staff we spoke with on A1 told us that qualified staff attended an essential skills day, which included scenarios around end of life care and pain control. They also told us they were able to attend a specific training course regarding the care of vascular access devices if this was relevant to their role.
- The trust had a vascular access team who supported ward based teams with access and management of vascular access devices..
- We observed members of the palliative care team reviewing patients and discussing their condition and needs with ward staff.
- Staff told us the practice development team supported staff with education and training and helped them implement ideas for improvements into action.
- Student nurses we spoke with told us they had an allocated mentor and felt well-supported with their learning.
- The physiotherapist leads for NIV had trained the nurses on CCU to enable them to initiate NIV. CCU staff told us this had improved response time in getting treatment started when physiotherapists were not immediately available.
- A patient on A1 told us he had to wait for physiotherapists to help him with his mask, as the nurses were not trained to do this. The physiotherapy team intended to train nurses on the respiratory ward to the same level to be able to provide full care to patients with NIV.
- We observed good multidisciplinary working in all areas and staff spoke very positively about working relationships with members of the multidisciplinary team (MDT).
- On the stroke ward, we saw good evidence of multidisciplinary team (MDT) working. We saw that patients had regular input from physiotherapists, occupational therapists, dieticians as well as nursing and medical staff. A MDT meeting was held once a week. We saw the meeting was consultant led and attended by therapy staff, dieticians, the nurse in charge of the ward and junior medical staff. Staff told us that often a member of the discharge liaison team and a social worker would attend. The team discussed each patient's medical management plans, therapy plans and discharge arrangements. Consideration of the patients' social circumstances, mental capacity and personal wishes was evident. The discussions were recorded on an electronic patient record used by therapy and community nursing staff by a therapist and on a green form by the consultant, which was filed in the patient's medical notes. We saw that goals were set for patients and appropriate referrals to other disciplines/ specialities were made.
- We saw that psychiatric medical staff regularly visited patients on the medical wards.
- Staff in the discharge lounge told us that therapy staff from the stroke unit provided ongoing therapy for stroke patients who were transferred there, prior to discharge.
- The transfer of care team told us there were social workers from the local authority in the hospital seven days per week, which facilitated the discharge of patients. Staff told us relationships with the local authority and the mental health trust were good. The team had some access to the electronic record system, which helped communication with therapy and community nursing teams and provided an oversight of what services were already involved in a patient's care at home.
- We observed a number of board rounds on different wards and saw that these were consultant-led reviews of patients with other members of the multidisciplinary team such as physiotherapy, occupational therapy ward nurses. Discharge facilitators, social workers and members of the pharmacy team would also attend

## **Multidisciplinary working**

# Medical care (including older people's care)

these when they were available. We saw that patient status was updated at these meetings, patients were highlighted for review and plans for care and discharge were discussed.

- The MDT discussions we observed included professional challenge and were very patient / family focussed.

## Seven-day services

- Consultant cover on the wards and AMU was 9am to 5pm Monday to Friday. On call, consultant cover was from 5pm to 9pm on site and 9pm to 9.30am the following day as non-resident on call. Twenty-four hour consultant on-call was provided at weekends with onsite cover between 8am and 8pm.
- From the records, we reviewed and from what staff told us, all patients were reviewed by a consultant within 12 hours of admission.
- The ward and board rounds we observed were consultant led, which meant that consultants were always present when decisions about treatment and interventions were made.
- Ward staff told us that consultants visited wards daily Monday to Friday to review their patients. They told us that on call consultants at weekends reviewed those recently admitted and any other patients highlighted by other medical colleagues or nursing staff. This implied that a consultant did not see all patients on Saturday and Sunday, however, these patients were reviewed by other members of the medical team.
- Staff on wards where there were medical outlying patients said it was sometimes difficult to get patients reviewed.
- There were on-call arrangements in place to ensure diagnostics, therapies and pharmacy were available 24 hours, seven days a week, in addition to routine seven day provision.
- There was a mental health liaison team and members of the social work team on site seven days per week. Staff on AMU told us the mental health liaison nurse visited the ward twice a day to review patients staff are concerned with or have a diagnosis of dementia.
- The cardiac catheter suite was open from 7.45am until the last patient left the department each evening, Monday to Friday. Out of hours, the Trust is part of a South Yorkshire Cardiac Network arrangement for emergency cardiac procedures, which are undertaken at Sheffield as part of that network agreement.

- Monday to Thursday, there were consultant surgeons and gastroenterologists rostered to cover emergencies during the day and at night, for patients who suffered a gastro-intestinal bleed. If a patient suffered a bleed between Friday evening and Monday morning, they were stabilised on the AMU then transferred by emergency ambulance to Doncaster.

## Access to information

- Patient care records were a mixture of paper records and electronic systems. Nursing and medical staff used paper records while therapists had access to an electronic records system. Therapy staff could share and access patients records / updates in treatment initiated by themselves, community colleagues and GPs.
- There was a new IT system called SEPIA, which enabled hospital and community staff to view patient demographic information and see what health and social care services were involved in a patient's care. Although this system was available on all medical wards, not all staff were familiar with it yet as this was still being rolled out. The system was in use on the stroke unit and transfer of care team. Staff in these areas showed us how the system was used and told us how the system facilitated integrated working and improved communication between hospital and community services. For hospital staff, knowing what services patients did and did not have access to made discharge planning easier and more effective.
- On most wards staff told us there were no problems with discharge letters; these were triplicate copies, one to GP, one in notes and one electronic. Patients were not routinely given a copy of the discharge letter for their own information.
- Staff on ward B11, gynaecology, raised concerns about the timeliness of patient reviews and discharge letters for medical patients who had been outliers on the ward. They had raised this with managers in the Division of Integrated Medicine and it was on the risk register. At the announced inspection, we saw there were discharge letters that had not been completed from patients discharged up to 17 days earlier.
- At the time of the unannounced inspection, there were 14 discharge letters waiting completion. These dated back to discharges on 6 September, which meant that discharge letters were completed up to three weeks

# Medical care (including older people's care)

after discharge. These should be completed within 24 hours of discharge. We saw the trust had introduced a process/ flow chart for staff to escalate issues if discharge letters were not completed in a timely way.

- We found it difficult to access policies, procedures and standard operating procedures via the trust intranet. Staff told us the system was being redeveloped and updated policies and procedures were being moved to a new 'sharepoint'.
- However, a junior doctor showed us that the trust had developed an 'IGNAZ app' that enabled staff to access policies and procedures from their mobile phones.
- We reviewed a small number of clinical policies and found these to be up to date and based on current NICE and other clinical guidance.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with understood the principles of consent, mental capacity and deprivation of liberty safeguards.
- Staff we spoke with were aware of how to gain both written and verbal consent from patients and their representatives.
- Doctors and nurses we spoke with demonstrated a good understanding of mental capacity and were able to articulate how this could change and how this would differ for each patient, under different circumstances and at different times. They clearly understood that while a patient may be unable to give a valid consent for a particular treatment or intervention, they were likely to be able to make other decisions regarding other aspects of care or activity.
- Doctors told us they had received training and felt competent and confident to assess mental capacity.
- Staff told us that members of the MDT usually undertook mental capacity assessments (MCA) and best interest decisions following discussion with each other.
- Occupational therapists (OT) carried out MCA assessments using the 'Montreal Cognitive Assessment' (MoCA) tool. We saw that this assessment was kept with the patients' daily care records for all staff to refer to. The form included assessment of capacity in relation to things such as carrying out personal care and sharing of information.
- However, we found that documentation of MCA in medical notes was poor in six of six sets of records we reviewed, where this was applicable. During the

inspection, we reviewed two sets of these case notes on the stroke ward, with the Safeguarding Lead and the Assistant Chief Nurse. This was to specifically to look at how the trust applied the Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DoLS). In both cases patients were identified by the nurse in charge as not having capacity however there was no record of the assessment of capacity despite the trust having approved documentation in place. There was a record of discussion with relatives in one set of notes. In discussions with staff we were not assured that staff were fully aware of the requirements of the MCA regarding documentation.

- Staff on the cardiac catheter suite told us that patients' capacity was assessed at pre-assessment and if any concerns were identified then they would have a plan in place for admission and taking of consent. This group of staff told us they had attended recent mental capacity act training.
- A specific consent form was in use for patients lacking mental capacity; staff we spoke to were very familiar with this form and when it should be used.
- Staff told us that members of the transfer of care team, in addition to the safeguarding team could support and advise staff when a DOL application may be required.
- Staff received training about Mental Capacity Act and DoLS, as part of their safeguarding of vulnerable adults training; however, compliance was 59% which was below the trust target of 80%.

## Are medical care services caring?

Good



We previously inspected the service in February 2015 and rated caring as 'good'.

At this inspection, we still rated the service as 'good' for caring because:

- We saw staff from all disciplines displaying warmth to patients and a genuine regard for their well-being.
- We observed patient care and patient staff interactions in all of the medical wards and departments and found that overall staff treated patients with kindness and respect. Privacy and dignity was maintained for most patients most of the time.

# Medical care (including older people's care)

- We saw that staff gave patients and relatives good explanations and involved them in decisions about their own or their loved one's care and treatment, where appropriate.
- Wards actively sought feedback from patients and relatives, which was usually extremely positive.
- We saw some outstanding examples of staff delivering care in a compassionate, inclusive and supportive manner.

However:

- We saw some isolated incidents where staff appeared less caring and where patients' dignity was not protected.

## Compassionate care

- Overall, we spoke with 39 patients and their loved ones and found that the majority of them were happy with the standard of care and the attitude of staff at all levels across the medical service.
- We spoke to 11 patients and five relatives in AMU and all were happy with the care provided. Patients told us that the nurses were very kind and respectful 'they are never sharp with anyone' no matter how busy they are. One patient told us they had been very impressed with how one nurse had handled a situation when a patient was being very abusive to her and throwing things.
- Patients described care and treatment as good although one patient told us there was a mix up with the type of scan she was booked for, due to her pregnancy, which delayed this for her.
- We did observe two occasions when patients had to wait to be taken to the toilet, but we observed many other positive interactions and provision of care. For example, we observed a nurse explaining to an elderly woman that she was going back to her care home following her assessment. This was handled in a very kind, respectful and patient manner.
- Patients told us it had been very good care and they were happy with everything. There was one comment from a patient regarding visiting times which were 3.30pm to 4.30pm and 6.30pm to 8pm. The patient felt these times were too close together.
- The mother of a patient with a learning disability felt care had been good and she had been kept informed of each step.
- Some relatives told us that AMU had improved since they last time their parent had been there.

- We observed staff and spoke with patients in the cardiac catheter suite and CCU. We saw and were told, by patients and relatives, that nurses were very caring, polite friendly and courteous. Patients told us they were involved in their treatment plans and were well cared for. One patient told us a nurse had offered to go to the shop for them when they had said they needed some safety pins.
- We observed care and interactions on ward A4 and spoke to four patients and two relatives. Our first impression of this ward was that it was frantic and noisy however, patient and relative feedback was that they were happy with care provided. Although we felt care was rushed due to staffing levels we observed good care and patient interactions were friendly with staff making themselves approachable if patients needed help.
- One patient told us that the staff "all deserve a medal they never stop and they are so nice, they can't do enough, nothing is too much trouble". The patient said she was kept informed of every step and doctors, nurses and other care staff were supportive.
- Two relatives of a patient said they were not sure what was happening concerning their parent's treatment. They kept missing the doctors or the doctors were too busy to see them when they were visiting. However, their parent had dementia and they were confident that she was getting enough fluids and food; they were happy with the nursing care and felt they could raise any concerns if they needed.
- Although we observed two incidents, where patients' dignity was not protected due to gaping gowns and confused behaviour, staff did rush to help as soon this was noticed or pointed out.
- We observed good examples of care and patient interaction such as a flexi worker sitting with a woman with dementia making sure she drank her tea. We saw that staff were very friendly and approachable towards patients and we heard staff give patients good explanations of what was being done and why.
- Three patients we spoke with all said they were happy with the care and treatment, although sleeping was a problem because other patients had been noisy on occasions.
- We saw HCAs explaining to a patient what to do and giving positive reinforcement and encouragement with mobility. We also saw these staff encourage the patient to use her call bell whenever she needed to go to the toilet and leaving this within reach



# Medical care (including older people's care)

- On the stroke unit, we spoke with two patients and three relatives and observed staff - patient interactions. We observed a mealtime and one of the inspectors carried out an observation using a short observational framework for inspection. Our observations of care on this ward were mixed with some examples of very good care and others not so good. Feedback from patients and relatives was good.
- We observed care and interaction in the four bays that was very caring considerate and saw that staff attended quickly if anyone needed help. For example, we saw a HCA was standing with an elderly blind patient who was agitated and refusing to move. The carer stayed with the patient for over an hour, talking to them in a calm, caring and professional manner. The staff communication skills and caring attitude prevented escalation of the patient's behaviour and any potential risk of harm to the patient or others.
- We heard staff discussions relating to patients' and their care that demonstrated genuine interest in their well-being.
- One relative told us "everything is spot on they treat us like one of the family" and another told us "as they discover things or change anything they let us know".
- One patient told us that they had been admitted eight times during the last six months and that staff did their very best and were in general very good. Their only suggestion for improvement was to try to improve continuity of medical staff for frequent patients. "I get a different doctor every single time, they quickly read the notes and we start from scratch".
- Staff on the stroke ward had implemented 'This is me' (an information sheet on the individual to enable personalised care) and the 'Forget Me Not Carers Passport' (this removes restrictions on visiting hours and enables assistance for families from the carers resilience service)
- We carried out a 25 minute observation using the short observational framework for inspection (SOFI) in one of the bays on the stroke ward and observed; staff undertaking manual handling using an appropriate aid but not giving the patient explanations, curtains were not fully pulled around a patient who was being returned to bed for pressure care and personal hygiene. A nurse also pulled open the curtains, unannounced, to obtain the patient's records whilst care was being delivered, we saw a nurse prepare a thickened drink for a patient, which was left in a lumpy state, and we saw a nurse tell two patients that a fan was to be turned on. These patients were not asked if they wished the fan to be turned on; however, it was not turned on within the 25-minute observation.
- We saw patients' privacy and dignity being maintained for most of the patients, most of the time, however, we also observed two patients whose continence pads had been left visible and one patient in a side room for infection prevention and control purposes who did not have their call bell within reach.
- On the discharge lounge, we spoke to three patients and five staff and observed staff patient interactions. We observed that there were dementia activities available and a care worker was sat with a man entertaining him with a twiddle mat.
- Staff showed us 'welcome to the discharge lounge' information sheet that they went through with each individual as they arrived. The sheet prompted staff to explain things such as possible delays, meal times and availability of drinks and snacks.
- We observed and spoke with three patients who were being discharged all of the patients had some degree of dementia. All patients looked comfortable and relaxed, one patient was resting in bed in a bay and the other two patients were waiting in the lounge area.
- On ward A2, we saw and heard many positive and caring interactions between staff and patients. We saw that staff had implemented open visiting and facilitated concessionary parking for visitors of dementia patients. Staff involved families in care and they provided activities for dementia patients using twiddle muffs and dolls. Staff would also organise tea parties for these patients in the dayroom, for example, when there were big sporting events such as Wimbledon or the Olympics on TV.
- On A5, we saw positive caring interactions between staff of all levels and disciplines and patients.
- A ward manager on A1 told us that one of her staff had received a PROUD award for her excellent care and compassion when caring for a dying patient. We saw staff on ward A1 identifying patients experiencing pain and providing reassurance, they treated patients with dignity and respect when delivering personal care. Feedback from patients on this ward was mainly very good with one negative comment about noise at night and one patient told us he had to wait for a physiotherapist if he needed his breathing equipment /

# Medical care (including older people's care)

mask adjusted, as the nurses were not trained to be able to do this. This patient was concerned about the safety of a patient opposite who was confused and kept trying to climb out of bed. Although the patient said the nurses were often slow to come when he rang the bell, we observed a quick response to the call bell during our visit.

- In the cancer patient survey the trust scored higher than expected for four questions, it scored within expectations for all other questions.
- All indicators for the trust, from the CQC inpatient survey in 2015 showed they were rated about the same as other trusts. All scores had either slightly increased or stayed the same when compared to 2014 results.
- The friends and family test (FFT), for the medical service, had an average response rate of 41% for June 2016, which was better than the England average of 26%. All wards showed a sustained satisfaction rate of over 90% between June 2015 and May 2016. Dermatology had a 100% recommend rate since June 2015.
- Staff on ward A5 told us they had worked to improve the numbers of patients giving feedback to the ward and had managed to increase the response rate of FFT from 24% July 2016 to 77% in August 2016.
- We saw that the wards displayed feedback from the FFT in public areas and some, but not all, displayed examples of what they had improved because of feedback.
- We saw evidence of regular comfort rounds across all wards we visited.
- We saw that male and female patients were nursed in separate bays in AMU and ambulatory care.
- Staff on the discharge lounge ensured only dressed patients used the communal sitting room area to protect patients' dignity.

## Understanding and involvement of patients and those close to them

- We observed staff give patients very clear explanations about what was to happen to them and why.
- We saw examples of patient's involvement in decision making in relation to discharge planning.
- We observed staff check patients understanding of information they had been given.
- Most of the patients and relatives we spoke with told us they were well informed and kept up to date at every stage of treatment.

## Emotional support

- Relatives of a patient on A7 told us that a nurse had spent an hour with them, in private, explaining their mothers care and health issues. They told us the nurse had asked for their opinion regarding her condition and found the nurse "wonderful and supportive".
- We observed staff providing emotional support to patients who were distressed. Staff spoke to patients who were upset softly and calmly and displayed empathy.
- Patients (on the stroke ward) had access to psychology services if they wished to receive them.

## Are medical care services responsive?

Good



We carried out this inspection because, when we inspected the service in February 2015, we rated medical care as 'inadequate' for responsive. We asked the provider to make improvements following that inspection.

At this inspection, we rated the service as 'good' for responsive because;

- The trust had addressed the issues we found in May 2015 relating to mixed sex accommodation breaches; there had been no breaches in the last 12 months.
- There was evidence that dementia care had improved, the trust had implemented 'this is me documentation' and was rolling out the 'Forget Me Not Carers Passport' across the trust.
- The transfer of care team were reducing the number of delayed discharges and saving hospital bed days.
- We saw posters and information readily available to patients regarding how to raise concerns and make a complaint.

However:

- There were some concerns regarding the management of medical outliers.

## Service planning and delivery to meet the needs of local people



# Medical care (including older people's care)

- The trust was in the process of moving towards a new model of Integrated Medicine and locality teams, working in partnership with the local authority and primary care to deliver improved and joined up services for local people.
- Cardiology staff told us how their service had been developed over recent years and of their plans to develop further. The service planned to expand the devices service and wanted to develop a one-stop cardiology clinic to improve patient access and experience. The team were working in collaboration with Doncaster to provide an additional cardiologist post.
- We saw that there was a pacing theatre on CCU where patients could have temporary pacing wires inserted. Transoesophageal echocardiograms could also be performed in this area, which meant patients could have these interventions close to the ward.
- Staff on A7 and haematology told us how their services had moved and expanded and that they had received a PROUD award for their work.
- The service had eradicated mixed sex accommodation breaches on AMU and all of the medical wards since our last inspection.

## Access and flow

- The Acute Medical Unit (AMU) cared for acutely ill adult patients admitted from ED and GP referrals. The AMU also provided Ambulatory Care Services Monday to Friday between the hours of 8am and 7pm. Medical staff told us that the average number of patients accessing AMU and ambulatory care was around an average of 55.
- AMU had 34 beds for inpatients (four of these were isolation rooms); there were six additional trolleys, and six chairs for assessment and ambulatory care. Ward staff told us that they sometimes worked up to 45 inpatient beds by changing the use of the assessment bays.
- The number of anticipated discharges for AMU was 18 on the day we visited the unit and staff told us this was an average level of activity. Staff told us the planned / ideal length of stay for the unit was 24 hours but patients could be there for four or five days if there were no inpatient beds on the wards.
- The ward manager for AMU told us that ambulatory care staff would proactively pull through patients from ED when possible.
- Trust wide data May 2015 – April 2016 indicated that 'completion of assessment' was the most common reason for delayed transfer of care (59.4%), the England average was 17%. The other main reasons were 'patient or family choice' 26.7% in comparison to the England average of 12.7% and 'waiting further NHS non-acute care' 12.4% in comparison to the England average of 18.2%.
- Staff told us the main causes for delayed discharges were waiting for doctors to write prescriptions for take home medications and discharge summary letters. There were sometimes delays in obtaining transport for patients due to late requests.
- The trust had a transfer of care team that worked Monday to Saturday with the aim of facilitating the discharge of patients with complex health and social needs (mostly from medical wards). The team was based on the discharge lounge and was made up of 1 wte Band 7, 1.7 wte Band 6, 0.85 Band 5 and 3wte Band 4. The team were having student nurses for placements from October 2016.
- The team was a relatively new initiative and they felt that their role was improving patient flow throughout the hospital. They told us they had managed to reduce the number of patients in hospital with delayed discharges. The team told us there had been 64 delayed discharge patients in hospital when this had been audited in December 2015, at the time of the inspection there were 26. Staff told us they were saving around 100 bed days a month.
- Team members would visit wards on a daily basis to identify patients with complex needs to start the discharge planning process. Ward staff told us they could contact the team directly if they required their help with making discharge arrangements for any patient. AMU staff told us this team helped arrange transfer back to intermediate care.
- A daily meeting with representatives from therapy services, social work team and the specialist mental health team was held to discuss patients who were medically fit and an appropriate pathway of care / discharge plan would be agreed.
- The wards provided a daily list to the team with actual and potential discharges for the day so that appropriate patients could be identified for transfer home or for transfer to a community unit if appropriate. The team were able to initiate re-starts of community care packages or refer to community-based rehabilitation

# Medical care (including older people's care)

facilities within the trust or the local authority. They also facilitated the completion of continuing health care assessments, the discharge of patients who were at the end of life and were able to stop discharges if they felt it was unsafe to proceed.

- Some of the wards were trialling a discharge coordinator role who linked with the transfer of care team, liaised with families, social care and care homes, specialist nurses and other community services. They arranged discharge transport, checked equipment was in place, ensured patients had keys, food and drink at home and that care package / community services were in place and ready to start. Staff told us this was working well and reducing discharge delays. They told us a business case was being submitted to make this a permanent post.
- Ward A2 had introduced an initiative where each month a staff nurse assumed the role of discharge coordinator to help reduce delays in patients being discharged when they had been assessed as medically fit.
- The clinical site management team had the responsibility of managing beds, patient flow and issues that occurred on site. There was a site manager on duty 24 hours a day, 7 days per week. During the day, there were two staff and at night, there was one. The site managers had a handover at the beginning and end of each shift.
- The clinical site managers had access to the electronic system that monitored activity in ED. They visited wards and proactively transferred patients to the discharge lounge or to base wards from assessment units and ED.
- The discharge lounge was open 8am until 8pm Monday to Friday, 9am until 5pm Saturdays and 10am until 6pm Sundays. The opening hours had been changed to better fit with patients likely transport arrangements and patient transport services operating times. The transfer of care team would identify discharges from the wards and collect them to bring them to the lounge area.
- Bed meetings were held four times a day with a representative from each directorate, pharmacy and diagnostics for discussion and escalation of issues as necessary. Out of hours, there was a senior manager and a director on call. The senior manager stayed on site until at least 9pm and was in contact with the director on call.
- Patients who were fit for discharge and who had not been able to leave the hospital due to transport issues were handed over as potential outliers to non-medical wards, if there was a shortage of beds on the medical wards.
- Trust data showed that there were 155 patients on outlying wards during June and July 2016. The number of bed days spent on outlying wards during this time was 531 and 563 for those respective months. Nurses on one of the outlying wards told us that one patient had been with them for 13 weeks.
- We visited ward B11 a gynaecology ward and saw that nine out of 14 beds were being used by medical patients. Staff told us they sometimes struggled to find beds for gynaecology patients needing treatments or surgery.
- Medical outlier wards had recently been allocated to a medical speciality service to provide treatment and review. That is, the cardiology team looked after all outliers on B11 regardless of which speciality the patient was receiving treatment from. Gastroenterology looked after B5 outliers and the endocrinology team looked after the outliers on B4. Nursing and medical staff expressed dissatisfaction with this arrangement and told us that this often caused problems. Staff told us patients were not always reviewed every day, discharges could be delayed, there was clear evidence of discharge letters not completed and staff reported that patients were also unhappy with this situation.
- Contradictory to what staff told us, senior managers told us that one of the matrons reviewed all outlying patients daily, to ensure these patients had clinical management plans in place and so patients who had not been reviewed by a consultant could be escalated and seen as soon as possible. However, it was apparent that this was a relatively new process and staff were still getting used to this system.
- Senior managers told us that the outlier situation on B11 was on the trust risk register and plans were in place to recruit additional consultants to the cardiology team. It was planned that these consultants would be allocated to manage the outliers on B11 with the expectation that these patients were reviewed earlier in the day and discharges were dealt with effectively.
- Trust wide bed occupancy had been above the England average since Q1 2015 /2016, consistently over 90%.

# Medical care (including older people's care)

- Overall, with the exception of March 2016 referrals to treatment times have been better than the England average since June 2015.
- The trust was exceeding the 90% national standard for meeting patients' constitutional right to start treatment within 18 weeks from referral to treatment time for all medical specialities with the exception of neurology.
- The average length of stay for medical patients was below (better than) the England average for elective admissions across all medical specialities except for general medicine, which is slightly above the average, 4.3 days in comparison to an average of 4 days. (March 2015 – February 2016)
- The average length of stay for medical patients was below (better than) the England average for non-elective admissions across all medical specialities. (March 2015 – February 2016)
- Information regarding bed moves at the trust between August 2015 and July 2016 indicated that, across the medical wards, 41% of patients were moved once during their stay, 20% were moved twice, 5% three times and 2% of patients were moved 4 or more times. This meant that 167 patients were moved four or more times during their hospital stay over a 12-month period.
- The percentage of inpatients that have had to make two or more ward moves had increased from 22% between August 2014 and July 2015 to 27% between August 2015 and July 2016
- Trust data indicated that 89 medical patients were moved after 10pm, between May 2016 and August 2016.
- Staff on outlier wards told us that they always completed an incident report if a patient was moved at night.
- We were told that the gastroenterology ward would be reducing its bed-base to allow for the current refurbishment. Senior managers had some concerns about this in terms of bed occupancy and availability of beds, especially over the coming winter and planned to monitor this closely.
- The stroke ward had 23 beds in total, four were hyper acute stroke and four were neurology beds. The stroke ward manager told us that they tried to ring-fence two beds for acute stroke admissions, however on occasions the site managers would inform the unit that these beds had to be used for non-stroke patients.
- The trust provided an interpreting service to support the communication needs of people who are non-English speakers, people for whom English is a second language, and people who are deaf.
- Spoken translation services were available by telephone and face to face translation. Document translation was also available.
- Interpreter bookings could be made either by telephone or online 24 hours/day
- We saw a wide range of information leaflets were available to patients on all of the wards.
- We saw that wards including the AMU had separate bed bays for male and female patients.
- We saw that individual needs were discussed within MDT meetings. For example; the requirement for an interpreter for a meeting to discuss discharge arrangements, health education needs of a patient related to driving and the needs of another patient with regard to stopping smoking were discussed.
- Staff in some areas were unclear regarding the use of the interpreters and told us that their first port of call would be a relative or another member of staff. This is not in line with best practice, which recommends the use of independent interpreters. Staff in other areas told us that they would arrange translators prior to patients coming in for planned treatments and only use family as interpreters if unable to access a professional translator.
- The trust employed a lead nurse for learning disability to provide advice and training to staff. This person was maternity leave at the time of inspection. The team leader, in the transfer of care team, told us they had received learning disability training and could provide advice to staff.
- The transfer of care team told us they talked to patients and families about the pathway of care and took into account the patients' ability to make decisions and their view about their capabilities and individual needs in relation to discharge.
- We were told by the nurse in charge of AMU that staff were very aware of the problems facing people suffering from dementia and that they had a dementia lead nurse. We saw there were activities equipment such as twiddle muffs and every patient had a "this is me" sheet. I spoke to a relative who was with her daughter who had learning disabilities she felt she had been kept informed at every step and was very happy so far.
- Staff told us there were dementia link nurses on all of the wards.

## Meeting people's individual needs

# Medical care (including older people's care)

- We saw nurses in this area giving patients very clear information in a way they could understand.
- On the stroke ward we saw a wide variety of leaflets were available with all kinds of information. For example, there were leaflets on; the stroke support service, stroke symptoms, speech and language therapy, Health Watch and how to complain. There was also comprehensive noticeboard with information about dementia.
- Staff on the stroke ward had implemented 'This is me' (an information sheet on the individual to enable personalised care) and the 'Forget Me Not Carers Passport' (this removes restrictions on visiting hours and enables assistance for families from the carers resilience service). Staff told us that the 'this is me' documentation was used throughout the medical wards and that the 'forget me not' passport was being rolled out to other wards. We saw this in use on AMU using the forget me not passport.
- The stroke ward also displayed discharge information showing the pathway through the discharge process and follow on care in the community.
- We saw there was a large therapy area on the stroke ward but patients had to be taken off the ward for occupational therapy kitchen assessments. The ward manager told us his plans for submitting a business case to the charitable funds office, to convert part of the existing therapy area into a kitchen so patients could receive all of their therapy and assessments in the ward area.
- The staff told us that a member of staff from the discharge lounge visited patients who were to be transferred, so that they saw a familiar face when they were moved there before going home.
- Managers told us that staff had received dementia awareness regarding 'this is me, documentation and 'forget me not passports'. Nursing staff training data indicated that the stroke unit, A1, A2, A4 and A5 had not yet reached the trust target of 66% attendance at these sessions all other medical areas had met or exceeded this target.
- Completion of dementia awareness among allied health professionals working in Integrated Medicine was good while medical staff compliance was poor.
- The trust had introduced open visiting hours for the primary carer of patients with dementia and gave them the opportunity to visit 24 hours a day and stay with the person they care for.

- AMU, A2 and A5 were dementia friendly with coloured bays, day clocks, dementia friendly signage and toilets.
- We saw that Halal meals were available for Muslim patients.

## Learning from complaints and concerns

- The Integrated Medicine received 93 formal complaints between June 2015 and July 2016. The top three reasons given for complaints were; patient care (39) 42%, clinical treatment (21) 23%, admission and discharge (10) 11%.
- Trust data indicated that the number of formal complaints has decreased each year since 2012-13.
- Staff gave us examples of how they dealt with concerns when they arose to prevent these escalating into formal concerns.
- We saw information and posters for patients and relatives explaining how to make a complaint.
- Patients and relatives we spoke with told us they knew how to raise a complaint if they needed to.
- Staff on ward A2 were able to tell us about their most recent complaint from a patient's family regarding an infection. They told us how this had been resolved through a meeting between the ward manager, a member of the IPC team and the patient's family.
- A relative told us how the trust had responded positively to her raising concerns about her mother's care on ward A5. The patient and relative had received a visit from the Medical Director and matron to discuss her concerns within 24 hours of emailing the chief executive.
- We saw from ward meeting minutes that complaints were discussed with staff.

## Are medical care services well-led?

Good



We carried out this inspection because, when we inspected the service in February 2015, we rated well-led as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated the service as 'good' for well-led because:

- Although staffing pressures continued, we saw an improvement in staff morale and a feeling that all was being done to improve staffing levels.

# Medical care (including older people's care)

- Staff were in the main positive about the hospital as a place to work and felt well-supported by their immediate line managers.
- The trust board had made efforts to become more visible and the head of nursing was more involved in local meetings and carried out monthly walk rounds on the wards.
- Each speciality had a vision and direction for their service and business plans had been developed regarding sustainability and future development.
- Ward managers, matrons and senior managers were aware of their risks and mitigations were in place. Risk registers were comprehensive and up to date.
- Staff felt the trust had an open culture and supported staff development (although this was constrained by staffing levels)
- We saw evidence of staff and public engagement and areas of improvement and innovation.
- Ward managers were aware of the challenges regarding improving staff compliance with training and appraisals and were taking action to improve these.

## **Vision and strategy for this service**

- We saw that the medical specialities had business and strategic plans in place regarding service sustainability and future development. Staff were aware of these including the opportunities and challenges their services faced in terms of areas for potential development and risks to sustainability.
- We saw, from the minutes of some ward meetings, that the values of the organisation were promoted through team meetings and made relevant to the staff members' area of work.
- There was a clear vision for the future of Integrated Medicine, which was a part of the integrated locality project. It was planned that patients known to the MDT and admitted to hospital will be contacted the day after admission and reviewed by a community nurse to ascertain their needs. Weekly MDT meetings will discuss the patients' needs and ensure that the most appropriate care is implemented. This approach is intended to ensure patients are discharged safely from the acute hospital in a timely manner and cared for in the most appropriate setting. It is hoped that this will result in better patient experience, reduction in hospital acquired infections, improved partnerships working across public and private sectors.

- The AMU ward sister told us that a frailty unit was planned with a specialist frailty team.
- Staff on the stroke ward had plans to improve the ward environment and facilities for stroke rehabilitation patients.

## **Governance, risk management and quality measurement**

- There was a structure of business and performance meetings across the specialities in Integrated Medicine. The minutes of these meetings demonstrated discussion of current risks and how issues were escalated. Areas were identified for local improvement and included items such as staffing, incidents, complaints, infection control, clinical effectiveness and best use of resources. The minutes also demonstrated shared learning and dissemination.
- Trust wide and service wide risk registers were in place and were regularly reviewed and updated, we saw that there were mitigations in place to reduce risks as far as possible. We saw that the service was already aware of the issues we identified in the ward areas and that these were recorded on the risk registers and had mitigations in place.
- Ward managers and matrons were aware of the risks in their areas and knew how to escalate risks through the organisation if needed.
- Senior managers told us that they used a number of indicators to measure quality of care and to identify wards struggling to maintain high standards. This system had been in place for about one year and included measures of staffing levels, numbers of serious incidents, pressure ulcers, falls and patient feedback. They told us wards were risk rated and colour coded to identify areas for improvement.
- Ward managers told us and showed us monthly performance posters that they displayed for staff to show what was improving and what needed to improve.
- Senior managers told us that the ward managers of areas in difficulty were asked to develop an improvement action plan with support from the governance team. Ward managers told us the practice development team were also able to support where training was required and new ideas or different ways of working were to be implemented.



# Medical care (including older people's care)

- The Medical Director highlighted his main concerns for the medical workforce as being recruitment, retention and unfilled vacancies and poor documentation of DNACPR and mental capacity assessments and discussions.
  - The matron and ward manager for AMU were very clear about the main risks for their area. These included the lack of beds in the wider hospital to move patients on, a lack of electric beds, staffing levels and the potential for violence and aggression against staff. All of these risks were on the local risk register.
  - Ward managers and matrons told us that they completed a weekly assurance tool for all wards. They told us the head of nursing did a monthly walk round of wards using an assurance checklist.
  - The ward manager for A1 told us the lack of hand wash basins was on her local risk register and anticipated this would be addressed when the ward was next refurbished, as the neighbouring ward had this addressed during their refurbishment. However, senior managers were unaware of the scale of this issue across the medical wards and that if wards were refurbished they needed to meet building regulations in relation to positioning and ratio of hand wash basins. This was not currently on the corporate risk register.
  - The senior managers told us they would look into this immediately and take appropriate action.
  - Risks and challenges raised by the manager of the stroke unit included staffing shortages and use of the stroke ring-fenced beds for non-stroke patients.
  - We observed that very few wards displayed their quality indicator information in public areas. Some wards had this information in staff only areas and some were not displaying this information at all. We saw that the performance department produced monthly laminated posters showing numbers and type of patient harm, medicine errors, FFT feedback, complaints, compliments appraisal rates, mandatory training rates and sickness rates in public areas. These should have been visible to patients and public on all of the wards.
- Leadership of service**
- At ward level there was clear leadership of the services. The majority of staff at all levels, told us they felt supported by their immediate line managers and knew who to escalate problems to if they could not solve something themselves.
  - Staff told us they were confident to raise concerns and were confident that their managers would support them with this if needed.
  - A member of staff on AMU told us her ward manager was a good leader and that she praised staff for their work, but also challenged poor practice. Some staff felt that the ward coordinator did not have enough time to spot and deal with issues all of the time.
  - The manager on the AMU worked one management day a week and worked as ward coordinator for the remainder of the week; the manager told us that she rotated onto night shift to keep in touch with night staff. The ward manager was in the process of recruiting to a temporary development post to cover a band 6 nurse's maternity leave. This would enable one of the junior members of staff act up into a more senior post on the unit and gain some leadership and management experience.
  - There were clear lines of accountability from the service leaders to the frontline staff.
  - There were a number of new ward managers who told us they were well supported by their matrons. Matrons gave support to the ward managers regarding day to day operations as well as monitoring performance.
  - Staff at all levels told us that personal development was encouraged.
  - Junior medical staff spoke highly of clinical leadership and support and said the trust was a good place to work "the best in the region".
  - The ward manager on A5 told us that she had been moved over the winter to cover the winter pressures ward and had been commended for her leadership. However, on return to her own ward in June 2016, sickness levels were high and compliance with mandatory training and appraisals had fallen. We saw that an action plan was in place to address these issues and that these were gradually improving. A band 6 development post to support the ward manager had been agreed and recruitment processes were underway. Due to significant improvement on this ward the manager had nominated her team for a proud award.
  - Staff in the cardiac catheter suite said they were well supported by their manager and they loved working in the unit.
  - We saw that staff were recognised for good performance and received emails from the senior nurses commending their practice and thanking them for their work.

# Medical care (including older people's care)

- Ward managers and Matrons told us they were well supported by the senior management team.
- The locum consultant we spoke with told us that they were treated as part of the team; they knew the plans for integrated locality teams, who the board were and felt that the trust was a good place to work. However, junior medical staff we spoke with were not aware of the trust's vision and were unable to identify members of the board. After the inspection the trust told us it had been agreed that key members of the Executive Team would meet the Junior Doctors on induction and afterwards.
- The ward manager on A1 was encouraging the development of band 6 nurses by allocating them to teams so they could become involved in the appraisal of members of their team.
- Staff and managers told us about STAR cards and PROUD awards and we spoke with a number of staff and managers who had received these in recognition of their hard work and or innovation. Individual staff and teams could be nominated for these awards by colleagues, managers or by patients.
- The senior managers for the service told us that the trust provided a leadership programme for newly appointed ward managers and matrons supported ward managers and band 6 nurses with identified development needs. They also told us about a 'Compass project' which was being developed to enable qualified nurses to rotate through surgical, medical and community specialities over the course of a year. This would also include a leadership module.
- Ward managers and staff told us that although regular ward meetings were planned as a forum to share learning from complaints and incidents and provide updates about service developments they were often cancelled due to staffing levels on the wards. Ward managers tried to hold these as often as possible and notes from meeting were displayed or emailed to all staff to read if they had missed the meeting. We saw communication boards on the wards for staff.
- The ward manager from the discharge lounge told us they received regular 1-1 meetings with their manager and obtained support from peers at the monthly team leaders meeting.
- Matrons met with the Head of Nursing for 1-1s and weekly matron meetings. Matrons told us they had good peer support and attended monthly governance meetings.
- There was a governance matron who oversaw incidents, complaints and nursing metrics in relation to their quarterly CQC self-assessments of compliance against the key lines of enquiry on the Health Assure system'.
- Although staffing pressures continued, staff and managers felt that the trust was doing all it could to improve staffing levels through ongoing recruitment.

## Culture within the service

- Staff told us they felt proud to work for the trust and they would be happy for their friends or family to receive care there. They told us they were well supported by their managers and there was good teamwork and support in all areas we visited.
- Sickness absence rates had been above the England average except for a period between July – September 2015.
- Sickness rates were displayed on the governance poster for staff information. Sickness rates for August 2016 were; A2 8%, CCU, stroke unit and A7 were around 5%, A4 was around 6%, A1 7% and A5 was almost 9%. We saw from minutes of meetings that the trust was promoting managers to improve return to work interviews and be more active in managing sickness.
- Staff gave positive feedback regarding the culture of the organisation and as a good place to work. They felt they were encouraged to report incidents and learn from them. Staff felt the culture was open and transparent.
- Staff felt confident to raise any concerns they had about patient safety, that managers would listen and would take appropriate action.
- The service leaders and managers encouraged learning and development and supported staff through career development. Support workers wishing to gain experience and then move on to professional training were encouraged.

## Public engagement

- The staff on the discharge lounge (transfer of care team) actively sought patient feedback by ringing six patients a week (three simple discharges and three complex). They collated the feedback and acted upon it. We saw some of the environmental changes staff had made because of patient feedback. The team is applying for funding to provide a very large back lit poster for the discharge lounge area because quite a few patients had



# Medical care (including older people's care)

commented that the room was bare and they didn't like the large blank wall. They are also planning replacement of the existing furniture to improve the comfort of patients.

- We saw that 'you said we did' information was displayed on some of the wards to show what actions had been taken because of patient feedback.
- The AMU displayed posters along the corridor inviting patients to take part in the patient survey.

## Staff engagement




- Staff were rewarded for good practice and innovation through STAR cards, PROUD awards and emails from senior managers.
- Staff told of examples where listening in action events had been a forum for hearing about good practice and had led to improvements such as the introduction of electronic handover.
- The transfer of care team were proud of what they had achieved, the decision was taken to redesign the service because all team members agreed it was not working. In January 2016, the team was given autonomy to fix things themselves. This resulted in improved communications between the acute areas, community services and social care, which has led to improvements in discharge and patient flow. The team had moved on to trial band 3 transfer of care support workers stationed on the wards to liaise with partner organisations to improve communication and continuity further and continue improving patient flow through hospital.

- Ward meeting minutes demonstrated staff involvement and engagement with service improvements in a number of areas, for example in AMU and ambulatory care.

## Innovation, improvement and sustainability

- Senior managers told us that core medical trainees were being encouraged to look at areas of service improvement as part of their training.
- Over the past 12 months, the trust had been incrementally improving the in-patient environment, upgrading them to make them dementia friendly, and increasing the number of toilets and hand basins available. This work was ongoing with the refurbishment of wards.
- The work of the transfer of care team and ward discharge coordinators was innovative and showing positive improvements in patient flow and reducing discharge delays.
- The hospital staff had direct access to electronic information held by community services through the SEPIA portal, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicines and community services involvement in their care. The community staff could also access hospital information through this system.
- Therapy staff had access to an electronic records system, which meant they could share patients' records / updates in treatment between themselves, community colleagues and GPs.

# Surgery

Safe	Good	
Responsive	Good	
Overall	Good	

## Information about the service

The division of surgery and planned care managed surgical services at The Rotherham NHS Foundation Trust. Within the division there were 10 clinical service units (CSU), each CSU had a clinical and a governance lead.

The hospital provides emergency inpatient surgical treatment, elective (planned) inpatient surgical treatment and day surgery across a range of specialities including orthopaedics, ophthalmology and general surgery. There are nine main operating theatres and two day surgery theatres. One of the main operating theatres is an emergency theatre and there is a dedicated trauma list seven days a week.

Between March 2015 and February 2016 there were 34,391 surgical episodes of care carried out at the trust. Emergency cases accounted for approximately 20% of all episodes, day cases approximately 65% and elective cases approximately 15%.

During this inspection we visited the following surgical wards; B4, (general surgery and oral and maxillofacial surgery), B5 (general surgery), surgical assessment unit, Fitzwilliam (trauma and orthopaedics), Keppel (elective orthopaedics), Sitwell (urology), day surgery, the operating theatres and recovery and fracture clinic.

We spoke with 38 members of staff. We observed staff deliver care and looked at 10 patient records. We reviewed staff records and trust policies. We also reviewed performance information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

We undertook a comprehensive inspection in February 2015 where we rated effective, caring and well-led as good, and we rated safe and responsive as requires improvement. The service was rated as requires improvement overall. We carried out a focused, follow-up

inspection between 27 and 30 September 2016 and an unannounced inspection on 12 October 2016. At this inspection, we re-inspected the safe and responsive key questions.

# Surgery

## Summary of findings

We carried out this inspection because, when we inspected the service in February 2015, we rated safe and responsive as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we found that:

- The trust had taken action on some of the issues raised in the 2015 inspection, for example, staff were confident in reporting incidents and received feedback from incidents. The World Health Organisation (WHO) safer surgery checklist was embedded in practice and additional staff had been recruited. The management of medical outliers was in line with trust policy, there had been no mixed sex accommodation breaches and access and flow had improved in fracture clinic.
- Senior staff planned and reviewed staffing levels and skill mix to keep people safe from avoidable harm. All wards used an early warning scoring system for the management of deteriorating patients. Systems and processes for infection control and medicines management were reliable and appropriate.
- Patients' needs were met through the way services were organised and delivered, for example, the division worked with local NHS organisations to provide satellite services. The trust's referral to treatment performance was better than the England average between June 2015 and May 2016.

However:

- At the time of the inspection the trust did not have a Hospital at Night team and out of hours senior doctors were not always resident on site to support junior doctors and advanced nurse practitioners.

## Are surgery services safe?

Good



We carried out this inspection because, when we inspected the service in February 2015, we rated safe as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated safe as 'good' because:

- The trust had taken action on some of the issues raised in the 2015 inspection, for example, staff were confident in reporting incidents and received feedback from incidents. The World Health Organisation (WHO) safer surgery checklist was embedded in practice and additional staff had been recruited.
- Some wards in the service displayed figures which showed there had not been an incidence of a pressure ulcer for over a year.
- Systems and processes for infection control and medicines management were reliable and appropriate.
- Senior staff planned and reviewed staffing levels and skill mix to keep people safe from avoidable harm.
- All wards used an early warning scoring system for the management of deteriorating patients.

However:

- Although compliance with mandatory training was good there was an inconsistency between the trust figures and local records held by ward managers.
- The trust did not have a Hospital at Night team, out of hours senior doctors were not always resident on site to support junior doctors and advanced nurse practitioners.

### Incidents

- Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. There was one Never Event reported in the service between July 2015 and June 2016. This happened at a clinic provided by the trust at a local NHS organisation, an investigation to identify the cause of the Never Event had been carried out.. The trust subsequently declared another Never

# Surgery

Event in September 2016; this was wrong route administration of medication. Staff explained new procedures that had been put in place on the ward as a result of the Never Event.

- Serious incidents are incidents that require further investigation and reporting. The trust had reported eight serious incidents in surgery between July 2015 and June 2016. We reviewed an investigation during our inspection which identified a root cause of the incident and contained recommendations and an action plan. We saw evidence during our inspection of changes made to practice as a result of the incidents.
- Information provided by the trust showed there were 2080 incidents reported in the service between August 2015 and July 2016; 87% were classified as no harm, 12% as low harm and 1% as moderate harm. Frequent incident categories that were reported were medication, patient accidents and access, admission, transfer and discharge.
- Staff we spoke with understood how to report incidents using the electronic reporting system. They told us they received feedback about incidents at team meetings, by email and from information shared by senior staff.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The trust was reviewing its training programme to include duty of candour to all relevant staff groups as an e-learning module.
- Staff were aware of the importance of being open and honest with patients and their relatives and the need to apologise if there had been a mistake in their care.
- Senior staff had a clear understanding of the duty of candour and gave examples of how they met the regulation in relation to the incidents that had occurred.
- Individual clinical service units within the division did not have separate mortality and morbidity meetings. Senior staff told us this was an agenda item in the governance and effectiveness meetings. We reviewed 22 sets of meeting minutes from eight clinical service units from over the last six months. Most clinical service units reviewed mortality cases, however, there was no

evidence of services reviewing morbidity cases. The mortality reviews had multidisciplinary attendance and the minutes showed evidence of a review of and learning from individual cases.

## Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).
- In the reporting period June 2015 to July 2016, the service reported 14 incidents of harm at the trust. Three pressure ulcers, two falls with harm and nine CUTIs.
- All wards displayed safety thermometer information. This meant staff, patients and relatives could see the amount of harm free care that was provided.
- Staff were extremely proud of the number of days since there had been an incidence of a pressure ulcer on the ward, at the time of our inspection it had been over 400 days on Fitzwilliam ward and over 700 days on Sitwell and Keppel wards.

## Cleanliness, infection control and hygiene

- All wards and theatre areas were visibly clean.
- Clinical areas displayed infection prevention and control information visible to patients and visitors.
- We observed that the ward layout and situation of hand basins was not ideal on some of the wards. The basins were situated on the ward corridor outside of the bays and not all bays had a basin immediately outside. This meant that staff needed to leave the bay after delivering care to remove personal protective equipment (PPE) and wash their hands before returning to the bay to carry on with their next task. We did not see this recorded as a risk on the risk register.
- We observed all staff were compliant with key trust infection control policies, for example, hand hygiene, PPE, and isolation.
- Information provided on the service divisional dashboard for July 2016, showed that in 2016/17 there had been no hospital acquired meticillin resistant staphylococcus aureus (MRSA) and one case of Clostridium difficile (C.difficile) infections. These were both below the trust target.

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- Keppel ward, the elective orthopaedic ward, was protected for elective only patients in accordance with best practice recommendations.
- Theatres completed monthly hand washing, peripheral cannula insertion and central venous catheter insertion audits and achieved 100% compliance between April and July 2016.
- The infection prevention and control team completed regular commode cleaning audits. The trust provided a number of audit reports across a selection of wards between April and August 2016. The commode cleaning audit measured compliance against six standards. In half of the audits provided wards achieved 100% compliance. The audit was a tick box form so there was a lack of evidence of follow-up actions or ongoing improvements.
- The infection prevention and control team completed regular hand hygiene audits. The audit measured compliance against 30 standards. The trust provided six audits completed in August 2016 across a selection of wards. One ward achieved 100% compliance. The audits did not specify the number of staff observed or spoken with. There were comments on gaps in compliance such as staff seen with nail varnish, nails too long and staff wearing inappropriate jewellery. However, the audit was a tick box form so there was a lack of evidence of follow-up actions or ongoing improvements.
- Information provided by the trust showed 62% of staff in the service had completed infection control training. This was lower than the trust target of 80%.
- Information provided by the trust showed the surgical site infection (SSI) rate for 2015/16 for hip arthroplasty was 1.8% and 1.3% for knee arthroplasty. The SSI rate for 2015/16 for fractured neck of femurs was zero. We observed staff completing SSI documentation in theatre.

## Environment and equipment

- All wards and department we visited were tidy and equipment was visibly clean. A housekeeper was based on every ward.
- Information provided by the trust showed an average compliance rate of 97% in the monthly ward cleaning audit in surgical areas between August 2015 and July 2016.
- Resuscitation equipment was available on all wards. Staff checked the resuscitation equipment daily and records for this were complete.

- We checked equipment in all the areas we visited, for example, observation machines, hoists and consumables on the wards; they had all been appropriately tested and were within their service/expiration date.

## Medicines

- We saw that the service had appropriate systems to ensure that medicines were handled safely and stored securely.
- We saw controlled drugs were appropriately stored with access restricted to authorised staff. Staff kept accurate records and performed daily balance checks in line with the trust policy.
- Staff monitored medication fridge temperatures in line with trust policy and national guidance. The records we reviewed were complete in all wards and departments. This meant that medications were stored at the appropriate temperature.
- The clinical pharmacist service had been removed from Sitwell ward. Staff we spoke with thought this led to delays in obtaining medicines, including discharge prescriptions.
- Information provided by the July 2016 service divisional dashboard showed that in 2016/17 to date there had been 48 medication errors. This was recorded as high risk on the divisional risk register and we saw actions had taken place to mitigate the risk, for example, training for nursing staff and guidance for prescribers.
- The trust provided information about monthly antimicrobial audits completed on the wards, however, the most recent information available was from November 2015. The main concerns at that time were around the stop or review date and staff recording the patients history of MRSA status on the drug card. No action plan for the audit or repeat audit was provided so we were unable to see if the practice had improved.
- National Institute for Health and Care Excellence (NICE) guidance recommends in an acute setting medicines reconciliation is carried out within 24 hours. The trust monitored medicines reconciliation over a 24 hour period each month. The trust provided information that showed at July 2016 an average 66.7% of medicines reconciliation was completed in 2016/17. This was about the same as the national rate of 67% but worse than the trust's own target of 70%.

## Records

# Surgery

- Records in the service were a mixture of paper based and electronic information that included test results, reports and images.
- On all the wards we visited medical notes were kept in unlocked trolleys on the corridor. Staff were not always present near the trolleys as they were attending to patient's needs.
- We reviewed 10 sets of records. None of the records we reviewed met General Medical Council guidance on keeping records as medical staff did not record their GMC number. Of the records we reviewed, components of professional and trust standards were missing, for example, evidence of the name and grade of staff, diagnosis and management plan, daily review by a senior clinician or an individualised care plan.
- Information provided by the trust showed 85% of staff in the service had completed information governance training. This was worse than the trust target of 95%.

## Safeguarding

- Staff we spoke to were clear about what constituted a safeguarding issue and how to escalate safeguarding concerns.
- Staff knew how to access the trust's safeguarding policy and the safeguarding lead.
- We saw evidence of geriatricians' attendance on the orthopaedic wards including clear management plans documented in the patient record.
- Information provided by the trust showed 79% of staff in the service had completed safeguarding adult's level 2 training and 70% of staff had completed safeguarding children level 2 training. This was below the trust target of 80%.

## Mandatory training

- The trust had a comprehensive package of mandatory training for staff.
- Staff we spoke with told us they could access mandatory training easily and that they were up to date with their training.
- Ward managers told us they kept local records of mandatory training compliance because of historical problems with the accuracy of the central record. During our inspection we saw evidence of these records, all wards and departments training compliance was over 90%.
- Information provided by the trust prior to our inspection showed 84% of staff had completed fire basic

awareness, 72% of staff had completed basic life support and 65% of staff had completed moving and handling for patient handlers training. The trust target for completion of these training modules was 80%.

## Assessing and responding to patient risk

- The World Health Organisation (WHO) surgical safety checklist is a core set of safety checks, identified for improving performance at safety critical time points within the patient's intraoperative care pathway. We observed the checklist being used in line with trust policy and national guidance in four theatres and saw five completed checklists in the patient record.
- Theatre staff completed a monthly WHO surgical safety checklist audit in every theatre. The results had much improved through 2015. In February 2015, 39% of audit forms in all theatres were returned; this had improved to 96% in December 2015 with an average of 85% over the 11 months. The two individual standards on the checklist with the lowest compliance of 94% were standard 7 "sign out done with all team members present and engaged" and standard 8 "all questions in sign out asked verbally."
- Staff completed risk assessments on patients. These risk assessments included moving and handling, falls, nutrition, tissue viability and VTE. In the 10 records we reviewed, seven of them had all the risk assessments completed. Where the assessment had been completed and risks were noted, staff had completed appropriate care plans.
- National Early Warning Score tools (NEWS) enable staff to recognise and respond to a deteriorating patient. The trust had recently introduced a modified early warning score tool (MEWS). We looked at these charts and found that the trust had incorporated a fluid balance chart. This meant that staff needed to use a new chart each day which meant that staff would not be able to plot the patients' baseline observations and identify any trends.
- The trust had a pathway for the deteriorating patient. Clinical areas we visited displayed the pathway. The records we reviewed had completed MEWS scores and appropriate responses documented.
- The trust had a sepsis pathway. Staff we spoke with demonstrated a good understanding of sepsis and we saw evidence of completed pathways in the patient record.
- A junior doctor we spoke with told us that the electronic system for ordering investigations could cause delays in



# Surgery

patients' treatment. For example, if a radiologist thought a request for a scan was not appropriate, they would cancel it on the electronic system. The system did not have an alert on to inform staff that the request had been cancelled.

- Patients that underwent day surgery received care in line with best practice guidance from the Association of Anaesthetists of Great Britain and Ireland and the British Association of Day Surgery Guidance 2011. Staff gave patients contact numbers for 24 hours a day and telephoned patients who had a general anaesthetic the following morning.

## Nursing staffing

- The trust used the safer nursing care tool and professional judgement on a six monthly basis review nurse staffing establishment. The trust planned to roll out the use of safecare. This was a tool to inform decision making about safe staffing on a shift by shift basis taking into account staffing numbers, skill mix, acuity of patients and activity on the ward. This was not in use at the time of our inspection, however, Sitwell and Keppel wards were planned to be the first areas to use it in surgery.
- Wards displayed the planned and actual staffing figures. During our inspection the actual number of staff on duty was lower than the planned number of staff on most of the wards we visited. Senior staff told us staffing was their highest risk and we saw evidence this was recorded on the risk register and there were controls in place to reduce the risk. Controls included active recruitment, weekly meetings with workforce colleagues, daily monitoring on wards and requests for clinical nurse specialists to work clinically on wards when possible.
- We looked at nurse staffing fill rates. The fill rate is calculated by comparing planned staffing hours and actual staffing achieved. In July 2016 the fill rate for surgical wards during the day were; B4 78% nurses and 96% care staff, B5 99% nurses and 96% care staff, Sitwell 100% nurses and 98% care staff, Fitzwilliam 91% nurses and 87% care staff Keppel 78% nurses and 79% care staff.
- Theatres were staffed in accordance with national guidance. A supernumerary theatre coordinator was included in the establishment. Information provided by the trust in August 2016 showed that there were just

under nine whole time equivalent (WTE) vacancies of registered nurse and operating department practitioners from the 105.9 WTE theatre staff establishment.

- The trust provided the registered nurse and non-registered health care staff establishment and vacancy figures by ward. The orthopaedic wards (Fitzwilliam and Keppel) had the highest registered nurse vacancies; 9.2 WTE across both wards out of a combined establishment of 42.2 WTE.
- The non-registered health care staff vacancy rate was low across the service.
- Our 2015 inspection found there were shortfalls in staffing levels in fracture clinic. During this inspection we saw that fracture clinic had recruited additional plaster technicians and staff we spoke with told us some nurses and health care support workers had received training to fit plasters.
- The service had two trauma coordinators in post.
- Information provided by the trust showed that nursing bank and agency staff usage was between 0 – 19% in the service between January and June 2016. The highest usage was on B4 and Keppel wards. We viewed wards induction policy for agency and bank staff during our inspection.
- Some wards used a standardised electronic handover sheet where clear information was collated including plans for investigations, tests and procedures.

## Surgical staffing

- Surgical cover encompassed a significant range of specialties. During daytime hours Monday to Friday, each speciality managed its own team of doctors.
- Consultant medical staff were accessible 24 hours a day, seven days a week. Senior medical staff reviewed patients daily.
- Within surgery, similar rates of medical staffing to the England average levels were noted: Consultant staffing at 46% versus 43% England average and junior medical staff 9% versus England average of 11%. However, registrar grade medical staff was lower at 23% versus 35% England average with middle career medical staff higher at 22% versus 10% England average.
- Information provided by the trust showed that there was seven WTE medical and dental vacancies in the service, these were in ear nose and throat, oral and maxillofacial surgery, ophthalmology, orthopaedics and urology.



# Surgery

- Information provided by the trust showed that medical agency staff usage was between 4.2 – 20.6% in general surgery and between 16.3 – 34.5% in orthopaedics between January and June 2016.
- The trust did not have Hospital at Night team; it was planned to start in November 2016. Out of hours junior doctors or advanced nurse practitioners were supported by a registrar and consultant (who may not be on site) and a senior nurse led clinical site management team.
- Junior doctors did not formally handover ward patients that had been seen out of hours. The formal handover only included new patients seen by the on call team. This meant ward based doctors had to rely on the patient record and information from nursing staff about any changes to patients on the ward.

## Major incident awareness and training

- Specialities within the service had business continuity plans. The actions described were in line with the trust's major incident plan.
- Staff knew how to access the major incident and continuity plans on the intranet and explained the steps they would take to seek instruction from senior staff.

## Are surgery services responsive?

Good



We carried out this inspection because, when we inspected the service in February 2015, we rated responsive as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated responsive as 'good' because:

- The trust had taken action on some of the issues raised in the 2015 inspection, for example, the management of medical outliers was in line with trust policy, there had been no mixed sex accommodation breaches and access and flow had improved in fracture clinic.
- Patients' needs were met through the way services were organised and delivered, for example, the division worked with local NHS organisations to provide satellite services.
- The trust's referral to treatment performance was better than the England average between June 2015 and May 2016.

- Cancelled operations had been lower than the national average for the last two years.
- Staff were able to support vulnerable patients, for example, patients living with dementia and patients whose first language was not English.
- Complaints and concerns were dealt with in an open and timely manner. Staff used the lessons learned from patient complaints to improve practice.

However:

- The trust had identified further concerns with the waiting list management system. A full investigation had taken place. No patient harm had occurred as a result and the incident had been recorded on the division's risk register.

## Service planning and delivery to meet the needs of local people

- The trust engaged with internal and external stakeholders, patients, governors, members, partners and staff to plan services. The local clinical commissioning groups commissioned services within the trust.
- The division worked with neighbouring NHS trusts to provide satellite surgical services for patients, for example, in ear, nose and throat and ophthalmology specialities.
- Surgical services were available 24 hours a day, seven days a week, with emergency access to operating theatres outside of normal working hours. The day surgery unit was open Monday to Friday from 7am to 8pm.

## Access and flow

- Bed occupancy in the surgery division from January to July 2016 was between 83 – 87%. This was around the target of 85%.
- There had been no mixed sex accommodation breaches in the last 12 months.
- No patients had stayed overnight in the recovery area of theatres in the last 12 months.
- The Referral to Treatment time (RTT) indicator is set within the NHS at 18 weeks from referral from general practitioner to treatment time. The trust had consistently performed better than the England average against the referral to treatment measure from June 2015 to May 2016.

# Surgery

- At our 2015 inspection, the trust had identified concerns with the waiting list management system, which resulted in 10 patients trust wide waiting over 52 weeks for an appointment. The management team confirmed at this inspection that no patient harm had occurred as a result of the incident. The trust had identified further concerns with the waiting list management system in 2016 and declared another serious incident in relation to 9500 patients that may have needed a follow up appointment or investigation who were not visible on a waiting list. The management team explained this had occurred due to staff entering the wrong outcome following a clinic. A full investigation had taken place, no patient harm had occurred as a result of the incident and staff had undergone further training. The management team recorded the incident on the division's risk register and we saw evidence of a review of the risk and the mitigation and controls that were in place.
- Eleven theatres were available at the trust and provided emergency, elective and day case surgery. Data provided by the trust showed the average main theatre utilisation rate was 92% between April and June 2016. This was around the target of 92%. The average day surgery theatre utilisation rate was 84% between April and June 2016. This was around the target of 85%.
- The surgical division clinical strategy planned a review of theatre efficiency and productivity. For this, senior staff required an individualised theatre data report on a monthly basis with the aim for complete theatre utilisation and the extension of the day surgery unit and range of day case work.
- The percentage of elective admissions with cancelled operations was below the England average in seven out of eight quarters for the last two years.
- The percentage of patients whose operation was cancelled and then were not treated within 28 days had been consistently lower than the national average for the last two years.
- At trust level the average length of stay had mixed results; five out of eight specialities reported shorter stays compared to the national average.
- The service had made a change to the consultant cover on the surgical assessment unit (SAU) since our inspection in 2015. A consultant was now based on SAU during the day. This had improved the service's discharge on the day rates.
- Discharge planning began at the pre-assessment stage. The trust set a planned date of discharge as soon as possible after admission. Wards worked with social services and community services to reduce delays for patients with complex needs. The number of delayed discharges in surgery was around 1% of patients which was below the target of 3.5%. This had improved since our inspection in 2015.
- Surgical wards had medical patients located on them (medical outliers). Staff we spoke with told us that this was a frequent occurrence, however, the process was in line with the trust's operational escalation plan. Specific wards had additional criteria or conditions, for example, Keppel ward (elective orthopaedics) should not have outlying patients transferred to it. Staff completed the patient assessment for outlying prior to transfer. Medical staff regularly reviewed patients, but ward staff told us this would always be after the main medical ward rounds and could be the afternoon. This meant patients treatment plans or discharge may be delayed.
- The service had made some changes to the environment in fracture clinic since our 2015 inspection which had improved access and flow. The clinics had additional consultation rooms, signposted waiting areas for patients and when we visited the department all the corridors were clear and there was sufficient seating for the patients who were waiting.

## Meeting people's individual needs

- The trust produced standardised up to date information for patients on specific conditions or aspects of being in hospital, for example, post total hip replacement - commonly asked questions by patients and preoperative assessment – preadmission centre.
- Leaflets were available in alternative languages and formats on request.
- Interpreting services were available for patients whose first language was not English. Staff explained the process of booking an interpreter to us.
- We observed multi lingual signage in place.
- The service was responsive to the needs of patients living with dementia. Staff were aware of the trust's lead nurse for dementia and of the dementia inpatient care pathway. This included prompts for staff to initiate a 'this is me' document to ensure person centred care, ensure the ward link nurse for dementia was aware of

# Surgery

the patient on the ward and to avoid inappropriate internal ward transfers. We observed a 'this is me' document completed in a patient record on Sitwell ward.

- Information provided by the trust showed 72% of staff in the service had completed dementia awareness training; this was better than the trust target of 66%.
- The trust had recently appointed a lead nurse for learning disabilities. Staff we spoke with felt confident in caring for patients with a learning disability and told us they would seek support from senior staff or the lead nurse if they needed to.

## **Learning from complaints and concerns**

- All areas displayed information on how to make a complaint and leaflets were available to patients and relatives.

- Staff were able to describe complaint procedures, the role of the patient experience team and the mechanisms for making a formal complaint.
- Ward managers we spoke with told us they would listen to informal complaints to try and resolve them.
- Staff in the day surgery unit gave an example of changes made following a patient complaint. The order of patients on the theatre list was changed so that obstetrics and gynaecology patients were put at the beginning of the day.
- Information provided by the trust showed the division received 16 complaints in April and May 2016. The themes of these were around staff attitude, lack of information about results, and waiting times in clinics.
- The division did not meet the trust's target of responding to 95% of complaints in 30 days.

# Critical care

Safe	Good 
Effective	Good 
Well-led	Requires improvement 
Overall	Good 

## Information about the service

The critical care unit at The Rotherham NHS Foundation Trust is made up of two units. Intensive care unit and high dependency unit. The intensive care had two side wards and four beds on the main ward. The high dependency unit had two side wards and six beds on the main ward. In total there were 14 beds. Both units are adjacent to each other and staff were able to gain access through the medication room if needed. The medication room had key pad access leading from both units therefore only authorised staff were able to gain access.

A comprehensive inspection was undertaken in February 2015, when we rated the overall service provided by critical care unit at The Rotherham NHS Foundation Trust as 'requiring improvement'. This was based on caring and responsive being rated as 'good', but safe, effective, and well-led as 'required improvement'. The trust informed us of the actions they had taken to make improvements.

We therefore carried out a follow-up inspection in September 2016 and focused on safe, effective, and well-led to find out the improvements made since our comprehensive inspection.

We visited both units, spoke with four patients, eighteen staff, three relatives, observed staff interaction, attended handover meetings at the beginning of the shifts by doctors and nurses, observed the daily multidisciplinary ward round, visited patients who had been discharged to the wards and viewed eight care records and four incident reporting electronic records.

During our previous comprehensive inspection, in February 2015, we found that:

- There was a poor incident-reporting culture with little evidence of sharing and learning from incidents.

- There were not enough critical care specialist consultants to provide 24-hour cover for patients on the critical care unit.
- Nurse staffing levels were low and therefore it was not always possible for the experienced specialist nurses to provide supernumerary support to staff team during shifts.
- There was a lack of accessibility to the current policies and guidelines which led to the use of custom and tradition rather than evidence-based best practice.
- Complaints and concerns were dealt with at senior management level. There was no evidence that outcomes of the investigations were discussed at staff meetings and that if any changes had been made in response to complaints/concerns.

# Critical care

## Summary of findings

We carried out this inspection because, when we inspected the service in February 2015, we rated safe, effective, and well-led as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we found that:

- There was a culture where patients were at the centre of activities. There was a clear process for escalation, investigation and feedback of incidents. Lessons learnt were shared with staff to minimise them reoccurring. Staff received training in vulnerable adult and children protection. They were confident in safeguarding patients.
- Outcomes for patients using this critical care service were measured against similar services; this unit were better in some areas and similar in others. Staff were appropriately qualified.
- Staff understood and were able to verbalise the principles of mental capacity act, duty of candour and the unit vision and aims.
- At our request at the inspection, the trust took immediate action to ensure the fire evacuation arrangement in place for intensive care unit was fit for purpose. We confirmed this during our unannounced inspection. We also wrote to the trust and they confirmed that fire safety officers were satisfied with the arrangements in place.

However:

- Due to staff shortages, the nurse coordinator on shift was unable to fulfil their duty of managing, supervising and supporting staff to ensure safety. There was also a lack of a designated pharmacist on the unit.
- Patients' notes were not stored securely within the units to maintain patient confidentiality.
- The governance arrangements including maintenance of a risk register and the review process did not promote effective risk control.

## Are critical care services safe?

Good



We carried out this inspection because, when we inspected the service in February 2015, we rated safe as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated safe as 'good' because:

- There was a clear process for escalation and investigation of incidents with email facility to share the outcome of the investigation with the person who had reported the incident. Lessons learnt through incidents were shared with staff to minimise them reoccurring.
- Staff received training in vulnerable adult and children protection. They were confident in safeguarding patients.
- At our request at the inspection, the trust took immediate action to ensure the fire evacuation arrangement in place for intensive care unit was fit for purpose. We confirmed this during our unannounced inspection. We also wrote to the trust and they confirmed that fire safety officers were satisfied with the arrangements in place.

However:

- Due to staff shortages, the nurse coordinator on shift was unable to fulfil their duty of managing, supervising and supporting staff to ensure safety. There was also a lack of a designated pharmacist on the unit.
- Patients' notes were not stored securely within the units to maintain patient confidentiality.

### Incidents

- There had not been any Never Events or any serious incidents between July 2015 and June 2016. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Multidisciplinary staff members we spoke with understood their responsibilities; they knew how to raise concerns, report safety incidents, concerns and near misses internally and externally using the hospital procedures.

# Critical care

- An electronic incident reporting system was used. We looked at some of the reported incidents and the process which had been followed. Depending on the severity of the incidents, they were discussed at the governance meetings and the managers cascaded the learning to their departments. This was evidenced in the minutes of the governance meetings we saw.
- Staff within the unit told us they were informed of any learning/changes to practice at the beginning of their shift during safety briefing at each handover and also at staff meetings. We saw how the safety briefing was shared when we attended shift handovers.
- Staff shared with us some of the recently implemented changes. For example, the use of abbreviations on the bed board had resulted in an incident. Following this incident, no abbreviations were used on the bed boards and this was monitored by the shift coordinator. In addition, due to medication errors involving incorrect calculations and wrong route administration, additional checks had been introduced and smaller dose of medication had been stocked to reduce the risk of it reoccurring.
- Critical care consultants' meeting were scheduled monthly and included discussion of morbidity and mortality. We saw minutes of meetings held in May and August 2016 where cases had been discussed and the minutes showed documentation of the lessons learnt.
- Guidelines for the Provision of Intensive Care Services (GPICS), 2015 states that units must hold multi-professional clinical governance meetings, including analysis of mortality and morbidity. Due to workload and shift patterns not all members of the multidisciplinary team were able to attend the part of the meeting when consultants discussed mortality and morbidity. However staff were able to refer to the minutes of the meetings to find out about the lessons learnt.
- Staff members understood the principles of Duty of Candour. They said it was about being honest, transparent and admitting when mistakes were made and keeping people/patients informed of the actions taken by them. They informed us that it was dealt with by the matron and above. Consultant intensivist and the deputy ward manager shared with us an incident where they were in the process of writing a letter of apology to the patient.
- The NHS Safety Thermometer is a tool for measuring, monitoring and analysing patient harm and 'harm free' care. It focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).
- Data was collected each month for the safety thermometer readings and outcomes were shared with the multidisciplinary staff. The results were also displayed on the unit so people using the service were able to see them.
- The safety thermometer readings between June 2015 and June 2016 showed that there had been a total of five pressure ulcers (category 2 to 4) and one urinary tract infection in a patient with a catheter.

## Cleanliness, infection control and hygiene

- All areas of the units including clinical areas, the corridors, bathrooms, offices and storage rooms were well presented and were visibly clean.
- Cleansing gel/foam was available at the entrances to each clinical area and in each bedroom. Visitors were encouraged to use it by staff. Posters were prominently displayed encouraging staff and visitors to cleanse their hands and the correct process to follow to do this efficiently. Staff worked on the units were 'bare below the elbow' to promote infection prevention.
- We observed staff decontaminating their hands immediately before and after every episode of direct contact or care on both Intensive care unit (ICU) and high dependency unit (HDU) during our inspection. This was also evident during multidisciplinary ward rounds when staff moved from patient to patient.
- Protective equipment, such as gloves and aprons, were available and we observed staff using this appropriately.
- Between 1 April 2015 and 31 March 2016, the percentage of patients admitted to the unit who were at high risk of sepsis was 14.3%, compared to similar units which showed 11.8%. Unit acquired infections in blood, for the same time period, achieved 0%, compared to 0.9% at similar units.
- Staff attendance of infection control training was 100% and the hand washing audit compliance rate in August 2016 was 96%.
- Regular MRSA surveillance was carried out to determine the number of patients admitted on to the unit with

## Safety thermometer



# Critical care

MRSA and those who had acquired MRSA on the unit. The results between September 2015 and August 2016 showed that there had been one case with MRSA was admitted in April and another in July 2016.

- There had been one case reported as having acquired MRSA whilst in the unit. We saw a root cause analysis investigation of this incident and the outcome of the investigation. This incident had been taken seriously and all staff were instructed to be more vigilant and report any non-compliance of infection prevention and control incidents to the person in charge.
- We requested evidence of cleaning audits for the last 12 months. We received a copy of an audit report from 19 January 2016. The areas audited were separated into three sections and staff responsible for each area was identified. They were nursing, cleaning and estates staff. In this report nursing staff scored 85.7% cleaning staff 94.3% and estates scored 100%. There was a lack of information on why all areas did not achieve 100% and why nurses scored 85.7%. There was no evidence of action needed to improve the scores.
- The results of five Infection Prevention and Control Clinical Practice observation audits undertaken in April and May 2016 were shared with us. The data did not specify the number of staff observed/spoken with on each occasion to ascertain compliance. There were comments on gaps in compliance such as staff seen with nail varnish, wearing inappropriate jewellery and a sink not kept clear. Since the audit was used as a tick box there was a lack of evidence of follow-up actions and ongoing improvements. We checked with the nurses who carried out the audits they told us that they approached the individuals during the audits and informed them and the audit outcome was discussed at the governance meetings with the managers so that action would be taken by respective managers.
- There were side wards available for the respiratory isolation of patients.

## Environment and equipment

- During our inspection on 29 September 2016, we noted that the fire evacuation arrangement in place for intensive care unit was not fit for purpose and it put patients, staff and visitors at risk. We highlighted this to staff and they informed us that this had been identified as a risk by them and it was documented on their risk register. Whilst no further action had been taken by the trust, the risk had been mitigated through the

Regulatory Reform Order fire risk assessment process which ensured staff had increased evacuation and fire suppression training on the unit. We highlighted our concerns to the management team during our inspection and requested immediate action. The trust responded immediately to resolve the issue and remedial work was completed. We visited the unit during our unannounced inspection on 12 October and found sufficient steps had been taken to make the unit safe. Staff told us that they had carried out a fire evacuation exercise with the fire safety adviser and found it useful. We were also informed by staff on the unit that local fire safety officers were to visit on 14 October to check the arrangements.

- At the last comprehensive inspection we reported the danger of free access to the unit during the day. Open doors to the unit allowed anyone access to the unit putting patients and staff at risk. On this visit we found the main entrance to the unit had fob entry to staff and intercom access to visitors. All the doors leading from the main corridor within the unit had key pad locks ensuring safety.
- Maintenance of equipment took place through the manufacturers' warranty and was supported by the in-house clinical engineering department. Nursing staff were responsible for reporting damaged or failing equipment. In the store room, equipment were labelled as clean and ready to use. Staff told us that special machinery, which was not always in use, such as the Continuous Venous Haemofiltration (CVH), was checked by a named nurse.
- A central record of training on medical devices was maintained. The trust submitted us the training log for the last three years. We were informed by staff that the training included their competence assessment. They said that yearly updates on the equipment usage were carried out once they had received the initial training. Recently recruited staff informed us that they had training, assessment of competency and supervision before being allowed to use equipment.
- Resuscitation equipment was stored in accessible positions on the unit and daily checks were carried out and documented without gaps.
- Staff said they submitted a business plan when new equipment was required and they had authorisation without delay.

## Medicines

# Critical care

- We checked the medicine management within the unit. We noted that the controlled drugs (CDs) management did not comply with the NMC Standards for medicine management. We found when boxes of controlled drugs were delivered to the unit, they were unopened and nurses assumed the number of ampoules / tablets in the boxes was correct as indicated on the packaging.
- NMC Standards for medicine management state that, 'the nurse should check the CDs against the requisition – including the number ordered and received. If this is correct then the relevant (usually pink) sheet in the controlled drug requisition book should be signed in the 'received by' section, enter the CDs into the ward controlled drug record book, update the running balance and check that the balance tallies with the quantity that is physically present.' This was not the practice at the time of our inspection.
- We also noted that CDs were checked weekly and not daily. The frequency of the checks was in line with the hospital policy. We shared our findings with the chief pharmacist who agreed that they needed to carry out a risk assessment and the policy needed to be revised in line with the Safer Management of Controlled Drugs, A guide to good practice in secondary care.
- We spoke to the nurses and the chief pharmacist about this. The pharmacists assured us that they will be reviewing the policies and updating them and look into increasing CD checks to daily.
- The unit did not have a designated pharmacist. GPIC standard state that 'clinical pharmacy services must be ideally available 7 days per week. However, as a minimum the service must be provided 5 days per week (Monday-Friday). This must include attendance at consultant-led multidisciplinary ward rounds'. This did not happen during our inspection. We were informed that funding had been secured to appoint a pharmacist to support the Critical Care Unit.
- There had been audits by a pharmacist and gaps had been highlighted such as gaps on MARs whether they were omissions, illegible writing and stock levels.
- We checked seven medication administration records (MARs). There were clear instructions, signatures of the prescriber with dates and allergies of the patients recorded on MARs. Staff had signed for the administered medication. If medication was not given reasons were

noted. There were no unexplained gaps on the MARs we checked. The unit maintained specimen signatures of all staff who had authorisation to administer medication.

## Records

- Patients' notes were not stored securely within the units to maintain patient confidentiality and privacy. The arrangement did not comply with the Data protection act 1998 and in breach of Records Management Code of Practice for Health and Social Care 2016.
- We observed multi-professional records stored at the bottom of each patient's bed to enable easy access to staff. This meant patient's relatives and visitors were also able to access any patients' notes on the main units. We discussed this with the staff on the unit. They informed us that several requests have been made for lockable notes trolleys to store patients' notes safely and so far no action had been taken by the trust to provide them with trolleys.
- We checked seven patients' records which included medical, nursing and allied health professional input. To maintain accurate records, daily records were updated by the multi-professionals following ward rounds, multidisciplinary team meetings and at shift end. Most records were legible, signed and dated with clear instructions/decisions. We noted some gaps, for example a consultant review was left incomplete, and one rehabilitation assessment was not completed.

## Safeguarding

- There were systems, processes and practices in place to keep patients safe.
- As part of induction to the unit all new staff received training on safeguarding.
- Safeguarding training was mandatory. The trust target for attendance was 100% and the records showed that 100% attendance was achieved for adult and children safeguarding training.
- Staff verbalised the process they followed to report safeguarding issues. They knew the trust lead for safeguarding and assured us that they were able to seek help from them when raising safeguarding concerns. They shared with us some examples where they had followed the trust policy on safeguarding and ensured patients were safe.

## Mandatory training

# Critical care

- Staff told us that most training was offered to them through electronic learning systems and they were able to complete them during their work time. Often they arrived early for work and took the time back if possible.
- Data provided on 16 September 2016 by the trust showed mandatory and statutory training (MAST) compliance for nursing staff as follows:
  - 100% compliance with moving and handling, resuscitation, fire safety, mental capacity, ethnicity and diversity training.
  - Between 93 – 98% for the other training such as information governance and dementia care. The trust target was 80% and the unit was compliant.
- We did not receive the training statistics for medical staff. They told us that they had all attended the necessary training and their records were held and monitored by the human resource department.

## Assessing and responding to patient risk

- We saw examples of comprehensive risk assessments with plan of care for the patients on the unit. Records showed that patients on admission received an assessment of VTE and bleeding clinical risk assessment. We checked six care records and found evidence of assessments and appropriate actions by staff.
- During ward rounds we observed staff discussions with regards to managing patients' risks positively.
- A modified early warning score (MEWS) chart was launched on 5 September 2016 which included fluid balance. The nurse consultant said the modification was in response to deteriorating patients increasingly having kidney damage and that they wanted to include it when assessing patients on the wards. The document was a hospital wide standardised approach to the detection of the deteriorating patient and it clearly stated the escalation response.
- The outreach team attended to the deteriorating patients on the wards during office hours. However, during out of hours and at the weekends, medical staff were called up on to attend.
- We saw a patient being transferred to another hospital for treatment. The transfer was organised and carried out by medical and nursing staff ensuring safety of the patient at all times.
- All patients admitted to the unit had screening for sepsis. Those who were admitted with sepsis received appropriate treatment and were monitored.

## Nursing staffing

- At our last inspection we identified that nurse staffing levels were inconsistent and did not always meet the levels recommended by the GPICs and ensuring supernumerary support by a care coordinator on each shift was not always possible.
- At this inspection, we requested patient dependency for three months with staffing levels to check the compliance. The information showed that Level 3 patients were nursed on a 1:1 nurse to patient ratio basis. For level 2 patients, the trust's Safe and Supportive Observation Tool was used to determine if an increased level of nurse: patient ratio was required rather than 1:2. Staff informed us that in some cases, patients' dependency levels were between level 2 and 1 depending on their support and stability; in these cases they used their professional discretion to decide on the staffing levels. We could not find a written standard procedure or a sample of the Trusts Safe and Supportive Observation Tool in use to support this.
- At the entrance of the unit the planned and actual nurse staffing levels were displayed. The information was in line with what we observed on the days.
- There was a band 6 shift coordinator during day shifts, but rarely during night shifts. During our inspection we met with night staff and we found the nurse who was to be the coordinator had to take care of a patient as well as coordinate the shift. They told us that this was common practice which could leave the unit unsafe. A coordinator described having to look after two patients the previous night; one of whom was at the end of life and the other was level 3. We were given further examples where the coordinator on nights looked after a patient instead of being supernumerary. GPIC standards stipulate that there will be a supernumerary clinical coordinator (sister/charge nurse bands 6/7) on duty at all times in Critical Care Units; this unit was not in compliance.
- There were six whole time equivalent (WTE) nurse vacancies on the Critical Care Unit. Action had been taken to address this including Band 5 staff interviews to recruit three WTE and also cover maternity leave. A further two WTE members of overseas staff had already started and they were on their supernumerary period.
- The sickness level on the unit was on the increase. In April 2016, the sickness rate was 3.4%, in June it was

# Critical care

4.4% and in August 2016 it was 8.2%. Staff on the unit told us that staff had been on long term sick and also gone on maternity leave. Managers said that they were looking to recruit staff.

- Nurses commented that they were moved from the unit to assist other wards and this meant the shift coordinator had to take care of a patient instead of being supernumerary. We checked the staff movement sheet for August 2016. On 15 out of 62 shifts, staff were moved on nine day and six night shifts. Staff told us they appreciated the need to help out on the wards but made the following comments. They reported there had been instances where they were sent to assist on wards to release coordinators on the wards to supervise staff on the wards. In other instances, they have been left in charge of a ward when they had never worked on that speciality. They told us that they had reported these concerns through their incident reporting process.
- We were informed that agency staff were rarely used prior to September 2016, as regular staff worked flexibly covering shifts. However, the trust management stopped all overtime for staff from 1 September 2016. This meant the critical care unit had to increasingly rely on agency nurses to support the shifts.
- Health care support workers (HCAs) were positive about their roles and responsibilities; however, they commented that at times they felt pulled between both intensive and high dependency units as there was one HCA during each shift. The nurses were aware of this and informed us that they had a HCA post vacant, but were unable to advertise as the trust's preferred option was to use staff currently working in the trust and this has not been possible. This was because HCA recruitment took place centrally to ensure new HCAs were enrolled onto the care certificate programme.
- A critical care lead nurse consultant was in post. They were supported by a band 7 and a band 6 nurse (equal to 1.8 WTE) to carry out outreach work where they dealt with deteriorating patients on the wards. This service was offered between 8am and 5pm Monday to Friday. That meant the outreach service was not provided during out of hours and during weekends. However, in the interim there were plans to develop a hospital at night service and involve Critical Care Unit staff in outreach work.

## Medical staffing

- Our comprehensive inspection in February 2015 highlighted that medical staffing levels were inconsistent and did not always meet the levels recommended by GPICS and there was not enough critical care specialist consultants to provide 24-hour cover.
- At this inspection we found that the trust had taken action and had employed sufficient number of medical staff to comply with GPICS. For example, eight Intensivists were in post and the daily consultant cover was from 8am until 6pm Monday to Fridays, at the weekend it was 8am to 1pm and then on call.
- During our inspection we found care in the unit was led by a Consultant in Intensive Care Medicine (ICM). All eight consultants with day time sessions were members of the Faculty of Intensive Care Medicine (FICM).
- There were handover ward rounds at 08:00 led by a consultant in ICM and at 20:00 between middle grades changing shifts.
- A multi-disciplinary ward round occurred at around mid-day to fit in with the work load. This happened every day including bank holidays. Due to the time commitment of the consultant microbiologist there was a separate microbiology ward round later in the day. However, the microbiologist maintained good communication with the medical staff when required.
- The night time consultant cover did not comply with GPIC standard. It states that 'a consultant in Intensive Care Medicine must be immediately available at all times and be able to attend within 30 minutes'. The night time consultant cover involved a rota of all anaesthetists with or without regular day time sessions on critical care unit. However the trust management were aware of this and were trying to agree funding for two further consultants with FICM to comply with GPICS.
- The trainee middle grade doctors at night also covered obstetrics and they were trying to appoint further speciality doctors in order to provide separate obstetric cover at night. Whilst there were vacancies, locum doctors were used to provide cover.
- The Consultant to patient ratio did not exceed a range between 1.8-1.15

## Major incident awareness and training

- Staff were aware of the action to be taken if there was a major incident. They told us that there was a folder with

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instruction cards for individuals to refer to and where it was kept. Senior staff told us the first step would be to decide on making beds available to help with the incident.

## Are critical care services effective?

Good 

We carried out this inspection because, when we inspected the service in February 2015, we rated effective as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated the service as 'good' for effective because:

- Staff had access to policies and procedures; these were being reviewed and updated.
- 54% nurses on the unit had achieved post registered intensive care qualification.
- Patients and relatives told us that staff monitored and responded to pain effectively without delay. They also said patients were asked regularly if they were comfortable or troubled by pain by all staff including allied health professionals.
- Outcomes for patients using this critical care service were measured against similar services; this unit were better in some areas and similar in others. Daily multidisciplinary ward rounds took place led by a consultant intensivist where patients' conditions were discussed and treatment plans were agreed by the team.
- Formal handover documents for patients being stepped down from the critical care unit were in use.
- Consent to treatment was sought by staff before commencing any treatment. All patients were assumed as having capacity to consent and staff assessed patients on an individual basis and took action to ensure appropriate steps were taken when best interest decisions were taken.H

However:

- The lack of attendance of pharmacist, microbiologist and dietitian during daily ward round did not comply with GPICS.
- We identified gaps in care coordinator support at night time.

## Evidence-based care and treatment

- At our previous inspection, we highlighted that there was a lack of accessibility to current policies and guidelines which had led to use of custom and tradition rather than evidence-based best practice. At this inspection we found that policies were made available to staff via the intranet; there were two systems in use. We were informed that as policies were reviewed and updated they would be transferred to Share Point and it would hold all the updated policies for the trust. Managers confirmed that this was work in progress. We tried accessing policies on 'Share Point' and it proved difficult as the system was not user friendly and staff on the unit agreed as they too found tracking policies difficult on the system. Managers informed us that, to improve access to policies and guidelines, a white guidance folder was kept on the unit which was updated regularly and maintained by Band 6 staff.
- Nurses told us that they had taken on additional responsibilities to ensure their practices were in line with critical care bundles and local best practice guideline.
- Any changes were discussed at staff meetings and shared at their daily safety briefing.
- Medical staff informed us that treatment and care was provided taking into account National Confidential Enquiry into Patient Outcome and Death contribution (NCEPOD) and findings and Royal College Surgeons (RCS) guidelines. This was evidenced in the minutes of meetings.
- The use of care bundles for ventilated patients and for intravenous access care was embedded and audited. This was evident from the care documents we saw.
- There was an evidence-based flow chart used by staff to assess the presence of delirium on all patients admitted to the critical care units.

## Pain relief

- All patients in critical care were assessed in respect of pain. This included observing for the signs and symptoms of pain and utilising a pain-scoring tool.
- Patients who were awake and able to respond were asked whether they were experiencing pain and staff used the tools to assess the severity. Those patients who were ventilated, physical signs and observations were used to deduce if they were in pain.



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- Administration of pain relief was recorded, patient's response was monitored and changes were made to medication as necessary.
- Patients and relatives told us staff monitored and responded to pain without delay. They also said patients were asked regularly if they were comfortable or troubled by pain by all staff including allied health professionals before attempting any therapy sessions.
- There was access to the pain management team for support and guidance. The anaesthetists assured us that they were familiar with the GPICs pain management standards and able to successfully manage patients' pain on the unit.

## Nutrition and hydration

- We saw on patients' records that they had been screened for malnutrition and the risk of malnutrition using the Malnutrition Universal Screening Tool (MUST).
- We saw there was a standardised feeding plan for patients who were being fed by nasogastric tube (NG) or Percutaneous Endoscopic Gastrostomy tube (PEG). This meant there was no delay in the feeding of patients if a dietitian was not available.
- Fluid balance monitoring for patients, which included hourly and daily totals of input and output. This was monitored by nurses and medical staff and recorded on the patients' chart and discussed at the ward rounds.
- There was access to a speech and language therapist (SALT) and a dietitian, when required. However, as recommended by GPICs, a designated dietitian was not assigned to the unit. We were informed that referrals from the unit were prioritised alongside of the other areas/wards within the hospital and patients were attended to by dietitians. Staff said they were able to contact a dietitian and discuss patients if they needed to.

## Patient outcomes

- The units participated in the Intensive Care National Audit and Research Centre (ICNARC) case mix programme. This meant the outcomes for patients using the critical care service were measured against outcomes achieved by similar services. The results from the latest ICNARC data at the time of our inspection were for 1 April 2016 to 30 June 2016. The data showed there was a total admission of 171 patients to the unit, 151 patients were discharged from the unit to the wards

and 135 patients were discharged home from the ward following admission to the Critical Care Unit. This meant patient mortality rate on the unit was 11.7% which was comparable to other similar units.

- For the same period risk adjusted mortality ratio was within expected range. This included 85 admissions of low risk patients to the unit. The risk adjusted mortality ratio was 0.7 which was better than the national aggregation of 1. This meant when comparing with other non-university hospitals that are similar to The Rotherham NHS Foundation Trust's Critical Care Unit, the mortality ratios were within expected range.
- This unit's performance compared to other similar units was good in most areas. For example, unplanned readmission within 48 hours to the unit during the set period was 0.7% (one patient) which was compared to 1% in similar units; out of hours discharges to the wards was nil and similar services had 2% and unit acquired infection in blood for this period was zero, compared to one for similar units.
- The unit participated and contributed to the North Trent Critical Care Network. This included audit activity and regular benchmarking against other Critical care services in the region. North Trent Adult Critical Care Operational Delivery Network- Annual Audit & Quality Report 2014/2015 outlined that some units, including at The Rotherham NHS Foundation Trust, had high numbers of level 1 patients in their Critical Care Unit beds. This may reflect the difficulties in discharging patients to a more appropriate environment and could lead to adverse situations where urgent critical care admissions are necessary.

## Competent staff

- All newly employed nurses to the unit had a supernumerary period until staff felt confident to look after patients on their own. Newly qualified staff received six weeks supernumerary shifts and all new staff were allocated a preceptor / mentor for support. This was confirmed by the nurses we spoke with.
- Staff on day shifts told us that since our last inspection there had been a named care co-ordinator on most shifts and this had improved leadership and support on shifts. They said nurses were able to maintain continuity of care by being allocated to same patients when possible and have a senior member of staff available to help them. On night shifts this was still highlighted as a problem since the co-ordinator was not supernumerary.



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- There was documented evidence that 54% of nurses had a recognised critical care training certificate. There were also plans to ensure each year staff to attend training to maintain compliance with the GPICs.
- We spoke with the clinical educator who was counted in the staff numbers on most shifts due to staff shortage. They said that they were responsible for the education, training and continuous professional development (CPD) framework for the staff on the unit. Although there was a named clinical educator, they did not have sufficient time to fulfil their duties and comply with GPIC Standards. The standard specifies that 'each critical care unit will have a dedicated clinical nurse educator responsible for coordinating the education, training and CPD framework for Critical Care nursing staff and pre-registration student allocation'.
- All the nurses we spoke with were aware of their registration revalidation and had commenced preparation. This included maintaining learning from incident documents and identifying their learning needs through clinical supervision. Revalidation is the method by which a nurse will renew their registration. The purpose of revalidation is to improve public protection by making sure that nurses remains fit to practice.
- All staff including medical, nursing and multidisciplinary staff we spoke with had yearly appraisal and the records showed they were compliant with the trust policy for appraisal.
- The nurse consultant told us that their time was divided between 50% clinical work including following up patients in clinic, carrying out audits and teaching staff. For example, they were teaching matrons and ward managers on the evening of 29 September 2016 the use of the new modified early warning score (MEWS) form. Health care support workers (HCAs) who worked on the unit either had NVQ level 2 or were working towards it.
- On admission to critical care, all patients were seen by a consultant in intensive care medicine and necessary staff including nurses and allied professionals were involved in assessing, planning and delivering treatment.
- Daily multidisciplinary ward rounds took place where patients' conditions were discussed and treatment plans were agreed by the team. To comply with GPIC standard the daily multidisciplinary ward round should be led by a consultant intensivist and attended by the doctors involved in the care of the patients, nurse caring for the individual patient, therapy staff such as the physiotherapist, the pharmacist, microbiologist, dietitian and others who may be involved in the care. However, the two ward rounds we observed it was not attended by all staff responsible for the care and treatment. Due to the time commitment of the consultant microbiologist there was a separate microbiology ward round later in the day. However, the microbiologist maintained good communication with the medical staff when required. The pharmacist and the dietitian were unable to attend due their work load.
- We observed a patient transfer to a ward and also a Critical Care Unit patient transfer to another hospital. In both instances multidisciplinary staff were involved in the decisions and they all worked seamlessly to ensure good patient outcomes.
- We observed and staff confirmed that there was a lot of respect between staff teams and they worked in a friendly environment.

## Seven-day services

- A Consultant intensivist was available seven days a week including out of hours and weekends. Multidisciplinary ward rounds took place seven days a week in compliance with GPIC standard 2015.
- Diagnostic, imaging and laboratory support was available outside normal working hours.
- Physiotherapy staff attended the unit seven days a week. A seven-day occupational therapy service was available as required and microbiologist and pharmacist advice was available via through the on call service. At the time of the inspection, there was no out of hours provision for speech and language therapy and dietetics.

## Multidisciplinary working

- There was a clear criterion for people who would benefit from admission to the critical care unit. This was clearly outlined on the MEWs document, so that all staff were able to refer to it. The consultant nurse explained that when they saw deteriorating patients on the wards they considered the criteria before seeking a bed on the unit. There was always a consultant intensivist who made the decision to admit a patient to the unit.

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- The critical care outreach team worked between 8am and 6pm Monday to Friday. Outside of these hours, the registrar on call for critical care provided the outreach support.

## Access to information

- To ensure effective delivery of care and treatment staff had access to relevant information in the form of care records, risk assessments and test results.
- We witnessed when people moved, including admission, discharge and transfer, all information belonging to the patient was shared appropriately, in a timely way maintaining confidentiality, and in line with Data Protection Act 1998.
- Supplementary Electronic Patient Index Aggregator (SEPIA) portal was being introduced to bring multiple electronic patient records together into one complete record to enable better access to information.
- Formal handover documents for patients being stepped down from the critical care unit was in use and we saw examples of the documents. The documents complied with the GPIC standard.

## Consent and Mental Capacity Act

- Staff understood the need for gaining informed consent and decision making requirements involving Mental Capacity Act 2005 (MCA).
- Nurses told us that they had attended training on MCA and the records showed that there was 100% attendance on 16 September 2016.
- We reviewed seven medical records; we saw examples where patients had been supported to make decisions as part of gaining consent for surgery. We also noted discussions with those close to the patient about the treatment plans for patients unable to be involved in decision-making due to their medical condition.
- The consent forms were completed legibly, signed by both parties (Patient and Doctor) and dated. A comprehensive list of possible outcomes discussed with the patient was also recorded.
- The multidisciplinary team discussed treatment plans at the daily ward round and involved the patients in their decisions. For those who were unable to contribute to the decision due to their illness, best interest decisions were made by the team of professionals treating them.
- We saw a patient with Deprivation of Liberty Safeguard (DoLS) in place and appropriate actions and paperwork had been completed with review dates.

## Are critical care services well-led?

Requires improvement



We carried out this inspection because, when we inspected the service in February 2015, we rated well-led as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated the service as 'requires improvement' for well-led because:

- The governance for risk management including maintenance of a risk register and the review process did not promote effective risk control.
- The trust leadership did not ensure a comprehensive outreach service for patients who had been on the Critical Care Unit in accordance with the principles in the Guidelines for the Provision of Intensive Care Standards.

However:

- Staff felt respected and valued by their line managers and colleagues and there was a culture where patients were at the centre of activities.
- The critical care unit had a local vision and strategy which encompassed the Guidelines for the Provision of Intensive Care Standards 2015.

## Leadership of the service

- The lead consultant intensivist had dedicated time for the management of the unit and they were involved with the decisions about the day to day running of the unit.
- They told us they were proud of all the staff working in the critical care unit for their commitment and their approach to care.
- The unit manager was a nurse and in charge of the Critical Care Unit. There was a deputy manager who supported them. The divisional head of nursing had the line management responsibility for the unit manager.
- There service had a Head of Nursing on the divisional board and a matron for Critical Care. This was in line with GPIC Standards which state that 'Each designated Critical Care Unit will have an identified lead nurse who is formally recognised with overall responsibility for the

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nursing elements of the service'. The divisional head of nursing explained that they had recently come into post and was looking into the management structure of the unit.

- Staff told us that they had seen the board members around the hospital and they seemed approachable.

## Vision and strategy for this service

- Critical care unit had a local vision and strategy which encompassed the Guidelines for the Provision of Intensive Care Standards 2015. These were shared with all staff and we saw the statement displayed in the staff room. All staff we spoke with were aware of local vision and strategy.
- The aim was to provide focused leadership and the best evidence based care to the patient population of Rotherham, to have robust monitoring, accountability and governance arrangements for critical care delivery and work collaboratively with all specialities within integrated partners.
- Managers said work had commenced in delivering best evidence based care to the patient and there was work to be done on monitoring and testing the governance arrangements.

## Governance, risk management and quality measurement

- There were monthly governance meetings with minutes which highlighted achievements and required actions by each division. Staff said that the information was shared with them on the unit.
- The arrangements in critical care for risk management needed to be revised. The present risk register and the review process did not promote active management of risk.
- We looked at the risk register for and up to August 2016. There were 18 risks reported. The last review took place on 9 September 2016.
- On reviewing the risk register we noted there were two types of risks that had been reported:
  - The identified risk should have been eliminated immediately by taking actions
  - An interim action to mitigate the risk with long term plan.
- We found risk records were kept for several months whether action had been taken or not without being removed from the register and serious risks were not

dealt with in a timely manner. For example, on 11 August 2015, a risk was identified regarding drugs not being readily available for emergency situation. Immediate action was taken by staff to keep two emergency drug boxes stored in an unlocked cupboard in the locked drug room, but this remained on the risk register in August 2016, some 12 months later. However, a serious risk regarding fire safety of the unit was reported on 17 July 2015 and it was rated as high risk. Limited action was taken to address this and it remained high risk on 9 September 2016. During our inspection we identified that, this still remained a high risk. Action was taken to resolve this as a result of the inspection team reporting the issues to the trust management. Another risk was reported on 15 January 2016 regarding the Critical Care Unit not meeting GPIC Standards by not having a dedicated pharmacist. There has not been any change to mitigate this and this risk remained high risk six months after being added to the risk register.

- There was a holistic understanding of performance, which integrated the views of people with safety, quality, activity and financial information. Staff were well aware of the financial restrictions at the trust.
- The trust has not ensured that patients who had been in the Critical Care Unit were provided a formal follow-up in compliance with GPICS. GPIC Standard stipulates that '20-30 minute appointments should be offered at two, six and twelve months following hospital discharge, by a team consisting of intensivists and nurses with appropriate expertise to support and treat patients. Other disciplines may need to be present such as clinical psychologists'. We saw a booklet in circulation which was produced and published (in 2007) by the nurse consultant which informed patients about the critical care follow-up service. The nurse consultant held a clinic on most Thursday afternoons. Patients were seen informally and they did not keep records of the discussions. We were informed if any patients needed further support or referral to psychologist or other professionals they would make the referrals. The present arrangement did not comply with GPIC Standard.

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- Management confirmed there had been slow progress in the development of the local Safety Standards for Invasive Procedures (LSSIPs). They said that work was underway using the national Safety Standards for Invasive Procedures to update LSSIPs.
- The services measured themselves against both the Intensive Care Society Core standards and the North Trent Critical care Network service specifications. Annual peer reviews were carried out by North Trent Critical care Network; however in 2015 a critical care network audit was completed which highlighted a large number of patients occupying critical care beds due to the lack of beds on the wards. The trust leadership team had taken action to address this issue by holding regular bed management meetings during the day to ensure that patients were moved to a more appropriate environment ensuring level 2 and 3 beds were made available for use.

## Culture within service

- Staff felt respected and valued by their line managers and colleagues.
- We were informed by the deputy ward manager of the action taken to address behaviour and performance that was inconsistent with the vision and values of the unit.
- All multidisciplinary staff we spoke with said there was a culture where patients were at the centre of their activities. We observed this in practice.
- Staff understood the principles of duty of candour, openness and honesty. We saw an example where a patient was sent a written apology.
- There was a strong emphasis on promoting the safety and wellbeing of staff within the unit, however this had proved difficult due to staff vacancies and sickness. .
- Staff teams worked collaboratively and constructively and shared responsibility to deliver good quality care.

- Staff appreciated the need to move to the ward areas to help out, however this was a regular occurrence and was affecting staff morale.

## Public engagement

- People's views and experiences were gathered through patient surveys and staff engagement. Between March and May 2016, twenty two patients responded to the survey carried out by the trust where patients' experiences in the Critical Care Unit were tested.
- The outcome of the survey was on the whole very positive; however there were some comments which required a response, such as high noise levels at nights. We saw managers had discussed the issues with staff and were taking action.




## Staff engagement

- Staff told us there were regular staff surveys, meetings and contact with their senior managers.
- They commented that they were moved from the unit to assist on other wards which they were not familiar with.
- Doctors in training told us they felt well-supported on the unit and were able to achieve their objectives and portfolio requirements.
- Nurses said they were supported on the unit by colleagues and their ward managers.

## Innovation, improvement and sustainability

- Staff said that following the last inspection they had introduced shift co-ordinator and a named clinical educator on the unit.
- Whilst policies and procedures had been reviewed when changes were made hard copies of the policy documents were distributed to staff to update them.
- Daily multidisciplinary ward rounds took place which were used as an opportunity for the members of the team to learn.

# Maternity and gynaecology

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

## Information about the service

The Rotherham NHS Foundation Trust provided a consultant-led maternity unit and gynaecology services. Between April 2015 and March 2016, there had been 2,733 babies delivered. The majority of these, 2718, were obstetrician-led births. The delivery suite had 15 ensuite rooms including one high dependency room. A triage unit was located next to the delivery suite.

There was a combined antenatal and postnatal ward, which also had a day unit. One bay in the ward was specifically for antenatal women, although bays were used flexibly as required. There was also an antenatal clinic in the hospital.

The gynaecology unit provided inpatient and outpatient services for the trust and saw around 9,300 outpatients each year. An early pregnancy assessment unit and pregnancy advisory service were located adjacent to the gynaecology ward. Between April 2015 and March 2016, there had been 480 medical and 80 surgical terminations of pregnancy at the hospital.

There was one dedicated theatre in the maternity unit which was used for elective and emergency surgery. The main hospital theatres were used for gynaecological surgery or if there was a second obstetric emergency.

The hospital employed community midwives to care for women and their babies antenatally and postnatally; all community midwives were aligned to a GP practice.

We visited all inpatient areas of the gynaecology department and consultant-led maternity service. We talked to 36 staff, spoke with thirteen patients and relatives, reviewed 18 patient records as well as other documentation.

We previously carried out an announced inspection of hospital between 23 and 27 February 2015. At that inspection we rated the service as requires improvement. There were concerns about staffing levels in each area of the maternity department. Some staff informed us that they did not always have time to report incidents, particularly about short-staffing. Arrangements for assessing and responding to patient risk were insufficient and there was a risk that patient safety needs were overlooked because appropriate prompts were not included on all documents. Mandatory training levels were below the trust's target for all staff groups. Safeguarding arrangements were in place, although improvements were needed for completion of documentation. The process needed to improve for women with social service involvement who had delivered their baby and may require an extended stay on the ward.

We also found at the previous inspection that outcomes for women were variable. There was a high rate of emergency caesareans and births being induced. The perineal tear rate fluctuated and was very high some months, with no consistent upward or downward trend. The number of maternal readmissions was also high. We saw that some midwives were responsible for providing care for women recovering from surgery, but they had not received an adequate level of training to do so. There was also a lack of midwives trained to perform basic tasks, for example,

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suturing and cannulation, as well as new-born baby checks; this impacted on the patient flow in the department. We also reported that the accuracy of discussion around performance could be improved and any required action agreed and documented.

## Summary of findings

We carried out this inspection because, when we inspected the service in February 2015, we rated safe, effective, responsive, and well-led as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated the service as 'requires improvement' because:

- Although action was taken to address most of the areas identified at the previous inspection, there were still some areas that required improvement.
- There was a backlog of incidents for review and the rate of safeguarding supervision was low and community midwives reported a lack of support.
- The trust had identified a number of poor outcomes since late 2015, which included neonatal deaths, stillbirths and maternal deaths. A multidisciplinary review of all the cases was taking place. Maternal incidents since 2014 were being reviewed and neonatal incidents that had occurred from 2015 onwards were also being reviewed.
- However, there had been some improvements since the previous inspection. Staffing levels and training had improved and arrangements for assessing and responding to patient risk were in place and monitored.
- The rate of emergency caesarean sections had improved and was similar to expected when compared with national rates. The rate of normal deliveries was better than the England average.
- There was evidence of good multidisciplinary working.



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## Are maternity and gynaecology services safe?

Requires improvement 

We carried out this inspection because, when we inspected the service in February 2015, we rated safe as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated the service as 'requires improvement' for safe because:

- Although action was taken to address most of the areas identified at the previous inspection, there were still some areas that required improvement.
- There was a backlog of incidents for review. This meant that there might have been missed opportunities to learn from incidents and prevent recurrence.
- The rate of safeguarding supervision was low and community midwives reported a lack of support.
- Some equipment was not suitable for use on the delivery suite; there were some suction tubes left unwrapped ready for use, resuscitaires had non-sterile, not for single use, laryngoscope blades. Medical gasses were not stored appropriately.
- There remained some concerns about information governance.
- Mandatory training compliance was still below the trust target in some areas, although compliance with safeguarding and equality and diversity training was improved and above the trust target. There were data discrepancies between the trust reported data; locally held data showed improved compliance.
- Out of hours, staff on delivery suite were required to be the scrub nurse in theatres. This could impact on the staffing levels and availability of senior staff on the unit.

However:

- Staffing levels were planned and achieved in accordance with national guidance.
- Arrangements for assessing and responding to patient risk were in place and monitored.

### Incidents

- There had been no Never Events between 1 July 2015 and 30 June 2016. Never Events are serious incidents

that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. There had been six serious incidents reported between 1 July 2015 and 30 June 2016.

- There had been 898 maternity and 274 gynaecology incidents between August 2015 to July 2016. The most common incidents in maternity related to labour and delivery, access, appointment, admission, transfer and discharge and infrastructure. The most common incidents in gynaecology related to access, appointment, admission, transfer and discharge.
- In maternity, three incidents had resulted in death, 51 moderate harm, 27 low harm and 815 no harm.
- There had been three maternal deaths between April 2016 and September 2016. A maternal death review had been held involving two members external to the trust; a consultant obstetrician from another trust and a local supervising authority (LSA) midwifery representative. The trust had taken steps to support safe practice, for example, a safety bulletin about prevention of venous thrombo-embolism had been sent to all staff.
- Following the recent maternal deaths, the trust had also invited the Royal College of Obstetricians and Gynaecologists to undertake an external review of practice. This was in the process of being arranged.
- A full day, neonatal/perinatal review meeting had also been held in August 2016 to review 30 perinatal deaths, eight of which had occurred since January 2015. A further review day was planned. The review included external stakeholders from the university and the Yorkshire & Humber Maternity Network.
- In gynaecology, 247 incidents caused no harm, 19 low harm and seven caused moderate harm.
- An electronic incident reporting system was used to report incidents. Most staff were aware of what and how to report incidents, although unregistered staff stated they were not aware of how to report incidents and would inform the nurse or midwife in charge.
- A system was in place to provide feedback to staff who had submitted an incident; staff spoke positively about how this had improved since the last inspection.
- Each obstetric consultant and some midwives had a topic to check on the incident reporting system to check for any recurrent themes.

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- We saw that serious incidents were escalated, for example to the trust's patient safety team. However, the process of escalation was not clear and staff recognised this needed clarifying.
- At the time of inspection, there was a backlog of incidents for review. There was a total of 181 incidents that had not been reviewed and 94 were overdue for review. The longest overdue for review dated back four months to May 2016. This meant that there might have been missed opportunities to learn from incidents and prevent recurrence. Senior managers had prioritised this and said the backlog would be cleared in six weeks following the inspection.
- Incidents were graded according to the risk. Staff recognised that the grading of incidents required further development to ensure consistency.
- We reviewed two serious incident investigations and found these had been appropriately investigated.
- It was recognised that further training in root cause analysis was required to ensure all investigators had the appropriate skills.
- Staff involved in the serious incident investigation process, told us how they met with families and included questions from the family within the terms of reference to ensure these were addressed.
- There was evidence of learning from incidents. Learning points were compiled by the ward manager on delivery suite; this was delivered at each handover for a two-week period before being updated. However, it was noted no discussion took place and a sheet to confirm the information had been shared at each handover was only fully completed once from 5 September to the time of inspection. Notice boards clearly identified lessons learned. Learning events had been held and learning was discussed at supervisory reviews and in a maternity newsletter. Staff gave examples of changes to practice as a result of learning.
- Joint perinatal mortality and morbidity meetings were held with the obstetrics and paediatric services. We reviewed the minutes from the meetings held in June and July 2016; individual cases were discussed and learning points identified.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that

person. Duty of candour stickers had been introduced in gynaecology notes, so it was clear when duty of candour applied and the incident had been discussed with the patient

- Within maternity services, duty of candour was applied. Staff said they explained what had happened to the patient. Letters were sent detailing when something had gone wrong. This included each incidence of 3rd or 4th degree tears; however, we were informed that some women had been upset to receive a letter as they had not understood anything had gone wrong.

## Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and the percentage of harm free care. It looks at risks such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.
- Safety thermometer information was clearly displayed on the gynaecology ward displayed. It was also displayed on the delivery suite, but was not as clear or the most recent results.
- We reviewed safety thermometer data for ward B11 (gynaecology ward). Harm free care was reported at 100% for nine out of 12 months between August 2015 and July 2016. It was approximately 92% for the other three months.
- Wharnccliffe ward (antenatal/post-natal ward) reported 100% harm free care in 11 out of 12 months between August 2015 and July 2016. For the same time period, labour ward reported 100% harm free care.
- Between January 2016 and August 2016, the maternity safety thermometer report showed that the rate of women who had a maternal infection was around or below 5.1%. This showed an improving trend. The rate of 3rd or 4th degree tears fluctuated between 10% in July 2015 and 2% in July 2016. The proportion of women experiencing a post-partum haemorrhage of more than 1000mls fluctuated from 2% in April 2015 to 12% in July 2015 with a median of 3.9%. The percentage of term babies with an Apgar score of less than seven at five minutes old was consistent with a median of 4.3%. The percentage of women and babies who received combined harm free care was on average 80.5%.

## Cleanliness, infection control and hygiene

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- During the inspection, we saw that handwashing facilities, hand gels and personal protective equipment (PPE) was available and used by staff. Hand gel was available at the entrances to wards and clinical areas.
  - Staff adhered to the 'bare below the elbow' policy.
  - Waste was appropriately segregated.
  - Monthly infection prevention and control audits, based on the national saving lives guidance, were undertaken by the infection control team. Maternity and gynaecology areas had consistently performed well with audit results showing an average of 98 to 100% compliance from April to July 2016. This included auditing compliance with 'bare below the elbow' policy.
  - Maternity surgical site infection rates for January to June 2016 were 1.8% for emergency caesarean sections and 0.69% for elective caesarean sections.
  - There were no gynaecology surgical site infections during the last 12 months.
  - There had been no MRSA bacteraemia or Clostridium difficile reported within maternity services.
  - The environment was visibly clean in the maternity and gynaecology departments, apart from some high level dust on the delivery suite.
  - There was a cleaning guide available for the birthing pool which included daily running of the taps for 10 minutes to minimise the risk of legionella.
  - We saw 'I am clean' labels used within the maternity and gynaecology unit.
  - Environmental cleanliness audits were undertaken. Results showed an average of 97% score for all areas between August 2015 and July 2016.
  - Trust-level data showed compliance with infection training was low at 55% against a trust target of 80%. However, locally held records showed improved compliance. For example, this showed 81% of midwives, 92% of community midwives, 73% health care assistants and 72% of consultants had received training.
- there were carpeted areas throughout. There were plans to provide an improved environment which was fit for purpose, but these had been put on hold. This was identified on the risk register.
- Building work was in progress to separate the early pregnancy assessment unit and the pregnancy advisory service so they had distinct areas and separate access. This had been identified as a concern at the previous inspection and was on the divisional risk register. In the interim, mitigating actions had been put in place including a separate waiting area and signposting.
  - Work was underway to improve the facilities on the gynaecology ward with an assisted mobility toilet.
  - Some areas on the delivery suite were well-organised such as the clean utility room. Other areas were in need of attention. For example, one delivery room had an old stain on the bathroom floor, the bath side had a dent in it leaving a gap between the wall and the bath side and there was flaking paint on the walls. A light above the bed had exposed wires that could be seen through a hole.
  - A birthing pool was available on the labour ward; evacuation procedures were in place.
  - Neonatal resuscitation equipment was checked daily; records showed that resuscitaires were checked with minimal gaps in September.
  - Records showed adult resuscitation equipment was checked daily. The triage area used the crash trolley on delivery suite.
  - Equipment safety checks were audited. Data on delivery suite for August showed 100% compliance with resuscitation trolley checks and 97% for resuscitaires.
  - In the maternity triage area, a test had been done of the emergency buzzer. The bell rang on delivery suite, but was a different tone so staff knew it was the triage area.
  - Some equipment was not suitable for use on the delivery suite; there were some suction tubes left unwrapped ready for use, resuscitaires had non-sterile, not for single use, laryngoscope blades and gym balls were used as birthing balls which may not have been appropriately load-tested.
  - The trust had a medical devices policy. This stated that all pieces of equipment were kept on a database in the Clinical Engineering Department with dates of maintenance and the expiry dates on all pieces of equipment in the ward or department areas. We looked at clinical equipment such as thermometers and CTG

## Environment and equipment

- Access to the maternity areas was restricted with the use of an intercom to manage entry and exit from the units.
- The antenatal clinic had been refurbished and new equipment, such as chairs, had been purchased. This addressed the concerns raised at the previous inspection in February 2015, when we identified the antenatal clinic building required attention to address concerns with the building, such as areas of loose plaster. The building was old and, although cleaned,

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machines and found these were labelled and in date. However, some non-clinical equipment on delivery suite, such as computers, fans and fridges were overdue a safety check according to the label.

## Medicines

- Medicines including controlled drugs were stored and managed in accordance with expected standards. This included arrangements to manage and dispose of insulin after it had been opened for 28 days.
- Drug fridge temperatures were mostly checked daily in all areas.
- We checked pre-prepared drug boxes, such as the hypoglycaemic kit, anaphylaxis box, post-partum haemorrhage and eclampsia box. All medicines were in date, although three ampoules of water had expired in Jan 2016 in one of the boxes. Staff were informed and these were replaced at the time of inspection.
- Medicines safety checks were audited. Data on delivery suite for August, showed 100% for portable oxygen checks, 97% for controlled drugs, 100% for emergency drugs trolley and 94% drugs fridge checks.
- Four prescription charts were checked on the gynaecology ward and eight charts were checked with the maternity unit during the inspection. These were completed appropriately. No unexplained gaps were found. Allergies were recorded.
- Pharmacy liaison had been withdrawn on the ante/postnatal ward due to staffing issues. Staff reported this had an impact on dispensing and waiting for discharge medication.

## Records

- Maternity records included appropriate completed antenatal risk assessments including venothromboembolism risk assessments.
- We reviewed eleven maternity records. All recorded the named midwife and there was an individualised care plan for pregnancy and labour.
- Two sets of notes did not contain a second signature for checking swabs pre and post perineal repairs.
- Women had a complete record of antenatal test results in their hand-held maternity notes in accordance with NICE quality standard 22.
- The 'fresh eyes' approach was used to review CTG's. We saw evidence of this in patient records.
- The minimum data set for CTGs was recorded on all records seen.

- An audit of the documentation of CTGs and fetal blood samples was undertaken monthly. The results from May 2016 identified a good standard of record-keeping. Areas for improvement were identified and actions identified with clear ownership and an implementation plan.
- There were some concerns about information governance, particularly within the maternity unit. On the delivery suite, medical records were stored on open shelves with the door propped open by a bin and at times were unattended; the triage office was often left unattended with the door open and the file and diary not stored securely; on Wharncliffe ward notes were stored in trolleys by each bay with the lid closed, but not locked; loose papers were found in most notes and there was insufficient storage or security to keep notes secure in some offices.

## Safeguarding

- There was a named midwife in post. There had been a long-term absence prior to the appointment in March 2016.
- Staff were trained to level 3 in children's safeguarding in accordance with national guidance.
- Compliance with level 2 and 3 children's safeguarding training was above the trust target of 80%. Training for safeguarding adults, levels 2, was 78%, just below the trust target.
- Staff could clearly articulate what they would escalate and what types of things they would look for. There were safeguarding flags on the electronic records system and hospital-based midwives reported they had good links with community midwives. Safeguarding information was included on discharge information.
- Midwives routinely asked about domestic violence at booking and at subsequent appointments in accordance with national guidance.
- Staff also reported good links with the trust-wide safeguarding team and the mental health crisis team.
- Band 6 and 7 staff on gynaecology had undertaken training regarding child sexual exploitation and female genital mutilation. Female genital mutilation assessment was also part of the antenatal screening process.
- Band 6 and 7 staff had also been trained to undertake domestic abuse, stalking and harassment (DASH) assessments.

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- There was a child sexual exploitation specialist nurse within the trust-wide safeguarding team.
- We reviewed one documented safeguarding plan that was in place; this was clear and comprehensive.
- Safeguarding supervision was below the expected standard. All midwives should undertake regular documented reviews of their safeguarding/child protection practice in accordance with national intercollegiate guidance. The named midwife had prioritised safeguarding supervision since coming in to post. At the end of quarter one (April to June 2016), 30.3% of community midwives had received supervision. Across the trust, 27 additional staff had received supervision training and were in the process of attaining competence.
- Community midwives felt that more safeguarding support was needed. Some midwives had large caseloads with complex safeguarding. Midwives were using their own time for writing reports and statements.

## Mandatory training

- There was rolling programme of mandatory training. A system was in place to remind staff when training was due. The newly appointed practice development midwives were involved in the training arrangements and had prioritised this as an area to improve.
- The trusts mandatory training programme included fire basic awareness, infection control, conflict resolution, resuscitation, moving and handling, venous thromboembolism, information governance, safeguarding children levels 2 and 3, safeguarding adults, equality and diversity and dementia awareness training. The trust target for mandatory training was above 80%. This was a rolling programme of training.
- Maternity services had a three-day mandatory programme which included skills and drills (scenario based) training on post-partum haemorrhage, pre-eclampsia and cord prolapse.
- Trust-level data showed compliance was below target of 75% in many areas, with the exception of safeguarding and equality and diversity training. Resuscitation training compliance was at 45%, moving and handling was 44% and basic fire awareness was 51%.
- However, we were informed that the trust mandatory training data was not accurate. The practice development midwife had developed local records

which showed that 78% of midwives were compliant with maternity and trust specific mandatory training, 82% of community midwives, 78% of health care support workers and 78% of consultants.

- Mandatory training compliance for staff on the gynaecology ward was above the trust compliance rate of 80%.

## Assessing and responding to patient risk

- A 'patient at risk' (PAR) scoring system was in place to help identify patients at risk of deterioration. Use of the scoring system was part of the mandatory training programme.
- An obstetric PAR audit of 90 case notes had been undertaken in September 2015 for the period April 2014 to July 2015. It concluded that the notes of those patients deemed to be at risk of deteriorating, and those who were escalated to a higher level of care, had excellent documentation of hourly and cumulative fluid balance. There was also clear documentation in the notes when frequency of observations could be stepped down and higher dependency care discontinued. Monitoring and recording of urine output and accurate documentation of fluid balance fell below the required standard. Of the eight patient's notes reviewed that required escalation, six were escalated appropriately and two were either delayed or the condition improved before escalation.
- We reviewed eight sets of maternity records during the inspection and found that patients had been assessed appropriately using the PAR scoring system. Risks assessments had also been completed including for gestational diabetes, smoking, venous thromboembolism and pre-eclampsia.
- A neonatal track and trigger system as in place for babies who required close observation.
- Staff were clear how to escalate and respond to patients at risk of deterioration.
- Midwives reported there was always a consultant presence on delivery suite if they were concerned about a patient.
- There was a designated room on the delivery suite for women needing a higher level of care; this was provided to level 1.



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- Audits had been undertaken February 2016 of the information, including GP records, routinely used by midwives to inform initial risk assessments. This had identified a number of recommendations to minimise risk.
- Risks assessments including for pressure ulcers, nutrition and falls, were completed for gynaecology patients. Patients at risk were identified on the ward board in the office, so staff could easily identify patients at risk of falls, for example.
- Risk of venous thromboembolism was assessed on admission and reassessed at 24 hours.
- Within gynaecology, a modified early warning score (MEWS) had been recently introduced to replace the previous system.
- An audit of five steps to safer surgery had been undertaken. This showed a high level of compliance. We also reviewed three records and spent time within the theatres. We saw the five steps to safer surgery documentation had been completed.
- The maternity service plan stated that there was regular review between clinical leads service managers and finance regarding staffing levels. Staffing was reviewed on a daily basis within the maternity unit and staffing issued escalated.
- Monthly staffing audits and reports were submitted to Chief Nurse and staffing data for maternity was published on the trust's website in accordance with national requirements. The management team stated red flag events were audited. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing.

## Midwifery staffing

- Most staff within maternity services reported an improvement in staffing levels since the previous inspection, although there were still some pressures when the units were busy.
- The midwife to birth ratio was 1:25. This had improved since the last inspection in February 2015.
- We reviewed the staffing figures for the months April to July 2016. The planned staffing levels had been met or exceed for most months.
- The trust had previously used the Birthrate plus acuity tool in conjunction with professional judgement and triangulation of care sensitive indicators to determine staffing requirements. This showed 102 midwives were required after skill mixing (107 prior to skill mixing).
- The planned establishment was 105.5; this met the Birthrate plus assessment. The workforce planning tool was planned to be used every two years. It had last been used in 2014; there were plans to undertake this again in 2017. The management team reported that the acuity and demographic profile of the population had not significantly changed since 2014.
- At July 2016, there were 98.4 wte midwives in post, with a further 3.3 wte due to start. There were 3.8 wte posts vacant.
- Data for the period October 2015 to June 2016 showed that 1:1 care was provided for 92% of women in labour. This was confirmed by midwives that we spoke with.
- The average vacancy rate was low at 3%. The annual staff turnover rate was 11.7%.
- The skill mix had been reviewed; some band 5 midwives had been recruited.
- Staff sickness rates were good at 3%.
- An experienced midwife (shift coordinator) was available on most shifts on the labour ward. However, out of hours, staff on delivery suite were required to be the scrub nurse in theatres. This could impact on the staffing levels and availability of senior staff on the unit.
- An escalation plan was in place; this included moving staff from the antenatal/postnatal ward to delivery suite which could impact on staffing levels on the ward.
- Community midwifery caseloads were between 90 and 123 per wte midwife.
- Ward clerk cover on both the delivery suite and the ante/postnatal ward was good. This was provided almost 24 hours a day, seven days a week.
- Handovers between shifts were carried out at least twice a day. We observed handovers on the delivery suite. Handover was concise. However, there was no structured safety brief as part of the handover; learning points were included, but these were not all relevant to the audience. For example, information about instrumental birth practices was included for midwives. A safety huddle was not routinely held on the ante/postnatal ward.



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- Escalation policies were in place and there was a clear process to implement plans during times of shortfalls in staffing levels.
- Bank or agency usage for June 2015 to July 2016 averaged 5.6% on the antenatal/postnatal ward and 0.6% in the antenatal clinic. There was no bank or agency usage in community midwifery.
- We observed a shift handover on delivery suite; we saw an overview and basic details were given with a more detailed 1:1 handover given by the midwife on night to the day midwife.

## Nurse staffing

- The gynaecology ward (Ward B11), the early pregnancy assessment unit and pregnancy advisory service had a combined planned nursing establishment of 17.6 wte registered nurses and an actual establishment of 16.6 whole time equivalent (wte) for April to July 2016. For unregistered staff, the planned establishment was 9 wte with 8.2 wte in post. Therefore, there was one wte nursing vacancy and 0.8 wte unregistered staff vacancy.
- Staffing on the gynaecology ward was determined using the Safer Nursing Care Tool, professional judgement and nursing metrics, as recommended by NICE.
- We reviewed staffing levels for April, May June and July 2016. Planned staffing levels were consistently achieved.
- Bank or agency usage for June 2015 to July 2016 averaged 6%.

## Medical staffing

- The average number of hours per week consultant cover on labour ward was 60 hours. This was consistent with recommendations by the Royal College of Obstetricians and Gynaecologists.
- The percentage of consultants and middle grade roles was similar to the England average at 38% and 5% respectively. The percentage of registrars was 57% compared with an England average of 46%.
- There was a consultant presence on the maternity unit from 8.30am until 9pm on weekdays. There was designated consultant on-call cover outside of these hours.
- Consultants on-call undertook ward rounds at weekends.
- There was on-site medical cover available at all times. The medical staff covered labour ward, gynaecology, emergency gynaecology theatre, maternity triage and the antenatal and postnatal ward.

- Medical staffing had a vacancy rate of 7%.
- Locum usage averaged 15 sessions between September 2015 and May 2016 which was higher than the trusts target of six sessions. However, there was overall a downward trend in locum usage.
- Nursing and midwifery staff reported that doctors were always available when needed and very accessible. Access to doctors for patients outlying on the gynaecology ward was less easy.
- Anaesthetic cover was appropriate for the size of the maternity unit. There were anaesthetic consultant sessions during the day and a separate consultant and staff for the elective section lists. Out of hours, anaesthetic cover was available with the anaesthetist also providing a service to the intensive care unit.
- A multidisciplinary handover took place twice a day. We observed one handover and saw this was well-attended. There was a handover sheet signed by the coordinator to ensure that appropriate staff were present. However, there were gaps in the signatures, for example, eight days in September had no signatures. Learning points were included in the handover.

## Major incident awareness and training

- A major incident policy was available on the trust intranet.
- Staff were aware of major incident policy and their roles. Action cards were available.

## Are maternity and gynaecology services effective?

Good



We carried out this inspection because, when we inspected the service in February 2015, we rated effective as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated effective as 'good' because:

- There had been improvements since the previous inspection.
- Midwives were no longer responsible for providing care for women recovering from surgery; this was provided by trained theatre recovery staff with a midwife present.

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- Midwives were trained to perform tasks, for example suturing and cannulation as well as new-born baby checks.
- The rate of emergency caesarean sections had improved and was similar to expected when compared with national rates. The rate of normal deliveries was better than the England average.
- There was evidence of good multidisciplinary working.

However:

- The trust had identified a number of poor outcomes since late 2015, which included neonatal deaths, stillbirths and maternal deaths. A multidisciplinary review of all the cases was taking place. Maternal incidents since 2014 were being reviewed and neonatal incidents that had occurred from 2015 onwards were also being reviewed.
- There was a high rate of births being induced. The trust were aware of this and auditing practice.

## Evidence-based care and treatment

- Policies and guidelines were available on the trust intranet. Most staff were able to locate guidance and further work was underway to improve accessibility.
- Policies were based on NICE and Royal College guidelines, including veno-thromboembolism prevention, third and fourth degree tears and reduced fetal movements.
- There was a process in place for reviewing and approving guidelines. At the time of inspection the management team reported there were 23 guidelines out of 90 that were out of date. This had been identified and guidance was prioritised and allocated to relevant staff for review. An extraordinary clinical governance meeting had been held to address the backlog.
- Care was provided in line with NICE guidance including quality standard 22 (antenatal care) and quality standard 32 (caesarean section).
- There was an audit plan in place. Audits were registered with the clinical effectiveness department.
- Quality assurance processes were in place to audit ultrasounds by individual sonographers.
- Integrated care pathways were in use, such as for ambulatory hyperemesis. The staff also used Acupins to alleviate hyperemesis.

- Sepsis management guidelines were available and the SEPSIS six was detailed on the observation charts. However, we did observe laminated guidelines on the sepsis 6 in the delivery suite office dated May 2011.
- Enhanced recovery pathways for women having caesarean sections had been introduced in July 2016.
- Audits were undertaken within antenatal and new-born screening. New-born blood spot sample and new-born and infant physical examinations were audited weekly using a quality assurance system. Actions were taken where issues were identified.

## Pain relief

- Women were able to access a range of pain relief methods across the maternity service. A birthing pool was also available on the labour ward.
- Midwives we spoke with said there were no delays in women receiving an epidural, including during out of hours, if that was the pain relief of choice.
- We spoke with seven women who all felt their pain was well-managed.
- Pain was assessed using a recognised pain scoring tool.
- A specific pain scoring tool was available and used on the gynaecology ward that was suitable for patients living with dementia.

## Nutrition and hydration

- The trust had achieved UNICEF baby friendly initiative level 3. This means that the hospital was assessed as having supported mothers and babies with their infant feeding choices and encouraged the development of close and loving relationships between parents and baby.
- Information was displayed on the delivery suite about breastfeeding and support offered including a drop in clinic.
- The percentage of women breastfeeding post-delivery from April 2016 to July 2016 was 57.4%. This was below the England average of 76%.
- The percentage of women breastfeeding at discharge from hospital was 43% and on discharge from maternity care was 31.4%.
- Patients on the gynaecology ward were assessed for the nutritional needs. They were supported with food and drink. A housekeeper role had been introduced, which included serving meals; patients and staff spoke positively about this role.

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## Patient outcomes

- The trust monitored and recorded patient outcomes on a monthly performance dashboard.
- There were no maternity outliers as determined by the CQC national maternity outlier programme. However, the trust had identified a number of poor outcomes since late 2015, which included neonatal deaths, stillbirths and maternal deaths. A multidisciplinary review of all the cases was taking place. Maternal incidents since 2014 were being reviewed and neonatal incidents that had occurred from 2015 onwards were also being reviewed.
- From April 2015 to March 2016, the service achieved a normal vaginal delivery rate of 63.2%, which was better than the national average of 60%.
- From April 2015 to March 2016, the rate of both elective and emergency caesarean sections was similar to expected when compared with national rates. Emergency caesarean section rates were 13.9%, which was better than the England average of 15.3%. For elective sections, the service achieved 9.3% which was better than the England average of 11.3%.
- Between September 2015 and June 2016, the rate of women being induced was 28%, which was above the England average of 25%. The trust were reviewing the reasons for this; they had implemented GROW to detect small for gestational age and stated this had increased detection rates and impacted on the induction rates.
- Between April 2015 and March 2016, there were 264 episodes of unexpected admissions to NICU. This had increased from 228 in the previous year. The number of admissions of full term babies to NICU had also increased to 117 compared to 88 the previous year.
- Emergency maternity readmission rates between September 2015 and June 2016 were on average higher than the England average. The rate was 1.3% for women having vaginal deliveries and 5.7% for those having caesarean sections compared to the England average of 0.8% and 1.4% respectively.
- Between September 2015 and June 2016, the number of obstetric admissions to the high dependency unit averaged four women per month against a target of seven or less.
- From April 2015 to March 2016, there had been five stillbirths. This had reduced from 14 in the previous year. For the same periods, there had been four and three early neonatal deaths respectively.
- Between September 2015 and June 2016, the number of women having a post-partum haemorrhage of over 1500mls was an average of four a month; this was equal to the trust target.
- Between September 2015 and June 2016, the percentage of women having normal births and developing a 3rd and 4th degree tear was 2% and for women who had an assisted birth the rate was 4%. There was no specified trust target and the rate fluctuated over that time period.
- The trust monitored the number of home births. This averaged two per month between September 2015 and June 2016.
- The National Neonatal Audit Programme (NNAP) includes two questions that would apply to the maternity area. The report for 2014 indicated the location achieved 100% (out of 3) compliance with temperature taking of babies born at less than 28 weeks and 6 days. The unit scored 91% (out of 64) for the percentage of mothers being given a dose of antenatal steroid when they delivered a baby between 24 plus 0 and 34 plus 6 weeks gestation, this was better than the NNAP standard of 85%.
- Antenatal screening for HIV was consistently at 100% of women. Timely referral of women who were positive was achieved in 82% of cases for April 2015 to March 2016. This was against a target of 70%.
- An audit of compliance with NICE CG63 Diabetes in Pregnancy (March 2008) had been undertaken in July 2015. This concluded that antenatal care was good with 100% women receiving appropriate advice and care.
- The use of the pool for water births was audited. This showed a steady increase with 12 babies being delivered in the pool in July 2016.

## Competent staff

- Between April 15 and March 16, 84% of staff in maternity and gynaecology services had received an annual appraisal. This had improved from 45% the previous year.
- Staff we spoke with confirmed that appraisals were undertaken and that they found them useful and constructive.
- Staff reported there was a good skill mix amongst the midwives; this was an improvement from the previous

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inspection when there was a lack of staff trained to perform basic tasks. Data showed that at May 2016, 73% of midwives had received training in suturing, 81% in intravenous cannulation and 77% in epidural top up.

- Since the previous inspection, there had been an increase in the number of midwives trained in new-born initial physical examination (NIPE). The ante/postnatal ward had eleven midwives trained in NIPE and reported this had made a big difference. At the previous inspection, a significant number of babies had to re-attend the unit to have the examination following discharge. At this inspection, babies only returned if clinically necessary.
- Midwives were no longer responsible for providing care for women recovering from surgery; this was provided by trained theatre recovery staff with a midwife present. This was an improvement since the last inspection.
- The effectiveness of statutory supervision was assessed as 'very good' at the last annual audit by the Local Supervising Authority in December 2015. However, the ratio of supervisors of midwives to midwives was greater than the recommended 1:15 and was up to 1:24 due to staff absence and shortage of supervisors.
- All midwives must have a supervisor of midwives (SOM). Their role is to provide support and guidance for all practicing midwives. National recommendations for the number of SOM to midwives is 1:15. Some mitigating actions had been taken to maximise the effective use of the SoMs such as removing them from the on-call duty rota, removing management responsibilities from supervisory activity, appointing a substantive contact supervisor of midwives and supporting additional midwives to undertake the training required. Midwives had access to a supervisor of midwives on-call at all times.
- The SoMs helped to prepare staff for revalidation of their registration.
- There were two part-time practice development midwives now in place. Their role was to support the training and development of the staff.
- Midwives were being recruited to be part of a teaching faculty. This meant they would have 12 hours a month allocated to deliver training.
- Three midwives were undertaking the course to care for women requiring higher dependency care.

- Health care assistants on the delivery suite undertook duties within the obstetric theatre. They had undertaken a month in theatre to provide training several years previously, however no refresher or further update training had been provided.
- Some healthcare assistants had been supported to extend their roles and recorded observations, took blood samples and inserted cannulae.
- There was no formal competency assessment for midwives working in triage. The team tried to allocate an experienced band 6 or above midwife.
- There was core midwifery staff that worked in each area, whilst other staff rotated between departments and this included the community midwives. This meant staff had the knowledge and skills to be able to work in different areas and flexibly meet the needs of the service. However, there was a lack of midwives wanting to rotate to community midwifery at the time of inspection.
- There were specialist midwives available for substance misuse, perineal trauma, teenage pregnancies, smoking cessation and diabetes.

## Multidisciplinary working

- Staff reported good multidisciplinary working in all areas.
- There were very good relationships between midwives and doctors and staff on the special care baby unit.
- During the inspection, we observed a discussion on the delivery suite between midwife and doctor; there was an open discussion about the plan for the woman with the midwives contributing to the management plan.
- Ward clerks we spoke with feel part of the team.
- The consultant with responsibility for ante/postnatal ward and the ward manager met weekly to discuss concerns and incidents.
- We also observed good multidisciplinary working within the obstetric theatre environment.
- Systems were in place to ensure good communication between the hospital-based and community-based midwives on transfer of care. Women at higher risk were identified and information was confirmed verbally as well as via the electronic system.

## Seven-day services

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- There was a consultant presence on the maternity unit from 8.30am until 9pm on weekdays. There was designated consultant on-call cover outside of these hours. Consultants on-call undertook ward rounds at weekends to review patients.
- There was access to on-call anaesthetic cover out of hours.
- There was an on-call rota of SOM. They were available 24 hours a day, seven days a week and provided midwives with support.
- Maternity and gynaecology services had access to diagnostic and imaging services out of hours.
- An on-call pharmacy service was available out of hours.

## Access to information

- The hospital staff had access to the electronic system used in the community by the midwives and GPs; this enabled information such as postnatal discharge summaries to be communicated electronically.
- Community midwives had raised concerns about access and functionality of their IT systems. This was recorded on the risk register.
- Information was available on two electronic systems and paper-based systems. A system which enabled information to be viewed through one portal was being rolled out, but was not used in maternity and not routinely used in gynaecology.
- Performance information was manually validated to ensure it was correct. This was time-consuming. The management team recognised this and had taken some mitigating actions.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed four sets of notes of women who had a termination of pregnancy. Consent forms were completed in accordance with the Abortion Act.
- An audit of consent in gynaecology had been undertaken in June 2015. We reviewed the action plan and saw actions had been completed.
- We reviewed seven consent forms within gynaecology and maternity services and found these were appropriately completed in line with Department of Health consent to treatment guidelines.

- There was a trust consent policy which included consent for children and young people. The trust consent policy used Fraser guidelines for assessing competency to make decisions about care and treatment.
- Staff received training in the Mental Capacity Act as part of their mandatory adult safeguarding training. Records showed 83% of staff on the gynaecology ward had received training on the Mental Capacity Act 2005.
- Deprivation of Liberty safeguards were infrequently used in gynaecology. To support staff a resource drawer containing relevant information was available for staff, if needed.

## Are maternity and gynaecology services caring?

Good



At our previous inspection, in February 2015, we rated caring of the maternity and gynaecology service as 'good'.

At this inspection we also rated caring as 'good'. This was because:

- Feedback from patients using the services was consistently positive from both surveys and speaking with patients during the inspection.
- There was a good level of emotional support, particularly for women who had experienced the loss of a baby.
- Patients and their relatives, where appropriate, felt involved and understood the decisions about their care.

## Compassionate care

- Friends and Family maternity test results from June 2015 to May 2016 showed the percentage of people recommending the hospital was consistently above the England average. Results for July 2016 confirmed that 97%, 100%, 96% and 100% of women would recommend the antenatal care, birth, postnatal ward and postnatal community care respectively.
- CQC's Survey of Women's Experiences of Maternity Services 2015, showed results similar to other trusts for 15 out of 16 indicators; the other indicator was better than other trusts (skin to skin contact with baby shortly after the birth).



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- A gynaecology oncology patient satisfaction survey report in August 2016 showed out of 14 responses, eight patients strongly agreed and six agreed that the doctors were caring. Patients felt supported: seven strongly agreed, six agreed and one patient gave a neutral response.
- During the inspection, we spoke with thirteen women and relatives across the maternity services and gynaecology. All of the people we spoke with were very positive about the care they had received.
- We witnessed positive interactions between staff and patients. Staff introduced themselves and we witnessed staff using 'Hello my name is.'
- We observed three phone calls in maternity triage; very caring manner, gave clear guidance and reassurance.
- There was a system in place to ensure women in labour were not unnecessarily disturbed. The delivery suite doors had specific 'do not disturb' signs displayed when women were receiving midwife led care.
- The maternity triage area had three couches in close proximity separated by curtains. There was a risk this could compromise privacy and dignity, however no concerns were raised by women regarding this.

## Understanding and involvement of patients and those close to them

- CQC's Survey of Women's Experiences of Maternity Services 2015, showed results similar to other trusts for questions relating to involvement in decisions about care.
- All women we spoke with felt they had been involved and understood what was happening.
- Partners also reported they felt involved and had things explained appropriately.

## Emotional support

- A specialist midwife for bereavement was in post to support women. There was a bereavement suite available on the labour ward.
- Bereavement support was offered to all women who had experienced a pregnancy loss. This included women who suffered early pregnancy loss on the gynaecology ward.
- Memory boxes were offered to women who experienced pregnancy loss. This included a handmade knitted blanket, that was described as 'angel wings.'

- There was an afterthoughts service provided by the supervisor of midwives. This afterthoughts service was offered to all women who experienced pregnancy loss and an annual remembrance service was held.
- We observed good emotional support offered to women including appropriate referral to support services and agencies.
- All women who had experienced a maternity emergency, instrumental birth or third or fourth degree tear were offered a debrief by senior medical staff.
- There was access to a psychotherapist.

## Are maternity and gynaecology services responsive?

Good



We carried out this inspection because, when we inspected the service in February 2015, we rated responsive as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated responsiveness as 'good' because:

- There had been improvements since the last inspection to the access and flow within the maternity unit. The triage unit had a positive impact on patient flow and women and their babies only needed to return to the department if checks indicated the need. Women with complex social needs were not delayed in being discharge due to non-clinical reasons.
- Services were delivered to meet patient's individual needs. Specialist obstetricians and midwives were available.
- There was evidence of learning from complaints.

However:

- For gynaecology patients admitted to hospital, referral to treatment within 18 weeks was 80% of patients, which was below the expected standard. The gynaecology ward was used to provide capacity for patients when other speciality wards were full.

## Service planning and delivery to meet the needs of local people

- The maternity service had held two workshops to identify the key areas for service development within the



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trust to meet the recommendations of the Better Births (2016) national report. These had led to the identification of a number of work streams including expanding the normalising birth work already underway and facilitating choice and home births. The home birth rate was 0.8%.

- Care was provided on the gynaecology ward to women who experienced the loss of their pregnancy under 20 weeks.
- The gynaecology service offered medical management of termination of pregnancy up to 18 weeks.
- Clinics were held within the antenatal clinic to support women, such as smoking cessation clinics, substance abuse clinics and a combined diabetes clinic. There was a midwife who specialised in perineal trauma who held clinics every two weeks and a consultant-led clinic was also held every two weeks.
- Booking clinics out of hours had been introduced to offer more choice for women.
- There was availability of facilities on the ante/postnatal ward for partners to stay.
- There was a bereavement suite available on the delivery suite. This had a sofa and facilities to make drinks. However, there was no separate entrance which meant women had to exit through the delivery suite. The room appeared cluttered and clinical.
- There was direct access to obstetric theatre from the delivery suite.

## Access and flow

- There had been improvements since the last inspection to the access and flow within the maternity unit.
- Maternity triage was in operation and positioned next to the delivery suite. Staff reported that access and flow was much better with triage in place. A standard operating procedure for telephone triage was in use. The triage unit took referrals taken from women, the emergency department, GP's and community midwives. The unit was open 7am to 7pm, seven days a week for women over 20 weeks pregnant.
- At the previous inspection, we found that babies who were jaundiced were sent to the hospital for review. Since the last inspection, bilirubinometers had been made available to community midwives. This had reduced the number of babies requiring readmission.
- At the previous inspection, we found that there was a high number of women who remained in the maternity unit for 'social services reasons.' This had been addressed and there had been no delayed discharges for these reasons since August 2015.
- The day assessment unit had extended their role to review women with reduced foetal movement; this reduced the pressure on triage at times of high activity.
- Bed occupancy in maternity from 1 April 2015 to 31 March 2016 was consistent with other trusts at around 60% with the exception of a period between July and September 2015 when it rose to approximately 90%.
- There had been no closures of the maternity unit between April 2015 and March 2016. This was consistently achieved over recent years.
- There was an elective caesarean section theatre list three times a week. This included the introduction of a low risk elective caesarean section list on the nearby day surgery unit; staff reported this had also helped improve patient flow.
- The service had introduced enhanced recovery pathways in maternity in July 2016; there was no audit data available yet to demonstrate any impact on length of stay.
- The service offered early discharge; more community staff were trained in the new-born examination (NIPE) training and this had a positive impact.
- The service did not collect data on the percentage of women in labour seen by a midwife within 30 minutes or seen by a consultant within 60 minutes.
- The percentage of women booked to access antenatal care at less than 12 weeks of pregnancy averaged 89% against a target of 90% between September 2015 and June 2016.
- For gynaecology patients admitted to hospital, referral to treatment within 18 weeks was 80% in June 2016. This was below the 92% standard.
- The gynaecology ward frequently had medical patients outlying on the ward; the ward manager reported this averaged seven patients a day. This was recorded on the risk register.
- Between February 2016 and August 2016, six gynaecology patients had their operations cancelled due to lack of beds.
- The early pregnancy assessment unit had 12 ultrasound slots available each weekday. These were able to be booked electronically and accessed by the emergency department, if required.

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## Meeting people's individual needs

- Action had been taken to address the needs of women with complex social care needs. This began during the antenatal period and included a pre-planned case conference with social services involvement one day post-delivery.
- There was a specialist consultant obstetrician with a special interest in mental health. A perinatal mental health pathway was in place.
- There were specialist midwives in place including a substance misuse midwife and a specialist midwife for perineal trauma who ran their own clinic.
- Pre-pregnancy counselling, antenatal care and postnatal follow up was available for high risk women. This included access to midwifery specialist input, psychotherapy and pharmacotherapy.
- Translation services were available and mostly used appropriately. We saw that staff had been reminded not to use family members as translators.
- We saw that leaflets were available in languages other than English including Polish and Urdu.
- There was trust-wide learning disabilities lead nurse. Midwives and nurses liaised with the specialist nurse for support in meeting the needs of patients with learning disabilities.
- There was a system to identify patients with learning disability needs, which flagged if patients were known to the system.
- Staff on the gynaecology ward had received training in the care of people living with dementia.
- The gynaecology ward were responsive to individual's needs. For example, they managed vomiting syndrome in pregnancy and had supported women to use a syringe driver at home to manage their symptoms.
- Equipment was available for bariatric patients including within the theatre environment.
- Twenty-five midwives had been trained in the use of aromatherapy.

## Learning from complaints and concerns

- The service had a system in place for handling complaints and concerns. Staff said they would try and resolve complaints at a local level and were aware of the procedure to follow.
- Posters were available to inform patients how to complain. On Wharncliffe ward, there was a poster displayed on how to complain in English and Polish.

- The service had received 18 formal complaints between August 2015 and July 2016. The most common theme related to patient care.
- Within gynaecology, the main theme of complaints was about waiting times and communication. In response, the service tried to ring-fence a gynaecology bed, whenever possible, to minimise waiting times.

## Are maternity and gynaecology services well-led?

Requires improvement 

We carried out this inspection because, when we inspected the service in February 2015, we rated well-led as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated well-led as 'requires improvement' because:

- Although there had been some improvements, there were still areas identified that required further improvement.
- The risk register did not include some of the key risks identified at inspection. For example, there was a backlog of incidents, with 94 overdue a review and investigation at the time of the inspection. This was not recorded on the risk register. Action was being taken to investigate and review the incidents of maternal deaths to enable learning and support safe practice. However, there was no reference to this on the risk register.
- The divisional risk management strategy was overdue review from August 2015.
- A weekly incident review, multidisciplinary meeting had been recently introduced in midwifery. However, this was not yet fully established and attendance was poor.

## Leadership of service

- Maternity and gynaecology services were part of the family health division at The Rotherham NHS Foundation Trust.
- The division was led by a Director of Clinical Services, General Manager and Head of Nursing, Midwifery and Professions.
- There was evidence of good medical leadership.

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- There was a matron post for the maternity and gynaecology inpatient and outpatient services. There was a manager on each of the wards and units.
- Concerns about leadership within midwifery, due to vacancies and long-term sickness, had been identified on the divisional risk register. Some mitigating actions had been put in place, such as the outpatient matron covering inpatients and there was active recruitment to vacant posts. Some posts, such as the delivery suite lead and risk midwife, had been filled at the time of the inspection and there had been some senior staff returned to work.
- Staff reported that the senior management and executive team were visible and approachable; this included the Head of Midwifery and the Chief Nurse.
- Staff reported good support from matrons and consultants.
- There was an executive director, but no non-executive director identified to champion maternity and gynaecology services.

## Vision and strategy for this service

- Service business plans for 2016/17 were in place for gynaecology and maternity. These included the service vision and key priorities. The timescales to ensure the operational plan was delivered remained unclear.
- The management team recognised the maternity service strategy needed updating in line with the Five Year Forward View (2015), Sustainability and Transformation Plans and Better Births work streams.
- Maternity staff understood the vision was to increase normality in birth. An application for funding was being submitted to support this.
- The trust's values were being reviewed. Some staff were aware of this, but there was a lack of engagement and the trust vision was not well understood by staff.

## Governance, risk management and quality measurement

- Monthly maternity risk and governance group meetings were held. We reviewed minutes of the meetings; these were comprehensive and risks were reviewed. We saw that risks agreed at the meetings were added to the risk register. The risk register was a standing item on the monthly maternity risk and governance group meetings.
- Risks within maternity and gynaecology were recorded on a divisional risk register. Risk registers could be accessed through the electronic reporting system.

- The risk register retained low risks on the register with an annual review. However, we found that some significant risks were not recorded. Managers had identified poor outcomes with three maternal deaths, neonatal deaths and still births. Action was being taken to investigate and review the incidents to enable learning and support safe practice. However, there was no reference to this on the risk register.
- There had been a gap analysis undertaken in February 2016 following the publication of the Kirkup report (2015). This followed a multidisciplinary learning event held in June 2016. There was an action plan in place to address areas for improvement with clear timescales and responsibilities. For example, the service identified the need to ensure all investigations concerning patient harm were completed in a timely manner. However, there was a backlog of incidents, with 94 overdue a review and investigation at the time of the inspection. This was also not identified on the risk register.
- The divisional risk management strategy was overdue review from August 2015.
- A weekly incident review, multidisciplinary meeting had been recently introduced in midwifery. This was not yet fully established; we attended a meeting during the inspection and found this was attended by only two midwifery staff. The terms of reference specified an obstetric consultant must be present for the meeting to be quorate.
- Patient Experience Group meetings were held.
- The risk midwife attended a trust-wide serious incident panel to review all serious incidents.
- Gynaecology service representatives attended the monthly/bimonthly sexual health risk and governance group meetings.
- There was an audit programme in place. The management team stated the division contributed to the trust's overall quality improvement programme and there were a number of improvement programmes including normalising births and reducing extensive perineal trauma (including third and 4th degree tears).

## Culture within the service

- Most midwives were positive about the culture and said they felt able to challenge medical teams on the delivery suite.
- We observed positive interactions between members of the team; for example we saw junior staff seeking advice

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from more senior staff, being provided with clear reasons for a management plan, being allowed opportunity to give their opinion and a check of their understanding being made.

- Staff felt safe to escalate concerns to senior staff.
- Staff on the gynaecology ward, reported excellent team-working. They felt listened to and valued although the high number of medical outliers on the ward impacted negatively on staff morale.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Duty of candour was a mandatory field on the incident reporting system and implementation was monitored corporately. Support systems, such as stickers, had been introduced in gynaecology notes, so it was clear when duty of candour applied and the incident had been discussed with the patient
- Within maternity services, duty of candour was applied. Letters were sent detailing when something had gone wrong. These were sent by the risk management midwife.

## Public engagement

- The maternity service had some links to the local Maternity Services Liaison Committee (MSLC). The committee was awaiting implementation of a new model to target specific areas of maternity care to gain a more in-depth views from patients regarding their experiences and views.
- It was recognised that engagement was more responsive than proactive at the time of inspection.
- A representative from the GROW project (part of the MSLC) was invited to attend the labour ward forum.
- Women were invited to speak with staff and share their experiences to aid learning. The management team provided an example of this.

- The management team received feedback from women who had used the services from the bereavement midwife and the afterthoughts service.







## Staff engagement

- Monthly multidisciplinary labour ward forum meetings were held.
- Community midwifery meetings were held every one or two months. The community midwives had raised some concerns, for example about on-call and working hours. A listening into action meeting had been held on 26 September.
- There was no forum for the midwives in the community and the acute hospital to meet at regular intervals.
- There were no community bases for community midwives. This meant staff had to undertake work at home and had limited engagement with other midwives. This was being looked at by the team leader.
- Staff received a monthly newsletter from the Chief Nurse.

## Innovation, improvement and sustainability

- There had been improvement since the previous inspection in the areas identified.
- There were some examples of innovative practice. For example, staff have been trained and use Acupin treatment (a form of acupuncture) for postoperative nausea and vomiting and for treatment of hyperemesis gravidarum.
- The work of the smoking cessation team has been recognised by NICE.
- Midwives have been trained to use aromatherapy support for women in labour.
- The trust had contributed to the development of the SABINE (Still birth reduction in North of England) care bundle and commenced a programme to achieve GAP accreditation with the Perinatal Institute.

# Services for children and young people

Safe	Good	
Effective	Requires improvement	
Caring	Good	
Responsive	Good	
Well-led	Requires improvement	
<b>Overall</b>	<b>Requires improvement</b>	

## Information about the service

Children services at The Rotherham NHS Foundation Trust were delivered from a 10-bedded children's assessment unit (CAU) and a 12-bedded children's ward (CW). Two beds on the children's ward were designated as high dependency beds. There was a separate children's clinic where children and young people attended outpatient appointments. The service was consultant-led.

On the special care baby unit (SCBU) there were 14 cots, two of which were intensive care cots and two of which were high dependency. The remaining 10 cots were for the special care of neonates.

There had been 2,210 paediatric admissions at Rotherham General Hospital between 1 April 2015 and 30 March 2016. Most of these (97.9%) were emergency admissions.

When we inspected this location in February 2015, we rated children's and young people's services (CYPS) as inadequate and we told the trust to make improvements. We went back on this inspection to check whether improvements had been made.

The main issues identified as the last inspection were:

- The children's ward environment was not safe, secure and appropriate for children and young people.
- Staffing establishment fell below nationally recognised guidelines on the CAU, CW and SCBU.
- Directorate and corporate risk registers were not regularly reviewed and monitored to ensure they reflected the current risks and contained appropriate mitigating actions

- There were no formal adolescent transitional arrangements for young people to transfer to adult services.
- The service's vision and values were not well developed or established. Governance arrangements were unclear and provided limited assurance about managing risks.

During this inspection, we spoke with 33 members of staff including medical staff, nurses, managers and health care assistants (HCAs), eight parents and two children. We reviewed care records, medication records and personal files on the children's ward and SCBU. We also looked at documents relating to the management of the service, such as audits, meeting minutes, risk registers and action plans.

# Services for children and young people

## Summary of findings

We carried out this inspection because, when we inspected the service in February 2015, we rated the service as 'inadequate'. We asked the provider to make improvements following that inspection.

At this inspection we rated the service overall as 'requires improvement'. We rated effective and well-led as 'requires improvement' and safe, caring, and responsive as 'good'. This was because:

- Compliance with National Institute of Health Care and Clinical Excellence (NICE) standards was variable. The clinical audit schedule was behind schedule and no nursing audits were carried out.
- More than half (55%) of the policies, procedures and guidelines in use were out of date.
- Audit data showed most patient outcomes were similar to or better than the England average. This included the National Paediatric Diabetes Audit and neonatal CQUINS (Commissioning for Quality and Innovation) measures. However, the rate of babies receiving mother's milk at final discharge from the SCBU was 32% against the England average of 60%.
- Arrangements for transition of patients between paediatric and adult services were still under development. Overall oversight of all patients involved in transition between services was lacking. This was identified as an issue at the last inspection.
- There was a lack of evidence to show there was effective risk management within the service and the vision and strategy was not clearly defined or understood. There was a lack of staff awareness of governance procedures and processes, such as risk assessment.
- There was no nursing co-ordinator on the SCBU as recommended by national guidelines. There were several vacancies for medical staff, including the clinical director role. Locum and agency staff covered gaps on the medical and nursing rotas.
- Not all staff working with children in outpatients' departments out with the children's outpatient clinic had received level three safeguarding and staff working in the theatres recovery room were trained to safeguarding level two. Staff with direct

responsibilities for involvement in reporting and contributing to the assessment of safeguarding concerns should be trained to safeguarding level three.

However:

- The nurse staffing establishment had improved significantly since the last inspection and nationally recognised guidelines were being met on the wards.
- Action had been taken since the last inspection and the children's ward environment was safe and appropriate for children and young people.
- Staff reported incidents in a timely manner and there was evidence to show actions were taken to improve services following incidents. Medication errors were the most frequent type of incident. Staff provided numerous examples of changes to practice in response to these.
- All clinical areas visited were visibly clean with well-maintained equipment, which was fit for purpose. Medicines were managed safely and stored securely.
- Access to psychiatric input for children and young people with a mental health needs (CAMHS patients) using the service had improved since the last inspection.
- There was good evidence of multidisciplinary working across children's services. Safeguarding procedures were well embedded and understood by staff.
- We saw staff treated patients and relatives with kindness and compassion throughout the inspection. Patients and families gave positive feedback about their care and treatment.



# Services for children and young people

## Are services for children and young people safe?

Good



We carried out this inspection because, when we inspected the service in February 2015, we rated safe as 'inadequate'. We asked the provider to make improvements following that inspection .

At this inspection we rated safe as 'good' overall because children and young people were protected from avoidable harm and abuse.

We found that:

- There were good examples of learning from incidents and trends were monitored.
- Infection prevention and control (IPC) was good; for example, infection rates were low.
- The environment and equipment was well maintained and fit for purpose; we observed some washbasins did not meet the latest published standards, staff told us these were due to be replaced.
- Medicines management, documentation and care records were good.
- There were robust safeguarding processes; healthcare assistants were undertaking safeguarding adults training even though it was not part of the trust's mandatory training.
- Nurse staffing and medical staffing was adequate to keep patients safe and had shown a significant improvement since the last inspection. Nurse staffing on the SCBU met the national British Association of Perinatal Medicine (BAPM) standards 80-90% of the time.
- There was a separate children's outpatient clinic, which most children and young people attended for their outpatient appointments.
- There was improved provision for children and young people with mental health needs and improved security arrangements on the children's ward and CAU.
- Staff working with children within children's services had undertaken appropriate safeguarding training for children and vulnerable adults.

However:

- Not all staff working with children in outpatients' departments out with the children's OP clinic had received level three safeguarding and staff working in the theatres recovery room were trained to safeguarding level two. Staff with direct responsibilities for involvement in reporting and contributing to the assessment of safeguarding concerns should be trained to safeguarding level three.
- The SCBU admitted patients aged up to six months from home or the children's assessment unit. This presented an infection control risk for the other babies on the unit and was on the risk register.
- Doctor's signatures in some of the care records reviewed were illegible. None of the medical staff had completed the signature lists at the front of the care records we reviewed and most did not use a GMC (General Medical Council) stamp next to their name / signature when making entries in patients' notes.
- The SCBU did not have a nursing co-ordinator on every shift in addition to those providing direct clinical care, as recommended by the Department of Health's Toolkit for High-quality neonatal services (2009).
- Staff did not have safeguarding supervision; training was being undertaken and safeguarding supervision sessions were planned to start in December 2016 with a new model of safeguarding supervision commencing in January 2017.

### Incidents

- We found good examples of learning from incidents and trends were monitored. There had been 411 incidents in the previous 12 months, 88 of which were medication errors in acute children's services (21%).
- Ward based staff were unclear about overall incident trends, but knew medication errors were one of their top incident types. The last two medication errors within the service had occurred on 8 July 2016 and 3 August 2016.
- When we asked staff about the reasons for medication errors, they told us they had recognised a training need when doctors rotated every six months. The paediatric pharmacist now delivered training to each new cohort of doctors, who also completed a pre-employment questionnaire around prescribing. These changes had been made to reduce / prevent medication errors.

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- Medications' training was also delivered to children's nurses as part of their resuscitation training day. There were plans for the paediatric pharmacist to provide monthly medicines management training from September 2016.
- The children and young people's services medication action plan showed medication incidents were discussed at safety huddles from September 2015. We observed a safety huddle during the inspection and found medication incidents were on the agenda.
- The medication action plan stated staff were reminded to check approved references prior to administration of medication to reduce the likelihood of prescription errors. Minutes of team meetings and newsletters reviewed confirmed this.
- Medication errors were discussed at doctors teaching sessions and nursing team meetings in order to learn lessons from medication errors.
- When we asked what actions were taken after medications incidents senior staff told us one to one sessions were held with the staff involved.
- The governance lead told us there had been three medication errors on the SCBU and four on the children's ward/CAU in September (up to the 29th). They said they monitored trends in medication errors every month. We saw this information on display in the ward areas.
- The children's outpatient clinic had reported twelve incidents in between January and August 2016; eight out of 12 of these were due to late starts for clinics.
- All staff, including healthcare assistants, knew how to report incidents on the trust's electronic system. Staff received email feedback about incident outcomes.
- There had been no Never Events reported in the service between July 2015 and June 2016 and one serious incident. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a Never Event.
- There had been no falls with harm or catheter-acquired urinary-tract infections reported in the acute children's service between June 2015 and June 2016. The serious incident related to sub-optimal care of a deteriorating patient in September 2015; a patient had developed a pressure ulcer. Actions following this incident included the introduction of a 'skin care bundle' for monitoring tissue viability.
- On the SCBU, we asked the ward manager about incidents. They described a recent incident, which occurred during the inspection. As soon as staff recognised what had happened they had been honest and open with the family and appropriate actions were being taken to prevent recurrence.
- We saw notices on display in clinical areas and staff rooms relating to the Duty of Candour requirements. Staff we spoke with, including medical staff, told us they had received training and knew what to do in the event of a patient coming to harm.
- The service held monthly mortality and morbidity meetings. We reviewed the minutes of the May, June and July 2016 meetings. We saw paediatric consultants, obstetrics and gynaecology consultants, nurses, midwives and governance leads attended the meetings. We saw the meetings included case presentations discussion about learning points and changes to practice and points for escalation.

## Cleanliness, infection control and hygiene

- Between July 2015 and August 2016, there had been no cases of MRSA or Clostridium difficile (C diff) reported in children's services.
- All of the areas visited were visibly clean and infection prevention and control was good; line infection rates were low. The infection control team carried out spot audits. The domestic supervisors carried out environmental audits and scores were good. For example, on the SCBU the most recent score was 90%.
- We looked at the infection control clinical practice process improvement tool for hand hygiene audit of the children's ward on 29 April 2016. We saw the audit was compliant with all 30 questions. However, there was no overall score.
- Waste segregation was observed to be good, with notices on display telling staff and patients about waste segregation. Bins, including sharps bins, were readily available. Personal protective equipment was readily available in all areas and hand-washing notices were observed next to wash hand basins.
- We observed good compliance with bare below the elbows and hand washing.

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- Admitting patients aged up to 6 months to the SCBU from home or the CAU presented an infection control risk, as they could potentially pass on infections to the babies on the unit.
- The SCBU sometimes admitted neonates up to six months old from the children's ward or CAU to the SCBU. This was due to the lack of high flow oxygen on the children's ward and/or to relieve bed pressures and was in line with the children's escalation policy. This was on the risk register, as there was risk of these babies introducing infectious diseases to the unit. Staff told us there was a risk assessment for babies admitted from outside the unit. The SCBU had an isolation cubicle for babies that were an infection risk.

## Environment and equipment

- There were five single cubicles and a six-bedded bay on the children's assessment unit, staff told us only 10 beds would be occupied at a time.
- Ligature risks and the lack of ligature risk assessments on the children's ward were identified as an issue at the last inspection. We observed, and staff told us, that ligature points had been removed from ward areas. Staff on the children's ward and CAU told us coat hooks had been removed, and they now had collapsible curtain rails and toilet doors which opened both ways.
- However, we found there were four en-suite bathrooms in patient cubicles with pull cords for the lights, which could be used as ligature points. We raised this issue with the management team and senior nursing staff who told us they would replace these pull cords with sensor-activated lighting in these four bathrooms.
- At the unannounced inspection, we were concerned as these pull cords were still in place. After the inspection, the executive team took immediate action to put satisfactory arrangements in place until the new sensor-activated lighting was fitted.
- We noted several of the washbasins on the children's ward and in the SCBU were not compliant with current standards. Most of the taps were not of a 'hands free' design. Senior nursing staff told us there was a risk assessment for this and infection control staff were aware. They said there were plans to replace these sinks.
- All the equipment observed was tested for electrical safety and had in date service stickers. Staff told us they knew how to report faulty equipment and had received medical devices training.

- Plans to refurbish the SCBU were at the design/feasibility stage and would be progressed through the business planning process. Plans included provision for storage of drugs, separate storage for feeding equipment and expressed breast milk fridges and freezers, and improved access to the blood gas analysers.
- We visited the new paediatric dental unit (PDU) used by ENT outpatients. Staff told us this was used for children one day a week and had been open for about six months. We saw the facilities were appropriate and included resuscitation equipment.
- Resuscitation equipment was available in all areas visited and daily checks were completed as required.
- The SCBU was adjacent to the labour ward and postnatal ward (Wharnccliffe). There was a small room on the unit for mothers to breastfeed or express breast milk.
- We visited the children's outpatient clinic; we observed the consulting rooms were carpeted. The clinic manager told us there was only one consulting room without carpet, but there were plans to refurbish all of the consulting rooms.

## Medicines

- Medicines management was good; all medicines checked were in date and accurate records were kept. The paediatric pharmacist came to the ward every day to check the medication records for each patient.
- We checked the controlled drugs storage and documentation on the children's ward and found these were all in order. There were no controlled drugs in the children's outpatient clinic. Staff told us the paediatric dental unit had emergency drugs readily available.
- Senior nursing staff told us there used to be two medicines cupboards on the children's ward, one on the ward and one on the CAU. They said there was now one medicines cupboard between the two areas. This action had been taken in response to the medication errors and had improved the system for staff. Medication errors were part of the appraisal process.
- We saw paper copies of the current British National Formulary (BNF) were available and staff told us they could also access the BNF online.

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- Staff told us two nurses checked all medicines that were dispensed and administered, or given to patients to take home; one of the two nurses took responsibility. When we observed a medication round we confirmed nurses on the children's ward were doing this.
- We checked 12 medication charts during the visit; these were all completed as required.
- The children's assessment unit had been using an external pharmacy for take-home medications since October 2015.
- We reviewed the training matrix for the children's ward and found three out of the 11 HCAs had undertaken adult safeguarding e-learning, two HCA staff had dates for future training sessions and dates for the remaining six HCA staff were still to be organised.
- We asked staff about identifying child sexual exploitation (CSE) and female genital mutilation (FGM). They told us FGM was part of safeguarding level three training and a psychotherapist from learning and development had delivered CSE training off-site. A consultant obstetrician provided drop-in training sessions about FGM.

## Records

- Patients care records were all paper-based; the SCBU had separate medical and nursing notes and the ward had integrated medical and nursing notes. We observed the SCBU medical and nursing notes kept together. Notes trolleys were kept locked at all times when not in use.
- We looked at three sets of patient care records on the SCBU and 10 sets of patient care records the children's ward. We found documentation was good and care pathways clear. Care plans were part of the multidisciplinary notes on the children's ward.
- However, we found some medical staff signatures were illegible and they had not signed the signature sheet in the front of each patient record. A GMC stamp next to the doctor's names was seen in a few care records but not all. This meant there was a risk of being unable to identify who had made entries in the patient's notes.
- Staff told us they knew how to recognise CSE and FGM and make a referral. The paediatric liaison nurse confirmed staff in the service were aware of CSE and FGM.
- The paediatric liaison nurse attended a safeguarding liaison meeting in the emergency department (ED) every day. They identified any vulnerable children and young people aged under 18 who were admitted to the hospital or attended the ED.
- Staff told us the safeguarding systems had changed in July 2016 and they now contacted the local Multiagency Safeguarding Hub (MASH). Staff knew the name of the trusts safeguarding named nurse and liaison nurses and could describe the referral process to us.
- There were named and designated doctors for safeguarding children within the paediatric and neonatal team. However, the named doctor for safeguarding was on long-term sick leave. To mitigate, the ward-based consultant on call was responsible for safeguarding and one of the registrars was temporarily acting as the safeguarding designated doctor. This was on the risk register.

## Safeguarding

- Staff working with children within children's services had undertaken appropriate safeguarding training for children and vulnerable adults. All the staff on the wards were trained to safeguarding level three, including the nursery nurses. We noted records indicated the housekeeper was trained to safeguarding level two.
- Level 1 safeguarding training was provided to all staff and was mandatory for all staff.
- However, not all staff working with children in outpatients' departments out with the children's OP clinic had received level three safeguarding and staff working in the theatres recovery room were trained to safeguarding level two. Staff with direct responsibilities for involvement in reporting and contributing to the assessment of safeguarding concerns should be trained to safeguarding level three.
- The service was part of the child protection information-sharing project (CP-IS). NHS England sponsors this project, which aims to ensure safeguarding concerns are shared between within the multi-agency safeguarding arena, including other healthcare providers.
- We heard examples of safeguarding issues being discussed and appropriately acted upon during the visit, including handover and safety huddle discussions.
- Plans were in place to start safeguarding supervision sessions with staff. The ward manager and governance

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lead were among the staff undertaking training to deliver these sessions. The safeguarding team was facilitating this training and sessions were due to start in December 2016.

- Safeguarding was a standard agenda item for discussion at the daily safety huddles on the children's ward and SCBU. Staff told us they had recently attended two multiagency safeguarding learning events.
- When we visited the recently opened paediatric dental unit, staff told us children's nurses did not work in that area, but staff received level three safeguarding training. Staff we spoke with told us they saw a high incidence of safeguarding issues; they related a recent incident, which they had referred to the safeguarding team.
- We saw safeguarding flowcharts were on display in areas where children were seen. These were extracts from the safeguarding 'green pack' for children, which had been approved at the April 2016 governance meeting. This was used on the children's ward as a multidisciplinary record of a child's safeguarding information.
- Staff were in the process of being issued with smartcards; these would allow them to access the safeguarding module on an electronic record system and see children and young people with 'red flags' which indicated there were safeguarding risks.
- However, the paediatric liaison nurse told us staff in ED did not always carry out a safeguarding check on the electronic record system. This meant there was a risk of vulnerable children and young people not being identified. However, they said staff on the children's ward/CAU always checked patient safeguarding records on the electronic record system on admission.
- Results of the 2014 CQC national survey of young hospital patients, which was published in July 2015, showed children aged 8 to 15 and parents of children aged 0 to 15 felt safe on the wards. Parents and patients we spoke with on the wards during the inspection also told us they felt safe.

## Mandatory training

- Mandatory and statutory training (MAST) compliance within children's and young people's services was good, at 79%. Mandatory training included dementia awareness, transgender awareness and PREVENT (anti-radicalisation) training.

- We saw MAST information for staff was on display in office areas in the children's ward, SCBU and children's OP clinic.
- Staff told us they could view their individual mandatory training record on the electronic staff record (ESR) system. Each area was keeping the own records of mandatory training completion; staff explained this was because the trust system was not always up-to-date/reliable. The management team confirmed this. In response to the high numbers of medication errors recorded in the service, training in paediatric medicines management had been added to the mandatory and statutory training for registered nurses from April 2016.
- Staff told us CAMHS (Child and Adolescent Mental Health Services) training was now part of MAST. They said they felt more supported in dealing with patients with mental health issues because of this.
- Specialist registrars attended monthly training sessions, which were arranged by the deanery, these were mandatory and attendance was recorded at 70%.

## Assessing and responding to patient risk

- We saw the children's ward had introduced a 'safe and supportive' observational tool for patients with mental health needs or other patients considered to be a risk. Staff told us they now undertook a risk assessment for all patients with mental health needs on admission and liaison with the CAMHS team had improved. The CAMHS liaison nurse visited the ward every morning to assess any new admissions of patients with mental health needs.
- Staff told us they did not spend more than two hours at a time on 'one-to-one' observation with patients with mental health needs. They said this was an improvement since the last inspection and had been suggested by the ward staff.
- The service was just introducing the Paediatric Early Warning Tool (PEWT); this was also in use at the local children's hospital. The ward manager told us the tool was ready to roll out once staff training was completed.
- The children's ward was also working with the tissue viability nurses and plans were in place to introduce a tissue viability tool called pressure ulcer prevention (PUP).
- There was a two-bed high dependency unit (HDU) on the 12-bedded children's ward. These beds were used as stabilisation beds. The service was commissioned for one paediatric HDU bed. This provided care for children



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in line with standards of a level 1 critical care bed, as defined by the Royal College of Paediatrics and Child Health report (High dependency care for Children – Time to Move On).

- The lead consultant paediatrician said patients in the HDU received non-invasive respiratory support. Five of the qualified children's nurses working on the children's ward had a critical care qualification (Care of the Acutely Ill Child). It was acknowledged there was a local paediatric intensive care unit at the children's hospital nearby, where dependent patients could be transferred quickly.
- The service was due to have a critical care service evaluation by the Paediatric Network on 7 December 2016. This would assess the service provided against national standards.
- Staff confirmed they did not have high flow oxygen or continuous positive airways pressure (CPAP) available for patients in the HDU. Patients in the HDU were nursed one to two, i.e. one nurse to two patients. The governance lead confirmed there had been no children requiring ventilation transferred for high flow oxygen during the previous six months
- Staff said the second on-call anaesthetist would be called if a patient in HDU deteriorated. However, they observed there was not always a paediatric-trained anaesthetist available.
- We observed defibrillators were available in the children's OP clinic and the HDU; staff checked these regularly.
- The nurse in charge on the children's ward carried an emergency call bleep; this meant they could be called to children and young people anywhere in the hospital.
- The governance lead confirmed the service did not have a policy for the care of deteriorating children. They said they were currently updating PEWT charts and the critical care network was working towards implementation of a standardised PEWS chart. They said this would contain a clear escalation plan for deteriorating patients.
- The governance lead also confirmed the service did not have a medical transfer policy for children. However, a time critical transfer policy had recently been ratified by the trust document ratification group, and was awaiting upload to the Internet document repository site (InSite).
- The children's ward and SCBU had safety huddles at 12 midday and 12 midnight every day; medical staff, ward staff and the paediatric liaison nurse attended these

when they were on duty. We observed a safety huddle on the children's ward during the inspection and found it was well organised and informative. The consultant of the week led the huddle using a standard agenda. The trust's practice development team had been into the department to observe the safety huddles, with a view to rolling them out in other areas of the trust.

- When we visited the paediatric dental unit, staff told us children's nurses did not work in that area but staff received paediatric resuscitation training once a year.
- We noted there was no call buzzer in the sensory room on the children's ward. We raised this with the ward manager.

## Nursing staffing

- Nurse staffing had improved since the last inspection. The ward managers on the children's ward /CAU and SCBU told us they were fully established and two band five positions had been approved to cover maternity leave until March 2017.
- Ward managers told us there was now an internal paediatric staffing escalation tool; the timings coincided with the hospital's bed meetings. We reviewed a copy of this tool and saw it clearly described what actions should be taken and what the escalation triggers were.
- When we visited the SCBU at 9am on the second day of inspection, we found there were 15 babies on the unit, two of which were in the high dependency unit. This meant the unit was one baby over capacity (which should have been 14 babies). There were five registered nurses and a nursery nurse on duty.
- The British Association of Perinatal Medicine (2010) standards state that neonatal services should provide one registered nurse for two babies in high dependency cots and one registered nurse for four patients in special care cots. The staffing on the unit on that date met with these standards.
- Information provided by the trust showed the SCBU met the national BAPM standards 80% of the time; however, they did not have a nursing co-ordinator on every shift in addition to those providing direct clinical care, as recommended by the Department of Health's Toolkit for High-quality neonatal services (2009). There was one WTE band five nurse vacancy on the SCBU at the time of the inspection. There was a practice educator on the SCBU who worked two clinical shifts and two non-technical shifts per week.



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- The ward manager told us they used agency and bank nurses on night shifts. They said if they could not increase the staffing to the levels required, they would escalate this through the Embrace network and fill in an incident report. Staff on the SCBU told us it was often very busy and they often left late and/or did not get their breaks. However, they confirmed they could usually get additional staff to cover when needed.
- At the last inspection, there were up to 30 patients on the children's ward and CAU. The reduction in beds from 30 to 22 meant that the child to staff ratio was now meeting requirements. Staff told us this was much better as they were only responsible for three or four children each, compared to 10 each at the last inspection.
- Staff told us the service now used the paediatric acuity and nurse dependency assessment tool (PANDA) staff acuity tool to work out how many staff were required for the number of children on the ward. Nurses assessed this twice a day, once per shift, and the healthcare assistants inputted the results on the computer system.
- The deputy head of midwifery, nursing and professions for children's services confirmed the PANDA acuity tool had been implemented in June 2015. The PANDA tool calculated safe staffing levels by assessing patients against 55 care categories to determine patient acuity levels.
- Data submitted by the trust showing planned staffing versus actual staffing between March and July 2016 showed nurse staffing at night on the children's ward/CAU was between six and 14% below planned. Actual staffing for day and night shifts on the SCBU and day shifts on the children's ward/CAU for the same period were not significantly below planned levels.
- Senior nursing staff told us the changes made since the last inspection had freed up more time for management tasks.
- They said the service very rarely used agency staff and staff turnover was low. Sickness in children's services was 3.2%, which was below the trust and national average. The ward manager on the children's ward told us sickness on the ward and CAU was low, at 0.7%.
- Children's services had started using the trusts e-rostering system three months ago. Completing the roster was time consuming for the managers and staff told us they were all still getting used to the new system.
- During the inspection, we attended a nurse handover on the children's ward and a safety huddle on the SCBU. Nurse handovers on the children's ward were at 7am and 7pm and safety huddles were at midday and midnight on both the children's ward and SCBU.
- There was a separate children's OP clinic where most of the outpatient appointments /clinics for children and young people were held. The children's OP clinic manager told us two nurses and the clinic manager usually staffed the clinic. They said they had a small team of four staff and a nursery nurse five days a week.
- The children's OP clinic manager told us the staffing establishment for the clinic was in place before they came into post. They said workload was increasing with no increase in staffing. For example, all enuresis patients now came to the children's OP clinic because community funding had been withdrawn. They said they had recently requested additional administrative or HCA support to help with answering the telephone and preparing the notes. There were three band four play specialist/nursery nurses attached to the children's ward /CAU.
- The service was advertising for another paediatric liaison nurse to be based in ED and the interviews were during our inspection week. The paediatric liaison role was part of the safeguarding team.
- Patients and families we spoke with felt there were enough staff on duty to meet their needs. One parent told us staff responded immediately when they pulled the call bell.

## Medical staffing

- Data submitted by the trust showed the medical staff establishment for the service was 25 WTE. The percentage of consultants and junior doctors working in the service was lower than the national average and the percentage of registrars was higher (61% compared with national average of 47%).
- We found medical staffing was adequate to maintain a safe service for patients as agency locums were covering the low numbers of vacancies. Staff on the wards felt there were enough medical staff and told us they were readily available.
- There were four full-time consultants, plus one consultant who had taken flexible retirement working part-time but did contribute to the on-call rota, and one consultant was on long-term sick leave. The absence of the consultant on sick leave meant there was a lack of

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in-house expertise in neurology and epilepsy; the service was liaising with the local children's hospital for support. There were lead consultants for SCBU, diabetes, and safeguarding. There were enough consultant hours to meet the 'facing the future' requirement of children been reviewed by a consultant within 14 hours of admission.

- At the time of the inspection, the service had 1.5 WTE consultant vacancies and no clinical lead. Adverts were out for two additional paediatricians; a full-time permanent 'paediatrician with an interest in diabetes' and clinical lead. The service was also advertising for a locum consultant to fill the 'paediatrician with an interest in diabetes' position on a temporary basis.
- There were no vacancies in specialty trainees at grade 1 to 3 and two vacancies at specialty trainee grades 4 to 8; locums were covering these. The lead consultant paediatrician told us they should have a full complement of consultants by the end of the year. They explained that the vacancies were due to medical staff who had retired and others who had taken flexible retirement.
- Medical handovers on the children's ward were at 8:30am. During the inspection, a paediatric doctor from the inspection team attended a morning medical handover and subsequent ward round in paediatrics. The handover was split into four areas; SCBU, postnatal unit, CAU and the children's ward. Handover sheets were used with the standard agenda, which included staffing and safeguarding. The handover was well-led, concise and effective, and clear plans were made for the day. The more senior members of the medical team were flexible about work allocation so that a trainee could attend clinic.
- There was a ward-based 'consultant of the week' for paediatrics and neonates, handover was on a Friday afternoon. There was a middle grade doctor on site 24 hours a day, there was one junior (ST1-3 or FY2) and one senior (ST4-8) member of medical staff on duty on site at night.
- The lead consultant paediatrician told us there should be seven on the acute out of hours' rota; there were currently 4.5 permanent staff and 1.5 locum staff. They felt they were providing a good service, despite the vacancies in medical staffing.

## Major incident awareness and training

- Staff told us there were action cards available to be used by the senior nurse in charge and the paediatrician on duty in the event of a major incident. They said they were part of the trust's major incident plan, and they knew where to evacuate to in the event of an emergency.
- All trust services were part of the trust's major incident plan and were required to adhere to the major incident policy.

## Are services for children and young people effective?

Requires improvement 

We carried out this inspection because, when we inspected the service in February 2015, we rated effective as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated effective as 'requires improvement' because:

- Compliance with National Institute for Health and Care Excellence (NICE) standards was variable; action plans to achieve required standards were seen to be running behind schedule. The service was not using the age-related sepsis six tool: however there were plans to introduce this.
- The clinical audit schedule was running behind and no scheduled nursing audits were carried out within the service, apart from the monthly saving lives audits. Medical staff carried out audits.
- Staff did not always have the complete information they needed before providing care and treatment. More than half of the documents and guidelines staff referred to were out of date; there was a plan in place to review all these documents by the end of 2016. Access to the InSite trust document repository system was slow.
- Transition services for children with long-term conditions moving from paediatric to adult services did not cover all pathways and conditions.
- Adult outpatient departments that saw children, such as dermatology, ophthalmology, ENT and audiology, had mixed clinic lists and no paediatric trained nurses on duty.

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- On the SCBU, 60% of the nursing staff were qualified in speciality (QIS); this did not meet the government recommendation of 70%.
- There was a lack of clinical and safeguarding supervision for nursing staff; plans were in place to introduce this and mentors were being trained.

However:

- Appraisal rates high and there were competent staff within the children's ward, SCBU and children's OP clinic.
- There were good examples of multidisciplinary (MDT) and we handovers and safety huddles.
- Access to psychiatric input for children and young people with a mental health need (CAMHS patients) using the service had improved since the last inspection.
- Pain relief and consent, using Fraser guidelines and competency, was good.
- Staff had access to all the information about patients they needed to deliver effective care and treatment. This included care plans, risk assessments and test results.

## Evidence-based care and treatment

- We found out of date paper copies of policies procedures and guidelines on the children's ward and SCBU. For example, in the HDU we found documents dated 2004, which were due for revision in 2006. Several of the available paper documents we reviewed did not have any date on them. We showed these to the ward manager who said they would remove the folders and documents immediately.
- When we asked staff on the children's ward where they would look up how to carry out a procedure, one told us they would use the documents in the folder on the HDU. This meant there was a risk staff might follow an out of date procedure.
- The ward manager on the children's ward told us staff could access documents they needed on the trust's InSite system. We asked them to show us this; we observed it took a long time for the system to load up on the computer and that it was difficult to find the documents required. This meant staff did not have ready access.
- We asked the governance lead for children's services about document control and policies and procedures. They told us 71% of paediatric documents and 87% of neonatal documents (approximately 200) had been out

- of date 18 months ago. They said the position had improved, with 55% of documents still requiring update and review. They said they were planning to complete this by the end of 2016, and upload all the documents to the trust SharePoint document management system.
- The ward manager on the children's ward told us they had audited 10 sets of case notes between January and April; the audits showed nine of the records reviewed were completed correctly. They told us audits were planned for the new 'skin bundle' tissue viability tool and the paediatric early warning tool when they were introduced. The service completed the monthly NHS safety thermometer; there was no evidence of any other nursing audits.
- We reviewed the clinical audit action plan for the SCBU dated May 2016. We saw there were no actions required for five of the seven areas audited. Some issues were identified with drugs charts, such as prescribers not signing and printing their names. As a result, the ward-based pharmacist was involved with training medical staff about prescribing requirements at induction. We checked 12 medication charts during the visit; staff had completed these as required.
- The previous quarter's reports were on NHS England website under NICU data submissions. The results were good, for example, there had been no positive blood cultures out of 45 babies tested in quarter one.
- The children's ward manager told us they were planning to introduce the new age-related sepsis six tool, as recommended by NICE.

## Pain relief

- Senior nursing staff told us the pain team visited the ward daily and visited children and young people when they came back from theatre.
- The service used a child-friendly chart to record children and young people's pain levels. Staff had received training in pain relief.
- None of the patients and families we spoke with during the inspection had experienced any problems with their pain relief.

## Nutrition and hydration

- Children and young people were offered a choice of meals that were age-appropriate and supported individual needs if patients were on special diets. Snacks and drinks were readily available.

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- The majority of the patients and families we spoke with during the inspection gave good feedback about access and quality of the food and drinks.
- Staff on the SCBU told us they provided food and drink for breastfeeding mothers if they were resident on the unit. Other parents had access to kitchen facilities to make their own food and drinks.

## Patient outcomes

- Compliance with National Institute for Health and Care Excellence (NICE) standards was variable; action plans to achieve required standards were seen to be running behind schedule. The governance lead told us they were addressing this issue. They said in December 2014, there were 15 outstanding NICE audits and now there were seven.
- The Rotherham NHS Foundation Trust performed similarly to the England and Wales average for the two measures included from the National Paediatric Diabetes Audit 2014/15.
- The readmission rates within two days of discharge for paediatrics were better than the England average, but worse for general surgery for patients aged between 1 and 17.
- The multiple readmission rates for asthma for this trust for aged 1 to 17 were better than the England average.
- The SCBU participated in the national neonatal audit programme (NNAP). Results for 2015 showed that 94% of eligible babies were screened on time for retinopathy of prematurity (ROP). However, the proportion of eligible babies receiving any mother's milk available at final discharge was 32%; this was significantly worse than the England average of 60% for this standard.
- The SCBU reported to BadgerNet; this is a national perinatal reporting system. The clinical audit action plan showed data quality and completion of documentation on this system had been audited in March 2016.
- The neonatal service on the SCBU was compliant with all 10 nationally audited neonatal CQUINS outcomes; the neonatal lead consultant oversaw this.
- The division of planned care and surgery managed the dental unit where children and young people were having treatment under general anaesthetic. However, the nursing and recovery staff were not paediatric-trained. Royal College of Nursing guidelines state that children in recovery should have a paediatric-trained nurse.
- We found these OP clinics were usually mixed between adults and children, and there were no arrangements to see children at the beginning or the end of the clinic session.
- Five of the staff working on the children's ward were critical care trained.
- When we asked managers about sending paediatric nurses from the ward to the ED, they acknowledged this did happen occasionally. However, staff did not move from the wards to the ED if this meant the nurse to patient ratio on the ward would not be met. They added that children's staff did not get asked to work on the adult wards anymore; which was identified as an issue at the previous inspection
- Two of the nursing staff were due to commence the advanced nurse practitioner course in September 2016; this would develop their skills and help meet children's needs.
- Staff from the local children's hospital were coming in to the service to deliver training about a rare disease which staff lacked understanding about.
- All the staff on the SCBU, apart from one, were UNICEF trained in infant feeding. The infant feeding coordinator delivered training.
- The service was working towards using our tissue viability tool, which was to be delivered across both areas however; they were waiting for training before the tool could be implemented.
- Nursing staff told us they attended life support training days; data submitted by the trust confirmed this.
- All staff working in the theatre recovery room were trained in paediatric life support (PLS) and one was trained in advanced paediatric life-support (APLS)
- At the time of the inspection, 93.7% of staff in children's services completed their annual appraisal; this was called at personal development review (PDR). The trust appraisal completion target was 90%.
- Senior nursing staff told us there were two types of induction packages; one for student nurses and one for

## Competent staff

- We found staff in adult outpatient clinics, such as dermatology ophthalmology, audiology and ENT were not trained to deal with paediatric patients. However, the pre-assessment nurse for day surgery had undertaken paediatric training.

# Services for children and young people

new starters. New staff were supernumerary for four weeks. We spoke with a student nurse who had recently started on the children's ward, they told us their induction and orientation on the ward had been good.

- We reviewed the nurse and student induction paperwork and saw it was good.
- Staff on the children's ward had received training provided by the CAMHS (Child and Adolescent Mental Health Services) Team. This included substance misuse, the suicidal child, self-harm and mental capacity act training. Monthly sessions were available, which were delivered by CAMHS liaison nurse.
- However, staff told us they had not been trained in restraint. They told us there was a restraint policy. They said they would use nursery nurses for diversion and occasionally use therapeutic restraint when taking samples such as lumbar punctures. Staff told us they would fill in an incident form in the event of an unexpected restraint being required.
- Senior nursing staff told us staff on the wards did not participate in regular clinical supervision. They said a clinical psychologist currently offered clinical supervision sessions every two months. The ward managers told us staff were receiving training in delivering clinical supervision, about half of the staff had been trained when we inspected.
- On the SCBU 60% of the nursing staff were qualified in speciality (QIS); this did not meet the government recommendation of 70%.
- Nursing staff told us they had received information and support from the trust about revalidation with the Nursing and Midwifery Council; they said several staff had already gone through the process. The ward managers and band six nursing staff had received training in revalidation.
- All paediatric trainees (medical staff) undertook the diploma in child health at Leeds University.

## Multidisciplinary working

- Communication with tertiary specialties was observed to be good. For example, referrals for cardiology and test requests to diagnose sepsis.
- Staff on the children's ward told us they worked closely with the surgical teams to provide care and treatment for children and young people undergoing surgery.

- They told us the paediatric liaison nurses were very useful for liaising with staff in community teams and looking up patient information on electronic records system.
- Access to multidisciplinary psychiatric input for children and young people with mental health needs had significantly improved since the last inspection. The CAMHS liaison nurse was based on the CAU and visited the wards and ED daily. There were monthly provider to provider meetings with the CAMHS service.
- The management team told us children's services were working closely with the ED on three new pathways. These included diarrhoea and vomiting and bronchiolitis. The lead consultant paediatrician was working with local GPs looking at GP hubs.
- Deficiencies in systems and processes for patients to transition from paediatric to adult services were identified as an issue at the last inspection. We found a transition policy had been written and some changes made. These covered common conditions such as asthma, epilepsy, and diabetes. The service was aware of the NICE guidance about transition, which had been published in February 2016. The governance lead told us children's services had recently been benchmarked against this new guidance and the findings had been presented at the clinical effectiveness group.
- A 'transition group' had been set up in February 2016, working with Rotherham Metropolitan Borough Council and the clinical commissioning group. This work was expected to take two years.
- There was a psychologist for children and young people with long-term conditions.
- The management team confirmed no one had an overall view or responsibility for all the children and young people who were in transition. They acknowledged better engagement with adult services was needed.

## Seven-day services

- The children's outpatient clinic was open from 8:30am to 5pm Monday to Friday and the children's assessment unit was open seven days a week
- The pharmacy department on site was staffed seven days a week. Out of hours, there was an on-call pharmacist available to respond to requests for pharmacy services, including medicines information.



# Services for children and young people

There was also partnership working across the EMBRACE network and the local tertiary hospital. Staff could access these services to discuss and agree treatment and plans of care for sick children.

- Staff told us there were no problems accessing pathology services 24 hours a day.
- The play specialists / nursery nurses worked seven days a week.

## Access to information

- Staff told us they had access to all the information they needed to deliver care and treatment in a timely and accessible way. This included care plans, care records and test results.
- In the children's outpatient clinic the administrative staff prepared notes for each clinic. The contact centre sent out appointment letters to patients' families during the month of their appointment, asking them to book an appointment.
- Staff told us they use the trust's Meditech system for ordering blood tests and getting labels for patient notes and specimens.
- Staff on the SCBU used the BadgerNet neonatal electronic patient record to record their patient information electronically; staff on the night shift updated this system each night.

## Consent

- There was a trust consent policy in place which included consent for children and young people. Staff understood the requirements for determining children and young people's rights and wishes. The trust consent policy used Fraser guidelines for assessing competency to make decisions about care and treatment.
- We reviewed ten sets of case notes on the children's ward. We found these were all completed as required. However, the name and job role of a member of medical staff was difficult to read. Staff told us the surgical or orthopaedic teams took consent from patients for theatre. On the children's ward, written consent was obtained for lumbar punctures.
- Staff received training in the Mental Capacity Act as part of their mandatory adult safeguarding training.

## Are services for children and young people caring?

Good



When we inspected this service in February 2015 we rated the service as 'good' for caring.

At this inspection we rated caring as 'good' because staff involved and treated patients with compassion, kindness, dignity, and respect.

We found that:

- Parents and children gave positive feedback about their care and emotional support.
- We observed staff had a caring and compassionate approach to children and families in all areas visited
- Friends and family test (FFT) results for the children's ward in July 2016 showed 95% of people would recommend the service; the response rate was 94%. Friends and family test results for the SCBU for the same month showed 100% of parents would recommend the service; the response rate was 86%.
- Staff had arranged for a parent of the child with a rare disease to give their story to enhance staff understanding.

## Compassionate care

- We observed staff had a caring and compassionate approach to children and families in all areas visited.
- During the inspection, we spoke with eight parents and two children and their feedback was all positive. One parent who had been resident on the ward for four days, told us, "the care has been amazing." Another told us they felt, "Very well looked after."
- Friends and family test (FFT) results for the children's ward in July 2016 showed 95% of people would recommend the service; the response rate was 94%.
- Results of the Friends and Family Test (FFT) for the SCBU in July 2016 showed parents were 100% satisfied with the care and treatment received. We saw these results displayed within the unit. In the children's clinic, we saw there was a box for people to put completed friends and family test forms in.
- The SCBU had open visiting for parents to spend time with their babies.
- We saw there were age-appropriate magazines available in the waiting area of the children's OP clinic.



# Services for children and young people

- Staff on the children's ward/CAU told us changes in staffing and bed numbers made since the last inspection meant they had more time to care for the whole family.
- In the 2014 CQC Children and young people's survey published in July 2015 the trust scored 'about the same as other trusts' for 35 out of 36 questions with the questions relating to caring. One question scored worse than other trusts, which was 'were staff available when your child needed attention.' However, we did not identify this as an issue during this inspection.

## Understanding and involvement of patients and those close to them

- Most of the parents we spoke with felt staff kept them updated. Parents on the SCBU told us they had a named consultant who always had time to answer their questions.
- One parent on the SCBU said they had raised a concern, which staff had resolved immediately. However, one parent on the children's ward felt communication with surgeons was poor. They had to ask for updates and test results.
- We saw there were numerous leaflets available on the SCBU, including leaflets about breastfeeding in the breastfeeding room. The children's ward and children's clinic also had relevant information leaflets readily available. For example, the diabetes service in the children's clinic had notices and leaflets on display.

## Emotional support

- Parents we spoke with were very happy with the emotional support they had received. For example, two mothers on the SCBU told us they had looked around the unit before they were transferred with their babies from neighbouring hospitals.
- The three nursery nurse/play specialists on the children's ward/CAU provided distraction therapies for children.
- The children's OP clinic had a nursery nurse who worked four days a week; on the fifth day a nursery nurse/play specialist from the ward attended the clinic. These staff provided emotional support and comfort to patients and families during and after procedures and if they were distressed or worried.
- A psychologist was available to offer support children and young people with long-term conditions.

- Staff had arranged for a parent of the child with a rare disease to give their story to enhance staff understanding.

## Are services for children and young people responsive?

Good



We carried out this inspection because, when we inspected the service in February 2015, we rated responsive as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated children's services as 'good' for responsive.

We found that:

- Access and flow was well established on the children's wards, and referral to treatment indicators had been above the national average for over 12 months.
- There were rapid access clinics in the children's clinic five days a week.
- Patients and relatives had access to interpreter services.
- There were child-friendly information leaflets.
- There was a sensory room on the ward for children and young people to use.
- Staff had undertaken training in transgender processes and requirements.

## Service planning and delivery to meet the needs of local people

- Since the last inspection, there had been significant improvements to the service delivery. For example, the service had undertaken a review of the paediatric bed base and CAU in order to meet the nationally recommended staff to patient ratios and timely access to care. This meant patients experienced better care and treatment from staff, particularly nursing staff.
- The children's ward and children's assessment unit now functioned as one unit, rather than two separate units. The children's ward manager managed both areas.
- The children's ward and SCBU had facilities for parents to stay overnight and a parent's kitchen.
- When we visited dermatology outpatients, we saw there was a separate waiting area for children's clinics.

# Services for children and young people

However, we saw this was not decorated in a child friendly manner and did not have access to appropriate toys / distractions to occupy children while they were waiting.

- In the 2014 children' survey the trust scored 'about the same as other trusts' for the questions relating to responsive.

## Access and flow

- Patient flow between the ED, CAU and children's ward was well established. Children and young people stayed on the CAU for a maximum of 24 hours. Patients were referred from the ED, GPs, midwives or directly if they were known to the service. The median length of stay for this trust was the same as the England average.
- The referral to treatment times in paediatrics and incomplete pathways had been consistently above the national indicators during 2015/2016 and up until August in 2016.
- Staff on the CAU told us nursing staff assessed all patients within 10 minutes of admission and a consultant would see them within 24 hours. Staff on the children's ward told us specialist teams assessed patients with mental health needs within 24 hours of admission.
- Discharged patients could self-refer and had open access to the CAU for 48 hours following discharge from the CAU or children's ward.
- The serviced used the regional 'Embrace' transfer team if a paediatric or neonatal patient needed transfer to a different hospital. The trust had a patient transfer policy, which included children's services. This stated children and young people would be transferred accompanied by a parent or carer and escorting nurse.
- One parent told us their child had been admitted the CAU from the ED, they said they had been seen and transferred within half an hour.
- Several parents on the SCBU told us they had been transferred there from other hospitals; they said the process was efficient and stress-free.
- Staff told us patients were not usually directly admitted to the children's ward.
- Staff on the SCBU said there was an open access protocol for their patients. They said they worked closely with parents in order to facilitate timely discharge.
- A mother on the SCBU told us they were due to take their baby home soon. They said all discharge planning and been completed including cardio pulmonary resuscitation training.
- There was no separate surgical ward; the children's ward admitted three surgical patients per day in winter and four per day in summer.
- Staff in the children's OP clinic told us there could be up to six different clinics running at once. There were several visiting consultants who ran specialist clinics at the children's clinic at varying intervals. These included a cardiologist nephrologist, and a neurologist. There were also speech and language therapist clinics.
- Staff told us the contact centre organised appointments for patients visiting the children's clinic.
- Children and young people were seen in the main outpatient clinics for dermatology, ENT, audiology, dental and ophthalmology. We visited maxillofacial outpatients where staff told us children were seen at the Friday pre-assessment clinic then came in for treatment on the following Tuesday. They explained that children were mixed with adults at this clinic and at all other ENT clinics.
- Initial assessments for children referred to the autistic spectrum disorder pathway had been between nine and 10 weeks for the six-month period March to August 2016, apart from June 2016 when it was 13 weeks.
- The children's OP clinic manager told us they had carried out a waiting times survey in 2015. Clinics running were monitored for time the clinician arrived, how many did not attend is, what time the clinics finished and whether any patients were kept waiting over one hour. As a result of this survey, waiting times were now displayed on a board in the clinic and staff informed patient's own arrival if clinics were running late. They said the reason for the late running of clinics was due to medical staff arriving late.
- Appointments in the children's clinic were 15 minutes for follow up appointments and 30 minutes for new appointments. Diabetic patients had a one-hour appointment; 30 minutes with the multidisciplinary team and 30 minutes with the consultant. Children's outpatients had nurse-led clinics for enuresis, diabetes and epilepsy. The clinic manager told us it would be helpful to have more nurse led clinics.

# Services for children and young people

- There were consultant-led rapid access clinics in the children's OP clinic five days a week. Data showed 60-70% of paediatric patients referred to these clinics from ED were seen within 48 hours. Staff told us the clinics were busy in winter.

## Meeting people's individual needs

- Staff on the children's ward told us they admitted patients up to the age of 16. Patients aged 16 to 17 were asked whether they would like to be admitted to the children's ward or an adult ward. The paediatric dental unit provided care and treatment for patients up to the age of 16.
- There was a CAMHS paediatric liaison nurse attached to the service. Their office was on the CAU and they worked between the emergency department, CAU, the children's ward, and CAMHS.
- There was a playroom for under 12's on the CAU; this was shared between children on the CAU and children's ward. Three nursery nurse/play specialists worked five days per week, with two staff on duty each day.
- There was a games room for over 12's on the children's ward; facilities for adolescents were good. We saw there were children's play areas in ophthalmology outpatients and ENT outpatients.
- There was a 'Snoezelen' multi-sensory room on the ward for children and young people to use. This had music, toys and soothing lighting and was used for patients with complex needs or patients who were distressed following procedures. This showed the service provided emotional support for their patients.
- We saw posters and notices on display in different languages. Staff told us these were Urdu and Polish as these were the most common languages used by the local non-English-speaking population.
- We saw there were child friendly versions of leaflets available relating to asthma, diabetes and pain control. For example, there was a 'pain, pain go away' leaflet.
- Staff told us they could book interpreters and Urdu, Romanian, Polish and Slovakian were common languages spoken in the local population. Interpreters either were used face-to-face or over the phone on a conference call. Sign language interpreters were also available if required. Staff told us they could print off leaflets in different languages if these were required.
- The trust had a policy for eliminating mixed sex accommodation. This included children and young people on the CAU and children's ward. It stated

children and young people should be offered the choice as to whether they would like to be segregated by age or gender. Staff on the children's ward had all received transgender training.

- Theatres had separate anaesthetic and recovery areas for children and young people.

## Learning from complaints and concerns

- Acute children's services at the trust had received 10 complaints the previous 12 months. We reviewed these complaints and found two were upheld, four were not upheld, one was withdrawn and one was closed due to lack of communication from the parent. Two recent complaints had not been fully investigated yet.
- We spoke with the governance lead during the inspection about complaints; they said there had been two formal complaints in the last six months in acute children's services. They told us verbal issues raised by patients and relatives were logged as 'concerns.'
- We observed posters and information about how to make a complaint on display in the children's ward, CAU and SCBU. These were also in Urdu and Romanian.
- The ward manager of the SCBU also told us there were low numbers of complaints. They told us verbal complaints were also recorded. They said these mostly involved communication issues and were usually addressed quickly and easily.

## Are services for children and young people well-led?

Requires improvement 

We carried out this inspection because, when we inspected the service in February 2015, we rated well-led as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated well-led as 'requires improvement'.

We found that:

- The vision and strategy for the service was not clearly defined or understood.

# Services for children and young people

- Staff were not aware of governance procedures and documents such as risk assessments. There was a lack of evidence of nursing audits. However, medical staff audits were taking place and registrars and trainees carried out audits as part of their training.
- The risk register contained 44 risks; several these had been on the register since 2010. There was a lack of evidence of actions taken to mitigate risks or close risks.
- Actions taken by the management team were reactive and not proactive.
- The clinical lead position was vacant.

However:

- The culture within the service was good; morale and teamwork had improved since the previous inspection.
- Local staff engagement was good.
- Paediatric input into the leadership team had improved since the last inspection and a new matron, who was paediatric trained, was due to start.
- The service was training advance nurse practitioners to mitigate for the shortfall in medical staff working within the service and the national shortage of paediatricians.

## Leadership of service

- Acute and complex children's and young people's care services were part of the family health division. A director of clinical services, general manager and the head of midwifery, nursing and professions led the family health division.
- There had been some improvements in the leadership of the service since the last inspection. There was a new deputy head of midwifery, nursing and professions for children's services who was paediatric training and qualified in community nursing. However, the acute CYPS leadership team had vacancies for a deputy director of clinical service and matron. The general manager told us the new management team did not have any members with paediatric experience; the divisional director was from obstetrics and gynaecology.
- Children's services had been without a matron for several months; the previous matron had started in January 2016 and left in July 2016 after a short period of sickness. However, the deputy head of midwifery, nursing and professions was an experienced, trained, children's nurse who was specifically recruited to be able to support the children's nursing agenda. They provided support throughout this period.

- The service had appointed a new matron, who was paediatric trained; they were due to start on the 30 October 2016.
- The management team told us they had submitted business cases for two new consultants and they were currently advertising for a clinical lead.
- There was a new deputy head of midwifery, nursing and professions for children's services who was paediatric training and qualified in community nursing. They had been in post for nine months and were responsible for acute and community children services including therapy services. They told us they had found the service supportive and welcoming when they started. They said the staff were engaged and, "Everybody just wants to improve."
- The deputy head of midwifery, nursing and professions told us they visited the children's wards, SCBU and children's OP clinic "almost daily." They said they had an open-door policy. Staff we spoke with confirmed this and told us the ward managers also had an open-door policy.
- The deputy head of midwifery, nursing and professions had introduced monthly one-to-ones with all the band seven staff; they said this had been successful and staff were very receptive.
- The ward manager in the children's outpatient clinic told us they had recently undertaken postgraduate leadership training.

## Vision and strategy for this service

- We saw posters on display in all children's staff areas entitled 'our strategy and goals.' These related to the trust strategy and were not specific to the children's and young people's service.
- The management team told us that the trust's vision and strategy for this service was being shaped, through the children's and young people's transformation programme, with input from partners across Rotherham and key stakeholders.
- The management team talked about the transformation programme which was happening locally, and how they were looking at different models of care, across acute and community settings.

## Governance, risk management and quality measurement

# Services for children and young people

- Staff were not aware of governance procedures and documents such as risk assessments. There was a lack of evidence of audits, staff told us registrars and trainees carried out audits as part of their training.
- The risk register contained 44 risks; several these had been on the register since 2010. There was a lack of evidence of actions taken to mitigate risks or close risks. Staff did not understand the difference between risk assessment and a risk register.
- Information on display in children's ward staff room showed the top three risks for the service were lack of air in the HDU, policies on 'InSite' and medication errors.
- Senior nursing staff told us the risk register was discussed at the monthly governance meetings. The ward managers attended these meetings.
- The deputy head of midwifery, nursing and professions told us risks on the risk register with high scores were escalated to the patient safety and risk team. They acknowledged the risk register needed further development.
- We saw one of the risks on the risk register was lack of high flow oxygen on the HDU. The governance lead confirmed there had been no children requiring ventilation transferred for high flow oxygen during the previous six months.
- The management teams told us the trust strategy was that all risks should be recorded on the risk registers; including emerging risks as well as current risks.
- There was no audit programme; nursing staff and managers told us the service did not carry out any scheduled or regular nursing audits. Staff showed us checklists when we asked them about audits, indicating a lack of understanding.
- We reviewed the trust's medicines management audit of all inpatient wards, which had been carried out over three month periods between February 2013 and May 2016. This considered seven standards including drugs charts, administration of medications and controlled drugs.
- The results for the children's ward and children's assessment unit showed significant improvements compared to the previous three-month annual audits. These showed actions taken to improve medicines management within children's services had been effective.
- We reviewed the minutes of the August meeting of the children and young people's operational board and terms of reference for this group. The group was

accountable to the trust management committee and included all teams with contact with children. The primary purpose of the group was to work in partnership across specialties to deliver seamless, child centric care for children and young people.

## Leadership of service

- Acute and complex children's and young people's care services were part of the family health division. A director of clinical services, general manager and the head of midwifery, nursing and professions led the family health division.
- There had been some improvements in the leadership of the service since the last inspection. There was a new deputy head of midwifery, nursing and professions for children's services who was paediatric training and qualified in community nursing. However, the acute CYPS leadership team had vacancies for a deputy director of clinical service and matron.
- The general manager told us that when the management team was created in January 2013 it did not have any members with paediatric experience; the divisional director was qualified in obstetrics and gynaecology.
- The management team for children's services was strengthened by creating the deputy head of midwifery, nursing and professions post and developing a business case for an additional consultant paediatrician to become clinical lead. The trust supported this by appointing a children's nurse as head of nursing for surgery.
- Children's services had been without a matron for several months; the previous matron had started in January 2016 and left May 2016 after a period of sickness. A new paediatric-trained matron, who was paediatric trained, had been appointed and was due to start on the 30 October 2016.
- The management team told us business cases had been submitted for two new consultants and they were currently advertising for a clinical lead.
- There was a new deputy head of midwifery, nursing and professions for children's services who was paediatric training and qualified in community nursing. They had been in post for nine months and were responsible for acute and community children services including



# Services for children and young people

therapy services. They told us they had found the service supportive and welcoming when they started. They said the staff were engaged and, “Everybody just wants to improve.”

- The deputy head of midwifery, nursing and professions told us they visited the children’s wards, SCBU and children’s OP clinic “almost daily.” They said they had an open-door policy. Staff we spoke with confirmed this and told us the ward managers also had an open-door policy.
- The deputy head of midwifery, nursing and professions had introduced monthly one-to-ones with all the band seven staff; they said this had been successful and staff were very receptive.
- The ward manager in the children’s outpatient clinic told us they had recently undertaken postgraduate leadership training.

## Culture within the service

- The acute and community children and young person’s service had taken part in a trust wide staff survey in September 2015. It was not possible for the trust to provide data to show acute responses alone. Of 86 questions, services for children and young people performed worse than the trust average scores for 32 questions, better than the trust average for five questions, and in line with trust averages for the remainder.
- Questions in which children’s services scored below average included questions about how valued staff felt in their role, whether they were able to and trusted to use their skills, and how frequently they had experienced harassment or bullying.
- Staff told us they felt there was an open culture within the service. They said teamwork within the service had always been good, but had become even better in the last 18 months. They said all grades of staff were friendly and approachable, including medical staff.
- Staff we spoke with all reported feeling well supported. Staff felt able to escalate worries or concerns. Staff felt care was patient focused with a strong team ethos and quality was a priority. One staff member “Work is more enjoyable and it feels more well-organised. We have more time for the patient and their families.”
- Managers told us staff told them the level of support was better than it had been in the past.
- Staff and managers told us about the monthly board assurance visits during which executive and

non-executive members of the board of directors visited departments across both the acute and community sites of the organisation. This demonstrated senior leaders’ commitment to communication with their staff. During these walk rounds staff had the opportunity to talk directly with members of the board of directors and to raise any concerns.

## Public engagement

- Friends and family feedback for the children’s clinic for the period 19th of October to 19 November 2015 showed that 17 out of 147 (11.5%) forms gave negative feedback relating to waiting times. As a result, a waiting time survey was carried out. Changes were made to booking rules and spacing of new patients at the children’s OP clinic and clinicians were asked to arrive at clinic 15 minutes before the clinic start time.

## Staff engagement

- The acute and community children and young person’s service had taken part in a trust wide staff survey in September 2015. It was not possible for the trust to provide data to show acute responses separately. Questions in which the service performed worse than the trust average included questions about whether staff were engaged in decision making by leaders, whether leaders acted on staff feedback and recognition for good work.
- The inspection team found staff engagement locally was excellent.
- Children’s and young people’s service produced a newsletter. Staff told us there were regular ward meetings, which included feedback about friends and family test results.
- Staff told us they were kept well informed about any changes within the service, for example, they would be emailed if a new policy had been issued.
- Staff told us there were debriefs following any incidents involving patients, which included the consultant(s) and the staff involved. Managers could refer staff to the trust’s occupational health counselling service.

## Innovation, improvement and sustainability

- All patients with mental health needs, admitted to the children’s ward were reviewed by the CAMHS liaison team/nurse within 24 hours of admission and were followed up after seven days, either in the hospital or at home. This service improvement was significant.



# End of life care

Effective

Requires improvement



Overall

## Information about the service

End of life care encompasses all care given to patients who are approaching the end of their life and following death, and may be delivered on any ward or within any service of a trust. It includes aspects of basic nursing care, specialist palliative care, bereavement support and mortuary services.

End of life care was delivered at The Rotherham NHS Foundation Trust across a wide range of services, including surgical and medical wards (including wards for older people), accident and emergency, and critical care. In addition, the chaplaincy, mortuary and bereavement teams also provide care as part of the end of life.

The trust employs a consultant-led specialist palliative care team (SPCT). The SPCT are available week days from 8:30am to 4:30pm, excluding most bank holidays. Out-of-hours consultant support and advice is shared with local NHS trusts and is available out of hours seven days a week through the hospital switchboard. Trust staff could also access advice out of hours by telephone from nursing and medical based at the local hospice.

Between 1 March 2015 and 29 February 2016 the trust had 965 in hospital deaths. The specialist palliative care team received 907 referrals between April 2015 and January 2016.

During our inspection we visited five wards where end of life care was being provided and spoke with 19 members of staff. We looked at two patient records and 37 DNACPR forms. We also reviewed trust policies and performance information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

A comprehensive inspection was undertaken in February 2015. We rated safe caring, responsive, well-led as good and effective as requires improvement. The service was rated as good overall. At this inspection we re-inspected effective.

## Summary of findings

We carried out this inspection because, when we inspected the service in February 2015, we rated effective as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated effective as 'requires improvement' because:

- The trust had not taken action on some of the issues raised in the 2015 inspection. DNACPR forms and mental capacity decisions were not documented in line with trust policy, national guidance and legislation.
- The DNACPR policy in use at the time of the inspection did not reference 2016 guidance. This did not provide evidence that the policy had been reviewed in line with best practice.
- Resources within the specialist palliative care team affected their ability to deliver evidence based care and treatment, specifically in relation to seven day working.
- The individualised care plan for adults had been launched in March 2016, however, its use was not yet embedded in practice.

However:

- Staff in the specialist palliative care team were skilled and competent and offered training to all staff groups in end of life care.
- We saw evidence of good multidisciplinary team working in the hospital, across the community and hospice.

# End of life care

## Are end of life care services effective?

Requires improvement 

We carried out this inspection because, when we inspected the service in February 2015, we rated effective as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated effective as 'requires improvement.'

### Evidence-based care and treatment

- We saw that trust policies relating to care at the end of life had been developed based on national guidance such as that recommended by the National Institute for Health & Clinical Excellence (NICE).
- Following our inspection in 2015, the trust developed an action plan. One of the actions was to review the DNACPR policy to ensure it was in line with best practice. The trust provided a copy of the current DNACPR policy – adult patients. The references in this policy did not include the “2016 Decisions relating to cardiopulmonary resuscitation: guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing”. This did not provide evidence that the policy had been reviewed in line with best practice.
- Staff used the policy for the use of the T34 ambulatory syringe driver. The review date of the policy was March 2016, and during our inspection staff informed us that they were still using this policy and the revised policy was being updated and ratified.
- Following the withdrawal of the Liverpool End of Life Care Pathway in 2014, the Rotherham Palliative Care Team had developed an individualised care plan for adults. The specialist palliative care nurses we spoke with told us that the guidance was based on the five priorities of care for the dying patient that succeeded the Liverpool Care Pathway (LCP) as the new basis for caring for someone at the end of their life.
- The SPCT launched the individualised care plan for adults in the hospital in March 2016, ward staff we spoke with during our inspection had limited experience of using the care plan which suggested it was not yet embedded in practice.

### Pain relief

- The SPCT had produced algorithms for symptom management in the last days of life which included pain relief. This was available on the trust intranet and on some wards.
- Ward staff we spoke with told us they received good support from the SPCT, particularly in relation to pain management.
- We observed a palliative care consultant discuss pain control with a relative and ward staff. They made changes to medications and suggested different strategies to manage pain.

### Nutrition and hydration

- Staff assessed patients for risk of malnutrition. Where appropriate food and fluid charts were used to monitor patients' intake and patients at risk were prescribed nutritional supplements.
- We observed patients had access to food and drinks that were within reach. Staff assisted patients who had difficulties eating and drinking.

### Patient outcomes

- The trust was not a CQC outlier in terms of any cancer related outcome measures.
- The End of Life Care Audit – Dying in Hospital 2016, showed the trust scored above or in line with the England average for three out of the five clinical key performance indicators however, they did not achieve five out of the eight organisational quality indicators. These were around the training in communication skills for staff, collection of feedback from bereaved relatives, the presence of an end of life care facilitator and a lay member on the board with a responsibility for end of life care.
- The service developed an action plan following the audit. We saw evidence of some of the actions in place during our inspection, for example, the introduction of the individualised care plan to improve documentation, communication skills training offered to all staff and the development of a business case to increase resource in the SPCT.
- The trust provided a copy of the palliative care audit plan 2016-17. This included an early audit of compliance

# End of life care

with documentation on the individualised care plan for the last days of life (started in July 2016) and an audit of care in the last days of life (due to start in December 2016).

- The case note audit of documentation of care plan decisions/actions and discussions following the publication of "One Chance to Get it Right" was awarded the trust's clinical audit of the quarter. During our inspection we saw evidence of implementation of the actions from the action plan of this audit, for example, education and training for trust staff on end of life care and the introduction of new documentation.
- The trust did not participate in the gold standards framework.

## Competent staff

- Information provided by the trust showed between April and August 2016 100% of staff in the service had received an appraisal. This meant all staff performance and development was discussed and monitored.
- Staff told us they received a trust and a local induction; they received training in end of life care at their induction.
- Staff in the SPCT received regular clinical supervision; this meant they were able to reflect on and review their practice and could identify their training and development needs. The SPCT planned to introduce some clinical supervision/reflection sessions for ward staff.
- The SPCT nurses and doctors were skilled and knowledgeable. They were responsible for training for staff groups in the trust, including nurses, doctors and allied health professionals. The programme included an annual update on palliative care at the nurse essential training, training on one chance to get it right and bespoke sessions developed for specific staff groups.
- The chaplains were involved in some staff training sessions where they covered the topics of compassion and care of self. Chaplains also provided spiritual support for staff.
- The palliative medicine doctors had developed and delivered advanced communication skills training for senior healthcare professionals. These sessions had good attendance and evaluated well. The Palliative Care Team had received funding from Health Education Yorkshire and Humber (HEYH) in order to support one chance to get it right.

- The SPCT planned to reintroduce the link nurse role; this had not been possible previously due to capacity within the team. The aim of the role was to share information and good practice and to give the link nurses the opportunity to gain experience with the SPCT.

## Multidisciplinary working

- Ward staff reported they had good working relationships with the SPCT across all wards and departments. We observed this in practice during our inspection.
- Patients referred to the SPCT were seen within 24 hours of referral and reviewed on a daily basis.
- The SPCT had a daily handover. This meant all staff in the team were aware of plans for the patients.
- Chaplains were part of the multidisciplinary team in end of life care and offered support to patients, families and staff. The chaplains were not authorised to document in the patient record. This was in line with the Data Protection Act 1998. The chaplains felt this lowered their profile in the trust and reduced the referrals they received.
- The SPCT worked closely with community and hospice teams and attended the regional operational meeting for palliative and end of life care.
- Ward staff told us there was effective communication in the multidisciplinary team to identify patients requiring end of life care.

## Seven-day services

- NICE guidelines state that palliative care services should ensure provision to visit and assess people approaching the end of life face-to-face in any setting between 9am and 5pm, seven days a week. Provision for bedside consultations outside these hours is considered to be high-quality care by NICE. The guidelines also state that specialist palliative care advice should be available, at any time of day or night, which may include telephone advice.
- At the time of our inspection, the SPCT operated a service from 8:30am to 4:30pm, Monday to Friday. A business case was due to be submitted in October 2016 to extend the service.
- Overnight and at weekends hospital staff contacted the local hospice for specialist advice. This included a palliative care consultant attached to the local hospice who would undertake out of hours visits in an emergency. Ward staff told us they received the good support and advice from the hospice staff.

# End of life care

- The trust chaplaincy team operated a seven-day service with an out of hours call out system in place.
- The mortuary operated a five day service with on call cover by the technicians if specialist support was required out of hours. Overnight and at weekends access to the mortuary was by the clinical site team.

## Access to information

- Ward staff were able to access palliative and end of life care policies and algorithms on the trust intranet.
- The SPCT had access to an electronic patient records system that was used in the community and by GP's. Staff were able to view and share end of life care patient details on the system. However, the SPCT also completed written documentation in the patients hospital paper based care record, which was resulting in duplication of work.
- The trust was developing an electronic clinical information portal. The aim was to link this to other electronic records, so that end of life patients could be identified when they were admitted to hospital.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- If a person does not have the mental capacity to make a decision about their treatment, professionals can make a 'best interest' decision. However, the professional must take reasonable steps to consult with the patient's family or closest person before making these decisions.
- Staff in the SPCT demonstrated an understanding of mental capacity and decision making, particularly in relation to DNACPR.
- Staff we spoke with on the wards demonstrated some awareness of mental capacity, however, they did not complete capacity assessments. They told us they would speak to the nurse in charge or the safeguarding team if they had concerns about a patient's capacity.
- We were concerned that DNACPR decisions were not always documented in line with national guidance and legislation, for example the Human Rights act and Equality act.
- Following our inspection in 2015, the trust developed an action plan, we found some of the actions related to DNACPR had not been completed. For example, changes had been made to medical documentation to

prompt staff to consider mental capacity and DNACPR status daily. In the records we reviewed where a DNACPR form was in place, staff had not completed these prompts.

- We reviewed 30 DNACPR forms across nine wards (medical and surgical) and found that 20 of the forms had not been completed in line with the trust policy. Of these 20 forms, five DNACPR decisions had not been discussed with the patient; it was clear on two of these forms that the patient had the capacity to make the decision.
- Three of the 20 DNACPR forms had been completed at another organisation. Staff had not reviewed the decision on transfer or admission to the trust. This was not in line with national guidance or trust policy.
- Twelve of the 20 DNACPR forms stated the patient did not have capacity to make the decision. However, there was no evidence on the form or in the patient record that staff had completed a capacity assessment on the patient.
- The trust provided a report following an external DNACPR documentation audit which was commissioned in August 2016. The results of this audit found similar concerns to those found at our inspection. These were in relation to discussion of the DNACPR decision with the patient, evidence of completion of a capacity assessment and evidence of a review of DNACPR decisions on transfer/admission to the trust. The trust produced an action plan in response to the report, whilst it was acknowledged our inspection took place in the weeks following the report, there was little evidence of the completion of some of the actions marked as achieved. For example, staff we spoke with on the wards were unable to find the DNACPR policy on the trust intranet.
- On our unannounced inspection we reviewed an additional seven DNACPR forms and found that five of the forms had been completed in line with trust policy and national guidance.
- Of the two DNACPR forms that had not been completed in line with the trust policy or national guidance, one had a review date of 25 May 2016 There was no evidence on form that decision has been reviewed.
- The other DNACPR form stated the decision had been discussed with the patient's relative in September 2014, the nursing documentation stated the patient lived alone and their next of kin was a different relative. The form was ticked that it was not discussed with the

## End of life care

patient, but no reason was specified, although it did state that the patient had dementia. No capacity assessment had been completed. We raised this with the patient's consultant at the time who said as the DNACPR decision had previously been discussed, there was no need to discuss it again.

- The trust's DNACPR policy stated resuscitation officers would audit DNACPR documentation annually in

January. The trust's CQC action plan following the 2015 inspection stated that the opportunity for a point prevalence audit of DNACPR forms on one set date each month would be established. Following our inspection we requested a copy of the most recent DNACPR audit and action plan from the trust, we had not received a copy four weeks after the request.

# Outpatients and diagnostic imaging

Safe

Good



Overall

## Information about the service

Outpatients and diagnostic services were managed in the Division of Clinical Support Services. Between March 2015 and March 2016 there were 335,533 outpatient appointments. Clinics with the highest out-patient attendances in June 2016 were orthopaedics, ophthalmology, dermatology, and ear nose and throat (ENT).

Outpatient clinics were held at Rotherham General Hospital, venues in the community and at other local NHS trusts. At this inspection we inspected outpatient services delivered at Rotherham General Hospital.

A contact centre based at Woodside provided appointment management by both paper and electronic referral.

Diagnostic imaging included services such as medical imaging, nuclear medicine, and medical illustration. Services were available for both inpatients and outpatients with some services available 24 hours a day, seven days a week for inpatients.

During our inspection we visited the following departments; the appointments contact centre, medical imaging and radiology, orthotics, main outpatients, ophthalmology outpatients and the Earl of Scarborough Macmillan Suite.

We spoke with 10 members of staff, observed care being delivered in the departments, and reviewed staff records and trust policies. We also reviewed performance information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

We carried out a focused, follow-up inspection between 27 and 30 September 2016. At this inspection we re-inspected the safe domain. We undertook a comprehensive inspection in February 2015 and we rated caring, responsive and well-led as 'good', effective was not rated and we rated safe as 'requires improvement'. The service was rated as 'good' overall.

## Summary of findings

We carried out this inspection because, when we inspected the service in February 2015, we rated safe as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated safe as 'good' because:

- The trust had taken action on some of the issues raised in the 2015 inspection, for example, procedures around sharps bins had been updated and were followed and records were now stored securely in clinics.
- Mandatory and safeguarding training levels were better than the trust target.
- Staff understood their responsibility to raise concerns and report incidents. They received feedback from incidents.
- Nurse staffing levels were planned and achieved to keep people safe.
- Medicines were managed safely and stored securely and regular radiation safety checks were carried out.

However:

- Some improvements had been made since 2015, but the environment continued to present significant challenges for most departments.
- There was a shortage of consultants employed by the trust. Locum staff were employed, however, this had affected continuity of care for patients.



# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good 

We carried out this inspection because, when we inspected the service in February 2015, we rated safe as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated safe as 'good.'

### Incidents

#### Outpatients

- Never events have the potential to cause serious patient harm or death. They are wholly preventable, where nationally available guidance or safety recommendations that provide strong systemic protective barriers have been implemented by healthcare providers. There had been no never events reported in the service between July 2015 and June 2016.
- Serious incidents are incidents that require further investigation and reporting. There was one serious incident reported in the service between July 2015 and January 2016. This incident was identified by staff through the weekly patient tracking meeting and found patients who should have been on a pathway to continue with treatment had been placed on a monitoring pathway instead. Senior staff completed a full investigation which found no patients had suffered harm and that the incident occurred due to a data quality issue. The service introduced changes to the way staff moved patients onto different pathways and senior staff were working with the health informatics team to build further assurance into the electronic system.
- There were 43 incidents reported in the service between August 2015 and July 2016; 86% were classified as no harm and 12% as low harm. The two most frequent incident categories that were reported were appointments and patient case notes and records.
- Staff we spoke with understood how to report incidents using the electronic reporting system.

- Staff we spoke with received feedback about incidents at department meetings, by email or from information shared by senior staff on notice boards or in a communication book.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The trust was reviewing its training programme to include duty of candour to all relevant staff groups as an e-learning module.
- Staff we spoke with were aware of the importance of being open and honest with patients and their relatives and the need to apologise if there had been a mistake in their care.
- Senior staff had a clear understanding of the duty of candour and gave clear examples of how they met the regulation in relation to the serious incident that occurred.

#### Diagnostic imaging

- There were no Never Events and no serious incidents reported in the service between July 2015 and June 2016.
- There were 82 incidents reported in the service between August 2015 and July 2016; 89% were classified as no harm, 10% as low harm and 1% as moderate harm. The most frequent incident that was reported was around images for diagnosis.
- Staff we spoke with understood how to report incidents using the electronic reporting system.
- The number of radiation incidents requiring notification to external regulators was low. We reviewed the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) notifications from 2015; there had been three incidents notified in this period.
- The trust was reviewing its training programme to include Duty of Candour to all relevant staff groups as an e-learning module.
- Staff were aware of the importance of being open and honest with patients and their relatives and the need to apologise if there had been a mistake in their care.

### Cleanliness, infection control and hygiene

#### Outpatients

# Outpatients and diagnostic imaging

- All areas we visited were clean and tidy. Departments displayed their cleaning schedules and records for these were complete.
- Clinical areas displayed infection prevention and control information visible to patients and visitors and hand gel was available.
- We observed all staff were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- During our inspection a tuberculosis clinic was held. A nurse specialist was present in the clinic. Staff had access to PPE and understood the infection control precautions that were required.
- The service completed monthly audits to ensure staff were compliant with trust IPC policies.
- Information provided by the trust for February to July 2016 showed that nursing and medical staff were compliant with the microbial decontamination policy, scoring 93% or above in every area of outpatients and with a departmental average of 99%.
- Information provided by the trust for February to July 2016 showed that nursing and medical staff were compliant with the bare below the elbows policy, scoring 100% in every outpatients area, except ear nose and throat (ENT) and oral and maxillofacial surgery (OMFS). The lowest average score was 75% for ENT doctors.
- Information provided by the trust showed 72% of staff in the outpatients and diagnostic service had completed infection control training. This was lower than the trust target of 80%.

## Diagnostic imaging

- All areas we visited were clean and tidy.
- Clinical areas displayed infection prevention and control information visible to patients and visitors and hand gel was available.
- Staff we observed were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- Information provided by the trust for April to July 2016 showed that staff in radiology were 100% compliant with the microbial decontamination, bare below the elbows and peripheral cannula insertion policies.
- Information provided by the trust showed 72% of staff in the outpatients and diagnostic service had completed infection control training. This was lower than the trust target of 80%.

## Environment and equipment

### Outpatients

- Staff told us the main outpatients and ophthalmology departments had outgrown their space. There was limited room for storage of equipment and some patient waiting areas were in corridors.
- The service had made some changes since our 2015 inspection, for example, there was now a purpose built children's dental clinic in a different area of the hospital, staff had worked to streamline the rheumatology clinic and had introduced some one stop clinics. The warfarin clinic had been moved into the community. Some rooms in the department had been moved to improve patient flow and experience, for example, the ECG room had been moved to be nearer the cardiology clinic area.
- Staff raised some privacy and dignity concerns at reception in main outpatients. A notice was displayed to patients to stand back from the desk, but staff told us not all patients adhered to this. A business case had been submitted to change the reception area to address these concerns.
- Staff told us the number of clinic rooms in ophthalmology outpatients could affect patient experience; clinics often overran as staff had to wait for rooms and equipment to be available.
- Space in the orthotics department was also a concern. The waiting area could only accommodate two wheelchairs at one time. The department had four clinicians and only three clinic rooms. Staff did not have the space to be able to treat bariatric patients in the department. Staff told us if they had a bariatric patient to see, they arranged an appointment in another department in the trust and took the equipment they needed with them. Staff told us the plans to rebuild the department had been put on hold but they were unsure why this was.
- We did not see the risk registers for all departments, however, on those we did see the risk associated with the environment was recorded on the risk register. Where this was recorded there was evidence of mitigation of the risk and regular review.
- Resuscitation equipment was available in departments. Staff checked the resuscitation equipment daily and records for this were complete.
- We observed that staff disposed of sharps safely and that the storage and disposal of sharps was in line with

# Outpatients and diagnostic imaging

trust policy. Following our inspection in 2015, the trust had reviewed and updated the policy. This was issued in October 2015 and was due for review in September 2018.

## Diagnostic imaging

- All the areas we visited in medical imaging were tidy, however, staff told us the department had outgrown their space. The manager told us that in relation to the accommodation, the number of patient attendances had increased from around 30,000 when the department was newly built to around 180,000 per year. Senior staff told us refurbishment plans had been put on hold.
- Resuscitation equipment was available in the department. Staff checked the resuscitation equipment daily and records for this were complete.
- We observed that staff disposed of sharps safely and that the storage and disposal of sharps was in line with trust policy.
- The department had a separate waiting area for inpatients to maintain their privacy and dignity.
- Staff in radiology had access to appropriate personal protective equipment. We observed radiology staff wearing specialised personal protective aprons; these were available for use within all radiation areas. Staff were also seen wearing personal radiation dose monitors; these were monitored in accordance with the relevant legislation and radiation doses to staff were within acceptable levels.
- Staff told us the department had one DR (digital radiology) mobile machine and one DR machine in the department.
- The service had standard operating procedures for the quality assurance of diagnostic imaging systems and machinery. Members of the diagnostic imaging team who had undergone training carried out the quality assurance checks on the equipment.
- We reviewed an equipment maintenance document provided by the trust that showed regular maintenance and servicing was carried out. Maintenance of equipment was carried out by either in-house clinical engineering department (CE) or external providers.

## Medicines

- We saw that the departments had appropriate systems to ensure that medicines were handled safely and stored securely.

- We saw controlled drugs were appropriately stored with access restricted to authorised staff. Staff kept accurate records and performed daily balance checks in line with the trust policy.
- Staff monitored medication fridge temperatures in line with trust policy and national guidance. The records we reviewed were complete in all departments. This meant that medications were stored at the appropriate temperature.
- Staff we spoke with in ophthalmology and diagnostic imaging told us they worked within trust policies and patient group directives (where prescription medicine can be supplied to patients without a prescription under certain conditions) to administer specific medications. We saw that the patient group directives were in date.
- If doctors prescribed medication to patients in outpatients, they took the prescription to the hospital pharmacy for dispensing
- Nurses in outpatients provided patients with medication support and counselling when required.

## Records

- Information provided by the trust showed 90% of staff in the outpatients and diagnostic service had completed information governance training. This was better than the trust target of 80%.

## Outpatients

- Records used in the outpatient department were a mixture of paper based and electronic information that included test results, reports and images.
- Nurses we spoke with told us some locum medical staff were not familiar with the electronic system and would need additional time and support during the clinic to use the system.
- Records were stored behind a closed door with a lock on at the reception desk. In one area of outpatients the reception desk was not behind a door. Records were stored at this desk when a member of staff was present. Staff told us the records were locked away if a member of staff was not present at the reception desk. We observed staff locking the records away when they left the reception desk during our inspection.
- If staff were unable to find a set of notes they would start a temporary set of notes for the clinician to record the

# Outpatients and diagnostic imaging

consultation which would be merged with the original notes when they were found. Clinicians had access to the information available electronically, for example, blood tests and diagnostic imaging.

- The service kept a monthly missing case notes log. Information provided by the trust showed the average number of missing case notes between January and July 2016 was 19 a month; this had reduced from an average of 25 a month between July and December 2015. Information provided by the trust showed less than 0.1% of patients were seen without their full medical record being available.
- The most frequent reason for missing case notes was out of date tracking. Regular and urgent communications about the importance of correct tracking of notes was sent to staff. We saw an example of this during our inspection.

## Diagnostic imaging

- Radiology stored and viewed images on the departmental PACS (picture archiving and communication system). The department also had an electronic reporting system. The radiology manager told us the majority of users, received their results electronically.

## Safeguarding

- Staff we spoke to were clear about what constitutes as a safeguarding issue and how to escalate safeguarding concerns.
- Staff knew how to access the trust's safeguarding policy and the safeguarding lead
- Information provided by the trust showed 90% of staff in the outpatients and diagnostic service had completed safeguarding adult's level 2 training and 89% of staff had completed safeguarding children level 2 training. This was better than the trust target of 80%.
- Information provided by the trust showed that the division for clinical support services compliance with safeguarding children level 3 training was 100%.

## Mandatory training

- Information provided by the trust showed in the outpatients and diagnostic service 80% of staff had completed dementia awareness training, 88% of staff

had completed fire basic awareness, 85% of staff had completed basic life support and 85% of staff had completed moving and handling for patient handlers training. This was better than the trust target of 80%.

## Outpatients

- The trust had a comprehensive package of mandatory training for staff. Senior staff in outpatients worked with staff in learning and development to ensure mandatory training was relevant to staff's role.
- Senior staff told us they kept local records of mandatory training compliance because of historical problems with the accuracy of the central record. If they noticed a difference between the two records they discussed it with the learning and development team who update the central record.
- Staff told us they were up to date with their training.

## Diagnostic imaging

- Staff told us they were up to date with their training and were able to access both face to face and on line training easily.
- One person in the department was responsible for coordinating mandatory training.

## Assessing and responding to patient risk

### Outpatients

- There were systems and processes in place for assessing and responding to patient risk to keep patients safe. For example, in ophthalmology, we saw there was a warning light outside the laser treatment room. Consultation rooms and treatment rooms had emergency call bells.
- Staff explained the actions they would take if a patient or visitor became unwell in the department including transfer to ED or contacting the cardiac arrest team if required.

### Diagnostic imaging

- We observed radiation warning signs on display in the department. We also observed notices in patient waiting areas, asking patients whether they could be pregnant.
- Staff explained the actions they would take if a patient or visitor became unwell in the department including transfer to ED or contacting the cardiac arrest team if required.

# Outpatients and diagnostic imaging

- WHO safety checklists were being used in both interventional radiology and clinical radiology departments. An audit on the process was underway in the service; however, at the time the trust provided information prior to the inspection it had not yet been completed.
- The service had named, certified radiation protection supervisors to give advice and ensure patient safety. We saw they had responsibility for actions on the April 2016/ March 17 radiation protection action plan.
- The trust had a medical physics expert available in a radiation protection advisor role. This was in line with IR(ME)R 2000 guidance.
- The service had policies and processes in place to identify and deal with radiation risks and incidents identify and deal with risks. This was in line with IR(ME)R 2000 guidance.

## Staffing

### Outpatients

- Local practice and professional judgement was used to determine safe staffing levels, based on number and type of clinics and expected number of patient attendances. There is no acuity tool available for staffing in the outpatients department.
- Senior staff told us the service aimed to provide each clinician who undertook a clinic, nursing support for the duration of the clinic. For the clinics where it was highly likely a procedure, for example, a biopsy would take place nurse support was guaranteed.
- Staff told us each reception area was supported by a registered nurse. All clinical areas had access to a senior nurse between 8am to 6pm Monday to Friday.
- Information provided by the trust showed main outpatients had an establishment of 30.7 whole-time equivalent (WTE) healthcare support workers and nursing staff. The actual number of staff in post was 27.4 WTE. There were vacancies in both healthcare support workers and registered nurses.
- The trust provided information about the planned and actual staffing in main outpatients and ophthalmology between April and July 2016. In main outpatients the actual number of nurses on duty was the same as the planned number on 83 out of 87 days, that was 95% of the time. The actual number of healthcare assistants on duty was the same as the planned number on 75 out of 87 days, so 86% of the time.

- In ophthalmology the actual number of nurses on duty was the same as the planned number on 84 out of 87 days, that was 97% of the time. The actual number of healthcare assistants on duty was the same as the planned number on 65 out of 87 days, so 75% of the time.
- At the time of our inspection two registered nurses were both leaving from ophthalmology outpatients. The posts had been advertised, but there had been no applicants. Due to the specific skills required in this area, staff that had the appropriate skills in main outpatients were going to work in ophthalmology. Although the service used a low proportion of bank staff at the time of the inspection, this would increase the number of bank staff working in the main outpatients area.

### Diagnostic imaging

- Information provided by the trust showed medical imaging had an establishment of 12 WTE healthcare support workers and nursing staff. The actual number of staff in post was 13.3 WTE.
- Information provided by the trust showed medical imaging had an establishment of 66.3 WTE radiographers and sonographers. The actual number of staff in post was 59 WTE. This meant the service had 7.2 WTE vacancies.

## Medical staffing

### Outpatients

- The individual specialities were responsible for identifying and managing the medical staffing for the outpatients clinics. There was a shortage of consultants employed by the trust and locum staff were employed to ensure that there were enough doctors to look after patients and cover clinics.
- Information provided by the trust showed the use of locums in most of the specialities. For example, between January and June 2016 locum usage was between 0% - 37.7% in cardiology and 22.8% - 76% in gastroenterology.

### Diagnostic imaging

- Information provided by the trust showed medical imaging had an establishment of 8.8 WTE consultants.

# Outpatients and diagnostic imaging

The actual number of consultants in post was 4.8 WTE. This meant the service had 4 WTE vacancies. Consultant radiologist staffing was recorded on the risk register and we saw evidence of regular review and controls in place.

- Consultant radiologists worked between 8am to 6pm Monday to Friday and provided an on call service outside of these hours.
- Due to staffing levels in the service, CT imaging reporting was outsourced between 10pm and 8am the following day.

## **Major incident awareness and training**

- Specialities within the service had their business continuity plans. The actions described were in line with the trust's major incident plan.
- Staff knew how to access the business continuity plans and explained the steps they would take to seek instruction from senior staff.



# Outstanding practice and areas for improvement

## Outstanding practice

- Safeguarding and liaison had a daily meeting with the ED to identify any safeguarding issues and concerns.
- All patients with mental health needs admitted to the children's ward were reviewed by the CAMHS liaison team/nurse within 24 hours of admission and were followed up after seven days.
- The trust staff had direct access to electronic information held by community services through the SEPIA portal, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicines and community services involvement in their care.
- Staff had successfully offered the use of acupins for the relief of nausea, particularly in gynaecology services.

## Areas for improvement

### Action the hospital MUST take to improve

#### Action the hospital MUST take to improve

##### Urgent and emergency care

- Ensure there are sufficient numbers of suitable qualified, competent and skilled staff deployed in the department.
- Ensure that facilities on the clinical decision unit are properly maintained in a good state of repair and able to meet patient needs.
- Ensure all staff are aware of their responsibility to report incidents and ensure learning is shared with all relevant staff.

##### Medicine

- Continue to take action to ensure there are sufficient numbers of suitably skilled, qualified and experienced staff.
- Ensure all relevant staff have received appropriate training and development. This should include, mental capacity, safeguarding adults and children, resuscitation and dementia awareness.
- Ensure all staff have an annual appraisal.
- Mental capacity assessments and discussions must be clearly documented in patient records.

##### Critical care

- Ensure risks are assessed, monitored and managed in a timely manner to ensure safety.

- Ensure patients' individual records are held securely on the unit.

##### Maternity

- Complete the reviews of maternal and neonatal deaths and implement any further identified actions to support safe practice.
- Ensure that identified risks recognised and recorded on the risk register.
- Ensure that incidents are reviewed and investigated in a timely manner.
- Ensure staff have access to safeguarding supervision and support.

##### Services for children and young people

- Ensure the policies and procedures for the management of the children's and young people's service are up-to-date, regularly reviewed, document controlled and readily accessible to staff.
- Ensure children and young people's service risk register reflect current risks, contains appropriate mitigating actions, is monitored and reviewed at appropriate intervals and acted upon.

##### End of life care

- Ensure all "do not attempt cardio-pulmonary resuscitation" (DNACPR) decisions are always documented in line with national guidance and legislation.

# Outstanding practice and areas for improvement

- Ensure there is evidence that patients' capacity has been assessed in line with the requirements of the Mental Capacity Act (2005).

## Action the hospital SHOULD take to improve

In addition the trust should:

### Medicine

- Improve the recording of fluid balance to ensure appropriate actions are taken when imbalances are present.
- Take action to improve compliance with good infection prevention and control practice and procedures.
- Review provision of hand wash basins in line with relevant guidance e.g. HBN 00-09 IC in the Built Environment and HBN 04-01 Adult inpatient facilities (when wards are being refurbished)

### Surgery

- Continue to review and implement on site support to junior doctors and advanced nurse practitioners at night.

### Critical Care

- Ensure the Guidelines for the Provision of Intensive Care Services (GPICS) 2015 guidance are implemented.

### Maternity

- The divisional risk management strategy should be reviewed.
- Review equipment on the delivery suite to ensure it is suitable for use.
- Review information governance arrangements.
- Review the use of staff, out of hours, on delivery suite to be the scrub nurse in theatres.
- Review information systems to ensure they are fit for purpose.

- Continue to improve mandatory training compliance.
- Improve the, referral to treatment time for gynaecology patients admitted to hospital.

### Services for children and young people

- Children should be seen in an appropriate environment by staff that are suitably skilled, qualified and experienced. In particular, in the adult outpatient clinics, on the high dependency unit on the children's ward and in the paediatric dental unit.
- Children's and young people's service should carry out appropriate and timely clinical and nursing audits
- There should be call buzzers available in all rooms, including the sensory room on the children's ward.
- Consider employing a nursing co-ordinator on the neonatal unit, which is recommended as good practice by the Department of Health's Toolkit for High-quality neonatal services (2009).
- Staff signatures in care record documentation should be completed and legible/traceable.
- The outside play areas for the children's ward and children's OP clinic should be well maintained and fit for children to use.
- The numbers of SCBU nursing staff that are qualified in speciality should meet the government recommendation of 70%.
- All staff with direct responsibilities for involvement in reporting and contributing to the assessment of safeguarding concerns should be trained to safeguarding level 3.

### Outpatients and diagnostics

- Continue to review the challenges the environment poses in all departments, particularly orthotics

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

#### Regulation

Treatment of disease, disorder or injury

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Need for consent

How the regulation was not being met:

We reviewed 30 DNACPR forms across nine wards (medical and surgical) and found that 20 of the forms had not been completed in line with the trust policy.

#### Regulated activity

#### Regulation

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance: assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity

How the regulation was not being met:

There was a backlog of incident reports overdue a review or investigation within maternity services. Serious incidents and Never Events regarding medicines were not identified in a timely manner.

There were policies and procedures, including for the management of the children's and young people's service, overdue for review.

This section is primarily information for the provider

## Requirement notices

Risk registers in children's services, maternity services and critical care did not reflect current risks, did not contain appropriate mitigating actions, and were not reviewed at appropriate intervals and always acted upon.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014

Staffing

How the regulation was not being met:

There were insufficient numbers of suitably qualified, competent, skilled and experienced staff in the Emergency Department, medical wards and specialities and pharmacy.