University Hospitals Sussex NHS Foundation Trust

Worthing Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Worthing Hospital

Inspected but not rated

We carried out this unannounced focused follow up safety inspection of maternity services provided by Worthing Hospital who are part of the University Hospitals Sussex NHS Foundation Trust on the 26th of April 2022 because, at our last inspection in October 2021 we found the following concerns: -

- A lack of sufficient number of suitably trained staff to deliver safe services.
- Daily and weekly equipment checks had not been completed in line with national guidance.
- A lack of safe storage and administration of medicines. We found out of date emergency medication in three out of four 'grab bags' and the medicines storage room temperatures exceeded temperatures of 20-25 degrees.
- Medical records were not always contemporaneous and observations charts were not always stored with the medical records.
- In maternity triage the trust had not implemented a standardised Red Amber Green (RAG) rating process for assessing women's risk factors.
- There was not an effective systems to review incidents to identify lessons learnt and share those lessons with staff to prevent the recurrence of incidents.
- The trust was unable to capitalise on the leadership skills of the head of midwifery & matron because they were continually managing the staffing crisis. This meant that there was a lack of safety oversight on the unit which resulted in many minor breaches as described above.

As a result, we issued a warning notice to make sure the trust made improvements. We carried out this return inspection to review compliance to the warning notice issued on the maternity services. We did not inspect any other core service. Although, we continue to monitor all other core services.

This inspection has not changed the ratings of the location overall and our rating of maternity services remains the same.

Maternity (inpatient services)

Inspected but not rated

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities in maternity services. This focused inspection did not include all our key lines of enquiry (KLOEs). We looked at KLOEs specific to the warning notice in the domains: safe, and well-led.

We visited the clinical areas of the labour ward, maternity day assessment unit and the antenatal clinic.

We spoke to 14 staff to better understand what it was like working in the service including senior leaders, midwifes, obstetric staff, practice development midwives, and the patient safety team.

We reviewed 5 sets of maternity records and 5 prescription charts. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, recently reported incidents and audit results.

After the inspection we requested further documentary evidence to support our judgements including policies and procedures, staffing rotas and quality improvement initiatives.

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

Is the service safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills to all staff and made improvements to make sure all staff completed it.

At our previous inspection in October 2021, we found not all staff had completed their mandatory training. The trust recruited key staff to implement and assess training within maternity services. Clinical practice assessors now supported the practice development midwives to deliver training and an administrator supported midwives to maintain clear training records.

On this re-inspection we found that most staff had now completed their Cardiotocograph (CTG) training. CTG machines monitor the babies heart to help identify any fetal wellbeing concerns, safe CTG interpretation is part of the National Institute of Care and Excellence 'Intrapartum Care CG190 (2017) guidance. The trust training target is 90%. Records confirmed that training compliance had improved with 98.87% of midwives training, and overall compliance for medical staff was 95.65%.

Midwifery staff received and kept up-to-date with their mandatory training. Records confirmed that 98% of staff across the service had received their trust mandatory training.

Maternity (inpatient services)

Staff compliance to mandatory skills drills training had increased. The trust had postponed physical simulated emergency skill drills training during the COVID-19 pandemic. They replaced this with obstetric core competency training which was completed online. Emergency simulated training was re-instated in January 2022.

Staff were on track to complete the simulated skills and drills and records confirmed that 87% of acute midwives and 88% of community midwives had now received this training. But only 73% of medical staff completed it. We could not report on basic life support training for Worthing Hospital because the trust did not submit all the data for this site. The trust submitted joint figures for the completion of either module with 96% of antenatal staff receiving one of the two modules and 98% of labour ward staff receiving one of the two.

However, staff had not received formal simulated training on how to evacuate women from the birthing pool in the event of an emergency. Pool evacuation training is vital to ensure that all staff can remove women from the pool quickly and safely. The trust told us that because of COVID-19 pool evacuation had not been completed and this was due to commence this year. There have not been any incidents involving the pool in the past year.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment and managed clinical waste well. However, managers did not always monitor equipment checks.

During our last inspection we had identified gaps in checks of emergency equipment and told the trust they must make improvements.

On this re-inspection we found that staff completed daily safety checks of specialist equipment and used a laminate on each ward to record the checks. Compliance was reported via the daily meeting with the director of midwifery. Records submitted by the trust confirmed that the checking system was monitored for April and May 2022. However, on labour ward we noted that although daily checks on the resuscitaires had been completed and documented on the safety board. Managers had not monitored compliance for daily checks of the resuscitaires, records confirmed that from January 2022 to April 2022 no audits had been completed.

At the time of the inspection the unit did not have a resuscitaire in every labour room. However, the service did submit a business plan. After the inspection we were told the trust had purchased resusciataires for every room.

Also, we found that the Resuscitation Council, resuscitation flow charts attached to the equipment were dated 2015. The Resuscitation Council asks healthcare organisations to annually review the versions to ensure they have the most up to date version and had updated the flow charts in 2021. However, this was not acknowledged on the resuscitaire. Managers told us that they sought advice from the hospitals resuscitation team who advised that there had been no clinical changes to the flow charts since 2015 and the guidance was current. However, as a result of our query the resuscitation team planned to implement the Resuscitation Council 2022 flow chart as it had been updated with clear colour coded algorithms.

Staff completed daily checks on adult resuscitation trolleys, which were stored in all area's and easily identifiable because they were red. Records confirmed that these were checked once a day in all areas. The checks were recorded in a log and on the safety board.

Assessing and responding to patient risk

Maternity (inpatient services)

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

During the last inspection we found that staff did not use a nationally recognised tool to risk assess pregnant women who attended the hospital via the trusts triage system. Also, there was no designated area for triage at Worthing Hospital. The Royal College of Obstetricians and Gynaecologists Workforce Report (2022) recommends that maternity services should implement a designated area to assess women attending for unscheduled care.

On this re-inspection we found that managers allocated experienced midwives across both sites (Worthing and St Richards hospitals) to answer triage calls between 8 am to 6 pm Monday to Friday to assess and plan care. When women arrived at the hospital during those hours, they were seen in the maternity day assessment area. Out of these hours the lines were transferred to the delivery suite and women were invited into the delivery suite for review.

Leaders had updated the guideline for triage of maternity patients and implemented the Birmingham Symptom Specific Obstetric Triage System (BSSOTS) tool in triage. Triage is an aspect of care for women who have unexpected health concerns and need to speak to or see a healthcare professional. The BSSOTS tool used a Red Amber Green (RAG) rating to identify those most at risk. Red for high risk and green for low risk concerns.

Managers completed audits on the use of BSSOTS to ensure that practice was embedded. The audits included a review of the time of arrival and time seen for initial assessment in triage. Records confirmed that women were seen within set time frames. For example, those women attending with red rated health concerns were seen within half an hour.

Staff used a standard operating procedure for 'Maternity Telephone Triage' which stated that only band 6 or 7 midwives should answer the calls, band 5 midwives needed to be trained to answer the calls. This practice does not reflect the BSSOTS framework, which refers to assessments only being completed by midwives.

On the day of our inspection triage calls were being taken at the St Richards hospital site, so we were unable to observe practice. We were shown the area used by staff to take calls, and the equipment they used, this was a quiet room on the labour ward. Staff told us that all calls were recorded on the electronic patient record, although we did not see any evidence of this on the day of the inspection. There was no evidence of a paper log, to help identify calls in the event of a system crash. However, we did see this at the St Richards site.

Staff working in the day assessment unit who reviewed patients admitted via community or the triage helpline did not always complete a Maternity Obstetric Early Warning Score (MEOWS) on arrival to record women's physical observations. Staff told us that MEOWS were only completed if the woman was admitted to the antenatal or labour ward. The impact of this is that healthcare professionals had to review several different sets of notes to look at physical themes and trends.

Staff used a maternity observation bundle when women were admitted to the labour or antenatal ward. The bundle contained general points, pain score, the escalation pathway, MEOWS charts and post operative monitoring. Managers monitored the use MEOWS chart and records confirmed 100% compliance.

Staff used an electronic World Health Organisation (WHO) theatre safety checklist which contains 19 patient safety items used to make sure women are prepared for theatre safely. The electronic system was implemented because a snapshot audit identified gaps in compliance to recording all aspects of the checklist. Records confirmed that managers planned to complete regular audits.

Maternity (inpatient services)

Staff monitored the fetal heartbeat on the antenatal day assessment unit, the antenatal ward and during labour. Staff used a Cardiotocograph (CTG) monitor to record the fetal heartbeat of pregnant women who had been identified as having a complication of pregnancy. Staff followed national guidance to review, interpret and document their findings and used pre-populated stickers to record patient details.

Midwives used a 'Fresh Eyes' approach to check fetal wellbeing via the CTG machine and this was recorded on the CTG print out. The fetal wellbeing midwife monitored compliance to documentation and interpretation of CTG's. The division provided data from February 2022 to May 2022 which reported gaps in documentation with 50% of staff not clearly writing the reason for the CTG and 17% of CTG's were not reviewed hourly. Also, 67% of CTG classifications were not always completed correctly. Findings were reported by the fetal wellbeing midwife at safety huddles and incident review meetings.

Midwifery and nursing staffing

The service had increased maternity staffing. Maternity staff had the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

At out last inspection we found that there was a lack of suitably trained midwives to deliver safe care and treatment. Because of this we asked the trust to review staffing and implement strategies to increase midwifery staffing across the unit. The trust had commissioned a Birth-rate plus staffing review which had highlighted gaps in staffing and this review helped the trust make improvements.

On this re-inspection we found that staffing had improved because the trust had employed 13 new midwives to work across both sites in West Sussex.

Leaders implemented a new strategy to tackle staff shortages. An overseas recruitment drive recruited 8 international band 5 nurses to provide postnatal care on the ward. The focus of their work was to support midwives, with routine nursing tasks. For example, wound care, monitoring catheters and taking bloods. Because the nurses had no formal midwifery training, they followed a nurse preceptorship program where key skills were identified and completed. The document was monitored by the practice development midwives who made sure the nurses were competent with their recent skills.

The division had employed seven nursery nurses across both sites to support neonatal care on the wards.

Leaders had increased the amount of hours for the practice development midwife role and employed two clinical practice assessors to support training and students.

The service had 3.8 midwife vacancies within the hospital setting and 5 midwife vacancies within the community setting. Staff told us that this had a positive impact on culture and wellbeing.

There were currently 4 maternity support worker vacancy's within the unit and 5 support worker vacancy's in the community and recruitment was ongoing. Support workers are essential members of the team because they support midwives with basic clinical and administrative tasks.

The division had recruited a fetal wellbeing midwife for 15 hours per week, who was responsible for reviewing, implementing, and delivering Cardiotocograph (CTG) training for medical, and midwifery staff to make sure CTG interpretation was embedded. However, completing all the required tasks in 15 hours was challenging. The lead had completed CTG documentation audits which identified gaps in recording, but there was little time to embed good practice.

Senior midwives completed a staffing acuity assessment every four hours to review staffing during the week to make sure that the service was safely staffed.

Managers monitored staff sickness using the trusts acuity and tool. At the re-inspection midwife sickness rates at Worthing Hospital averaged 7.1% in the acute setting and 14.5% in the community, data included staff isolating due to COVID-19.

The division reported staffing and safety concerns twice weekly to systems partners to allow ongoing oversight of the increase in acuity and poor staffing levels. Staffing data was presented at the quality and safety meetings but was not formally reported to the trust board. There was a plan to incorporate maternity staffing within the trusts safer staffing monthly reports.

Records

Staff kept detailed records of women's care and treatment, but the systems staff used did not support contemporaneous record keeping. Records were stored securely but paper medical records not always available to those providing care.

At our last inspection we saw that the unit had a combination of paper and electronic record systems. However, the electronic system did not always support staff to record events when they happened and sometimes required staff to complete or print records in retrospect. This was a potential risk to monitoring continuity and health care professionals ability to prioritise clinical care.

On this re-inspection we found little improvement compliance to this aspect of our warning notice. Medical records were not always contemporaneous; Staff continued to use a combination of digital and paper records. Staff working in clinical areas were not consistent in how they documented care. For example, in antenatal clinic and the day assessment unit staff recorded their care plans on the digital maternity care record. However, maternal observations and the Birmingham Symptom Specific Obstetric Triage System (BSSOTS) assessment record were stored in the medical records and patient notes.

Staff working on delivery suite and the antenatal ward updated patients handheld records but did not record their care on the digital system. This meant that when women called the antenatal clinic or community staff did not have a record of their care plan to hand. Women were being asked photograph the documentation and email this to the antenatal clinics generic email box.

Leaders told us that the trust had invested in a new maternity digital care system and were in the process of recruiting a lead midwife to help oversee the implementation and compliance to the new system, which was being used nationally at other trusts. The new system is electronic, and all staff will be required to update care on the system, this includes patient observations, diagnostic testing, and care plans. Audits could be drawn from the new system when it was installed.

Maternity (inpatient services)

Medicines

The service had made improvements to the processes to safely prescribe, administer, record and store medicines.

During our last inspection we had concerns about the storage of medicines. We told the trust it must make improvements as we had found that medicines were not always stored securely.

On this re-inspection we found that staff followed systems and processes when safely administering, recording, and storing medicines.

Staff completed daily checks on controlled drugs and during February, March, and April 2022 there were no gaps in these checks. Pharmacy services checked and updated stock levels.

The trust funded the installation of air conditioning in the medication room to maintain the correct ambient temperature, which was checked and recorded daily, and records confirmed this.

Staff could access emergency 'Grab Bags' of vital medication in the event of emergencies. We checked the 'grab bags' for Sepsis, Post-Partum Haemorrhage, and Eclampsia. Each bag contained the correct medication which was in date and checks were recorded on the labour wards safety board. However, we found that the flow chart within the eclampsia 'Grab Bag' did not include a flow chart of the immediate actions staff should take when caring for a woman having an eclamptic episode. The impact of this was that care may be delayed whilst staff access trust guidance on the intranet.

Staff made sure they followed the trust policy for storing Oxygen and Nitrous Oxide cylinders. The cylinders on resuscitaires were secured.

Staff did not complete annual medicines management competency testing, and training as this was not a current requirement of the trust. Leaders relied upon the fact that students had exposure to medicines management during their training. The impact of this was that any changes to practice and any staff not regularly exposed to medicines calculation may be de-skilled. This meant leaders had lack of oversight on the current knowledge and skills of midwives working on the unit.

Incidents

The service had made improvements to manage safety incidents well. Most staff recognised and reported serious and moderate harm incidents and never events but did not always report near misses or incidents resulting in low levels of harm.

At the last inspection we found that although staff knew what incidents to report and how to report them, due to low staffing levels they were not always able to report incidents. During the re-inspection antenatal clinic staff told us that they rarely reported no harm incidents. For example, staffing issues, or documentation errors, because they would have to do this often and it was time consuming.

Since our last inspection the division had appointed an interim governance lead who reviewed Incidents and allocated them to the relevant teams for investigation. We found that the service had made improvements to the way incidents were handled, reviewed, and graded. All incidents were triaged by the governance lead using a systematic approach to identify expected levels of care.

Maternity (inpatient services)

A Quality and Safety panel reviewed incidents rated moderate and above to make sure they were categorised correctly. The patient safety team generated a report for the Quality and Safety Group and the Maternity Safety Champion as well as the Maternity leadership safety lead.

Improvements to the incident review process had resulted in much lower rates of outstanding incidents. Records confirmed that at Worthing Hospital there were 247 incidents between 1st October 2021 and 29th of April 2022. There were 33 open incidents, 14 were over 20 days, and none were over 6 months old.

Staff told us that although they had not always received feedback from the investigation in the past, systems had improved, and the process was more transparent because learning was shared. Staff received a monthly newsletter which included hot topics and the dates of clinical governance sessions. Staff advised us that they still struggled to find time to read the newsletter but were more aware of the clinical governance and risk review meetings and felt more supported in attending the sessions.

All staff could attend weekly incident reviews, although this was dependent on their workload. Incidents were discussed at the monthly clinical governance meetings attended by the triumvirate and matrons for the service.

Staff involved in traumatic events had access to supervision, mental health, and Trauma Risk Management (TRiM) support. TRiM is a trauma-focused peer support system designed to help people who have been involved in a traumatic event and the hospital had several staff trained to be TRiM practitioners.

There were no 'never events' reported in the last 12 months.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women, and visitors although not all staff were aware of this.

The division monitored safety performance. Some of this data was displayed on ward information boards and available to patients. The trust circulated safety performance data in their monthly newsletters. This included information on breastfeeding uptake, post-partum hemorrhage and shoulder dystocia.

Leaders displayed basic outcomes of data for staff, women, and visitors however, the data was limited and did not reflect all aspects of care. For example, there was no Obstetric Anal Sphincter Injury (OASI) data on the current 3rd and 4th degree tear rate. This meant staff and women did not have the most up to date safety information available to them.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced and implemented strategies to improve services. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Maternity (inpatient services)

The senior leadership team (SLT) formed a triumvirate that included the interim head of midwifery, chief of service and interim divisional director of operations. The interim head of midwifery had been in post since March 2021. The interim head of midwifery was line managed by the chief nurse. They were normally supported in their role by two matrons. However, at the point of re-inspection the trust were actively recruiting a matron for the St Richards hospital site.

At the last inspection we found that the senior leaders at Worthing Hospital were constantly trying to manage the poor staffing levels and the matron frequently worked clinically whilst being responsible for many front-line roles. Whilst this leadership style showed solid support for staff, it meant they were unable to fully utilise their leadership skills and safety oversight of the unit.

On this re-inspection we found that this situation had not changed, because the service was awaiting the appointment of a Matron at St Richards and the Worthing matron still covered both sites, managing acute and community services. The impact of this was that aspects of our previous warning notice had not been properly implemented because they did not have the capacity to have full oversight of all services. For example, there still issues regarding patient record documentation and not all emergency 'grab bags' contained care guidelines.

Staff spoke highly of the matron. Most staff felt supported, listened to, and felt able to raise concerns. Staff said they had an 'open door' policy and felt able to raise serious concerns.

Changes to the leadership structure were ongoing. We found improvements within the governance and practice development teams. The trust had identified a Board level safety champion and a Non-Executive Director (NED) Safety champion. Staff knew who they were and told us they had been introduced to the NED.

Governance

Leaders had made improvements to the governance processes. Staff at all levels were clear about their roles and accountabilities and had opportunities to meet, discuss and learn from the performance of the service.

Maternity service's formed part of the women's and children's division. As a result of our last inspection the trust had implemented a new governance strategy to make sure the service reviewed and improved governance processes.

The board and executive team reviewed the integrated performance report, Ockenden action plan and the national NHS maternity incentive scheme.

Leaders implemented a strategy to reduce the backlog of incidents and make sure that there was a meaningful approach to closing outstanding incidents. They created a clear process for sharing learning using various methods which included, regular staff meetings. Email alerts and information sharing at safety huddles.

Managers attended weekly incident review meetings, where the details of incidents were reviewed by a ream which included patient safety administrators, consultants, the patient safety midwife, and managers of various departments within maternity. Any lessons and actions were clearly documented and followed up.

Maternity and Gynaecology quality and safety meetings were held monthly across both sites. Attended was documented. Serious incidents were reviewed and followed up. Root cause analysis investigations were discussed and signed off where appropriate and records confirmed this.

Leaders including consultants attended monthly Perinatal Mortality Review tool (PMRT) which aims to provide a robust and standardised review to provide answers for bereaved parents about why their baby had a poor outcome. Also, senior staff attended monthly Avoiding Term Admission into Neonatal Units (ATAIN) Meetings to review babies over 37 weeks gestation admitted to the neonatal unit to make sure the care provided throughout pregnancy and labour was safe. Poor outcomes were reported via nationally recognised data sets.

Maternity and Neonatal safety champions met monthly to discuss outcomes of incidents and review themes and trends to help inform future training. Concerns were fed back to the trust board.

The interim governance lead held formal departmental staff meetings where incidents, risks, performance, guidelines, audits, and user experience could be discussed, or fed into divisional meetings. Although there were discussions about these during safety huddles, there was no formalised meeting for staff to receive and pass on feedback. Staff told us that since COVID-19 it had been difficult to facilitate staff meetings due to roster challenges, social distancing, and staff sickness.

Maternity performance was reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The maternity dashboard was reviewed monthly at the maternity quality and safety meeting and quarterly at the divisional governance review and by the trust board. The monthly governance report also included information on women from minority ethnic groups to monitor outcomes in relation to COVID-19 complications and increased morbidity and mortality rates overall.

As a result of our last inspection, leaders updated the clinical guidelines database, and these were reviewed monthly to ensure that they reflected the most recent evidence based practice. Records confirmed that the service had updated all guidelines and was 100% compliant. This work was ongoing as the service had recently commenced the development of trust wide guidelines.

Leaders had made improvements to how complaints were reviewed and how learning was shared. The change meant all complaint responses were signed off by the chief nurse. To embed performance managers were responsible for identifying themes, providing feedback, and closing actions.

Management of risk, issues, and performance

The service and teams used systems to manage performance effectively. Current systems for managing risk were not kept current. They had plans to cope with unexpected events.

The service had a division specific risk register. The risk register included a description of each risk, alongside mitigating actions, and any assurances already in place. The possible impact and the review date were also indicated.

The risk register had been reviewed and updated since our last inspection. Risks were Red Amber Green (RAG) rated. The division had 19 departmental risks recorded on the risk register, there were eleven high risk items which included but not limited to, the current maternity information systems because it did not support ease of access to woman's care records, midwives providing immediate recovery care for patients, workforce pressure, shortage of basic monitoring systems on labour ward. Actions to mitigate risks were documented and dated. However, there were no time frames for rectifying the risks.

Maternity (inpatient services)

Risks with a high score were monitored at executive level via the divisional integrated governance and performance meetings. The director of nursing, medical director, and a non-executive director completed a review with the support of senior divisional leads at the quarterly divisional clinical governance review.

The division engaged with Healthcare Safety Investigation Branch (HSIB), through quarterly safety meetings. Leaders made sure HSIB recommendations were actioned. There were five case referrals from Worthing Hospital to HSIB in the past six months. This was a high number within the South-East area. Stakeholders discussed HSIB reports and action plans in monthly clinical governance meetings.

The division had an up to date business continuity plan. Staff were aware of their roles in the event of an unforeseen event.

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure but did not always function effectively. Data or notifications were consistently submitted to external organisations as required.

On re-inspection there had not been a significant change to the way information was handled. The trust ran an electronic and paper-based records systems. We found the electronic patients record systems did not always support staff to maintain a contemporaneous care record because of connectivity or system glitches. It relied on a pressured workforce to enter data and print records in retrospect. This was identified was a significant risk to the service.

As a result of the risk the trust had been awarded funds to make improvements. This included the roll out of a nationally recognised digital maternity system. The proposed system will bring the added benefit of drawing data for audit purposes. The project had been set up and a new project manager was due to start in May 2022. The service was in the process of recruiting a lead midwife to support the project and help train staff. The implementation of the new system will continue throughout 2022.

Clinical records were not always easy to find. Not all staff used the records traceability software, which meant finding notes was sometimes a challenge.

Information stored by the trust was confidential and stored securely at the Worthing Hospital site. The service had not reported any data breaches and systems were secure. Patient identifiable information was handled correctly, and patient names were not visible from the ward areas to ensure privacy.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Worthing Hospital Maternity Service.

Maternity (inpatient services)

Action the trust MUST take is necessary to comply with its legal obligations

The service must ensure it continues to monitor regular checks on resuscitaires to limit the risk of any gaps in the daily checks. (Regulation 12 (2) (b, e)).

Action the trust SHOULD take to improve:

Worthing Hospital Maternity Service.

The trust should ensure the maternity telephone triage services are delivered by experienced midwives. (Regulation 12 (1) (2) (a, b))

The service should ensure that it continues to monitor cardiotocographs (CTG) documentation to embed accurate documentation of CTG readings and accurately categorise their findings. (Regulation 12 (a))

The trust should ensure that simulated pool evacuation training is completed as a priority for all staff caring for women in labour. (Regulation 12 (1) (2) (a, b))

The service should ensure it maintains securely an accurate, complete, and contemporaneous record in respect of each service user (Regulation 17(C)).

The service should ensure that the divisional risk register continues to be update on a regular basis and that it includes clear time frames for completion. (Regulation 17(C)).

The trust should consider updating the job description for the band 5 nurses working on the maternity ward to reflect their remit and ensure clear boundaries between midwifery and nursing care.

The trust should consider increasing the working hours of the fetal wellbeing midwife to make sure outcomes of audits can be followed up and improved.

The trust should consider implementing annual medicines management competency training. So that they are confident all staff administering medication to mothers and babies are doing so safely.

The trust should consider using MEOWS observations charts as soon as a woman arrives for care.

The trust should consider identifying a designated area to safely and appropriately triage women who call the unit unexpectedly.

Our inspection team

The team that inspected the service comprised of one CQC lead inspectors, one CQC inspectors, and two CQC specialist advisors. The inspection team was overseen by Carolyn Jenkinson Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment