Worcestershire Acute Hospitals NHS Trust

Alexandra Hospital

Quality Report

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Date of inspection visit: 12, 12 and 25 April 2017
Date of publication: 08/08/2017

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.

Ratings

Overall rating for this hospital

Urgent and emergency services	
Medical care (including older people's care)	
Surgery	
Maternity and gynaecology	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) previously carried out a comprehensive inspection in November 2016, which found that overall; the trust had a rating of 'inadequate'.

We carried out a focused inspection on 11 and 12 April 2017. We also visited on 25 April 2017, specifically to interview key members of the trust's senior management team. This was in response to concerns found during our previous comprehensive inspection on Worcestershire Royal Hospital, the Alexandra Hospital and Kidderminster Hospital and Treatment Centre whereby the trust was served with a Section 29a Warning Notice. The 29a Warning Notice required the service to complete a number of actions to ensure compliance with the Health and Social Care Act 2008 Regulations and the trust had produced a comprehensive action, which reflected these requirements as well as additional aims and objectives for the service.

Focused inspections do not look at all five key questions; is it safe, is it effective, is it caring, is it responsive to people's needs and is it well-led, they focus on the areas indicated by the information that triggered the focused inspection.

The inspection focused on the following services; adult emergency department (ED), medical care, surgery, and maternity and gynaecology. We inspected parts of the five key questions for these services but did not rate them.

Areas where significant improvements included in the Section 29a Warning Notice had not been made were:

- There was inadequate investigation of, and learning from, serious incidents and inadequate mortality and morbidity reviews in the emergency department (ED).
- There was minimal reporting of patient safety incidents relating to patients waiting on trolleys in corridors and when the department was over capacity.
- There was very little response from the hospital as a whole when the ED safety matrix showed that the department was overwhelmed.
- This was not sufficient medical cover to provide a consultant presence in the department for 16 hours a day as recommended by the Royal College of Emergency Medicine.
- The trust had told us that a new full capacity protocol had been developed describing the actions to be taken when the hospital and ED were full. This had not been completed and the trust appeared to take very little action on the many occasions when the ED was full and unable to treat any more patients.
- There remained long delays for patients at every stage of their assessment and treatment. There had been no improvement in the ability to meet the national standard to admit or discharge 95% of patients within four hours. In February and March 2017, this had been achieved for only 80% of patients which was similar to our previous inspection. We observed six patients who spent between eight and 12 hours in the department.
- There was very little privacy and confidentiality for patients waiting on trolleys in the corridor in ED.
- There had been no clinical governance or performance management meetings since our last inspection. High levels of clinical activity in the ED meant there was little time for governance and risk management.
- There was little understanding of the processes for escalating significant risks to divisional or board level. Doubt remained regarding the degree of oversight of ED risks by senior leaders within the trust.
- There was significant concern about the lack of effective leadership in the ED and at trust level to tackle the ongoing risks to patient safety.
- During this inspection, we still observed that most staff did not generally wash their hands before and after patient contact on ward 12 and the medical assessment unit (MAU). In surgery, some staff were not compliant with infection control precautions including hand hygiene and appropriate use of personal protective equipment.
- Time critical medicines were not always given when required in some medical care wards.
- In surgery, medications were not administered as prescribed. Medications were stored in temperatures above manufactures recommended guidelines.

Summary of findings

- Venous thromboembolism (VTE) assessments were not carried out on all patients in line with trust and national guidance in medical and surgical wards.
- Despite assurances from the trust, we saw no evidence that obstetrics and gynaecology mortality and morbidity reviews were held. Furthermore, whilst countywide perinatal mortality and morbidity meetings were minuted, we were not assured that action was taken to address any learning identified from case reviews.
- The trust had monitoring systems in place to ensure medicines were stored within recommended temperature ranges. However, these were not consistently followed across the service.

Additional areas of concern, that were not included in the Section 29a Warning Notice, that we found during this inspection were:

- There was a lack of advanced training in child safeguarding for doctors and nurses.
- Safeguarding adults training for doctors and nurses in the ED was inadequate.
- There was a lack of immediately accessible equipment for the care and treatment for patients being cared for in the corridor area of ED.
- There was a risk that there would be no appropriately qualified doctors on duty if a child needed resuscitating in the ED.
- Only 78% of patients were assessed by a member of ED staff within 15 minutes of arrival: this had not improved since the last inspection.
- There were fewer nurses than required for the numbers of patients in the department, particularly at night.
- The trust had told us that a frailty team was to be implemented in order to improve response for frail patients with complex health needs. This had not happened.
- Only twenty-four per cent of staff were up-to-date on medicines' management training and this was below the trust target of 90% in medical care wards.
- Patient weights were not routinely recorded on drug charts we looked at. Patients declining to take prescribed medication were not always escalated to or reviewed by medical staff. Doctors prescribed medication but did not always review drug charts to ensure patients were either taking their medication as prescribed or declining to take them. This meant that effective treatment was not provided.
- Patient's medical notes were not stored securely as they were left in unlocked trolleys that could be easily accessed by unauthorised individuals. Visitors to medical and surgical wards could see patient identification details on electronic white boards.
- All wards displayed the actual number of staff on duty. However, some surgical wards did not display the planned number of staff and therefore patients and visitors could not identify any staff shortages.
- Staff compliance with Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training was very low.
- In response to high capacity demands for medical beds, the hospital had converted a surgical ward to a medical ward: however, nurses said they did not always have the required skills to care for medical patients.
- Some surgical nursing staff, who cared for gynaecology patients on the designated wards, had not received any specific gynaecology training, such as management of surgical miscarriage and bereavement care. However, the gynaecology medical team were available for advice as needed.
- The medical service leadership team had not addressed all issues identified as areas for improvement in our last inspection. This meant that there were still potential risks to the safety and quality of care and treatment of patients' care.
- Senior leaders were aware of the trust's failure to follow national guidance in relation to venous thromboembolism risk assessments (VTE) and compliance with hand hygiene. However, we saw examples throughout surgery where national guidance had not been followed. When risks had been escalated, there was a lack of follow up and resolution.

Areas where we found improvements included in the Section 29a Warning Notice had been made were:

- We observed good infection control precautions performed by all staff in ED clinical areas.

Summary of findings

- Staff were now confident in the use of paediatric early warning scores in ED.
- Improvements were noted in completed of National Early Warning Score (NEWS) records in the medical care wards visited.
- Staffing levels in the discharge lounge met patients' needs.
- The service had taken steps to improve the management of medical patients cared for on non-medical speciality wards with evidence that patients were reviewed regularly by medical doctors.
- All staff had 'arms bare below the elbows' in surgical clinical areas.
- We saw fewer medical outliers on most surgical wards. However, one surgical ward had nine medical outliers at the time of our inspection.
- Patients undergoing surgery had the correct consent form.
- Patients who lacked capacity had evidence of a mental capacity assessment.
- The trust had implemented a new quality dashboard. The dashboard provided monthly quality data for all wards and clinical areas.

Areas of improvement, that were not included in the Section 29a Warning Notice, found from the last inspection were:

- There were improved processes for the recording of medication that had been given to patients by ambulance crews.
- Staff felt that increased availability of ambulatory emergency care had improved some aspects of patient flow through the department.
- The lead consultant and matron were highly visible within the ED and led clinical activity. The matron had recently implemented new clinical audits.
- Staff had documented competencies to work in the non-invasive ventilation (NIV) unit. This was identified as an issue during our inspection in November 2016 and had improved during this inspection.
- Adequate staffing levels were observed on all surgical wards during our inspection. Staff explained their new staffing application (an electronic tool which measured how many staff were on duty against how many should have been on duty), which helped escalate any shortages rapidly.
- Patients undergoing surgery had the correct consent form. Patients who lacked capacity had evidence of a mental capacity assessment.
- All clinical areas we visited in the maternity and gynaecology service were clean and there was good adherence to infection control policies and the use of personal protective equipment.
- There had been an improvement in compliance with safeguarding children level three training in maternity and gynaecology service.
- Compliance with Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training in maternity and gynaecology service had improved. Staff demonstrated awareness of relevant consent and decision making requirements relating to MCA and DoLS, and understood their responsibilities to ensure patients were protected.
- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard (SQuID). This was used as a drive for improvement and had improved staff's understanding of safety and quality in the service.

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

Importantly, the trust must:

- Ensure that the privacy and dignity of all patients in the ED is supported at all times, including when care is provided in corridor areas.
- Ensure that systems or processes are fully established and operated effectively to assess, monitor and improve the quality and safety of the services provided within the ED.
- Ensure that systems or processes are fully established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients while using the ED.
- Ensure that medicine's management training compliance meets trust target of 90%.

Summary of findings

- Ensure all staff have completed their Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training.
- Ensure the completion of VTE assessments and re-assessments is in line with national guidance.
- Ensure drug charts have patient weights recorded.
- Ensure all anticoagulation medication is administered as prescribed. All non-administrations must have a valid reason code.
- Ensure all medicines are stored at the correct temperature. Systems must be in place to ensure medication, which has been stored outside of manufactures recommended ranges, remains safe or is discarded.
- Ensure there are processes in place to ensure that any medicine omissions are escalated to the medical team for review.
- Ensure when patients refuse to take prescribed medication, this is escalated to the medical team for a review.
- Ensure patient identifiable information is stored securely and not kept on display.
- Ensure all staff comply with hand hygiene and the use of personal protective equipment policies.
- Ensure all staff have completed the required level of safeguarding training.
- Ensure all staff comply with hand hygiene and the use of personal protective equipment policies.
- Ensure all staff have completed their Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training.
- Ensure all staff have completed the required level of safeguarding training for vulnerable adults and children.

In addition the trust should:

- Achieve the required numbers of consultants in the ED on duty to meet national guidelines.
- Review its processes to confirm that all ED consultants and middle grade doctors hold a current advanced paediatric life support qualification and that they would lead resuscitation of children. Including those from temporary staffing agencies.
- Consider displaying actual and planned staff numbers in all clinical areas.
- Review nurse staff competence for the management of medical patient outliers.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of four of the five key questions but did not rate them. We found significant improvements had not been made in these areas: • There was inadequate investigation of, and learning from, serious incidents and inadequate mortality and morbidity reviews in the ED. • There was minimal reporting of patient safety incidents relating to patients waiting on trolleys in corridors and when the department was over capacity. • There was very little response from the hospital as a whole when the ED safety matrix showed that the department was overwhelmed. • This was not sufficient medical cover to provide a consultant presence in the department for 16 hours a day as recommended by the Royal College of Emergency Medicine. • The trust had told us that a new full capacity protocol had been developed describing the actions to be taken when the hospital and ED were full. This had not been completed and the trust appeared to take very little action on the many occasions when the ED was full and unable to treat any more patients. • There remained long delays for patients at every stage of their assessment and treatment. There had been no improvement in the ability to meet the national standard to admit or discharge 95% of patients within four hours. In February and March 2017, this had been achieved for only 80% of patients which was similar to our previous inspection. We observed six patients who spent between eight and 12 hours in the department. • There was very little privacy and confidentiality for patients waiting on trolleys in the corridor.

Summary of findings

- There had been no clinical governance or performance management meetings since our last inspection. High levels of clinical activity in the ED meant there was little time for governance and risk management.
- There was little understanding of the processes for escalating significant risks to divisional or board level. Doubt remained regarding the degree of oversight of ED risks by senior leaders within the trust.
- There was significant concern about the lack of effective leadership in the ED and at trust level to tackle the ongoing risks to patient safety.

We also found other areas of concern:

- There was a lack of advanced training in child safeguarding for doctors and nurses.
- Safeguarding adults training for doctors and nurses in the ED was inadequate.
- There was a lack of immediately accessible equipment for the care and treatment for patients being cared for in the corridor area of ED.
- There was a risk that there would be no appropriately qualified doctors on duty if a child needed resuscitating.
- Only 78% of patients were assessed by a member of ED staff within 15 minutes of arrival: this had not improved since the last inspection.
- There were fewer nurses than required for the numbers of patients in the department, particularly at night.

However, we found improvements in some areas:

- We observed good infection control precautions performed by all staff in clinical areas.
- There were improved processes for the recording of medication that had been given to patients by ambulance crews.
- Staff were now confident in the use of paediatric early warning scores.
- Increased availability of ambulatory emergency care had improved some aspects of patient flow through the department.

Summary of findings

- The lead consultant and matron were highly visible within the department and led clinical activity. The matron had recently implemented new clinical audits.

Medical care (including older people's care)

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected elements of four of the five key questions but did not rate them. We found significant improvements had not been made in these areas:

- During this inspection, we still observed that most staff did not generally wash their hands before and after patient contact on ward 12 and the medical assessment unit (MAU).
- Time critical medicines were not always given when required.
- Venous thromboembolism (VTE) assessments were not carried out on all patients in line with trust and national guidance. Nine out of 29 patient records reviewed lacked an initial VTE assessment.

We also found other areas of concern:

- Only twenty-four per cent of staff were up-to-date on medicines' management training and this was below the trust target of 90%.
- Patient weights were not routinely recorded on drug charts we looked at.
- Patients declining to take prescribed medication were not always escalated to or reviewed by medical staff.
- Doctors prescribed medication but did not always review drug charts to ensure patients were either taking their medication as prescribed or declining to take them. This meant that effective treatment was not provided.
- Patient's medical notes were not stored securely as they were left in unlocked trolleys that could be easily accessed by unauthorised individuals. Visitors to wards could see patient identification details on electronic white boards.

Summary of findings

- Staff compliance with Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training was 42%, which was below the trust target of 90%.
- In response to high capacity demands for medical beds, the hospital had converted a surgical ward to a medical ward: however, nurses said they did not always have the required skills to care for medical patients.
- The medical service leadership team had not addressed all issues identified as areas for improvement in our last inspection. This meant that there were still potential risks to the safety and quality of care and treatment of patients' care.

However, we observed improvement for the following:

- Improvements were noted in completed of NEWS records in the wards visited.
- Staffing levels in the discharge lounge met patients' needs.
- Staff had documented competencies to work in the non-invasive ventilation (NIV) unit. This was identified as an issue during our inspection in November 2016 and had improved during this inspection.
- The service had taken steps to improve the management of medical patients cared for on non-medical speciality wards with evidence that patients were reviewed regularly by medical doctors.
- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard. This was used as a drive for improvement and had improved staff's understanding of safety and quality in the service.

Surgery

We carried out this focused inspection to inspect three of the five key questions but we did not rate them. This was a focused inspection to review concerns found during our previous comprehensive inspection in November 2016 and therefore we did not inspect every aspect of each key question. We found significant improvements had not been made in these areas:

Summary of findings

- Venous thromboembolism risk assessments were not completed in line with national guidance.
- Medications were not administered as prescribed.
- Medications were stored in temperatures above manufactures recommended guidelines.
- Some staff were not compliant with infection control precautions including hand hygiene and appropriate use of personal protective equipment.

We also found other areas of concern:

- Patient details were visible to all staff and visitors on the ward.
- All wards displayed the actual number of staff on duty. However, some surgical wards did not display the planned number of staff and therefore patients and visitors could not identify any staff shortages.
- Less than 20% of nursing and medical staff had received training in Mental Capacity Act 2005 and Deprivation of Liberty.
- Senior leaders were aware of the trust's failure to follow national guidance in relation to venous thromboembolism risk assessments and compliance with hand hygiene. However, we saw examples throughout surgery where national guidance had not been followed.
- When risks had been escalated, there was a lack of follow up and resolution. For example, medications were stored in fridges at higher temperatures than recommended by medicine manufactures and clinical staff had escalated this to managers. However, clinical staff were unable to identify any action taken to reduce the risks of patients receiving medication stored in these fridges.

However, we found improvements in some areas:

- All staff had 'arms bare below the elbows' in clinical areas.
- Adequate staffing levels were observed on all wards during our inspection. Staff explained

their new staffing application (an electronic tool which measured how many staff were on duty against how many should have been on duty), which helped escalate any shortages rapidly.
- We saw fewer medical outliers on most surgical wards. However, one surgical ward had nine medical outliers at the time of our inspection.
- Patients undergoing surgery had the correct consent form.
- Patients who lacked capacity had evidence of a mental capacity assessment.
- The trust had implemented a new quality dashboard. The dashboard provided monthly quality data for all wards and clinical areas.

Maternity and gynaecology

Requires improvement

We carried out a focused inspection to review concerns found during our previous comprehensive inspection on 22 to 25 November 2016. We inspected parts of four of the five key questions but did not rate them. We found significant improvements had not been made in these areas:

- Despite assurances from the trust, we saw no evidence that obstetrics and gynaecology mortality and morbidity reviews were held. Furthermore, whilst perinatal mortality and morbidity meetings were minuted, we were not assured that action was taken to address any learning identified from case reviews.
- The trust had monitoring systems in place to ensure medicines were stored within recommended temperature ranges. However, these were not consistently followed across the service.

We also found other areas of concern:

- Surgical nursing staff, who cared for gynaecology patients on the designated wards, had not received any specific gynaecology training, such as management of surgical miscarriage and bereavement care. However, the gynaecology medical team were available for advice as needed.

However, we found improvements in some areas:

Summary of findings

- All clinical areas we visited were clean and there was good adherence to infection control policies and the use of personal protective equipment.
- There had been an improvement in compliance with safeguarding children level three training. Staff demonstrated awareness of safeguarding guidance, including female genital mutilation. Staff understood their responsibilities and were confident to raise concerns. However, training compliance was still below the trust target.
- Equipment was clean, maintained and serviced to ensure it was safe for patient use.
- Compliance with Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training had improved. Staff demonstrated awareness of relevant consent and decision making requirements relating to MCA and DoLS, and understood their responsibilities to ensure patients were protected.

Alexandra Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Maternity and gynaecology.

Detailed findings

Contents

Background to Alexandra Hospital

The Alexandra Hospital in Redditch was opened in 1985. It serves a population of approximately 200,000 and has over 300 beds.

The hospital is the major centre for the county's urology service. The hospital has eight operating theatres, MRI and CT scanners and has cancer unit status for breast, lung, urology, gynaecology and colorectal cancers.

In 2015/16, the trust had an income of £368,816,000 and costs of £428,732,000; meaning it had a deficit of £59,916,000 for the year. The deficit for the end of the financial year for 2016/17 was predicted to be £34,583,000.

Our first comprehensive inspection took place in July 2015, when the Alexandra Hospital was rated as inadequate and the trust entered special measures. We carried out a second comprehensive inspection of the trust in November 2016, and whilst some improvements were noted, the trust was again rated as inadequate and remained in special measures.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultants and nurses from surgical services and general medicine and emergency department doctors and nurses. The team also included an executive director and a governance specialist.

How we carried out this inspection

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 of people's needs?
- Is it well-led?

We reviewed a range of information we held about Worcestershire Acute Hospitals NHS Trust and asked

other organisations to share what they knew about the hospital. These included the clinical commissioning group, NHS Improvement, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch.

We spoke with people who used the services and those close to them to gather their views on the services provided. Some people also shared their experience by email and telephone.

We carried out this inspection as part of our programme of re-visiting hospitals to check improvements had been made. We undertook an unannounced inspection from 11 to 12 April 2017 and an announced inspection on 25 April 2017.

Facts and data about Alexandra Hospital

Alexandra Hospital is part of Worcestershire Acute Hospitals NHS Trust.

The trust primarily serves the population of the county of Worcestershire with a current population of almost 580,000, providing a comprehensive range of surgical, medical and rehabilitation services.

The trust's main Clinical Commissioning Groups (CCG) are NHS Redditch and Bromsgrove CCG, NHS Wyre Forest CCG and NHS South Worcestershire CCG.

The health of people in Worcestershire is varied compared to the England average. Deprivation is lower than average and about 15% (14,500) children live in poverty. Life expectancy for both men and women is similar to the England average.

As at August 2016, the trust employed 5,053.82 staff out of an establishment of 5,532.69, meaning the overall vacancy rate at the trust was 9%.

In the latest full financial year, the trust had an income of £368.8m and costs of £428.7m, meaning it had a deficit of £59.9m for the year. The trust predicts that it will have deficit of £ 34.5m in 2016/17.

In the last financial year the trust had:

- 120,278 A&E attendances.
- 139,022 inpatient admissions. (2014/15 financial year)
- 588,327 outpatient appointments.
- 5,767 births.
- 2,181 referrals to the specialist palliative care team.
- 51,444 surgical bed days.
- 1,945 critical care bed days (March to August 2016).

Urgent and emergency services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The emergency department (ED) at the Alexandra Hospital (AH) provides a 24-hour a day, seven day a week service and serves the population of Redditch and surrounding areas. There are approximately 56,000 attendances each year. Almost 11,000 (20%) of these are children up to the age of 16 years. The department has seen a decrease in attendances of 10% over the last year, which mainly relates to the reconfiguration of paediatric services to another trust site.

The ED consists of a minor treatment area with seating and five trolley cubicles, a major treatment area consisting of 10 trolley cubicles and three side rooms, and a resuscitation area consisting of three bays.

There is a five-bedded observation ward known as the emergency decision unit.

During our inspection, we spoke with 25 members of staff, three patients, and one relative. We also reviewed 12 patient care records.

Summary of findings

We carried out a focused inspection on 11and 12 April 2017 to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of four of the five key questions but did not rate them. We found significant improvements had not been made in these areas:

- There was inadequate investigation of, and learning from, serious incidents and inadequate mortality and morbidity reviews in the ED.
- There was minimal reporting of patient safety incidents relating to patients waiting on trolleys in corridors and when the department was over capacity.
- There was very little response from the hospital as a whole when the ED safety matrix showed that the department was overwhelmed.
- This was not sufficient medical cover to provide a consultant presence in the department for 16 hours a day as recommended by the Royal College of Emergency Medicine.
- The trust had told us that a new full capacity protocol had been developed describing the actions to be taken when the hospital and ED were full. This had not been completed and the trust appeared to take very little action on the many occasions when the ED was full and unable to treat any more patients.
- There remained long delays for patients at every stage of their assessment and treatment. There had been no improvement in the ability to meet the national standard to admit or discharge 95% of patients within four hours. In February and March

Urgent and emergency services

2017, this had been achieved for only 80% of patients which was similar to our previous inspection. We observed six patients who spent between eight and 12 hours in the department.
- There was very little privacy and confidentiality for patients waiting on trolleys in the corridor.
- There was significant concern about the lack of effective leadership in the ED and at trust level to tackle the ongoing risks to patient safety.
- There had been no clinical governance or performance management meetings since our last inspection. High levels of clinical activity in the ED meant there was little time for governance and risk management.
- There was little understanding of the processes for escalating significant risks to divisional or board level. Doubt remained regarding the degree of oversight of ED risks by senior leaders within the trust.

We also found other areas of concern:

- There was a lack of advanced training in child safeguarding for doctors and nurses.
- Safeguarding adults training for doctors and nurses in the ED was inadequate.
- There was a lack of immediately accessible equipment for the care and treatment for patients being cared for in the corridor area of ED.
- There was a risk that there would be no appropriately qualified doctors on duty if a child needed resuscitating.
- Only 78% of patients were assessed by a member of ED staff within 15 minutes of arrival: this had not improved since the last inspection.
- There were fewer nurses than required for the numbers of patients in the department, particularly at night.

However, we found improvements in some areas:

- We observed good infection control precautions performed by all staff in clinical areas.
- There were improved processes for the recording of medication that had been given to patients by ambulance crews.
- Staff were now confident in the use of paediatric early warning scores.
- Increased availability of ambulatory emergency care had improved some aspects of patient flow through the department.
- The lead consultant and matron were highly visible within the department and led clinical activity. The matron had recently implemented new clinical audits.

Urgent and emergency services

Are urgent and emergency services safe?

We carried out a focused inspection on 11 and 12 April 2017 to review concerns found during our previous comprehensive inspection in November 2016. We found significant improvements had not been made in these areas:

- There was inadequate investigation of, and learning from, serious incidents and inadequate mortality and morbidity reviews in the emergency department (ED).
- There was minimal reporting of patient safety incidents relating to patients waiting on trolleys in corridors and when the department was over capacity.
- There was very little response from the hospital as a whole when the ED safety matrix showed that the department was overwhelmed.
- This was not sufficient medical cover to provide a consultant presence in the department for 16 hours a day as recommended by the Royal College of Emergency Medicine.

We also found other areas of concern:

- There was a lack of advanced training in child safeguarding for doctors and nurses.
- Safeguarding adults training for doctors and nurses in the ED was inadequate.
- There was a lack of immediately accessible equipment for the care and treatment for patients being cared for in the corridor area of ED.
- There was a risk that there would be no appropriately qualified doctors on duty if a child needed resuscitating.
- Only 78% of patients were assessed by a member of ED staff within 15 minutes of arrival: this had not improved since the last inspection.
- There were fewer nurses than required for the numbers of patients in the department, particularly at night.

However, we found improvements in some areas:

- We observed good infection control precautions performed by all staff in clinical areas.
- There were improved processes for the recording of medication that had been given to patients by ambulance crews.
- Staff were now confident in the use of paediatric early warning scores.

Incidents

- There had been three serious incidents in the department since our last inspection in November 2016. Although all had severe outcomes for the patients concerned, none had been investigated using root cause analysis or the NHS serious incident framework. This meant that the fundamental causes of the incidents had not been identified and so no action had been taken to prevent a recurrence. Only one consultant had recently received training in root cause analysis limiting the department's ability to learn from the causes of serious incidents.
- Incidents and accidents were reported using a trust-wide electronic system. All staff had access to this and knew which incidents required reporting. However, a finding from our previous inspection was that senior staff had been discouraged from reporting safety incidents relating to a crowded department and patients waiting on trolleys in corridors. Despite the trust telling us that they now encouraged staff to report such incidents, only two concerns related to bed management issues had been reported in January to March 2017. This was despite the fact that the department's own safety matrix showed that patient safety levels had been "critical" on twelve occasions and that the department had been "overwhelmed" on a further seven occasions during March 2017. This lack of reporting onto the trust-wide system meant that there was no established process to inform senior leaders of the degree of risk associated with an over capacity department and patients being cared for on trolleys in corridors.
- We were told that formal mortality and morbidity meetings had not taken place but cases and lessons learnt had been discussed in senior doctors teaching at the end of each month. However, there was no process of disseminating learning outside of this teaching session and so the majority of staff were unaware of any required changes to practice.

Cleanliness, infection control and hygiene

- We observed good infection control precautions performed by all staff in clinical areas. This was an improvement from the last inspection.

Environment and equipment

- We did not gather evidence for this as part of the inspection.

Urgent and emergency services

Medicines

- At the last inspection, we had noted that there was no robust system for recording medicines given to patients by ambulance crews. The crews recorded the medicines on their own computer system and verbally told nursing staff what had been given. There was no specific section of the ED record where these medicines could be recorded and we found they had been documented in a variety of different places. We had found two examples of intravenous morphine that had either been incorrectly recorded or not recorded at all. This meant that doctors were unaware of the previous drugs that had been given and so there was a risk that repeat doses would be given in error.
- At this inspection, we found that a printer had been installed that produced a paper copy of the ambulance records. This was incorporated into the ED records and included details of medicines given by the crew. ED staff could refer to this document thus reducing the risk of repeat medication being given in error.

Records

- We did not gather evidence for this as part of the inspection.

Safeguarding

- In 2016, the trust had been unable to provide us with records of safeguarding training undertaken by ED staff. Therefore, we were unable to establish if staff were trained to an appropriate level of safeguarding to undertake their job roles and keep people safe from harm or abuse. However, staff verbally told us that they had only been trained at levels one or two. Senior ED staff are required to have the more advanced level three training but this had not been provided by the trust.
- At this inspection the ED matron told us that no further training had taken place. Level three training was planned but that no definite dates had been agreed**.**
- The trust provided data as of the end of April 2017 regarding safeguarding training. Safeguarding children's level three compliance for medical staff was 7% (one doctor had completed this training out of 15).
- Safeguarding children's level three compliance for nursing staff was 47% (20 nurses had completed out of 42).
- Safeguarding adults training level two compliance was 0% for medical staff and 41% for nursing staff.

Mandatory training

- We did not gather evidence for this as part of the inspection.

Assessing and responding to patient risk

- The ED used a safety matrix to determine whether current conditions promoted patient safety. Information such as patient numbers, ambulance arrivals, complexity and available staff were entered into the matrix on a two hourly basis. In 2016, this had been paper based and was only used for monitoring purposes. In March 2017, it became part of the hospital computer system so that senior staff in other parts of the hospital could see immediately if patient safety was at risk. However, nurses told us that this innovation had not changed the hospital's response when the matrix showed that risk was increasing. They did not know who in the hospital was meant to monitor the on-line information from the matrix. For example, on the night of our inspection the matrix showed that the department was "overwhelmed" between midnight and 8am. This was due to large numbers of ambulances arriving, patients being cared for in the corridor, and several highly dependent patients in the department. The new matrix did not display any guidance for staff in these circumstances and response from the hospital was no different than previously.
- When the department was full, it was sometimes necessary for patients brought by ambulance to wait in the corridor. At our previous inspection, we had seen patients who had been spinally immobilised (lying flat while fixed to a rigid surface so that the head and back are unable to move) spending up to two hours in the corridor. There was no medical suction equipment nearby. If they had started to vomit there would have been no suction equipment readily available in order to clear their airway. This situation was unchanged on this inspection.
- Senior nurses told us that a new risk assessment was about to be introduced called the ED 'global risk assessment tool'. They thought that this would help to identify high-risk patients and help to reduce the time that they spent in the corridor. However, no specific date had been agreed for the introduction of this new system. Waterlow skin care assessment scores helped staff to identify those patients who are at high risk of pressure damage and would therefore need to be cared

for on a hospital bed. Senior managers told us this assessment should be completed within four hours of arrival to ED. All staff were aware of the high risk conditions which would require a patient to be cared for on a hospital bed as opposed to a trolley.

- Paediatric early warning scores (PEWS) were used in the department. This was a quick and systematic way of identifying children whose condition was at risk of deteriorating. Once a certain score was reached a clear escalation of treatment was commenced. At our last inspection, a new method of calculating the scores had recently been introduced. No training had been provided and nurses were unsure whether the scores achieved were correct. During this inspection, nurses that we spoke with were confident in the use of PEWS. We looked at five sets of children's records and found that the scores had been calculated correctly and the appropriate action taken.
- As at our previous inspection, adult early warning scores (NEWS) were used for all appropriate patients. Scores were accurately calculated and the correct action taken when indicated.
- There were no paediatricians (children's doctors) in the hospital after 5pm. For this reason, it was intended that the ambulance service would not bring children with severe illnesses or injuries to the ED. However, the guidance given to ambulance crews by the trust was not comprehensive and was sometimes difficult to follow. At our last inspection, we saw children with potentially serious injuries, such as suspected cervical spine fractures, brought to the department. However, in April 2017, there were fewer children brought to the department in error. We did not observe any during the inspection. The hospital ambulance liaison officer that we spoke with said that updated guidance had been given to ambulance crews. They were now advised that only children that they would take to a minor injuries unit should be brought to the department. This was easier to follow and so was more successful.
- At our last inspection, senior ED doctors told us that, if a child needed to be resuscitated, this would be done by doctors from the adult intensive care unit. However, the trust did not provide data to assure us that there was always an intensive care doctor in the hospital with an advanced paediatric life support (APLS) qualification, if a child in ED needed resuscitating.
- In April 2017, the trust sent a document stating that their policy was that all ED consultants and middle grade doctors should hold a current APLS qualification and that they would lead resuscitation of children. We had previously established that one of the consultants and two middle grade doctors did not have a current qualification. In addition, five of the 12 consultant and middle grade doctors were from temporary staffing agencies which made the monitoring of qualifications more difficult. This meant there was a risk that there would be no appropriately qualified doctors on duty if a child needed resuscitating.
- There was little improvement in the numbers of patients who received an initial clinical assessment within 15 minutes. The Royal College of Emergency Medicine and Royal College of Nursing state that all patients should be assessed within 15 minutes in order to determine the severity of their illness or injury and to initiate appropriate treatment. In September 2016, only 77% of patients were assessed in this timeframe and in February 2017 it was 78%.
- The trust provided information regarding the ED's standard operating procedure (SOP) that was introduced in June 2016. This procedure defined the procedures for the triage and early assessment of all patients arriving in the Emergency Department; and the processes for further management through the department. The procedure aimed to facilitated the flow of patients from initial reception through to discharge or admission to a ward as well as to ensure that all patients received care and treatment within an appropriate time. This procedure also gave direction to staff for working as a multi-disciplinary team in collaboration with other departments and the trust's other ED to deliver appropriate care and treatment to patients even when the department was busy.

Nursing staffing

- At our last inspection, we had found that there were not enough nurses to look after the numbers of patients in the department.
- Although there had been some improvement, there were not always enough nurses in the major treatment area or the resuscitation room. Guidance issued by the National Institute for Health and Care Excellence (NICE) indicates that there should be one nurse for four patients in a major treatment area. At the Alexandra hospital, between midnight and 11.30am, each nurse

looked after six or seven patients. There was one nurse to look after three patients in the resuscitation room whereas NICE guidance states that minimum staffing levels should be one nurse for two patients.

- At night, there was no nurse allocated to look after patients in the corridor and so the nurse in charge is the only person available to do this. During the night of our inspection, there were up to six patients in the corridor between midnight and 8am. This meant that the nurse in charge of the department was trying to look after six patients in the corridor, assess new patients arriving by ambulance, and run the department as a whole.

Medical staffing

- The hospital employed one full-time consultant in the ED and obtained three others from a temporary staffing agency. This was not sufficient to provide a consultant presence in the department for 16 hours a day as recommended by the Royal College of Emergency Medicine. The trust had risk assessed the long standing risks posed to the effective operation of the ED by a lack of permanent consultants. The trust stated that approval had been given to recruit additional consultants both this hospital and WRH. An advert had been placed and interviews were planned for September.
- Instead, there were two consultants from 9am to 5pm, with one staying until 7pm. After that time, they were on-call from home. Recently two new consultants had been appointed and were due to start work in September 2017. However, it was not clear whether they would replace two of the locum consultants or would be in addition to them. Although the lead consultant hoped that there would be five consultants working in the department, this had not been confirmed in writing.
- The department had experienced difficulty in recruiting middle grade doctors. Two of the eight doctors were employed by a temporary staffing agency and a further two were temporary doctors from the hospital's staffing bank. Those that we spoke with told us that they had undergone an orientation period and were familiar with local working practices.
- No incidents associated with a shortage of senior doctors had been reported.

Major incident awareness and training

- We did not gather evidence for this as part of the inspection.

Are urgent and emergency services effective?
(for example, treatment is effective)

We have not rated the service for effective. As this was a focused inspection, we did not inspect this key question.

Are urgent and emergency services caring?

We carried out a focused inspection on 11 and 12 April to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found that:

- Staff treated patients with compassion and respect.

Compassionate care

- We saw many examples of patients treated with compassion, dignity and respect.
- Staff spoke in a courteous but friendly manner and worked hard to maintain patients' confidentiality.
- However, when the department was crowded, levels of privacy and dignity were reduced despite staff attempts to respect this.
- When urgent personal care was required staff would temporarily move patients from the corridor area to a cubicle in order that basic privacy and dignity could be preserved.

Understanding and involvement of patients and those close to them

- We did not gather evidence for this as part of the inspection

Emotional support

- We did not gather evidence for this as part of the inspection

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

We carried out a focused inspection on 11 and 12 April to review concerns found during our previous

comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found significant improvements had not been made in these areas:

- The trust had told us that a new 'Full Capacity Protocol' had been developed describing the actions to be taken when the hospital and ED were full. This had not been completed and the trust appeared to take very little action on the many occasions when the ED was full and unable to treat any more patients.
- There remained long delays for patients at every stage of their assessment and treatment. There had been no improvement in the ability to meet the national standard to admit or discharge 95% of patients within four hours. In February and March 2017, this had been achieved for only 80% of patients which was similar to our previous inspection. We observed six patients who spent between eight and 12 hours in the department.
- There was very little privacy and confidentiality for patients waiting on trolleys in the corridor.

We also found other areas of concern:

- The trust had told us that a frailty team was to be implemented in order to improve response for frail patients with complex health needs. This had not happened.

However, we saw some improvements:

- Staff felt that increased availability of ambulatory emergency care had improved some aspects of patient flow through the department.

Service planning and delivery to meet the needs of local people

- Changes had been made to the process of diverting ambulances from the Worcestershire Royal Hospital to the AH ED. Previously; there was no consultation with staff at the AH when this happened. The first staff knew when ambulances were being diverted was when their arrival time was displayed on a computer screen at the staff base. This meant that there was no time to make plans to accommodate additional patients. Now, staff at the AH were asked if they are in a position to receive extra ambulance patients. If the department was already busy, a discussion would take place regarding the diversion process to be followed. For example, two ambulance patients an hour may be diverted or those referred by GPs who could be treated in the ambulatory emergency centre.
- There was a 'Full Capacity Protocol' that defined the actions to be taken throughout the hospital when long delays occurred in the emergency department. This had proved to be ineffective and had not reduced frequent and severe crowding in the department. The trust had told us that a new protocol had been developed but senior ED staff were unaware of this. No consultation had taken place. We asked the trust to send us a copy of the new protocol. The document we received was dated 2015 and so there is doubt that any new policy has been completed.
- A long promised frailty intervention team, aimed at treating frail elderly patients in their own home had still not been implemented. During the inspection, we met an elderly patient who spent 12 hours in the department while various specialist teams tried to decide whether she needed to be admitted to hospital. The patient's needs would have been better met by a frailty intervention team.

Meeting people's individual needs

- When the department was very busy patients arriving by ambulance often had to wait on trolleys in the corridor. Staff told us that this happened several times a week and trust data showed it had happened over several hours on seven different days during March 2017**.**
- Trolleys in corridor had no space between them and there was no room to use screens in order to maintain privacy. Confidential conversations relating to patients clinical care could be overheard. Doctors described having to take blood and taking clinical histories while patients were in the corridor.

Access and flow

- Staff told us that patient flow through the department had improved slightly in recent months. Senior staff thought this might be due to extended opening hours of the ambulatory emergency centre and a reduced number of ambulances being diverted from the Worcestershire Royal Hospital. However, they had not seen any figures confirming this impression.
- During the previous inspection, a pilot study was taking place to evaluate the advantages of an ambulatory emergency centre (AEC). This provided day case medical

care to appropriate patients who present as an emergency and prevented them being admitted to a hospital ward. The pilot study had proved successful and the centre was now open seven days a week from 7am to 7.30pm. Some patients who had been admitted to the acute medical unit overnight would be transferred to the AEC first thing in the morning, thus freeing up space for patients to be admitted from the ED. The AEC charge nurse came to the ED on several occasions during the inspection so that suitable patients could be identified and transferred as quickly as possible.

- Emergency departments in England are expected to ensure that 95% of their patients are admitted, transferred or discharged within four hours of arrival. There had been little improvement in the department's ability to meet this standard. For the year ending November 2016, 82% of patients were admitted or discharged within four hours. This was worse than the England average of 90%. In February 2017, this decreased to 76% and in March 2017 it was 84%.
- There was no agreed method for solving treatment delays caused by differences in opinion between senior doctors in the hospital. During our inspection, we observed two patients who were in the department for more than 10 hours because specialty staff could not agree on treatment actions. One patient with a heart condition was thought to need treatment in the cardiac care unit (CCU). However, the unit would not accept the patient without the approval of the consultant cardiologist, who could not be contacted for several hours. The patient was later seen by an acute medical consultant who also decided that the patient needed treatment in CCU. Again, the consultant cardiologist could not be contacted and so the patient waited in the ED.
- A second patient was referred to surgeons during the night who decided that a CT (computerised tomography) scan was required. Radiographers were concerned about the levels of ionising radiation that the patient would require and so declined to carry out the scan. No senior staff were contacted in order to gain an expert opinion. In the morning, a consultant radiologist also felt that a CT scan was contra-indicated and suggested that a plain X-ray would be better. By this time the surgical team were doing a ward round and ED staff were told that it would be at least another hour before they could complete an X-ray referral form. We spoke to senior ED staff about these episodes as well as the duty bed manager. All confirmed that the hospital did not have an agreed process for escalating such difficulties to a senior clinician who could make a timely decision. We later learnt that the patient spent over 10 hours in the emergency department.
- We observed a further four patients who had spent between eight hours and 12 hours in the department due to delayed responses from specialist doctors as well as a lack of empty beds on a ward.
- Response times from specialist doctors had declined. In 2016, internal monitoring showed that 49% of specialist doctors arrived within an hour when emergency patients were referred to them. In March 2017, it was 46%.
- In March 2017, once a decision to admit a patient had been made, delays in admission had decreased significantly. In February 2017 25% of patients had to wait between four and 12 hours for a bed to become available. This was similar to delays at the end of 2016. However, in March 2017 this had reduced to 9%.[TP1]
- Between February 2016 and January 2017, trustwide data showed that 312 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in January 2017, when 167 patients waited more than 12 hours. This is part of a longer increasing trend covering November and December 2016, when 37 and 84 patients waited more than 12 hours respectively.
- The department's ability to take over the care of patients arriving by ambulance had improved. In November 2016, 40 patients had had to wait for over an hour to be handed over from ambulance crews to ED staff. Although this had increased to 61 patients in January 2017, it had decreased to 11 in February and 8 in March 2017. The percentage of patients waiting more than 30 minutes had decreased from 15% in November 2016 to 9% in March 2017.

Learning from complaints and concerns

- We did not gather evidence for this as part of the inspection

Urgent and emergency services

Are urgent and emergency services well-led?

We carried out a focused inspection on 11 and 12 April to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found significant improvements had not been made in these areas:

- There was significant concern about the lack of effective leadership in the ED and at trust level to tackle the ongoing risks to patient safety.
- There had been no clinical governance or performance management meetings since our last inspection. High levels of clinical activity in the ED meant there was little time for governance and risk management. This meant that senior leaders in the trust were not able to assure themselves that patients were being cared for safely in the ED.
- There was little understanding of the processes for escalating significant risks to divisional or board level. Doubt remained regarding the degree of oversight of ED risks by senior leaders within the trust.

However, we found improvements in some areas:

- The lead consultant and matron were highly visible within the department and led clinical activity. The matron had recently implemented new clinical audits.
- The trust's new chief nurse had met with ED staff and displayed commitment to addressing immediate as well as medium term problems.

Leadership of service

- Local leadership of the emergency department (ED) was trusted and stable: however there was only one substantive consultant in post. The lead consultant and matron were highly visible and led clinical activity of the ED. We were told by a senior doctor that the divisional director for ED across the trust now worked in the department once a week. A general manager was shared with the ED at the Worcestershire Royal (WRH) Hospital but was only able to visit the ED at AH for two or three hours a week.
- High levels of clinical activity in the ED meant there was little time for governance and risk management. There was a continued lack of focus on effective management of risks to patient safety with a lack of effective support from divisional level. A lack of general management activity meant that there was little awareness of performance monitoring or management amongst senior ED staff. Escalation of risk was poorly understood which meant that senior leaders in the trust were not able to assure themselves that patients were being cared for safely in the ED.
- A new chief nurse had recently been appointed at the trust. Within a week of arriving, they had visited the emergency department and talked to staff. A discussion took place with senior staff about action that could be taken by the trust's executive team to improve patient flow, thus reducing the severity of a crowded department.
- As a result improvements had been made to the speed of response by specialty doctors and the process of diverting ambulances from WRH to the AH.

Vision and strategy for this service

- We did not gather evidence for this as part of the inspection.

Governance, risk management and quality measurement

- There had been no improvement in the governance framework required to support good quality care. One of the locum consultants had recently been appointed as clinical governance lead but had not yet taken up their duties in this regard. There had been no formal clinical governance meetings but we were told that clinical governance was an agenda item on monthly ED seniors' meetings. These had not taken place since November 2016 and so there had been no overview of clinical governance in that period. Performance data such as patient waiting times for treatment or admission were not routinely monitored in the department.
- Risks, incidents and complaints were discussed at divisional meetings but these were not attended by staff from the emergency department.
- The department maintained a risk register, which defined the severity and likelihood of risks in the department causing harm to patients or staff. Four risks had a high current risk level. They were associated with an overcrowded department, long delays for patients, ambulance patients waiting in corridors and out-of-hours mental health services. Although the ED

was part of the Division of Medicine, none of these risks appeared on the divisional risk register. It was not clear whether senior managers within the hospital were aware of these risks to patient safety.

- The matron had recently started to carry out web-based clinical audits in order to check the quality of patient records, clinical observations, skin integrity maps and infection control measures. As a result, doctors had been issued with name stamps so that their entries in patient records could be identified more easily.
- A new safety, quality and information dashboard (SQuID) had been introduced two weeks previously. This was aimed at identifying when parts of departmental activity were not meeting quality standards. This new dashboard had been implemented two weeks prior to our inspection and the matron in the ED was unclear about how the information in the dashboard was being used to drive improvements.

Culture within the service

- We did not gather evidence for this as part of the inspection.

Public engagement

- We did not gather evidence for this as part of the inspection.

Staff engagement

- We did not gather evidence for this as part of the inspection.

Innovation, improvement and sustainability

- We did not gather evidence for this as part of the inspection.

Medical care (including older people's care)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The Alexandra Hospital in Redditch opened in 1985. It serves a population of approximately 200,000 and has 136 inpatient beds. The hospital is the major centre for the county's urology service.

The hospital has nine medical care wards including general medicine, gastroenterology, cardiology, respiratory and haematology specialty wards. It also has a medical assessment unit (MAU) with male and female wards, a discharge lounge, and a chemotherapy Suite.

In November 2016, we inspected the hospital and found that medical services at the hospital was inadequate for safe and well-led, requires improvement for effective and responsive and was good for caring. This meant that the medical care services at Alexandra hospital was rated overall inadequate. We carried out this focused inspection to follow up on these concerns identified during our inspection November 2016.

During this inspection, we visited ward 5, 11, 12, and 18, the discharge lounge and the MAU. We spoke with 17 members of staff, including nurses, doctors, pharmacists, and therapists. We spoke with nine patients and relatives. We observed interactions between patients and staff, considered the environment and looked at 29 patient care records. We also reviewed the trust's medical performance data for this hospital.

Summary of findings

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected elements of four of the five key questions but did not rate them. We found significant improvements had not been made in these areas:

- During this inspection, we still observed that most staff did not generally wash their hands before and after patient contact on ward 12 and the medical assessment unit.
- Time critical medicines were not always given when required.
- Venous thromboembolism (VTE) assessments were not carried out on all patients in line with trust and national guidance. Nine out of 29 patient records reviewed lacked an initial VTE assessment.

We also found other areas of concern:

- Only twenty-four per cent of staff were up-to-date on medicines' management training and this was below the trust target of 90%.
- Patient weights were not routinely recorded on drug charts we looked at.
- Patients declining to take prescribed medication were not always escalated to or reviewed by medical staff.
- Doctors prescribed medication but did not always review drug charts to ensure patients were either taking their medication as prescribed or declining to take them. This meant that effective treatment was not provided.

Medical care (including older people's care)

- Patient's medical notes were not stored securely as they were left in unlocked trolleys that could be easily accessed by unauthorised individuals. Visitors to wards could see patient identification details on electronic white boards.
- Staff compliance with Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training was 42%, which was below the trust target of 90%.
- In response to high capacity demands for medical beds, the hospital had converted a surgical ward to a medical ward: however, nurses said they did not always have the required skills to care for medical patients.
- The medical service leadership team had not addressed all issues identified as areas for improvement in our last inspection. This meant that there were still potential risks to the safety and quality of care and treatment of patients' care.

However, we observed improvement for the following:

- Improvements were noted in completed of National Early Warning Score assessment records in the wards visited.
- Staffing levels in the discharge lounge met patients' needs.
- Staff had documented competencies to work in the non-invasive ventilation unit. This was identified as an issue during our inspection in November 2016 and had improved during this inspection.
- The service had taken steps to improve the management of medical patients cared for on non-medical speciality wards with evidence that patients were reviewed regularly by medical doctors.
- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard. This was used as a drive for improvement and had improved staff's understanding of safety and quality in the service.

Are medical care services safe?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found significant improvements had not been made in these areas:

- During this inspection, we still observed that most staff did not generally wash their hands before and after patient contact on ward 12 and the medical assessment unit.
- Time critical medicines were not always given when required.
- Venous thromboembolism (VTE) assessments were not carried out on all patients in line with trust and national guidance. Nine out of 29 patient records reviewed lacked an initial VTE assessment.

We also found other areas of concern:

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- Patient weights were not routinely recorded on drug charts we looked at.
- Patients declining to take prescribed medication were not always escalated to or reviewed by medical staff.
- Doctors prescribed medication but did not always review drug charts to ensure patients were either taking their medication as prescribed or declining to take them. This meant that effective treatment was not provided.
- Patient's medical notes were not stored securely as they were left in unlocked trolleys that could be easily accessed by unauthorised individuals. Visitors to wards could see patient identification details on electronic white boards.
- Not all nurses on ward 18 said they had the medical care skills to look after medical care patients.

However, we found improvements in some areas:

- Improvements were noted in completed of National Early Warning Score assessment records in the wards visited.
- Staffing levels in the discharge lounge met patients' needs.

Incidents

- Staff were aware of their roles and responsibilities in the reporting internally and externally of incidents and near misses.
- In accordance with the Serious Incident Framework 2015, medical care services reported five serious incidents which met the reporting criteria set by NHS England, from March 2016 to February 2017. Slips/trips and falls, pressure ulcers accounted for most of the incidents reported. To help reduce the number of hospital acquired pressure ulcers the trust had implemented an increased training programme, which included improved staff awareness of risks.

Safety thermometer

- We did not gather evidence for this as part of the inspection.

Cleanliness, infection control and hygiene

- During our inspection in November 2016, we saw poor adherence to infection prevention and control practices with doctors not 'arms bare below the elbow', a lack of hand washing and incorrect use of personal protective equipment. In response to this concern, the trust said a task and finish implementation plan had been developed. Key themes from the plan included refreshing the trusts' hand hygiene campaign to raise the focus, re-energising hand hygiene audits and ensuring staff are 'arms bare below the elbows'.
- During this inspection, we still observed that most staff did not generally wash their hands before and after patient contact on ward 12 and the medical assessment unit (MAU) in line with the with the World Health Organisations (WHO) "Guidelines on Hand Hygiene in Health Care' (2009). Although the service had implemented processes to address the poor adherence to infection prevention and control practices, concerns remained regarding poor infection prevention and control practices.
- Adequate hand washing facilities and hand gel were available for use at the entrance to the ward areas, within the wards, at the entrance to bays and side rooms.
- There was prominent signage reminding people of the importance of hand washing at the entrances to wards and within the toilet and bathroom areas.
- Staff were observed wearing personal protective equipment, such as gloves and aprons while delivering care.
- We saw that infection prevention and control information displayed across all clinical areas detailed the correct procedures for hand washing, contact details for the trust's infection control and prevention team and audit results.
- We observed staff adhering to the trust's 'arms bare below the elbow' policy, applying gloves and aprons as required.

Environment and equipment

- We did not gather evidence for this as part of the inspection.

Medicines

- Arrangements were not always in place for the appropriate recording and administration of medicines.
- We identified concerns with administering doses of time critical medicines to patients at the correct time during our inspection in November 2016. In response, the trust said time critical medicines have been audited by pharmacy which identified a significant need for a review of the broader medicine administration processes. Current audits have been halted and the department along with the nursing practice development team are reviewing the process, competencies and supporting procedures. Any incidents that were identified as part of the audit have been logged onto the electronic recording system. During this inspection, we still saw gaps in the administration of time critical medication on ward 12 without explanation. We raised this with nursing staff during our inspection as an urgent concern.
- During our inspection in November 2016, we identified concerns with recording of patient weights on drug charts. We raised this with senior staff following our inspection.
- On this inspection, we found that the recording of patients' weights had not improved. We reviewed 29 drug charts and found that patient weights were not recorded on 12 out of 29 of them. Recording a patients' weight is important as it is often used to calculate the appropriate individual medicine dosage.
- Arrangements were not always in place for the appropriate recording and administration of drugs. We saw that in 26 out of 29 drug charts had the patient's allergy recorded. This was escalated with medical staff on duty.

- Drug charts enabled staff to record details of any omissions and the reason for the omission. During the inspection in November 2016, we found drug charts detailing that patients had missed medicines due to it not being available.
- During this inspection, we saw five drug charts on ward 12 and ward 18 where medication had been missed because they were either unavailable or missed without explanation. We looked at nursing documentation and saw no evidence of actions taken in response to the omissions, or whether patients had received a medical review in relation to missed medication. We raised this with senior staff on duty as an urgent concern.
- We did not see evidence to support that doctors reviewed drug charts to ensure patients were either taking their medication as prescribed or declining to take them. For example, we reviewed the drug chart of a medical patient who had been discharged from ward 11 and saw that they were discharged home on a medication that had been signed as "patient refused" for 10 days prior to discharge. The doctors had not reviewed this and the patient was discharged home on medication they had been refusing to take. We saw another example of a patient who had declined their medication for six days, and this had not been reviewed. This was not in line with the 'Medicines Optimisation Guidance' (2015).
- The doctors' signature and bleep number was not recorded on eight out of 29 drug charts reviewed on ward 12 and the medical assessment unit. This meant that nurses or pharmacists could not identify the prescriber and this was not in line with NICE 'Medicines Optimisation Guidance' (2015).
- We saw that when antibiotics were prescribed, there was no evidence of the length of time the antibiotics should be taken or a review date. This meant that patients could end up taking the antibiotics for a longer period which could lead to antibiotics resistance.
- Trust data showed that 24% of staff across medicines division at Alexandra Hospital were up-to-date with medicines management training which was significantly below the trust target of 90%. Compliance had dropped from 36% to 24% since our last inspection in November 2016. This meant that not all staff had up-to-date knowledge relating to potential risks associated with medicines. The trust responded to actual training figures and stated that this has been raised as an issue to be addressed by the trust.
- Nursing staff we spoke with were aware of medicine policies and relevant assessments, including self-medication. We observed nurses administering and following the required medicines' protocol on Ward 18. This ensured patients received the correct medicines at the correct time.
- Nursing staff wore a red tabard during medicine rounds, which indicated that they should not be disturbed.

Records

- Following the inspection in November 2016, feedback was given to senior managers about safe storage of patients' records and patient identifiable information being shared on ward boards. The trust was asked to improve the safe storage of patient records and address patient identifiable information being shared on ward boards.
- During this inspection, we saw the trust had not taken steps to address issues identified in the November 2016 inspection.
- During this inspection, we found that, notes such as risk assessments and observation charts were by the patient's bedside while medical notes were stored in lockable trolleys at either the nurse's station or the entrance to bays. However, we found that these trolleys were left unlocked in two medical wards (ward 5 and ward 18) meaning that patient confidential records were potentially accessible to unauthorised individuals.
- White electronic boards were used to display patient name and location on the wards, which included some care and treatment information. On most wards, these were visible to staff and visitors, therefore we were not assured that patient confidentiality was maintained. This was raised as a concern with senior staff during our previous inspection in November 2016.
- Patients had paper care records and drug charts. We saw that all records were legible although there was limited details relating to the date of and signatures of individuals for completed risk assessments. This does not comply with guidance from the General Medical Council (Keeping records 2013) guidance on maintaining contemporaneous patient records.
- Patient records on MAU, wards 5, 11, 12 and 18 showed observation charts, National Early Warning Score (NEWS) charts, and intentional rounding charts were

fully completed and up-to-date. Intentional rounding is a structured process where nurses on wards in acute and community hospitals carry out regular checks with individual patients at set intervals.

Safeguarding

- We did not gather evidence for this as part of the inspection.

Mandatory training

- We did not gather evidence for this as part of the inspection.

Assessing and responding to patient risk

- The NEWS system was used for identifying and escalating deteriorating patients. This system alerted nursing staff to escalate patients for review if routine vital signs were abnormal. The trust had determined to use NEWS system in order to identify and escalate deteriorating patients.
- During our inspection in November 2016, we identified concerns with escalating NEWS for deteriorating patients. In response, the trust had introduced competencies relating to accurate NEWS and escalation across clinical areas. NEWS training has been included in the mandatory training and training compliance for registered nurses was 91%.
- During this inspection, all records we looked at showed NEWS were fully recorded and patients were escalated appropriately where they scored NEWS of five or above.
- The trust was monitoring NEWS escalation figures and their own data showed that 50% of patients scoring NEWS above five were referred for a medical review. The trust figures showed escalation of NEWS remained the same as last inspection with no improvement identified despite the introduction of a quality improvement plan. This meant there was a risk of deteriorating patients not being appropriately referred and seen by the medical team.
- During our inspection in November 2016, we identified concerns with carrying out venous thromboembolism (VTE) assessments on admission and reassessment within 24 hours. The service used a VTE and risk of bleeding assessment tool, which should be completed on admission and re-assessed within 24 hours of admission. The trust had been issued with a warning notice in January 2017 to improve on VTE assessments following our findings. In response to our concerns, the trust told us it had established a VTE rapid improvement working group. Actions from the group included, a proposed new VTE assessment form, further education for medical staff, training for ward administrators on data input and increased audit and feedback to senior managers.
- During this inspection, we saw that the service did not always follow the National Institute for Health and Care Excellence (NICE) (QS3 Statement 4) 'Reducing VTE risk in hospital patients' guidelines on all wards. For example, no initial VTE assessments were carried out on 9 out of 29 records on ward 5, 11, 12 and 18. In addition, it was difficult to establish if any patients had been reassessed within 24 hours of admission. This meant we could not be assured that patients had received the relevant assessment to manage their care and patients risk of thrombosis (blood clot) or risk of bleeding could not be determined. The service had not taken appropriate steps to address concerns identified in the November 2016 inspection.
- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard (SQuID). The dashboard was developed to include performance indicators specific to the service. Data from the SQuiD showed that from January 2017 to March 2017, VTE assessment rates for the medicine division (across Worcestershire Acute Hospital, Alexandra Hospital and Kidderminster Hospital and Treatment Centre was 89% which was below the trust target of 100%.
- We saw that seven out of 29 VTE forms had names and signatures, but contained no completed assessment with no boxes ticked to indicate whether the patient was either at risk of thrombosis (blood clot) or at risk of bleeding. Twenty-two VTE forms were completed accurately. This meant that some patients were at risk of not being treated according to their risk.
- During this inspection, we saw that risk assessment templates were not routinely completed in their entirety. This included elderly patient risk assessments and sepsis bundle assessments and where they were completed; there were consistently no dates or signatures.
- The trust had implemented the 'Guidelines for the management of Sepsis and Septic Shock in Adults',inpatient ward and EDsuspected sepsis screening toolsand inpatient ward and ED sepsis patient pathways in September 2016. These were available on

the trust treatment pathways intranet site. The trust was in the process of data collection for quarter one (April to June 2017) for the 2017/18 Sepsis Commissioning for Quality and Innovation (CQUIN) and therefore did have data available to evidence compliance from April2017 at the time of the inspection.

Nursing staffing

- During our unannounced inspection in December 2016, we visited the discharge lounge and raised concerns about staff and patient safety when untrained staff were left alone to care for patients. This was escalated to senior staff during our inspection and was followed by a warning notice. The trust responded that they have developed a risk assessment tool which documents if the allocated registered nurse has to leave the department for a short time and safer staffing is discussed at each bed meeting on both sites and recorded manually. During this inspection, we saw this issue had been addressed and appropriate staffing levels were in place.
- Ward 18 had been changed from a surgical ward to a medical ward in order to increase bed capacity for medical patients. However, the ward was staffed by surgical nurses who said they had not had sufficient training to enable them look after medical patients. There was no admission criteria for this ward at the time of the inspection.

Medical staffing

- We did not gather evidence for this as part of the inspection.

Major incident awareness and training

- We did not gather evidence for this as part of the inspection.

Are medical care services effective?

We carried out a focused inspection in April 2017 to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found that:

- Staff had documented competencies to work in the non-invasive ventilation unit. This was identified as an issue during our inspection in November 2016 and had improved during this inspection.

However, we also found:

- Staff compliance with Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training was 42%, which was below the trust target of 90%.

Evidence-based care and treatment

- We did not gather evidence for this as part of the inspection.

Pain relief

- Analgesia (pain relief) was not always given in a timely manner. For example, a patient had fallen and presented with hip pain, pain relief was given three hours after arrival.

Nutrition and hydration

- We did not gather evidence for this as part of the inspection.

Patient outcomes

- We did not gather evidence for this as part of the inspection.

Competent staff

- During the last inspection in November 2016, nursing staff had received relevant training in the management of non-invasive ventilation (NIV) patients. Ward 5 had a four-bedded bay for high dependency unit patients requiring NIV. NIV refers to the provision of ventilated support through the patient's upper airway using a mask or similar device. The British Thoracic Society (2008) guidance states that "there should be a minimum staffing ratio of one nurse to two NIV patients for at least the first 24 hours of NIV." However, most staff spoken to were unclear about their understanding of what constituted as being an NIV patient. For example, during our visit to the ward, we observed only one patient required NIV support whilst the other three were able to access their airway device as and when required. This was brought to the attention of senior management during our last inspection.
- During this inspection, we saw the policy for NIV and staff had documented competencies to work in the NIV

unit and could clearly articulate the criteria for patient admission into the NIV unit and the criteria for NIV initiation. Level two patients had oversight and support from the trust's critical care team.

Multidisciplinary working

- We did not gather evidence for this as part of the inspection.

Seven-day services

- We did not gather evidence for this as part of the inspection.

Access to information

- Staff reported that they had access to all information required to review patient's conditions and plan safe care and treatment. For example, when patients transferred to other wards, staff gave comprehensive handovers to the receiving nursing staff.
- Discharge letters were sent to GPs with a list of prescribed medication. We saw that patients were sometimes discharged home on medication they had been refusing to take. This meant that GPs were getting incorrect information about the medication patients were taking.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- During the November 2016 inspection, we found that 41% of staff across the medical service had completed their Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. During this inspection, we saw that 42% of staff had completed the MCA/DoLS training and this was below the trust target of 90%.
- Staff understood their responsibilities in relation to gaining consent from patients, including those who lacked mental capacity to consent to their care and treatment. Staff said they would seek advice from a senior member of staff should a formal assessment of mental capacity require completing.
- We observed a patient with mittens on ward 5 and when we asked why they had mittens, staff said they were in place because the patient was hitting staff. A mental capacity assessment and DoLS form had been completed. However, we looked at the patient's record and saw no risk assessment had been carried out and there was no care plan in place to determine how frequently staff should check the covered area. Hand control mittens are a form of restraint and are designed to restrict the movement of one or both hands following a decision made in the patients' best interest. They are used on patients who disrupt their medical treatment and who due to lack of capacity have a recent history of removing essential lines or tubes. We raised this with senior staff on duty who said the mittens would be removed.

Are medical care services caring?

We have not rated the service for caring. As this was a focused inspection, we did not inspect all elements of this key question.

Compassionate care

- Interactions between staff and patients were caring and compassionate.
- We observed staff respecting the privacy and dignity of patients during our inspection.

Understanding and involvement of patients and those close to them

- We did not gather evidence for this as part of the inspection.

Emotional support

- We did not gather evidence for this as part of the inspection.

Are medical care services responsive?

We carried out a focused inspection in April 2017 to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found significant improvements had not been made in these areas:

- In response to high capacity demands for medical beds, the hospital had converted a surgical ward to a medical ward.

However, we found improvements in some areas:

Medical care (including older people's care)

- The service had taken steps to improve the management of medical patients cared for on non-medical specialty wards with evidence that patients were reviewed regularly by medical doctors.

Service planning and delivery to meet the needs of local people

- We did not gather evidence for this as part of the inspection.

Access and flow

- Our last inspection in November 2016 identified issues with high demand for medical beds and medical patients were moved to non-medical speciality wards.
- The trust was not collecting separate data for the number of bed moves due to clinical reasons and non-clinical reasons (for example, to alleviate bed capacity issues) but was planning to do so.
- During this inspection, we saw that ward 18 had been changed from a surgical ward to a medical ward in order to increase bed capacity for medical patients. This had improved flow of medical patients through the trust.

Meeting people's individual needs

- Medical patients on surgical wards were routinely reviewed by medical doctors. We saw evidence that where they were unwell and escalated to medical staff by nurses, they were reviewed in a timely manner.
- Medical outliers are patients who require medical care rather than surgical care but because there are no beds on a medical ward, have to be cared for on a surgical ward. However, staff on ward 11 (surgical ward) told us they still had many medical outliers on most days. There were nine on the ward during our inspection and staff told us there had been 14 in the previous week.

Learning from complaints and concerns

We did not gather evidence for this as part of the inspection.

Are medical care services well-led?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found that:

- The medical service leadership team had not addressed all issues identified as areas for improvement in our last inspection. This meant that there were still potential risks to the safety and quality of care and treatment of patients' care.
- Leaders had not taken sufficient actions to minimise all patient safety risks.

However, we found improvements in some areas:

- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard. The dashboard was developed to include performance indicators specific to the service. This was used as a drive for improvement and had improved staff's understanding of safety and quality in the service.

Leadership of service

- Divisional medical directors, a director of operations, clinical directors, a divisional director of nursing, medical governance lead and a quality governance lead led the medical care directorate. Nursing staff reported that clinical leads within specialities were visible and easily accessible.
- During this inspection, we found that the leaders did not always respond and act upon known concerns. For example, during our last inspection in November 2016, we identified issues with lack of oversight for venous thromboembolism (VTE) assessment. During this inspection, we still found poor practice in these areas. This meant that concerns raised at the previous inspection had not been addressed appropriately.
- Leaders had not taken sufficient actions to minimise all patient safety risks.

Vision and strategy for this service

- We did not gather evidence for this as part of the inspection.

Governance, risk management and quality measurement.

- During our last inspection, we identified issues with poor escalation of the National Early Warning Scores (NEWS), poor assessment and reassessment of VTE after 24 hours and insufficient recording of patient weights on drug charts. The trust told us that audit processes for

NEWS have been supplemented by weekly notes audits which also review NEWS compliance and had launched a web based assurance system to highlight performance around quality and safety.

- During this inspection, we still found poor practice in some of these areas. This meant that whilst some improvement had been made, overall, there was insufficient oversight and management of risks to patient safety.
- During this inspection we noted that the trust had implemented a new quality dashboard, known as the safety and quality information dashboard (SQuID). Staff we spoke with were aware of SQuID and demonstrated how to access the dashboard on the trust intranet. However, despite the introduction of this quality dashboard, some issues identified had shown no improvement and there was insufficient oversight and management of these risks. For example, there was lack of oversight VTE assessments, recording of patient weights on drug charts and inconsistent compliance with hand hygiene. This demonstrated that the service's governance system in relation to the management of VTE risk and hand hygiene did not operate effectively to ensure that senior leaders effectively managed the risk of harm to patients.
- The quality improvement plan for April 2017 identified that NEWS and VTE assessments had been added to the risk register.
- The trust had a divisional framework for governance arrangements in medical care services. During the last inspection, sharing of information was not established at ward level. During this inspection, this had improved in some areas and ward managers attended divisional meetings. There was evidence of ownership and improvement at ward level.

Culture within the service

- We did not gather evidence for this as part of the inspection.

Public engagement

- We did not gather evidence for this as part of the inspection.

Staff engagement

- We did not gather evidence for this as part of the inspection.

Innovation, improvement and sustainability

- We did not gather evidence for this as part of the inspection.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Surgery services provided by Worcestershire Acute Hospitals NHS trust are located on four hospital sites. Worcestershire Royal Hospital is the main site with Alexandra Hospital, Kidderminster Hospital and Treatment Centre and Evesham Community Hospital as additional sites. The trust provides services to a resident population of 550,000 people in Worcestershire.

Worcestershire Royal Hospital, Alexandra Hospital and Kidderminster Hospital and Treatment Centre were visited as part of the inspection process and each location has a separate report. Surgery services on all four hospital sites are run by one management team and are regarded by the trust as one service.

This report relates to surgery services provided at Alexandra Hospital which provides planned (elective) and emergency surgery and consists of six surgical wards (wards 10, 11, 14, 16, 17, 18), a day unit and seven theatres. There are 146 surgical inpatient beds. The day unit, which has 10 beds, provides surgical care for patients who are admitted and discharged on the same day as their operation. Surgical specialities include general surgery, orthopaedics, trauma care, ear nose and throat (ENT) and urology. In addition, there is a six bedded surgical decision unit open from Monday to Friday between 7am and 9.30pm.

From April 2015 to March 2016, there were 15,014 surgical admissions, 45% of these were day surgery, 20% were elective surgery and 35% were admitted for emergency surgery.

This was a Care Quality Commission focussed follow up inspection. We carried this out because of concerns identified during our inspection of Worcestershire Acute Hospitals NHS Trust in November 2016. During that inspection, we found surgical services at the trust overall, to be requires improvement. At Alexandra Hospital, surgical services were inadequate.

We visited all surgical wards as part of this focused inspection but we did not visit the operating theatres. We spoke with 21 staff including, nurses, health care assistants, doctors, and therapists. We spoke with 10 patients and reviewed 36 sets of patient notes.

Surgery

Summary of findings

We carried out this focused inspection on 11 and 12 April 2017. We inspected three of the five Care Quality Commission key questions but we did not rate them. This was a focused inspection to review concerns found during our previous comprehensive inspection in November 2016 and therefore we did not inspect every aspect of each key question. We found significant improvements had not been made in these areas:

- Venous thromboembolism (VTE) risk assessments were not completed in line with national guidance.
- Medications were not administered as prescribed.
- Medications were stored in temperatures above manufactures recommended guidelines.
- Some staff were not compliant with infection control precautions including hand hygiene and appropriate use of personal protective equipment.

We also found other areas of concern:

- Patient details were visible to all staff and visitors on the ward.
- All wards displayed the actual number of staff on duty. However, some surgical wards did not display the planned number of staff and therefore patients and visitors could not identify any staff shortages.
- Less than 20% of nursing and medical staff had received training in Mental Capacity Act 2005 and Deprivation of Liberty.
- Senior leaders were aware of the trust's failure to follow national guidance in relation to VTE and compliance with hand hygiene. However, we saw examples throughout surgery where national guidance had not been followed.
- When risks had been escalated, there was a lack of follow up and resolution. For example, medications were stored in fridges at higher temperatures than recommended by medicine manufactures and clinical staff had escalated this to managers. However, clinical staff were unable to identify any action taken to reduce the risks of patients receiving medication stored in these fridges.

However, we found improvements in some areas:

- All staff had 'arms bare below the elbows' in clinical areas.
- Adequate staffing levels were observed on all wards during our inspection. Staff explained their new staffing application (an electronic tool which measured how many staff were on duty against how many should have been on duty), which helped escalate any shortages rapidly.
- We saw fewer medical outliers on most surgical wards. However, one surgical ward had nine medical outliers at the time of our inspection.
- Patients undergoing surgery had the correct consent form.
- Patients who lacked capacity had evidence of a mental capacity assessment.
- The trust had implemented a new quality dashboard. The dashboard provided monthly quality data for all wards and clinical areas.

Surgery

Are surgery services safe?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found significant improvements had not been made in these areas:

- Venous thromboembolism risk assessments were not completed in line with the trusts own, or national guidance.
- Some staff did not clean their hands before or after patient contact and some staff wore personal protective equipment inappropriately.
- Fridge temperatures for the storage of medications exceeded recommended ranges.

We also found other areas of concern:

- Visitors to wards could see patient identification details on electronic white boards.
- Anticoagulation medications had not always been administered as prescribed.
- Some patients were prescribed inappropriate doses of anticoagulation medication without regard to their weight.
- Some wards did not display their planned staff on duty only their actual staff on duty.

However, we found improvements in some areas:

- All staff we saw in clinical areas had 'arms bare below elbows'.
- There were fewer reported staff shortages and shortfalls were escalated and risk assessed.

Incidents

- We did not gather evidence for this as part of the inspection.

Safety thermometer

- We did not gather evidence for this as part of the inspection.

Cleanliness, infection control and hygiene

- During our inspection in November 2016 we reported some clinical staff were not 'arms bare below elbows'. During this inspection, we saw that this had improved and all staff had short sleeves and no wristwatches in the clinical areas.
- During our inspection in November 2016, we reported some staff did not always follow the trust's infection prevention and control policy with regard to hand hygiene and the use of personal protective equipment (PPE). This remained the same during this inspection. We saw some staff failed to clean their hands prior to contact with patients and their environment. For example, a nurse disconnected a patient from their oxygen tubing and did not clean their hands before or after and a group of therapy staff assisted a patient to their walking frame without cleaning their hands afterwards. We saw a health care assistant wipe up liquid outside of a toilet wearing an apron and no gloves and then return to the patient without cleaning their hands. We also saw staff using PPE inappropriately and this included a doctor/anaesthetist reviewing patient notes and meeting a patient on the ward while wearing their theatre cap and staff wearing the same pair of gloves and aprons while carrying out multiple tasks.
- Hand hygiene was brought to the attention of senior staff during our previous inspection in November 2016 and after, in January 2017, when we issued the trust with a warning notice to improve. The trust acknowledged it was not consistently meeting its own hand hygiene targets of 95% compliance and told us it had taken measures to improve. The trust provided us with an action plan to address this issue and this included further hand hygiene education and weekly audits plus spot checks by the infection prevention team. We saw evidence that hand hygiene audits had been carried out. In surgery, most of the trust's own audits indicated staff cleaned their hands 100% of the time.
- Hand hygiene training was carried out regularly. In trustwide data for surgical services, 87% of staff were up-to-date with their hand hygiene training which was slightly below the trust target of 90%.

Environment and equipment

- We did not gather evidence for this as part of the inspection.

Medicines

- During our inspection in November 2016, we found medicines that required refrigeration were not always kept at the correct temperature and that some wards failed to record fridge temperatures every day. This was brought to the attention of senior staff during our

previous inspection in November 2016 and in January 2017 when we issued the trust with a warning notice to improve. The trust acknowledged it did not have proper oversight of fridge temperature monitoring and it undertook several measures to improve. This included reviewing and assessing all medication fridges, staff training, introducing a new temperature recording chart and audits which would be reviewed by the medicines optimisation group.

- During this inspection, temperatures were recorded on most days. However, five out of seven wards recorded medication fridge temperatures which exceeded the maximum of 8°C. For example, on ward 17, fridge temperatures were recorded at 10°C or above for 13 days in March 2017 and six days out of 10 in April 2017. On 30th March 2017, the recorded maximum temperature was 16°C. Staff documented that they had escalated the issue to estates and pharmacy. However, staff were unable to tell us of any actions taken to ensure the medications in the fridge remained safe to use. The storage of medications outside manufactures recommended temperature ranges had not resulted in any reported incidents.
- Prescribed anticoagulation medication was not always recorded as being administered in line with the patient's prescription. We saw that 10 doses of anticoagulation medication had not been signed for out of the 36 medication administration records (MAR) we checked. This affected six different patients and included two patients who had missed doses recorded on sequential days. In addition, we saw that two MAR had non administration codes recorded as 'patient refused', for patients known to have dementia. From December 2016 to March 2017, the service reported nine incidents of non-signed for anticoagulation therapy including one which resulted in minor harm due to a cancelled operation.
- Some patients were prescribed anticoagulation medication without reference to their weight and therefore some patients may have received more or less medication than required. Four out of 36 drug charts had changes recorded by pharmacy due to a patient weighing less than 50kg. One patient who had a recorded weight of 39kgs was prescribed 40mg of anticoagulation therapy. This did not follow the trust prescribing guidelines, which required dose related therapy at extremes of body weight. The dose was later reduced to 20 mg upon review by pharmacy staff. Prescribed doses of some anticoagulation medication had been changed on the drug chart without the prescription being crossed out and rewritten. It was unclear by who or when changes to the prescriptions had been made. It was unclear from the drug chart if any doses of medication had been administered at the incorrect dose.
- The majority of medication charts did not include a patient weight.

Records

- During our last inspection we saw white electronic boards were used to display patient name and location on the wards, which included some care and treatment information. These were visible to staff and visitors to the ward, therefore we were not assured that patient confidentiality was maintained. This remained the same on this inspection and was raised as a concern with senior staff during our inspection in November 2016 and in January 2017. The trust did not provide us with an update or an action plan regarding this.

Safeguarding

- We did not gather evidence for this as part of the inspection.

Mandatory training

- We did not gather evidence for this as part of the inspection.

Assessing and responding to patient risk

- The service was not always assessing and responding to risk in line with national guidance. For example, we saw that the National Institute for Health and Care Excellence guidelines (NICE): 'venous thromboembolism (VTE): reducing the risk for patients in hospital' (2015) was not being followed. This was raised with senior staff following our inspection in November 2016 and after, in January 2017, when we issued the trust with a warning notice to improve. In response to our concerns, the trust told us it had established a VTE rapid improvement working group. Actions from the group included, a proposed new VTE assessment form, further education for medical staff, training for ward administrators on data input and increased audit and feedback to senior managers. A review of funding was also scheduled recruit specialist VTE nursing staff. However, despite

these measures, the issues remained. The service's own audit data showed a compliance of 85% for an initial VTE assessment. Reassessments within 24hours of admission were not audited.

- We reviewed 36 patient records across the surgical wards and found all patient notes contained a VTE risk assessment. However, four assessment charts were left blank with no selection boxes ticked other than a date and the doctors' initials and a further four VTE assessments had been undertaken more than 48 hours after the patient had been admitted. One patient had their VTE assessment done in the outpatient clinic, six days prior to their admission. One VTE assessment had requested TEDS only (tight stockings which improve the blood flow in patients who are unable to move regularly), but pharmalogical anticoagulation therapy had been prescribed and administered. VTE reassessments following 24 hours of hospital admission were not done in 35 out of 36 records reviewed. Therefore, although patients had a VTE assessment, these were not always done in line with national guidance and the trust's own VTE policy. We also found that patients had been prescribed and given medication to prevent VTEs, and there was no evidence that a risk assessment had been carried out. This meant some patients may have received medication which was unsuitable for them. The trust reported 13 incidents relating to the administration of anticoagulation therapy.
- A National Early Warning Score (NEWS) was used to identify sick patients. This was in line with the NICE guidelines, CG50, Acute illness, recognising and responding to the deteriorating patient.
- During our inspection in November 2016, we reported that surgery services were escalating NEWS appropriately. During this inspection we saw this mostly remained the same. However we found one patient had a NEWS of six recorded without any escalation in place. The NEWS scale runs from 0 to10 and a NEWS of six means the patient is deteriorating and will usually require increased observation. No entries had been made in the patient's notes and no further observations were recorded for five hours when a second NEWS of six was recorded by the outreach team. A third NEWS was recorded four hours later when it had reduced to three. This patient's' observations were not recorded in line with the trust's escalation guidance. We reviewed the patient's medical notes and saw a documented record of the outreach team assessment. However, this had not been verbally communicated with ward staff who told us they were unaware of any plans for the patient. Additionally, staff had not documented a sepsis risk assessment or used one of the trusts 'think sepsis' stickers. This was raised with staff looking after the patient during our inspection and they ensured the patient remained safe.

Nursing staffing

- Nursing staff numbers, skill mix review and workforce indicators such as sickness and staff turnover were assessed using an electronic rostering tool. The surgical directorate used an acuity tool, dependency reviews, NICE guidelines and professional judgement to assess and plan staffing requirements.
- Vacancy rates in surgical services at the Alexandra Hospital in March 2017 were 11%. This had increased from January 2017 when it was 6%.The nurse vacancy rate remained documented on the surgical risk register and actions to improve staffing which were reported to us during our November 2016 inspection to address this continued. This included the use of bank and agency staff and monthly reviews of recruitment. Since our last inspection, a new staffing application (an electronic tool which measured how many staff were on duty against how many should have been on duty), had been introduced. This helped risk assess areas identified as having staff shortages on a daily basis and escalated shortages to senior managers responsible for the hospital and prompted incident reports where low staff numbers could put patients at risk.
- In March 2017, there were 380 unfilled nurse shifts and 345 unfilled healthcare assistant shifts in the surgical services at this hospital. This is considerably worse than our last visit when the service reported that from May 2016 to October 2016, there were 133 unfilled nurse shifts and 79 unfilled health care assistant shifts. Despite the number of unfilled shifts, and the new staffing application, the service reported no incidents due to staff shortages between January and March 2017.
- The number of actual staff on duty each shift was displayed on all wards except the surgical decision unit (SDU). We were told this was due to the manager being absent. Additionally, planned staffing numbers were not displayed on ward 10, although the number of actual

staff on duty was displayed. Displaying both planned and actual staff allows patients and visitors to identify when there are staff shortages and it demonstrates greater transparency.

- During our visit, there were adequate staff on duty to meet the needs of the patients they were looking after. Wards that displayed both planned and actual staff numbers did have the appropriate number of nurses on duty most of the time. Any shortages identified had gone out to agency or the shift coordinator changed duty to work clinically and provide assistance with patient care.
- In March 2017, the sickness rate was 3% for registered nursing staff in surgical services at Alexandra Hospital. This was better than the trust target of 3.5% and better than during our previous inspection when in September 2016, it was 4%. However, in March 2017, the average sickness rate for unregistered staff was 12%.

Surgical staffing

- We did not gather evidence for this as part of the inspection.

Major incident awareness and training

- We did not gather evidence for this as part of the inspection.

Are surgery services effective?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected one part of this key question but did not rate it. We found that:

- Patients undergoing surgery had the correct consent form.
- Patients who lacked capacity had evidence of a mental capacity assessment.

However, we found areas of concern:

- Less than 20% of nursing and surgical staff had received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, some staff we spoke with were able to describe elements of the MCA and DoLS.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- Staff we spoke with understood consent, decision-making requirements, and guidance. There was an up to date consent policy for surgical treatment.
- The hospital had four nationally recognised consent forms in use and staff were able to describe the different uses for these. For example, staff described what would be required for patients who were unable to consent to surgery themselves.
- There was a trust policy to ensure staff were able to meet their responsibilities under the MCA and DoLS. Staff we spoke with were able to describe elements of the MCA and DoLS and understood their responsibilities for protecting patients. Most staff had not received training in MCA and DoLS but all were aware of their need to attend the training and some told us of training dates they had planned or booked.
- Patients who required a mental capacity assessment or a dementia screen received this in line with the trust policy. Dementia screens are simple tools which can help staff identify patients who may have dementia.
- Junior nursing staff told us they would contact senior nurses for help if they were required to make an application for a DoLS for a patient.
- All patients we reviewed were consented for surgery using the correct form. We found examples where the correct consent form had been used for a patient who lacked capacity.
- From April 2016 to March 2017 in surgery services at Alexandra Hospital, 16% of surgical staff and 19% of nursing staff had received training in MCA and DoLS level one.

Are surgery services caring?

We have not rated the service for caring. As this was a focused inspection, we did not inspect all elements of this key question.

Compassionate care

- Interactions between staff and patients were caring and compassionate.
- We observed staff respecting the privacy and dignity of patients during our inspection.

Understanding and involvement of patients and those close to them

- We did not gather evidence for this as part of the inspection.

Emotional support

- We did not gather evidence for this as part of the inspection.

Are surgery services responsive?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found that:

- Most surgical wards reported having more beds available, due to fewer medical patient outliers.

Service planning and delivery to meet the needs of local people

- We did not gather evidence for this as part of the inspection.

Access and flow

- During our inspection in November 2016, there was a high demand for medical beds and this affected surgical bed capacity and resulted in cancelled operations.
- During this inspection, we saw most surgical wards had few or no medical outliers. However, ward 11 staff told us they still had many medical outliers on most days and said this impacted on their ability to plan for elective surgical patients. The trust was only carrying out urgent and life limiting surgery at the hospital at the time of the inspection.

Meeting people's individual needs

- We did not gather evidence for this as part of the inspection.

Learning from complaints and concerns

- We did not gather evidence for this as part of the inspection.

Are surgery services well-led?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found that:

- Senior leaders were aware of the trust's failure to follow national guidance in relation to venous thromboembolism risk assessments and compliance with hand hygiene. However, we saw examples throughout surgery where national guidance had not been followed.
- When risks had been escalated, there was a lack of follow up and resolution. For example, medications were stored in fridges at higher temperatures than recommended by medicine manufactures and clinical staff had escalated this to managers. However, clinical staff were unable to identify any action taken to reduce the risks of patients receiving medication stored in these fridges.

However, we found improvements in some areas:

- The trust had implemented a new quality dashboard. The dashboard provided monthly quality data for all wards and clinical areas.

Leadership of service

- The surgical division was led by a divisional director, a divisional manager and a director of nursing who led the surgical services care division. Senior leaders were aware of the trust's failure to follow national guidance in relation to venous thromboembolism risk assessments and compliance with hand hygiene. However, we saw examples throughout surgery where national guidance had not been followed. This meant senior leaders had not driven the improvements required in the service to address the concerns we identified on the last inspection.

Vision and strategy for this service

- We did not gather evidence for this as part of the inspection.

Governance, risk management and quality measurement

- The trust had a divisional framework for governance arrangements in surgical services. During the last inspection, sharing of information was not established at ward level. During this inspection, we were told this had improved in some areas and ward managers attended divisional meetings. The service had developed a quality dashboard which contained audit data for each ward and clinical area and included data on staffing, falls, hand hygiene compliance and venous

thromboembolism (VTE) assessments plus other metrics. Ward sisters accessed the dashboard and demonstrated how it worked. However, despite the quality dashboard, some issues remained and there was a lack of consistent follow-up and improvement when issues were identified. For example, VTE assessments were not been done in line with trust policy, and there was inconsistent compliance with hand hygiene. This demonstrated that the trust's governance system in relation to the management of VTE risk and hand hygiene did not operate effectively to ensure that senior leaders effectively managed the risk of harm to patients.

- Similarly, robust action following the reporting of high fridge temperatures was not evident. Staff demonstrated they had reported high temperatures but were unable to tell us if any action had been taken to ensure the medications within the fridge remained safe to use. This shows that there are not effective processes in place to ensure that the trust policy on medicines management was being adhered to, and this had not been recognised as a risk.

Maternity and gynaecology

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

Information about the service

Worcestershire Acute Hospitals NHS Trust provides maternity and gynaecology services to women living in Worcestershire, surrounding counties and further afield, including Herefordshire, Dudley, South Staffordshire, Shropshire, Warwickshire and Birmingham. Since 5 November 2015, inpatient maternity services have solely been provided at Worcestershire Royal Hospital. Outpatient maternity services are also provided at Alexandra Hospital (Redditch) and Kidderminster Hospital and Treatment Centre. Inpatient gynaecology services are provided at Worcestershire Royal Hospital and Alexandra Hospital. Outpatient gynaecology services are provided at these three sites.

The maternity and gynaecology service is under the women and children division. The current leadership structure includes a divisional medical director, divisional director of nursing and midwifery, divisional director of operations and divisional governance and quality lead. A clinical director and medical governance lead for obstetrics and gynaecology, and matrons support this team.

The Alexandra Hospital serves a population of approximately 200,000 people in Redditch and surrounding areas. Outpatient maternity services are provided at the hospital site, and in conjunction with community services and GP practices. Antenatal outpatient clinics are situated within the main outpatient department, which is located on the ground floor. Consultant and midwifery led clinics are held from Monday to Friday, 8.30am to 4.30pm. Phlebotomy and ultrasound scanning services are available during these clinics. The hospital also has a maternity day assessment unit, which is situated on the first floor next to ward 15. The unit is open Monday to Friday, 8.30am to 5pm.

There is no dedicated gynaecology inpatient ward at Alexandra Hospital. Two designated gynaecology beds are situated on ward 14, a female ward, which specialises predominantly in trauma and orthopaedic surgery. Gynaecology patients who require day case surgery, such as diagnostic laparoscopy and laparoscopic sterilisation, are cared for on Birch ward. This is a 10-bedded surgical day case unit, for patients admitted and discharged on the same day as their operation. The hospital also has an early pregnancy assessment unit. The hospital provides outpatient clinics and services, which includes urogynaecology, fertility, hysteroscopy, colposcopy, endometriosis and pelvic pain service, and gynaecological oncology. These are situated within the main outpatient department and Elias Jones unit.

Worcestershire Acute Hospitals NHS Trust provides a termination of pregnancy service for fetal abnormality only.

The trust reported 5,426 births between October 2015 and September 2016. Of these births, 61% were normal (non-assisted) deliveries, which is slightly higher than the England average (60%). Additionally, 15% were elective caesarean deliveries, which is higher than the England average (12%), and 13% were emergency caesarean section deliveries, which is lower than the England average (15%).

In November 2016, the Care Quality Commission (CQC) inspected maternity and gynaecology services at Alexandra Hospital, as part of our comprehensive inspection of Worcestershire Acute Hospitals NHS Trust. We found the service was requires improvement for safe, effective and well-led, and good for caring and responsiveness. Overall, we rated the service as requires improvement. The trust were required to complete a number of actions to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Maternity and gynaecology

We carried out a focused inspection on 11 and 12 April 2017 to review concerns found during our previous comprehensive inspection in November 2016. During this inspection, we visited clinical areas within the service including ward 14, Birch ward, the maternity assessment unit, early pregnancy assessment unit, Elias Jones unit, and outpatient antenatal clinics. We spoke with 14 members of staff. We observed the environment and infection prevention and control practices, and reviewed other supporting information provided by the trust.

Summary of findings

We carried out a focused inspection to review concerns found during our previous comprehensive inspection on 22 to 25 November 2016. We inspected parts of the five key questions but did not rate them. We found significant improvements had not been made in these areas:

- Despite assurances from the trust, we saw no evidence that obstetrics and gynaecology mortality and morbidity reviews were held. Furthermore, whilst the countywide perinatal mortality and morbidity meetings were minuted, we were not assured that action was taken to address any learning identified from case reviews.
- The trust had monitoring systems in place to ensure medicines were stored within recommended temperature ranges. However, these were not consistently followed across the service.

We also found other areas of concern:

- Some surgical nursing staff, who cared for gynaecology patients on the designated wards, had not received any specific gynaecology training, such as management of surgical miscarriage and bereavement care. However, the gynaecology medical team were available for advice as needed.

However, we found improvements in some areas:

- All clinical areas we visited were clean and there was good adherence to infection control policies and the use of personal protective equipment.
- There had been an improvement in compliance with safeguarding children level three training. Staff demonstrated awareness of safeguarding guidance, including female genital mutilation. Staff understood their responsibilities and were confident to raise concerns. However, training compliance was still below the trust target.
- Equipment was clean, maintained and serviced to ensure it was safe for patient use.
- Compliance with Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training had

improved. Staff demonstrated awareness of relevant consent and decision making requirements relating to MCA and DoLS, and understood their responsibilities to ensure patients were protected.

Are maternity and gynaecology services safe?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found significant improvements had not been made in these areas:

- Although perinatal mortality and morbidity meetings were minuted, there was no evidence that action was taken to address learning from case reviews.
- Staff did not consistently follow trust processes for ensuring medicines were stored at the recommended temperature, despite there being policies in place.
- There was no system in place to ensure medicines stored in the antenatal clinic were safe for patient use. Immediate action was taken by the trust once we raised this as a concern.

However, we found improvements in some areas:

- Standards of cleanliness and hygiene were well maintained. Staff adhered to infection control and prevention guidance.
- Equipment was well maintained and had been safety tested to ensure it was fit for purpose.
- Staff understood their roles and responsibilities in the safeguarding of adults and children from abuse, harm and neglect. The number of staff who had completed safeguarding children level three training had improved. However, compliance was still below the trust target, particularly with medical staff.

Incidents

- During our comprehensive inspection in November 2016, we found staff understood their responsibilities to raise concerns and felt confident in doing so. Lessons were learned from incidents and action was taken to improve safety within the service. However, we also found perinatal mortality and morbidity meetings were not formally minuted and any learning, including actions taken to prevent and/or minimise reoccurrence, were not clearly recorded. Furthermore, when actions were identified, no timescales for completion were documented, nor was it evident which member of staff was responsible for ensuring actions were completed. This meant we were not assured there was a robust

system in place to ensure learning from perinatal mortality and morbidity meetings was shared and actions were addressed. We also reported that the service did not hold morbidity meetings within maternity and gynaecology. We were told that plans were in place for these to be introduced in 2017. National bodies, such as the Royal College of Obstetricians and Gynaecologists (RCOG), recommend that maternity care providers hold regular multidisciplinary team meetings to review perinatal and maternal mortality and morbidity, so that patient safety and quality of care is improved.

- In response to concerns found during our previous inspection, a quality improvement plan (QIP) had been developed by the trust to ensure countywide mortality and morbidity meetings were standardised, actions were taken and lessons learnt were shared. However, we found that this had not been applied consistently across the maternity and gynaecology service.
- The trust provided a schedule for countywide perinatal, obstetrics and gynaecology mortality and morbidity meetings for 2017; nine perinatal, 11 obstetrics and 11 gynaecology mortality and morbidity meetings had been scheduled for 2017. The obstetrics and gynaecology mortality and morbidity meetings were not held separately, but were included as a standing agenda item within monthly governance meetings.
- We saw that the monthly gynaecology clinical governance meetings included mortality and morbidity as a standing agenda item. We reviewed three sets of minutes for meetings held in January, February and March 2017. However, we saw no evidence that mortality and morbidity reviews were discussed. Nor any evidence that any learning and improvement actions from mortality and morbidity reviews were identified. The minutes for the gynaecology clinical governance meeting held in February 2017 stated that this item was to be removed from the agenda. No explanation for this was provided.
- Similarly, we reviewed four sets of minutes for divisional governance meetings held in January, February and March 2017 and found no evidence that maternal mortality and morbidity reviews were discussed. This may have been due to the fact that maternal mortality is rare. The minutes we reviewed showed only issues relevant to perinatal mortality and morbidity were discussed, such as the child death overview panel report 2015/16. Therefore, we could not be assured that obstetrics and gynaecology mortality and morbidity reviews were held. We reported this as a concern.
- We requested the minutes of perinatal mortality and morbidity meetings held in January, February and March 2017, as per the trust's schedule, but were only provided with minutes for February and March. Therefore, we were unable to determine whether the January meeting was held.
- In response to our concerns regarding the lack of formal minutes for perinatal mortality and morbidity meetings, since our previous inspection a member of the governance team had been employed to take the minutes. The meeting minutes for February and March 2017 included a list of attendees and their designation. This was an improvement from our previous inspection. The meetings were attended by members of the multidisciplinary team, including consultants, junior doctors, midwives, and student midwives. Case histories and learning points were documented. However, there was no evidence that any actions were taken as a result of learning points identified. Nor was it evident which member of staff was responsible for ensuring actions were completed, or how any learning would be shared within the division. Therefore, we were not assured a robust system was in place to ensure learning from perinatal mortality and morbidity meetings was shared, and actions were taken to improve the safety and quality of patient care. We reported this as a concern following our previous comprehensive inspection.
- The divisional director of nursing and midwifery told us the service was in the process of introducing the standardised clinical outcome review (SCOR), developed by the Perinatal Institute. SCOR would be used to review all perinatal deaths over 22 week's gestation, in line with national recommendations (MBRRACE). SCOR is a software tool, designed to facilitate the comprehensive review of perinatal deaths. It includes the identification of substandard care factors and system failures, and prompts an action plan to help implement multidisciplinary learning. We were told SCOR was expected to be in use by mid-May 2017.

Safety thermometer

- We did not gather evidence for this as part of the inspection.

Maternity and gynaecology

Cleanliness, infection control and hygiene

- For gynaecology inpatient services, please see surgery section of the report.
- During our previous comprehensive inspection, we observed poor adherence to infection prevention and control practices, including a lack of hand washing and the incorrect use of personal protective equipment.
- In response to concerns found during our previous inspection, the trust's quality improvement plan (QIP) included actions to address poor adherence to infection prevention and control practices, such as refreshing the hand hygiene campaign, staff training, and regular auditing of hand hygiene compliance. The chief nursing officer oversaw the improvement plan. A total of nine actions had been developed and according to the QIP dated 6 March 2017, the trust were 'on track' to complete all actions by the date specified.
- During our focused inspection, we found there were reliable systems in place within the service to protect people from a healthcare-associated infection, such as hand washing and correct use of personal protective equipment (PPE).
- The service participated in monthly hand hygiene and arms bare below the elbow audits, in line with the trust's infection prevention programme. From December 2016 to March 2017, hand hygiene and arms bare below the elbow compliance for antenatal clinic averaged 100% and 100% respectively. For December 2016, compliance with hand hygiene on the Elias Jones unit was 50%. This was because one doctor did not wash their hands. We saw evidence from meeting minutes that action was taken to address issues with hand hygiene, such as the provision of additional training. Compliance with hand hygiene on the Elias Jones unit for February and March 2017 was 100%. Compliance with arms bare below the elbow audits was 100% for December 2016 to March 2017.
- We observed clinical staff adhered to the trusts 'arms bare below the elbow' policy to enable effective hand washing and reduce the risk of infection. There was access to hand washing facilities and a supply of PPE, which included gloves and aprons, in all clinical areas.
- We observed staff washing their hands between patient contact, in accordance with National Institute for Health and Care Excellence (NICE) guidance (Quality Standard (QS)61 Infection prevention and control: statement 3, April 2014).
- We saw healthcare assistants clean their hands and use appropriate PPE (gloves and aprons) when taking blood from patients attending antenatal clinic. Staff disposed of the PPE and cleaned their hands after each patient contact, in line with national guidance.
- We saw that all areas of the maternity and gynaecology service we visited were visibly clean and tidy during our inspection.
- Midwifery, nursing and auxiliary staff were responsible for cleaning the equipment and we saw that "I am clean" stickers were placed on items of equipment stating when they had last been cleaned. In all areas we visited we observed that the equipment which was not in use had been cleaned that day.
- Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Bins were not overfilled. We saw all clinical areas had appropriate facilities for the disposal of clinical waste and sharps. All sharps bins we observed were clean, dated, not overfilled, and had temporary closures in place. Temporary closures are recommended to prevent accidental spillage of sharps if the bin is knocked over and to minimise the risk of needle stick injury.

Environment and equipment

- During our previous comprehensive inspection, we found the early pregnancy assessment unit (EPAU) and maternity day assessment unit (MDAU) were small and cramped, with inadequate space for equipment. We were told the trust had plans in place to develop a women's health unit on the site of the former delivery suite and neonatal unit, which would include EPAU, MDAU, antenatal clinic, and gynaecology outpatient clinics. During our focused inspection, we saw that work was still ongoing to complete the refurbishment programme. It was hoped the unit would be operative by the end of April 2017.
- On our previous inspection, we found some equipment had not been safety tested. For example, we found four sonicaids (a device for listening to a baby's heartbeat) that required electrical testing. We raised this concern with the trust at the time of inspection. Following further enquiry, the trust confirmed these items of equipment did not require annual electrical safety testing because they were battery operated. The sonicaids were listed on the trust's servicing schedule; routine maintenance was scheduled two yearly.

- During the focused inspection, we reviewed 17 items of equipment from antenatal clinic, EPAU, MDAU, and Elias Jones unit. Stickers were placed on each item of equipment, which detailed the date the equipment had been serviced and the date the next service was due. All equipment was found to have been serviced within the date indicated. Therefore, we were assured that the maintenance and use of equipment within the service kept people safe.

Medicines

- For gynaecology inpatient services, please see surgery section of the report.
- During our previous comprehensive inspection, we reported no concerns in relation to the safe storage of medicines within the maternity and gynaecology service. Medicines were stored securely and in accordance with temperature limits set by manufacturers. However, we did observe the unsafe storage of medicines with poor monitoring, escalation and insight into the effect of storing medicines above or below recommended temperatures across other services. This meant we were not assured that all medicines stored in both refrigerators and at ambient room temperature were safe for patient use.
- In response to concerns found during our previous inspection, the trust's quality improvement plan (QIP) included actions to ensure all medicines were stored at appropriate temperatures and any exceptions were escalated appropriately and in a timely manner. According to information provided by the trust, a simplified recording template for refrigerator and ambient room temperatures had been introduced. Furthermore, training and written guidance had been provided and shared with all areas on refrigerator temperatures, the use of thermometers, temperature recording and escalation protocols.
- The revised recording template stated that the minimum, maximum and current temperature of the medicines room and fridge should be recorded daily. The template was based on a traffic light system, which alerted staff to take action if the temperature exceeded the required range. Guidance on what actions should be taken, and a table for staff to document actions they had taken, was included on the reverse of the template.
- During the focused inspection, we found trust policy was not consistently followed in all areas of the service. We were not assured all staff were aware that minimum, maximum and current temperatures should be recorded and of the procedure to follow when temperatures exceeded the recommended range.
- We reviewed the ambient room temperature records on the Elias Jones unit from 21 December 2016 to 11 April 2017. We found that from 21 December 2016 to 28 February 2017, only the current temperature had been recorded; minimum and maximum temperatures had not been documented. From 1 March to 11 April 2017, we found a further four occasions when only the current temperature had been recorded (13 to 16 March).
- We also found five occasions when the maximum ambient room temperature exceeded the recommended range, with no evidence that any action had been taken to address the exceeded ambient room temperature. The exceeded temperatures were all 'amber' rated (between 25°C and 29.9°C) and according to trust policy, the nurse in charge and estates department should have been informed.
- During the focused inspection, we found the ambient room temperature where medicines were stored within the antenatal clinic were not monitored. Therefore, we could not be assured these medicines were safe for patient use. We raised this concern at the time of our inspection. According to information received from the trust, the antenatal clinic manager had been told by pharmacy that ambient room temperature monitoring was not required in this area. Since our inspection, the pharmacy department had replaced all medicines stored within the antenatal clinic areas. Furthermore, these medicines had been moved to medicine cupboards within the main outpatient department, where ambient room temperatures were routinely monitored.

Records

- We did not gather evidence for this as part of the inspection.

Safeguarding

- During our previous comprehensive inspection, we found that arrangements were in place to safeguard adults and children from abuse that reflected legislation and local requirements. Staff generally understood their responsibilities and adhered to safeguarding policies and procedures. However, we also found not all staff had completed the appropriate level of safeguarding

children training. Furthermore, we found that there was poor awareness of female genital mutilation (FGM) and staff told us they had not received training in FGM identification or awareness.

- Training data provided during our previous comprehensive inspection showed that 44% of midwifery staff and 0% of medical staff had completed safeguarding children level two training, and 51% of midwifery staff and 19% of medical staff had completed safeguarding children level three training. The trust target was 90%.This did not meet with national recommendations, which state that clinicians who are potentially responsible for assessing, planning, intervening and evaluating children's care, should be trained to safeguarding children level three ('Working together to safeguard children' (2015); 'Intercollegiate Document, Safeguarding children and young people: roles and competences for health care staff'(March 2014)).
- As of April 2017, training data showed that 86% of midwifery staff and 53% of medical staff had completed safeguarding children level three training. This was an improvement from our previous inspection. However, compliance was still below the trust target of 90%. Senior staff told us safeguarding children training sessions had recently been cancelled by the safeguarding team. Staff would be rebooked when sessions were made available.
- Staff were required to complete safeguarding adults and children training on trust induction, following commencement of employment, and refresher training every three years. Refresher safeguarding training was completed via e-learning modules, with some ad hoc sessions provided for safeguarding children training. The safeguarding children e-learning module was developed in collaboration with experts from six safeguarding children boards and had been updated to include FGM, radicalisation, forced marriage, child trafficking and child sexual exploitation (CSE).
- Midwifery staff we spoke with told us they had completed safeguarding children level three training via the e-learning module and face-to-face sessions. Training included recognising children at risk, signs of abuse, FGM, CSE and how to report safeguarding concerns.
- We spoke with three midwives who told us that FGM was covered in safeguarding children level three training, and included women at risk of FGM and identifying the signs of FGM. Staff we spoke with had hot had to make a safeguarding referral for FGM but could explain the process if they identified a concern. Staff could obtain additional support and/or advice from the safeguarding team as needed.
- We saw there were safeguarding policies in place and clear pathways to follow if staff had concerns. Pathways included CSE, domestic violence and FGM. Staff could access safeguarding adults and children information via the trust intranet. Support was also available from the lead midwife for safeguarding.

Mandatory training

- We did not gather evidence for this as part of the inspection.

Assessing and responding to patient risk

- The trust had processes in place to divert urgent deliveries with risk to WRH (e.g. reduced fetal movements) and provided staff with guidance via appropriate polices regarding this.

Midwifery staffing

- We did not gather evidence for this as part of the inspection.

Medical staffing

- We did not gather evidence for this as part of the inspection.

Major incident awareness and training

- We did not gather evidence for this as part of the inspection.

Are maternity and gynaecology services effective?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection on 22 to 25 November and 7 December 2016. We inspected one part of this key question but did not rate it. We found that:

- The number of staff who had completed Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training had improved.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Maternity and gynaecology

- For gynaecology inpatient services, please see surgery section of the report.
- During our previous comprehensive inspection, we found staff we spoke with had limited understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), but knew whom to contact if they needed advice. We also found not all staff had completed MCA and DoLS training. Data provided showed that as of September 2016, 37% of staff had completed MCA and DoLS training. The trust target was 90%. Therefore, we were not assured all staff had up-to-date knowledge of MCA and DoLS.
- During our focused inspection, we saw evidence that the trust had taken action to address our concerns and we found some improvements had been made.
- All clinical staff, which included consultants, junior doctors, midwives, nurses and healthcare assistants, were required to complete MCA and DoLS training three yearly. We were told that between January and March 2017, training had been prioritised by the trust. As of April 2017, training data showed that 80% of midwifery staff, 100% of staff on the early pregnancy assessment unit, and 75% of staff on the Elias Jones unit had completed MCA and DoLS training. This was an improvement from our previous inspection.
- Senior staff (band 7) were also undertaking additional training in DoLS. At the time of our inspection, five members of staff had completed this training and a further three were booked to attend upcoming sessions.
- Staff were able to describe the relevant consent and decision making requirements relating to MCA and DoLS and understood their responsibilities to ensure patients were protected.
- Staff we spoke with had not had to make mental capacity assessments or DoLS applications, but knew who to contact for advice and support if they had any concerns regarding a person's mental capacity.
- We observed DoLS prompt cards, and the contact details for MCA and DoLS leads displayed on staff noticeboards during our focused inspection.
- The trust had up-to-date policies regarding consent, MCA and DoLS. Staff could access these policies via the trust intranet.

Are maternity and gynaecology services caring?

We have not rated the service for caring. As this was a focused inspection, we did not inspect all elements of this key question.

Compassionate care

- Interactions between staff and patients were caring and compassionate.
- We observed staff respecting the privacy and dignity of patients during our inspection.

Understanding and involvement of patients and those close to them

- We did not gather evidence for this as part of the inspection.

Emotional support

- We did not gather evidence for this as part of the inspection.

Are maternity and gynaecology services responsive?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found that:

- The trust's plans to develop a women's health unit were behind schedule. However, it was hoped the unit would be operational by the end of April 2017.
- Some staff caring for gynaecology patients on ward 14 and Birch ward had not received additional gynaecology training, such as management of surgical miscarriage and bereavement care.

Service planning and delivery to meet the needs of local people

- Following the previous inspection, we reported that the trust planned to relocate women's services to the former delivery suite and neonatal unit in December 2016. During our focused inspection, we found this work was still ongoing. Staff told us it was hoped the women's

health unit would be operational by the end of April 2017. Therefore, we were unable to determine the impact a women's health unit would have on service provision.

Access and flow

- We did not gather evidence for this as part of the inspection.

Meeting people's individual needs

- Some staff we spoke to on ward 14 and Birch ward, where elective (planned) and day case gynaecology patients were admitted, told us they had not received any specific gynaecology training such as management of surgical miscarriage and bereavement care. Therefore, we were not assured the service always met individual patient needs. However, we were told that the gynaecology medical team reviewed patients daily and could be contacted for advice via the on-call system, 24 hours a day as needed. We reviewed the medical records of the one gynaecology patient who had been admitted to ward 14 and saw evidence of daily gynaecology medical review. Emergency miscarriages patients were seen and treated at the WRH, whilst this hospital cared for those patients that were on the elective list. After the inspection, the trust told us that the skill mix on this combined female trauma/ Gynaecology ward did comprise of nurses who had had gynaecology training and could care for a post operation patient following elective gynaecology surgery.
- Staff told us that patients undergoing surgical management of miscarriage were allocated a side room on ward 14, so that a partner, relative or friend could stay with them to provide additional support whilst they underwent treatment.

Learning from complaints and concerns

- We did not gather evidence for this as part of the inspection.

Are maternity and gynaecology services well-led?

We carried out a focused inspection to review concerns found during our previous comprehensive inspection in November 2016. We inspected parts of this key question but did not rate it. We found that:

- The risk register was reviewed regularly and staff were aware of risks within the service.
- The trust had implemented a new quality dashboard, known as the safety and quality information dashboard. The dashboard was being developed to include performance indicators specific to the service. Key performance indicators were reviewed regularly and actions were taken to address patient safety and quality issues.

Leadership of service

- The maternity and gynaecology service was under the women and children division. The leadership structure included a divisional medical director, divisional director of nursing and midwifery, divisional director of operations, and divisional governance and quality lead. A clinical director, medical governance lead for obstetrics and gynaecology, and matrons for gynaecology inpatients and outpatients, community and antenatal clinics, delivery suite and theatres, and maternity inpatients supported the divisional team.

Vision and strategy for this service

- We did not gather evidence for this as part of the inspection.

Governance, risk management and quality measurement

- As of April 2017, the service had identified 15 risks. Two of which were specific to the Alexandra Hospital; the lack of dedicated antenatal facilities within the outpatient department, and the inadequate infrastructure/environment of the Elias Jones unit, leading to the inability to develop gynaecology ambulatory services. Actions taken to mitigate risks, review dates, progress and assessment of the risk level were included.

- We saw evidence that the risk register was reviewed regularly at monthly governance meetings. Staff we spoke with were aware of risks within the service.
- Since our previous inspection, the trust had introduced a web based 'ward to board' quality assurance system, known as the safety and quality information dashboard (SQuID). The SQuID dashboard was designed to measure performance against quality and safety metrics, such as number of incidents, medication errors, friends and family test scores, and complaints. Staff we spoke with were aware of SQuID and demonstrated how to access the dashboard on the trust intranet.
- At the time of our inspection, the trust were in the process of developing the dashboard to include key performance indicators specific to the service, such as the number of women who had booked for antenatal care by 12 weeks and six days gestation, but this work had not been completed at the time of our inspection. The minutes of divisional and directorate governance meetings confirmed that key performance indicators were regularly reviewed, and actions were taken to address performance issues where indicated.

Culture within the service

- We did not gather evidence for this as part of the inspection.

Public engagement

- We did not gather evidence for this as part of the inspection.

Staff engagement

- We did not gather evidence for this as part of the inspection.

Innovation, improvement and sustainability

- We saw some improvements to service provision had been made since our November 2016 inspection. These included improved compliance figures for safeguarding children level three, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training. There was also evidence that service provision was being developed in order to meet the needs of people within the local community, such as the setting up of a dedicated women's health unit. However, this unit had not been completed at the time of our inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that the privacy and dignity of all patients in the emergency department (ED) is supported at all times, including when care is provided in corridor areas.
- Ensure that systems or processes are fully established and operated effectively to assess, monitor and improve the quality and safety of the services provided within the ED.
- Ensure that systems or processes are fully established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients while using the ED.
- Ensure that medicine's management training compliance meets trust target of 90%.
- Ensure all staff have completed their Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training.
- Ensure the completion of venous thromboembolism (VTE) assessments and re-assessments is in line with national guidance.
- Ensure drug charts have patient weights recorded.
- Ensure all anticoagulation medication is administered as prescribed. All non-administrations must have a valid reason code.
- Ensure all medicines are stored at the correct temperature. Systems must be in place to ensure medication, which has been stored outside of manufactures recommended ranges, remains safe or is discarded.
- Ensure there are processes in place to ensure that any medicine omissions are escalated to the medical team for review.
- Where patients refuse to take prescribed medication, ensure it is escalated to the medical team for a review.
- Ensure patient identifiable information is stored securely and not kept on display.
- Ensure all staff comply with hand hygiene and the use of personal protective equipment policies.
- Ensure all staff have completed the required level of safeguarding training.
- Ensure all staff comply with hand hygiene and the use of personal protective equipment policies.
- Ensure all staff have completed the required level of safeguarding training for vulnerable adults and children.

Action the hospital SHOULD take to improve

- Achieve the required numbers of consultants in the ED on duty to meet national guidelines.
- Review its processes to confirm that all ED consultants and middle grade doctors hold a current advanced paediatric life support qualification and that they would lead resuscitation of children. Including those from temporary staffing agencies
- Consider displaying actual and planned staff numbers in all clinical areas.
- Review nurse staff competence for the management of medical patient outliers.

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
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The service was not meeting this regulation because:** • Patients did not always have venous thromboembolism assessments completed. • Prescribed medication was not always reviewed by medical staff. • Staff did not comply with infection prevention and control measures.

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The service was not meeting this regulation because:** • Poor oversight of the service which included; medicine management and mental capacity and Deprivation of Liberty Safeguards training. • Medical records were not always stored securely. • The medical service leadership team had not addressed all issues identified as areas for improvement in our last inspection. This meant that there were still potential risks to the safety and quality of care and treatment of patients' care. • Senior leaders were aware of the trust's failure to follow national guidance in relation to venous thromboembolism risk assessments (VTE), records' management, completion of drug charts and compliance with hand hygiene. However, we saw examples throughout surgery and medical care where national guidance had not been followed. When risks had been escalated, there was a lack of follow up and resolution.

This section is primarily information for the provider

Requirement notices

- Despite assurances from the trust, we saw no evidence that obstetrics and gynaecology mortality and morbidity reviews were held. Furthermore, whilst perinatal mortality and morbidity meetings were minuted, we were not assured that action was taken to address any learning identified from case reviews.

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The service was not meeting this regulation because:** • Not all staff were compliant with medicines' management and Mental Capacity Act 2005/ Deprivation of Liberty Safeguards training.

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The service was not meeting this regulation because:** • Not all staff were trained to the required level of safeguarding. • Safeguarding adults training for doctors and nurses in the ED was inadequate.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The service was not meeting this regulation because:** • Patients' privacy and dignity was not respected whilst being cared for in the corridor area of the emergency department.

This section is primarily information for the provider

Requirement notices

- Some medical care wards did not ensure that patient privacy, dignity, and confidentiality were maintained at all times because other patients and relatives could hear handovers.
- Patient identifiable information was not stored securely and kept on display in some medical care and surgical wards