CareQuality Commission

Sherwood Forest Hospitals NHS Foundation Trust
Kings Mill Hospital
Quality Report

Mansfield Rd,
Sutton-in-Ashfield,
Nottinghamshire
NG17 4JL
Tel: 01623 622515
Website: **http://www.sfh-tr.nhs.uk**

Date of inspection visit: 18, 19, 20 July 2016
Date of publication: 09/11/2016

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	Requires improvement ●
Urgent and emergency services	**Requires improvement** ●
Medical care (including older people's care)	**Requires improvement** ●
Maternity and gynaecology	**Requires improvement** ●
Outpatients and diagnostic imaging	**Requires improvement** ●

Kings Mill Hospital

Detailed findings

Services we looked at:

Urgent and emergency services; Medical care (including older people's care); Maternity and gynaecology; Outpatients and diagnostic imaging.

Detailed findings

Contents

Background to Kings Mill Hospital

Kings Mill Hospital in Sutton in Ashfield is the main acute hospital site for Sherwood Forest Hospitals. It provides over 550 inpatient beds (more than half in single occupancy rooms), 13 operating theatres and a 24 hour emergency department. Each year there are more than 76,000 inpatient admissions and 30,000 day case patients; 102,000 patients attend the emergency department, around 3,000 babies are delivered and more than 270,000 people attend outpatient and therapy appointments in the King's Treatment Centre.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Carolyn Jenkinson, Care Quality Commission

Inspection Manager : Helen Vine, Care Quality Commission

The team included CQC inspectors, inspection managers, clinical fellows, a paramedic operations officer, nurse practitioner, a geriatrician, a junior doctor, a head of nursing and midwifery, an associate director, a non-executive director, a director of nursing and a mental health act reviewer.

How we carried out this inspection

This was a focused unannounced follow up inspection to check progress against our findings from our inspection of June 2015. We inspected:

- Emergency and Urgent Care Services at Kings Mill Hospital, looking only at the safety of these services.
- Medical Services at Kings Mill Hospital, looking only at the safety and effectiveness of these services.
- Maternity Services at Kings Mill Hospital, looking only at the safety of these services.
- Outpatient (but not diagnostic) Services at Kings Mill Hospital, looking only at the safety of these services.

Before visiting, we reviewed a range of information we held including information from clinical commissioning group, NHS England, NHS Improvement, Health Education England and the local Healthwatch.

We carried out an unannounced inspection from 18 – 20 July 2016. We inspected three of the trust's locations; Kings Mill Hospital, Newark Hospital and Mansfield Community Hospital.

We talked with patients, their carers and staff from support services, ward areas and outpatient areas. We also reviewed patient records.

Detailed findings

Facts and data about Kings Mill Hospital

Each year there are more than 76,000 inpatient admissions and 30,000 day case patients: 102.000 patients attend the emergency department, around 2,000 babies are delivered and 270,000 people attend outpatient and therapy appointments at the King's Treatment Centre.

Urgent and emergency services

Safe	Good 🟢
Overall	**Requires improvement** 🟠

Information about the service

The emergency department at Kings Mill Hospital provides consultant-led emergency care and treatment 24 hours per day, seven days per week. The trust has a single point of access reception and shared triage with the co-located urgent care centre. A separate waiting and treatment area is available for children between 9am and 9pm. The department treated 100,758 patients between July 2015 and June 2016, and 19.9% of these were children. The department regularly treats over 300 patients in a 24 hour period. The department is a designated trauma unit within the East Midlands regional trauma network.

During our inspection we spoke with 18 staff including nursing, medical and ambulance staff. We looked at 10 patient records.

We also spoke with staff in the urgent care centre.

Summary of findings

We rated the safety of Kings Mill Hospital emergency department as good.

Urgent and emergency services

Are urgent and emergency services safe?

Good 🟢

We rated the safety of Kings Mill Hospital emergency department as good because:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses; they were fully supported when they did so. Learning from incidents and near misses was shared across the trust.
- When something went wrong, patients received a sincere and timely apology and were told about any actions taken to improve processes to prevent the same thing happening again.
- There were clearly defined and embedded systems, processes and standard operating procedures to keep patients safe and safeguarded from abuse. Staff were aware of safeguarding procedures and worked effectively with other relevant organisations.
- Staff had received up-to-date training in all safety systems.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff could manage risks to patients who used the service.
- Risks to patients who used the service were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies or behaviours that challenged.
- Plans were in place to respond to emergencies and major situations. All relevant parties understood their role and the plans were tested and reviewed.

However we also found:

- Children did not have a separate waiting area between 21.00 and 09.00hrs.
- Whilst paediatric nursing numbers had not increased since our last visit, nursing staff had received training and been assessed for competencies in relation to the care of sick children.
- When all the patient beds in the resuscitation area were fully occupied nursing staff levels were insufficient.

Incidents

- The department used an electronic incident reporting system and all staff we spoke with including bank staff were familiar with the system and the subsequent management and investigation of incidents.
- Staff received regular information about incidents through e mail, staff notice boards and at the morning handover meeting. The department held a monthly 'grand round' meeting. The meeting included feedback on incidents and any learning identified. We saw the minutes of the emergency department clinical governance meetings which included information about serious incidents and patient safety incidents. The department also used a closed group, electronic mobile phone application to communicate quickly with staff if any immediate learning from incidents needed sharing. Staff told us about a recent incident which had resulted in the introduction of oral syringes throughout the department. We saw oral syringes available in all areas including the Newark hospital minor injuries unit which showed that learning was shared across the two departments.
- In the period June 2015 to May 2016 the trust reported two serious incidents which had taken place in the emergency department. Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. The serious incidents had been thoroughly investigated and actions taken where learning was identified.
- There were no never events reported between June 2015 and May 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were 21 missed fractures between February 2016 and July 2016. All missed fracture cases were reviewed by a consultant and any learning fed back to individual practitioners. We saw reports of the missed fracture audits between February 2016 and July 2016 which confirmed this took place and also identified shared learning to be discussed at the grand round meeting. The majority of the missed fractures were small bone fractures.

Urgent and emergency services

- Fortnightly mortality and morbidity meetings took place. A senior manager told us about learning shared across the trust from the investigation of morbidities resulting from gastric (stomach) bleeds. A new pathway had been developed to escalate gastric bleeds so they could be investigated in the operating theatre within two hours. We saw the new pathway displayed in the emergency department.
- Errors in the administration of intravenous fluids were reported as medicines errors through the incident reporting system.
- Staff were able to demonstrate they understood duty of candour and gave examples of when they had witnessed duty of candour being implemented. The trust Duty of Candour policy date December 2015 was available on the intranet. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Cleanliness, infection control and hygiene

- All of the areas we visited including the dirty and clean utility rooms and storage rooms appeared visibly clean and well organised.
- The trust monitored environmental cleanliness using the national patient safety agency (NPSA), National Standards of Cleanliness Audit. We saw the completed score sheets for April 2016; scores were mostly above 90% indicating a high level of cleanliness.
- There were adequate hand washing facilities in the department. A plentiful supply of hand gel dispensers were located in cubicles, clinical areas and corridors; this was an improvement since our last inspection. Cleansing hand gel was available at the entrances to each area and in each cubicle.
- We observed staff carrying out good hand hygiene and using personal protective equipment when necessary in line with the trust policy and procedures.
- Mandatory training for staff included sessions on infection prevention and control and hand hygiene. Training compliance was 83.31% which was above the trust target of 80%.
- All patients were asked by the triage nurse if they had any history of methicillin resistant staphylococcus aureus (MRSA) infection. MRSA is a type of bacteria and is resistant to many antibiotics.

- There were three isolation cubicles in the department. Patients presenting with diarrhoea and vomiting were prioritised as part of streaming and were taken straight through to one of the isolation cubicles if necessary. If the patient needed to be admitted, the ward was informed the patient would require an isolation cubicle. Streaming is directing patients to the right level of care following initial assessment.
- We observed a diabetic patient with diarrhoea and vomiting being admitted to one of the isolation cubicles within 15minutes of presenting to the emergency department reception.
- We inspected equipment such as drip stands and commodes and found they were visibly clean and displayed stickers indicating that they were ready for use
- Sharps bins were easily accessible and used according to trust procedure.
- Waste was segregated and disposed of according to trust policy and staff showed us where the specialist spills cleaning equipment was kept such as the blood spillage kit.
- We saw nurses adhering to sterile non touch technique procedures when necessary and staff told us procedures were available on the intranet for reference.

Environment and equipment

- During our visit we found the department to be well organised and calm, therefore providing a relaxed atmosphere for patients. Waiting areas were light, spacious and airy. Additional information signs had been placed at regular intervals around the department since our last inspection and were clear and easy to follow.
- At our last inspection we were concerned that not all of the patient cubicles had a call button. At this inspection we found all patient cubicles had nurse call buttons, patients told us they were aware of how to use the call buttons to summon a nurse.
- We found at our last inspection that ligature risk assessments had not taken place and ligature risks were visible in the department. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes and radiators, bed frames, window and door frames, ceiling fittings, handles, hinges and door closures. This had been addressed since our last inspection.

Urgent and emergency services

- A ligature point risk assessment had been carried out in November 2015 and had identified that non collapsible curtain rails were present in the majors part of the department. We were told the work to replace these with collapsible rails would be complete by the end of July 2016. Ligature cutters were available throughout the department and staff told us they knew where to find them.
- A risk assessment with mitigating actions was in place for mental health patients at risk of harming themselves. Staff showed us the flowchart, Managing Self Harm, and described instances when they had used it.
- Eight additional patient trolleys had been purchased since the last inspection which meant that patients did not have to wait on an ambulance trolley for an extended period until an emergency department trolley was available.
- Since the last inspection the department had purchased 10 new cardiac monitors and one additional defibrillator machine; this meant there were adequate numbers of these items to meet demand. A defibrillator is an electrical device that provides a shock to the heart when there is a life-threatening arrhythmia present.
  - At our last inspection we found that there were insufficient computers for staff to access in the ambulatory care area of the emergency department but we found this had been improved by the addition of two more computers.

- The radiology department was located next to the emergency department which meant that patients did not have to travel far from the department and were seen promptly.
- The children's waiting and treatment areas were separate from the adults. The children's area was decorated and equipped in a child friendly manor. There was another area within the children's area which was decorated and equipped with older children in mind and included a play station. However the children's area was only open from 09.00hrs to 21.00hrs. After this time children waited in the main waiting area.
- Bariatric chairs were available. If bariatric trolleys were needed the staff could order these and they were delivered quickly. Bariatric equipment is specially designed for larger or obese patients.
- We inspected 15 items of electrical equipment and found they had all been appropriately tested within the last 12 months.

- Staff told us they felt they had enough equipment to carry out their work for example; pressure relieving aids and we observed these being used for frail elderly patients.
- We inspected three resuscitation trolleys and found they were fully equipped and regularly checked. The paediatric trolley had equipment in a variety of sizes.
- Clinical specimens were collected safely and sent to the pathology laboratories via a chute system.
- We saw the most recent patient led assessment of the care environment report dated May 2016. The report did not highlight any areas of significant concern.

Medicines

- Medicines were stored, managed, administered and recorded safely.
- We saw prescription pads were stored in a locked cupboard and a record was kept of when the prescription pads were used.
- Controlled drugs were stored checked and recorded as per trust policy and the drugs fridge was checked daily.
- Qualified nurses were working under a patient group direction (PGD) for the prescription of simple pain relief, eye drops, respiratory medicine and antihistamines. Patient group directions provide a legal framework that allows some registered health professionals to supply and / or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor. We saw copies of these PGDs which were all correctly completed and authorised.
- Allergies were clearly documented and patients with an allergy were given a red wrist band to wear.
- Staff told us microbiology protocols for the administration of medicines were on the intranet. This included what antibiotic to prescribe in different scenarios, for example what to prescribe for someone who had a dog bite.
- We observed nursing staff administering medicines, two nurses checked the medicines and administered them as per trust policy.

Records

- The department used a mixture of electronic and paper patient records. We looked at ten patient records and found they were generally completed in line with trust policy.

Urgent and emergency services

- We found some hand written notes were difficult to read and some signatures illegible. However patient risk assessments were completed in the appropriate timescales and transfers of care were well documented.
- Full sets of medical records could be accessed 24 hours a day. Staff told us obtaining medical records was not a problem.
- Medical records were in constant use in the emergency department but stored securely when not needed.
- Staff had access to the electronic, clinical computer system used in primary care, general practice (GP). This meant staff could access the patient's GP record if required. This system was also used to send discharge information to the patients GP.
- We reviewed ten sets of patient records. Discharge letters were sent to GPs electronically.

Safeguarding

- Policies and procedures were available to staff and they knew how to raise concerns regarding adults and children. The department had a system to identify patients who were vulnerable or at risk, for example, of domestic violence. This meant staff were able to respond appropriately and discreetly.

- Safeguarding training included information about female genital mutilation. Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons.

- The paediatric assessment notes included six detailed questions about the presentation of the child. If the answer was yes to any of the questions a safeguarding concern was raised. For example one of the questions was 'Does the history fail to fit injury/presentation?' In the notes we reviewed we saw these questions had been asked and recorded.
- We saw notes from April 2016, May 2016 and June 2016 for safeguarding children supervision meetings. Individual cases were discussed, learning and actions identified with completion dates and named responsible persons.
- The trust reported that in June 2016 95% of emergency department staff had attended Level one, 85% level two, and 77% level three safeguarding children training. Level one safeguarding children training is for all staff working in health care settings. Level two safeguarding children training is for all non-clinical and clinical staff

who have any contact with children, young people and/or parents/carers. Level three safeguarding children training is for all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns. At our last inspection we told the trust they must take action to ensure all staff involved in the care of children in the children's emergency area have completed level three safeguarding training.

- Safeguarding issues were highlighted on the primary care electronic system by a specific icon next to the child's name. This meant staff had access to previous safeguarding information relating to the child. Information was sent to general practitioners about all child attendances at the emergency department, this was via the electronic system.

Mandatory training

- We saw a copy of the trust's mandatory training policy dated May 2016. Along with the trust corporate induction course the topics covered were in line with UK core skills training framework recommendations. Mandatory training is training which is essential to comply with legislation or to maintain key standards.
- Mandatory training included; safeguarding for children and adults, moving and handling, mental capacity act, major incident planning, infection prevention and control, mental awareness, adult life support and paediatric life support.
- The trust reported that in June 2016 87% of emergency department staff had attended their mandatory training against a target of 90%. This was an improving figure.

Assessing and responding to patient risk

- A clear streaming and triage process was in place all patients received a clinical assessment by a registered health care practitioner this meant that patients symptoms were prioritised appropriately and the most urgent recognised quickly and escalated rapidly.
- We observed patients arriving at the emergency department. Receptionists quickly took personal details and identified if the patient was attending the urgent

care centre or the emergency centre. The urgent care centre was located next to the emergency department and was a primary care service run by nurse practitioners and GPs.

- All receptionists had a two day training course on how to recognise the ill patient. Receptionists told us that if they were at all concerned about a patient they could quickly and easily summon help from nurses or doctors working in the triage area.

- Patients who had been assessed by the NHS 111 service and been given an appointment to attend the urgent care centre were sent to a specified waiting area. All other patients were asked to sit in the red chair waiting area which indicated to the triage nurses that they were waiting for assessment. The waiting area patients were all clearly visible to the reception and triage staff.

- Children were directed to the paediatric waiting area or the urgent care centre if they had already been assessed by the NHS 111 service.

- A protocol was in place which described presenting problems in children which were suitable for referral to the primary care centre.

- The department had recently introduced joint triage with the rapid response liaison team for mental health patients. The team were alerted to the arrival of a mental health patient if this was known and they could be in the department when the patient arrived.

- The time to initial assessment for patients attending the emergency department was better than England average and the time to treatment was also better than England average and consistently meeting the 60 minute standard. This meant that patients were being seen within the recommended target times.

- Between August 2015 and July 2016, there 11,602 ambulance handovers within the 30-minute target, and 22,548 which did not meet this target (66% of total handovers). 20,575 (60%) of handovers were achieved within 30-60 minutes, and 1,973 (6%) took more than 60 minutes. This meant that some patients waited longer, on ambulance service trolley's with ambulance staff in attendance, than they should have before being handed over to emergency department staff.

- Triage nurses carried out an initial assessment of the patient and streamed them to the most appropriate area of the emergency department for example, majors, minors or minor injuries.

- Patients arriving by ambulance were taken straight through to the emergency department and handed over to emergency department staff.

- We observed two ambulance handovers, these took place promptly with a full verbal handover of the patient's condition and written information for the emergency department staff

- Hospital arrivals screens for the local NHS ambulance trust were visible to staff in the emergency department. This meant staff were able to see the number of ambulances on the way to the hospital. This enabled the nurse in charge to ensure that sufficient resources would be available to admit patients quickly and safely. For example if a patient with a suspected stroke was expected the stroke team would be contacted and be in the department for the arrival of the patient.

- The department status board was located behind the nurse station out of public view. It gave a visual picture of all the patients in treatment areas and brief details about their condition. Frail elderly patients were also clearly identified on this board. This meant that staff could see at a glance where vacant cubicles and trolleys were so patients could be quickly moved to the most appropriate and safest area for their on-going care.

- Once patients were admitted to the emergency department a full assessment was carried out. The assessment documentation contained all the relevant risk assessment and checklists to ensure patients were protected from avoidable harm for example; pain assessment, mini mental test for the over 75's, falls assessment, safeguarding questions, national early warning score (NEWS), sepsis screening tool, fluid balance chart, handover checklist, domestic violence prompts and stroke assessment.

- All children had a paediatric observation priority score calculated (POPS). Children with a POPS of 3 – 6 were commenced on paediatric early warning score (PEWS) observations. NEWS and PEWS enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.

- Risk assessments for pressure areas were completed on admission to the department using a nationally recognised pressure ulcer risk assessment tool. We saw this recorded in the notes we reviewed. We reviewed ten sets of notes, including paediatric notes and found they were all completed in line with trust policy and

procedure including fluid balance sheets and sepsis screening. Two out of ten patients were screened as positive for sepsis and treatment was commenced within sixty minutes.

- A range of stickers were clearly visible on the front of patients' notes. These were used to alert staff to any specific patient concern such as, patient living with dementia, patient with learning difficulties, patient with sepsis and vulnerable adults.
- Paediatric assessment notes included six detailed questions about the presentation of the child. If the answer was yes to any of the questions a safeguarding concern was raised. For example one of the questions was 'Does the history fail to fit injury/presentation'.
- Staff told us that if a patient's condition deteriorated at any time they could easily be transferred within the emergency department. For example the urgent care nurse told us that she could hand over patients to the emergency department and staff in the minors area could transfer patients to the majors area.
- We observed a triage nurse handing over a patient to a doctor in the majors area. The nurse signed in the patient notes to say she had handed the patient over and also recorded the patient details on the department status board. We also observed a patient who had collapsed in the x ray department being treated in the majors area and then moved to the resuscitation area. This was done in a calm, effective and co-ordinated manor and demonstrated effective management of an acutely deteriorating patient.
- In the event that a patient was in the emergency department for longer than four and a half hours an additional assessment tool was completed every two hours for pressure areas, continence, hygiene, nutrition, hydration and comfort. Staff told us they had not had to use this tool for a long time.
- There was a weigh bridge in the department and all patients with a fractured neck of femur were weighed before they were transferred to the ward. This meant that drugs which were calculated on body weight could be accurately prescribed.
- We observed patients being referred and admitted to the clinical decision unit (CDU). Only patients with a NEWS score of two or less would be accepted by the CDU. Clear medical pathways were in place to assess the suitability of the patient to be treated in the CDU. For

example there were pathways for pyelonephritis (kidney infection), anaemia, deep vein thrombosis, cellulitis (inflammation of soft tissue), suspected pulmonary embolism and low risk cardiac chest pain.

- We saw when patients were referred for other tests, for example x ray, they were routinely escorted by a health care assistant. More acutely ill patients were escorted by a qualified nurse.

Nursing staffing

- The department used the Royal College of Nursing baseline assessment of
- emergency staffing (BEST) tool. This tool enables a department to highlight any disparity between nursing workload and staffing.

- The department was fully staffed to their own establishment numbers with no nurse vacancies and sickness absence levels running at around one percent.
- The department occasionally used bank staff to support gaps in staffing levels. For the quarter April 2016 to June 2016, 29 shifts were covered by bank staff. During our inspection we observed a new bank nurse being supervised as part of her induction. All bank staff completed an induction checklist before commencing work and had access to the trust policy and procedures on the intranet.
- The department used a closed electronic mobile phone application group to communicate quickly with staff if additional staff were needed to cover sudden gaps in the rota.
- We observed the 9am briefing meeting which included nursing and medical staff. The meeting covered topics such as staffing gaps, any issues on the previous night shift, policy changes and practice changes resulting from incidents.
- Handovers also took place at the beginning of each shift with as many staff attending as possible without compromising patient safety. The nurse in charge would speak individually to members of staff who had not managed to attend the main hand over.
- At our previous inspection we were concerned at the low level of experienced paediatric nurses in post. The department had a nurse lead for the care of children. This nurse was still the only paediatric trained nurse in the department. This meant the department did not comply with best practice guidance which requires a minimum of one children's trained nurse per shift. The

Urgent and emergency services

trust had implemented a competency based programme of learning for all staff in the emergency department. Training was delivered in topics such as treating the sick child, epilepsy, diabetes and common injuries in children. 89% of nurses working in the emergency department had completed competency assessments to enable them to treat children. We saw evidence of other resources to support staff in the care of children such as a booklet 'Caring for Children and Young Adults in Accident and Emergency' and a selection of protocols/guidance on the intranet in the paediatric folder such as head injury, surgery pathway and national institute for clinical excellence guidance on fever. Staff working in the children's area had a minimum of two years nursing experience; one nurse and one emergency nurse practitioner were allocated to work in the area supported by one health care assistant.

- The trust had also recently commenced a trial involving a ward paediatric nurse working in the children's emergency area from 3pm to 10pm three days per week. Results of the trial were not available at the time of inspection.

- Staff from the majors area were used to support the resuscitation area when all the patient trolleys were being used. Staff told us this could then put pressure on the nurses in the majors area. A business case had been submitted to increase staffing in the resus area by one whole time equivalent qualified nurse per shift.

Medical staffing

- We interviewed several members of the medical team who told us staffing levels had improved over the last year particularly at night. There were a minimum of two consultants present in the department between 8am and 11pm on weekdays. At weekends one consultant was present between 8am and 11pm and an extra consultant worked for two hours between 3pm and 5pm. This meant there was a minimum of 17 hours consultant presence at weekends and a minimum of 30 hours on weekdays.

- The emergency department had a larger proportion of middle career doctors and a smaller proportion of registrar and junior doctors than the England average.

- There were seven whole time equivalent consultants in post and four whole time equivalent long term locums. This meant that although the medical staff were not all substantive they were all familiar with the policies and procedure and working practices of the department.

- One consultant had sub specialist training in paediatrics. The trust had also recently commenced a trial involving a ward paediatric consultant working in the children's emergency area from 3pm to 10pm three days per week. Results of the trial were not available at the time of inspection.

- The trust was working closely with health education east midlands to review the work force and skill requirements in the emergency department. We saw the latest version of the action plan dated July 2016 which had several actions complete and updates on the remaining actions.

- All substantive consultants and tier three doctors had up to date European Paediatric Life Support (EPLS) training and 75% of locum consultants and tier four doctors, that is six out of eight doctors. That is two out of 18 emergency department doctors were not up to date with this specific training. All emergency department doctors had up to date Advanced Life Support (ALS) training. Tier three and four doctors are undergoing specialist training, for example tier three means that the doctor is in their third year of specialist training.

- There was a morning handover meeting each day at 9am. This was attended by nursing and medical staff and led by the consultant in charge for the day. Information was shared about changes or learning from incidents.

Major incident awareness and training

- The department had suitable major incident plans in place. Staff told us about a recent major incident scenario involving flooding. Learning was identified from the event but the report was not available at the time of our inspection as it was not complete.

- The department took part in the regional major trauma network and the urgent care network along with other emergency services such as police, ambulance and the fire service. These meetings included discussion about major incidents and joint planning for regional major incident scenarios and joint training for the management of major incidents.

- We saw the Chemical, Biological, Radiological and Nuclear Contamination Plan dated April 2016. The plan had been developed in consultation with other relevant agencies such as police, fire and rescue, ambulance service and Public Health England. It detailed clear

guidance and information including responsibilities, available equipment, contact information and the process to follow in the event of contamination with hazardous materials.

- Security staff were based in the department and available 24 hours per day. Panic alarms were in place throughout the department and staff told us they felt safe.

Flow and Capacity Planning

- The flow and capacity planning carried out by the trust contributed significantly to patient safety in the emergency department.
- Flow and capacity planning meetings took place regularly throughout the day at 11am, 3pm and 6pm and the emergency department had a flow co coordinator 24 hours per day. We observed a flow and capacity meeting take place

- The trust had a dedicated flow and capacity team who collated information from around the hospital about ward capacity, planned discharges and intelligence which could impact on capacity.
- Estimated figures for emergency department admissions were monitored and compared with bed capacity. By doing this the trust were managing resources and capacity in order that beds were available and patients did not remain for too long in the emergency department impacting on flow and ultimately ambulance handovers Patient safety risks are increased the longer patients wait in an ambulance hand over queue and the longer they are waiting in the emergency department for a hospital bed.

Medical care (including older people's care)

Safe	**Good**	🟢
Effective	**Requires improvement**	🟠
Overall	**Requires improvement**	🟠

Information about the service

Sherwood Forest Hospitals NHS Foundation Trust provides medical care (including older people's care) at Kings Mill Hospital as part of the Speciality Medicine division.

The trust has 447 inpatient medical beds across three sites; 347 are located within 14 wards at Kings Mill Hospital. During our inspection we visited 15 clinical areas including the Emergency Assessment Unit, the Coronary Care Unit and Endoscopy. Specialties included; care of older person, cardiology, haematology, endocrinology, respiratory, and stroke medicine.

Between January 2015 and December 2015 there were 31,736 medical admissions to Kings Mill Hospital. Of these, 60% were emergency admissions, 38% were treated as a day case and the remaining 2% were planned admissions. General medicine represented the largest number of admissions at 60%.

This was a focused inspection following a comprehensive inspection that had taken place in June 2015. At that time medical care was rated as inadequate for safe and for effective, therefore this inspection was focused on these two domains.

During our inspection of this hospital we spoke with 15 patients, five relatives and 59 staff. We spoke with staff including junior and senior medical staff, junior and senior nursing staff, allied health professionals, pharmacy staff, matrons, support workers, receptionists, house keepers, nurse specialists, student nurses, nursing agency staff, the critical care outreach team and nurse endoscopists.

As part of our inspection we used the Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experience of people who could not speak with us. We observed interactions between patients, their relatives and staff, considered the environment and looked at 30 medical and nursing care records, 15 medicine administration charts and 21 patient observation/sepsis screening pathway records. Following our inspection, we reviewed performance information from and about the trust.

Medical care (including older people's care)

Summary of findings

Safety of medical services was rated as good because:

- There were systems, processes and standard operating procedures in place to ensure infection prevention control, records, medicines management and maintenance of equipment was given sufficient priority.
- Patients received the correct treatment in a timely manner. Nursing staff adhered to trust guidelines for the completion and escalation of Early Warning Scores (EWS); frequencies of observations were appropriately recorded and where patients had met the trust criteria for sepsis screening, patients were screened appropriately.
- Care records were mostly completed or updated appropriately to minimise risks to patients. For example, hydration, malnutrition and pressure ulcers.
- Patients were protected from abuse. Staff had an understanding of how to protect patients from abuse.

We judged that medical care services in the effective domain required improvement because:

- Patients were not always reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week. However, an appropriately trained middle grade doctor did review all patients and the consultant was available if required.
- Where patients were subject to the Mental Health Act (MHA), their rights were not always protected and staff did not always have regard to the MHA Code of Practice. Staff did not always understand the requirements of the Mental Capacity Act 2005 in relation to their roles and responsibilities.
- Some outcomes for patients who use services were below expectations when compared nationally against similar services.

However, we also found:

- Patients' care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. and outcomes for patients were mostly within expectations when compared with similar services.
- We saw where patient's symptoms of pain were suitably managed and staff were mostly proactive in assessing the patient's nutrition and hydration needs.

Medical care (including older people's care)

Are medical care services safe?

Good 🟢

We rated safety of medical services as good. Patients were protected from avoidable harm and abuse.

We found:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There were effective and consistent systems for learning from incidents to be shared across the trust; nursing and medical staff could demonstrate where changes to practice had been made as a result of an incident.
- Patients were protected from abuse; staff had an understanding of how to protect patients from abuse. Staff could describe what safeguarding was and the process to refer concerns.
- Systems, processes and standard operating procedures in infection prevention control, records, medicines management and maintenance of equipment were mostly reliable and appropriate to keep patients safe.
- Staff identified and responded appropriately to changing risks to deteriorating patients. Where patients had met the trust criteria for sepsis screening, patients were screened appropriately; this meant patients received the correct treatment in a timely manner.
- Nursing and medical staff told us they were up to date in mandatory training. Whilst we saw high numbers of nursing staff vacancies and high use of bank and agency, levels of staffing and skill mix of staff was managed appropriately and recruitment was underway. An effective induction process was in place for locum, agency and bank staff. This ensured patient's safety.

However, we also found:

- Health and Safety Executive (HSE) guidance was not always given sufficient priority; on wards 24, 35, 51 and 54 we saw oxygen cylinders stored on the floor in the clinical area.

Incidents

- An incident reporting policy and procedure was available to all staff. Incidents were reported through the trust's electronic reporting system. Without exception all staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system.
- There were no never events in medical care services between May 2015 and May 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although a never event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Medical care services reported 14 serious incidents between May 2015 and May 2016. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant they warrant using additional resources to mount a comprehensive response.
- Prior to this inspection we reviewed the full investigation reports for three serious incidents. Investigation reports were thorough and demonstrated robust reviews had taken place. We could see where relevant staff and people who used services were involved in the review or investigation. Investigation reports showed lessons had been learned and actions had been identified. People who use services were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result.
- Medical care services reported 3932 incidents at Kings Mill Hospital between May 2015 and May 2016. Of these 1131 incidents related to patient falls, 536 to medications and 18 to hospital acquired pressure damage of grade two or above. Pressure damage is graded from one to four, depending on the severity of the pressure sore, grade one being minor, to grade four, being severe.
- There were effective and consistent systems in place for learning from incidents to be shared across medical care services. Staff reported receiving feedback through emails, during board rounds and during handover. On ward 51 we saw where shared learning from incidents had been displayed on a staff notice board.
- Staff we spoke with were able to tell us of incidents they had reported and of more serious incidents that had

Medical care (including older people's care)

occurred in other areas. For example, a number of incidents had occurred trust wide involving the care of patients with a mental health illness. On ward 52, following a high number of patient falls, nursing staff were allocated to specific patient areas on the ward, the environment had been changed to accommodate those patients living with a cognitive disorder for example, dementia and meaningful activities for patients had been introduced. Staff told us this had significantly reduced the number of falls on this ward.

- Mortality and morbidity (M&M) meetings were held monthly for each medical specialty. Mortality and morbidity meetings allow health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. Following our inspection we reviewed a range of minutes for M&M meetings held by the emergency assessment unit, cardiology and health care for older people (HCOP). Minutes we looked at demonstrated where individual morbidity reviews had taken place.

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

- Staff we spoke with had a variable understanding about duty of candour. Junior staff talked of being open and transparent with the public. Senior medical and nursing staff had a full understanding and gave examples of where duty of candour had been applied appropriately. On ward 24 nursing staff told us duty of candour leaflets were given to patients and/or relatives where required.

- Where incidents of moderate harm or above had been raised through the electronic reporting system a series of questions and prompts would have to be answered by the member of staff raising the incident. This ensured the duty of candour process was acknowledged at the earliest opportunity.

Safety thermometer

- The hospital participated in the national safety thermometer scheme. Data was collected on a single day each month to indicate performance in key safety areas for example, falls with harms, catheter associated urinary tract infections, pressure damage and venous thromboembolism (VTE). VTE is the formation of blood clots in the vein.

- Data for the reporting period June 2015 to May 2016 showed an average of nine months where patients were free from a 'new harm'. Four areas (Wards 23, 24, 35 and the Stroke Unit) exceeded this average at 10, 11, 11 and 10 months respectively.

- Safety thermometer data was publicly displayed on most of the wards and clinical areas we visited. This meant patients and the public could see how the ward was performing in relation to patient safety.

Cleanliness, infection control and hygiene

- All areas inspected were visibly clean and tidy. Recent cleaning audits from May 2016 showed all ward areas were compliant with the national cleaning standards. All medical inpatient wards were identified as significant risk areas and therefore had to meet standards of 85%.The endoscopy department was identified as a high risk area and was therefore required to achieve a standard of 95%. Results from the audit completed in May 2016 showed Endoscopy were achieving this standard of cleanliness.

- Kings Mill Hospital participated in Patient-Led Assessments of the Care Environment (PLACE). PLACE are a self-assessment of non-clinical services which contribute to healthcare delivered in both the NHS and independent/ private healthcare sector in England. The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing providers. The assessment of cleanliness for this hospital demonstrated a compliance level of 99.7% which was better than the England average of 95.5%.

- Trust wide there were 36 cases of clostridium difficile (c. difficile) infections between July 2015 and June 2016 with 25 cases occurring at this hospital in the division of medicine. Clostridium difficile (c. difficile) is an infective bacteria that causes diarrhoea, and can make patients very ill. The trust trajectory (forecast) for this reporting period was 48.

- Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections. There had been no cases of MRSA reported at this trust since August 2015. We saw evidence of regular MRSA screening in patient notes although results were not always entered on the screening document. Each patient was risk assessed for the presence of MRSA and

Medical care (including older people's care)

a rescreening frequency determined on this risk. Where applicable we saw where patients were rescreened within 21 days. The trust trajectory (forecast) for this reporting period was zero.

- Meticillin-susceptible Staphylococcus aureus (MSSA) differs from MRSA due to the degree of antibiotic resistance. Between July 2015 and June 2016 there were 16 recorded cases of MSSA at this trust, of which 10 occurred at this hospital within the division of medicine. The trust did not have a trajectory (forecast) for MSSA.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) 5 Moments for Hand Hygiene. These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients.
- In medical care services, hand hygiene audit results for the reporting period July 2015 to July 2016 demonstrated greater than 90% compliance, across four out of five staff groups. Compliance amongst medical staff was reported as the lowest level of compliance at 88%. Throughout medical care services we observed the majority of staff to be complying with best practice with regard to infection prevention and control policies. There was access to hand washing facilities and a supply of personal protective equipment, which included gloves and aprons.
- Infection prevention control training was considered mandatory at this trust. Up to May 2016 86% of staff in medical care services had completed this training. This was better than the trust target of 80% with eleven areas better that the 80% target.
- Where it was suspected patients had an infection they were cared for in side rooms with signage to alert staff and visitors of the risk of infection. However, staff were not consistent in isolating patients at risk of spreading infection to others. On ward 51 we saw doors left open to three side rooms where it had been identified patients might present an infection control risk to others. Where the door was open to the side room of a patient with Escherichia coli O157 (E. coli O157) we could not see where a risk assessment had been undertaken detailing why the door could remain open. E. coli O157 is a bacterial infection that can cause severe stomach pain, bloody diarrhoea and kidney failure.
- Dedicated decontamination facilities were available in Endoscopy with processes in place to ensure the clear separation of dirty and clean equipment. We saw the decontamination process was consistent across all areas where endoscopes (an instrument which can be introduced into the body to give a view of its internal parts) were processed; the decontamination process ensured equipment was safe, clean and disinfected or sterilised to control the spread of micro-organisms.
- The decontamination process followed Health Technical Memorandum 01-06: Decontamination of flexible endoscopes. For example, protein testing was consistently carried out. Endoscopes undergo additional checks for the effectiveness of the cleaning process by using a protein testing kit to swab the scopes. This detects any protein residue following the decontamination process; a protein residue would indicate the decontamination process had not been successful and may therefore present an infection control risk to other patients.
- Where endoscopes had been used in theatres endoscopes and reusable accessories were manually cleaned immediately after use before being returned to the endoscopy unit for decontamination.

Environment and equipment

- We checked the resuscitation equipment on eight ward areas. It was clean, single-use items were sealed and in date and emergency equipment had been serviced. We saw evidence, on most wards that the equipment had been checked daily by staff and was safe and ready for use in an emergency. However, on ward 35 we saw where there had been nine occasions since May 2016 where staff had not signed to say the trolley had been checked.
- A medical equipment management department (MEMD) was available on this hospital site. MEMD was responsible for decontaminating, checking and servicing equipment to ensure it was immediately available for patient use. This included, pressure relieving equipment, replacement resuscitation equipment and sepsis boxes. None of the staff we spoke with raised concerns regarding the provision and access to patient-care equipment.
- We looked at 21 items of patient-care equipment. All were observed to be visibly clean and ready for use. With the exception of one item of patient-care

Medical care (including older people's care)

equipment the remainder had been routinely checked for safety with visible safety tested stickers demonstrating when the equipment was next due for service.

- We saw good use of 'I am Clean' stickers in ward areas to indicate where staff had signed to say equipment had been cleaned and was ready for patient use.
- On wards 24, 35, 51 and 54 we saw oxygen cylinders stored on the floor in the clinical area. Health and Safety Executive (HSE) guidance states oxygen cylinders should be stored in a purpose-built trolley in a well-ventilated storage area and cylinders should be chained or clamped to prevent them from falling over.

Medicines

- We looked at the prescription and medicine administration records for 15 patients. We saw appropriate arrangements were in place for recording the administration of medicines. The hospital used a paper-based prescribing and medication administration record system for patients. Records were mostly clear and fully completed. The records showed patients were getting their medicines when they needed them. Allergies to any medicines were recorded on 14 out of 15 medicine administration records.
- There were local microbiology protocols for the administration of antibiotics and we saw where these were mostly followed. A microbiologist was also available to offer support and guidance.
- A pharmacist visited all wards each weekday and an on-call service was available out of hours. Pharmacy staff checked the medicines patients were taking when they were admitted were correct and records were up to date. Medicines interventions by a pharmacist were recorded on the medicine administration records to help guide staff in the safe administration of medicines.
- Medicines, including intravenous fluids, were stored securely and we saw controlled drugs were stored and managed appropriately. Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs. We saw records to assure us that medicines requiring refrigerated storage were stored at the correct temperatures to ensure they would be fit for use.
- An automated pharmacy robotic system was in operation on the Emergency Assessment Unit (EAU).

This allowed for the automatic dispensing of certain medications. Nursing staff told us this assisted in reducing medication errors related to dose and administration.

- On ward 35 (discharge ward) pre-packed medicines were available to dispense as tablets to take out (TTO) and included antibiotics, blood pressure medicines, laxatives, and pain medicines. The TTO trolley was re-stocked by a pharmacy technician at the end of each day. An on-call pharmacist was available to complete late discharges.
- The pharmacy technician was also available to give advice to patients about their discharge medicines and an information card was given to patients detailing the medicines helpline'.
- Red wristbands were in use to identify if a patient had an allergy. The purpose of the red wristband was to prompt staff to seek further information from the patient's notes about the known allergen.
- In February 2015 a patient safety alert was issued by NHS England to raise awareness of the need for proper storage and management of thickening powder used as part of the treatment of people with dysphagia (swallowing problems). During our inspection of ward 23 we saw where thickening powder was stored on the bedside table of a patient who had a learning disability. We raised this immediately with the staff caring for the patient to ensure it was stored securely. Staff were not aware of the patient safety alert raised by NHS England.

Records

- Individual care records were mostly written and managed in a way that kept patients safe. This included ensuring patient's records were accurate, complete, legible, up to date and stored securely.
- During our inspection we reviewed 30 medical and nursing care records. Records were paper-based and held at the patient's bedside and in notes trolleys in the main ward corridors. We observed notes were mostly stored securely and were in an area where they could be seen at all times by a member of trust staff. However, on ward 42 we saw one notes trolley open and a second notes trolley had a set of patient notes on top. This meant that there was a risk of access to a patient's medical notes by an unauthorised person.

Medical care (including older people's care)

- On the Emergency Assessment Unit it was not always easy to determine the patient's progress through their pathway. Records were difficult to navigate, loose papers were present and records were not always stored or numbered in a chronological way.
- Patient records were multidisciplinary and we saw where entries had been made by nurses, doctors and allied health professionals including physiotherapists, occupational therapists, speech and language therapists and dietetics staff.
- Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools.

Safeguarding

- At our last inspection in June 2015 we raised concerns about the level of training staff received in safeguarding children and vulnerable adults.
- Staff we spoke with during this inspection had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns. Staff gave examples of safeguarding concerns they had raised in their ward areas.
- Staff received safeguarding of vulnerable adults training as part of their mandatory training. Information received following our inspection demonstrated completion rates for medical care services were above the trust target of 80%. As of May 2016 99% of staff had received safeguarding adults training. The level of training provided or specific staff group compliance rates were not defined by the trust.
- Staff received safeguarding children and young people training (levels one and two) as part of their mandatory training. Information received following our inspection demonstrated completion rates were above the trust target of 80% for level one training with all ward areas at 100%. Average compliance rates for level two training were 83%. Specific staff group compliance rates were not defined by the trust.
- The trust had a safeguarding lead; staff knew the name of the safeguarding lead and they told us they could approach them for advice if they needed to.

- Arrangements were in place to safeguard women or children with, or at risk of, Female Genital Mutilation (FGM). Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons.

Mandatory training

- Staff received training in mandatory topics such as infection control, fire safety, basic life support, medical devices, slips, trips and falls, medicines management, patient safety and emergency planning, blood transfusion, tissue viability, alcohol and drugs, information governance, manual handling, health and safety, safeguarding adults, mental capacity act, conflict resolution, safeguarding children (level one, two and three) and equality and diversity.
- The trust target for compliance with mandatory training was 80%. Information received after our inspection showed as of June 2016 mandatory training compliance within medical care services, trustwide, exceeded the trust target for nursing staff (86%), medical staff (84%) and allied health professional staff (89%).
- Clinical guidelines for the treatment of suspected sepsis were available to all staff to provide information and best practice guidance on the assessment and management of sepsis. Without exception all staff we spoke with were aware of these guidelines and were able to access them through the trust intranet.
- Sepsis training was considered mandatory at this trust. As of 31 March 2016 training compliance (trust wide) in sepsis was; consultant 99%, nursing staff 90% and junior doctors 100%.
- The National Sepsis Module was to be a compulsory section of the mandatory e-learning for all junior doctors prior to entering the trust from August 2016 onwards.
- The Mental Capacity Act (MCA) training was considered mandatory. Training Compliance figures for MCA, split by staff group, for medical care services as of 30 June 2016 were; medical staff 85%, nursing staff 99% and other 99%.

Assessing and responding to patient risk

- Nursing staff used an early warning scoring system (EWS), based on the National Early Warning Score, to

Medical care (including older people's care)

record routine physiological observations such as blood pressure, temperature, and heart rate. EWS was used to monitor patients and initiated calls to the medical staff when required.

- Patients with a suspected infection or an EWS of three or more were screened for sepsis, a severe infection which spreads in the bloodstream, using an Adult Sepsis 6 Screening Tool.
- At our last inspection in June 2015 we raised concerns about the management of patients with sepsis. In 2010 and 2012 we raised mortality outlier alerts with the trust, when routinely collected information showed there were a higher number of deaths than expected for patients with sepsis. The trust had identified a third mortality outlier for patients with sepsis in the period April 2014 to January 2015.
- In August 2015, following an inspection of medical care (including older people's care), we served an urgent Notice of Decision to impose conditions on the trust's registration under Section 31 (1) (2) (a) of the Health and Social Care Act 2008. During our inspection of all areas we saw where the trust was meeting the conditions of this notice.
- During this inspection we reviewed 21 electronic patient observation records. In all 21 cases we found nursing staff adhered to trust guidelines for the completion and escalation of EWS, frequencies of observations were appropriately recorded and medical staff had documented a clear plan of treatment if a patient's condition had deteriorated. Where screening for sepsis had been indicated we saw where this had been completed appropriately.
- Where specific interventions had been required we saw where the Sepsis Six Care Pathway had been completed in a timely way. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality (death) of patients with sepsis, it consists of three diagnostic and three therapeutic steps, all to be delivered within one hour of the initial diagnosis of sepsis for example administering oxygen and intravenous (IV) antibiotics. Sepsis Six has been associated with decreased mortality.
- There were regular audits to monitor delays in observations being taken. For the reporting period May 2015 to January 2016 the audit showed between three and seven per cent of patient observations were delayed by an average time of between 29 and 112 minutes.

- We reviewed 30 medical care records. Where patients were admitted as an emergency medical admission we saw where they were seen and assessed by a consultant within 12 hours of admission and assessed by a member of the medical team within 30 minutes.
- Staff identified and responded appropriately to changing risks to patients, including deteriorating health and wellbeing, medical emergencies or challenging behaviour. Additional support for nursing staff could be accessed through the medical staff, the acute response team (ART) and the critical care outreach team. Out of hours support was provided by a hospital at night team led by a duty nurse manager. During our inspection we observed staff on ward 51 taking appropriate action and seeking support through the ART.
- Staff in endoscopy used a document based on the World Health organisation (WHO) safety procedures: WHO surgical safety checklist, to ensure each stage of the patient's journey was managed safely.
- Comprehensive risk assessments were carried out for patients and risk management plans developed in line with national guidance. For example, falls, pressure ulcer prevention and malnutrition.
- As part of the falls pathway a postural hypotension assessment was completed on all new admission to medical care services. Postural hypotension is a form of low blood pressure in which a person's blood pressure falls when suddenly standing up or stretching. We saw where this assessment had been completed in 50% of the nursing care records we reviewed.
- On ward 42 policies and guidance were available for the care of patients with a tracheostomy. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help a patient breathe. Where patients had a tracheostomy, a tracheostomy trolley was available on the ward. This provided all necessary equipment should an emergency arise.
- A policy for the assessment and management of patients at risk of self-harm was available to all staff. The purpose of the guidance was to provide information, best practice guidance and support for staff assessing, treating and deciding on best courses of action for all patients who presented with previous or current

self-harming behaviour or intent, during all stages of their admission. It also provided guidance for staff on how to access specialist mental health advice and support when required.

- A Reducing Harms Team based on the Emergency Assessment Unit (EAU) could be accessed by ward staff through the duty nurse manager. This team was available to support wards where enhanced observation of an individual patient was required.

Nursing staffing

- In order to ensure patients received safe care and treatment at all times staffing levels and skill mix were regularly reviewed. Patient acuity and dependency data was collected through the use of a nationally recognised Safer Nursing Care Tool. The data collected was considered alongside staffing information from the electronic rostering system and patient centred information including admissions and discharges and additional tasks undertaken in different clinical areas. Senior nursing staff told us this data was currently being used to review the capacity in each ward area and there were plans to reduce bed numbers in line with the number of permanent nursing staff available. Information received following our inspection outlined the proposed plan for the re-structuring of bed numbers across three ward areas within medical care services.

- Staffing levels were displayed in all the clinical areas we visited and we saw where information displayed indicated, actual staffing levels mostly met planned staffing levels. Where there were gaps in staffing bank and agency staff had been requested. We observed the presence of bank and agency staff on most ward areas.

- During our inspection we observed staffing levels in most areas to be sufficient to deliver safe care in accordance with National Institute for Health and Care Excellence (NICE) guidelines SG1: Safe staffing for nursing in adult inpatient wards in acute hospitals. For example we saw, a daily review of nurse staffing numbers, a system in place for avoiding red flag events (delays or omissions of care or treatment) through the use of the hospital reducing harms team and plans in place for those patients requiring enhanced monitoring.

- However, concerns around staffing levels and high agency use were raised by most nursing and medical staff we spoke with. We saw from ward staffing rotas and trust wide vacancy data that there were vacancies on 13 out of 14 ward areas. The extent of the vacancies varied

from ward to ward. For example, as of July 2016, the vacancy rate on the Emergency Assessment Unit (EAU) was 18 whole time equivalent vacancies (35%) out of a nursing establishment of 50.8 whole time equivalent. The vacancy rate on ward 43 was 15.9 whole time equivalent vacancies (57%) out of a nursing establishment of 27.8 whole time equivalent.

- Ward sisters told us where there were vacancies these had been addressed and wards were at various stages of the recruitment process with most wards expecting a number of newly qualified staff to start in September 2016. Staffing vacancies had also been raised as a concern by the senior leads within medicine and had been identified as a significant risk within medical care services.

- Across medical care services ward mangers and matrons told us of processes in place to manage nurse recruitment. These included; rolling adverts, annual recruitment fairs, international recruitment, rapid access to jobs for third year student nurses and the use of ward budgets to create supportive roles for example, band four associate nurse practitioner. On EAU we were told where a band six preceptorship role had been advertised to support seven newly qualified staff due to start on EAU in September 2016.

- There was an extensive use of bank and agency nurses to maintain staffing levels on medical wards. Information received following our inspection for the reporting period January 2016 to June 2016 showed a total of 6,950 registered nurse shifts had been filled by agency staff.

- A policy for the engagement of temporary workers was available to all staff. The purpose of the guidance was to support trust staff responsible for booking temporary workers. It also covered the required actions when a temporary worker arrived for duty or if there were any concerns related to performance. All the ward managers we spoke with were aware of this guidance and were able to explain this guidance. For example, the process of induction for temporary staff and what they would do if they had concerns about the abilities of the member of temporary staff.

- There was an effective system in place for providing an induction to each ward where locum, agency and bank staff, including nurses, allied health professionals and healthcare assistants worked. This meant wards could be assured that those staff were suitably competent,

skilled and experienced to work on that ward. During our inspection we saw, on two occasions, where an agency nurse received an induction before commencing their shift.

- On Ward 43 there were two four-bedded bays and on the Stroke Unit a four-bedded hyper acute unit for those patients deemed as requiring Level two care. Level two care is defined by the Guidelines for Provision of Intensive Care Services (GPICS) as; patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those stepping down from higher levels of care. GPICS suggest Level 2 patients require a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care. Whilst these services were not led by a Consultant Intensivist and did not therefore have to meet GPICS, at the time of our inspection we observed staffing levels in line with GPICS. Ward managers of both areas told us the ward establishment for both level two areas ensured a nurse/patient ratio of 1:2 at all times.

- During our inspection we observed a shift handover taking place on three ward areas. An initial handover involved the whole nursing team; this ensured all staff had an appropriate awareness of each patient on the ward. This was followed by an accountability handover at the patient's bedside. Accountability handover involved the named staff identified to care for a group of patients. The handover process required both trained staff to sign an Accountability Sheet at the point of handover (change of shift). The signature was confirmation for example, that all care had been given, significant changes had been handed over and medication charts had been reviewed.

Medical staffing

- Staffing levels and skill mix was planned and reviewed so that patients received safe care and treatment on the Emergency Assessment Unit (EAU). Consultant cover was available on the unit until 9pm each day with on-call consultant cover provided outside of these times. Day to day cover on EAU was also provided by two specialist registrars (a Specialist Registrar or SpR is a doctor who is receiving advanced training in a specialist field of medicine in order to eventually become a consultant), and three junior doctors. Three junior

doctors and an SpR were available overnight for admissions on EAU in addition to providing medical cover for the wards. Medical staff we spoke with on EAU told us they felt the medical cover was adequate.

- As of July 2016 the highest medical vacancies within medical care services were; health care of older person (12 whole time equivalent), respiratory (seven whole time equivalent), stroke (6.5 whole time equivalent), diabetes (1.6 whole time equivalent) and neurology (three whole time equivalent). The vacancy rates in health care of older person accounted for 46% of the total number of budgeted posts and diabetes 12% of the total number of budgeted posts.

- Following our inspection we reviewed a report submitted to NHS improvement (the newly formed organisation merging the National Trust Development Authority and Monitor) outlining the trusts plans to address medical vacancies. These included for example; service redesign in stroke medicine, access to specialist registration programmes by overseas medical staff, funding for long-term employment of locum staff and the use of Clinical Fellows (specialty training posts which allow 25% of time on academic training as well as 75% in clinical training) to cover junior doctor posts.

- Where recruitment processes were underway, information received following our inspection showed two consultants and four junior doctors had been recruited and were due to join the trust in August/September 2016. There were also joint recruitment processes underway with another NHS trust.

- During our inspection we observed locum (temporary) medical staff in most ward areas. Information received following our inspection for 1-7 August 2016 showed, across 11 specialties 35.1 whole time equivalent locum staff had been used. The extent of the locum use varied with lowest use in dermatology medicine at 1.9 whole time equivalent, where the vacancy rate was 2 whole time equivalent out of a budgeted establishment of 5.8 whole time equivalent. The highest use was in health care of older person at 10.4 whole time equivalent, where the vacancy rate was 8.1 whole time equivalent out of a budgeted establishment of 23 whole time equivalent.

- Medical cover out of hours, including weekends, was provided by a dedicated hospital at night team led by a duty nurse manager who was responsible for

coordinating activity amongst the team. Junior and senior doctors including specialist medical registrars were part of this team. On-call consultant support was provided to individual specialties as required.

- The medical handover on EAU occurred three times daily, seven days a week at 8am, 3.30pm and 9.30pm and involved discussions of all new admissions and those patients at risk of and/or deteriorating. Medical handover from the medical wards to the hospital at night team took place at 8.30pm and included a summary of all deteriorating patients.

Major incident awareness and training

- There were arrangements in place to respond to emergencies and major incidents. A major incident plan and action cards were available in the ward areas detailing actions to be taken by ward staff in the event of a utilities failure or major incident. Plans were available at ward level and via the trust intranet. Nursing staff we spoke with were familiar with these plans.
- Patient safety and emergency planning was included as part of the trust mandatory training programme.

Are medical care services effective?

Requires improvement ●

The effectiveness of medical care required improvement. Whilst we saw significant improvements since our last inspection in June 2015 patients were at risk of not always receiving effective care and treatment.

We found;

- Some outcomes for patients who use services were below expectations when compared nationally against similar services.
- Staff did not always understand the requirements of the Mental Capacity Act 2005 in relation to their roles and responsibilities. Patient's capacity was not always suitably assessed.
- Patients were not routinely reviewed by a consultant at a weekend. However, an appropriately trained middle grade doctor did review all patients and the consultant was available if required.

However, we also found;

- Patient's care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. We saw good use of patient pathways aligned to National Institute for Health and Care Excellence (NICE) quality standards.
- Following a Joint Advisory Group (JAG) accreditation visit on 29 July 2016 the endoscopy unit at King's Mill Hospital had met all of the required JAG accreditation standards and was therefore awarded full JAG accreditation for one year.
- We saw where patient's symptoms of pain were suitably managed and staff were mostly proactive in assessing the patient's nutrition and hydration needs.
- We saw evidence of effective multidisciplinary working with staff, teams and services working together to deliver effective care and treatment. Staff were qualified and had the skills they needed to carry out their roles effectively and staff were supported to maintain and further develop their professional skills and experience.

Evidence-based care and treatment

- Patients being treated for sepsis were treated in line with the Sepsis Six Bundle; key immediate interventions that increase survival from sepsis. There is strong evidence that the prompt delivery of 'basic' aspects of care detailed in the Sepsis Six Bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions when applied within the first hour.
- The Sepsis Clinical Lead for the trust was aware of latest National Institute for Health and Care Excellence (NICE) guidelines (NG51); Sepsis: recognition, diagnosis and early management and told us there were plans to review the current sepsis policy in line with these guidelines by April 2017.
- Patients had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice. For example, we saw where best practice was followed in line with the National Institute for Health and Care Excellence (NICE) quality standard CG68 Stroke and transient ischaemic attack in over 16s: diagnosis and initial management. The sentinel stroke national audit programme (SSNAP) data submitted by the trust audited stroke services against NICE evidence-based standards.
- Staff followed NICE guidance (CG92) in the assessment and management of venous thromboembolism (VTE). We reviewed 30 patient care records. All records

demonstrated where patients had received a venous thromboembolism (VTE) risk assessment and had prophylactic venous thromboembolism (VTE) medication if indicated.

- In addition to this staff on the stroke unit were using intermittent pneumatic compression (ISC) therapy. ISC is a therapeutic technique used in medical devices that include an air pump and inflatable boots in a system designed to improve venous circulation in the limbs of patients who are at risk of a deep venous thrombosis (DVT). A DVT is a blood clot that develops within a deep vein in the body, usually in the leg.

- Guidance was available to medical staff for the treatment of fluid and electrolyte disorders. For example, hyperkalaemia (a medical term that describes a potassium level in the blood that's higher than normal) and hyponatraemia (a condition that occurs when the level of sodium in the blood is abnormally low).

- Care pathways; multidisciplinary plans of anticipated care and timeframes were in place for specific conditions or sets of symptoms. These included pathways for acute kidney injury, gastro-intestinal (GI) bleeding, delirium, parenteral nutrition, falls prevention and management, non-invasive ventilation, malnutrition, sepsis, Parkinson's disease and dementia. We reviewed 30 nursing and medical patient records during our inspection and observed the use of care pathways. Where generic pathways were in use we saw these individualised to meet the specific needs of the patient.

- During our inspection we saw good use of the This is me documentation, used for those patients living with a cognitive disorder for example, dementia. This provided staff with information about the patient and reflected the patient's individual needs and preferences.

- Patient pathways were multidisciplinary and included input from other specialties. For example, within medicine the EGO pathway had been implemented in November 2015 by trauma and orthopaedics, acute medicine and health care of the older person (HCOP).

- The EGO pathway described the pathway through which a frail, elderly patient would go through following admission to the emergency department with a suspected fracture. The pathway was designed to ensure best possible care was provided from the three specialties. This was in recognition that although a patient might have had a surgical need their greater clinical need was likely to revolve around their medical co-morbidities. (A co-morbidity is the presence of one or more additional diseases or disorders co-occurring with a primary disease or disorder). This meant the patient was reviewed in a timely manner so that their medical condition could either be improved should they require a surgical intervention or, if for conservative (not requiring a surgical intervention) management; they were either discharged with the appropriate support in place or admitted under the most appropriate team who could best meet their needs.

- Telecommunications technology was used out-of-hours for the remote diagnosis and treatment of patients requiring thrombolysis. Thrombolysis is the breakdown of blood clots with a clot-busting drug to try to disperse the clot and return the blood supply to the brain. Telecommunication is the exchange of information over significant distances by electronic means. This meant patients admitted to the Hyper-Acute stroke unit out-of-hours would have their diagnostic tests reviewed and treatment commenced under the direction of a stroke consultant.

- Local audit activity included audits for sepsis, accountability handover, documentation, infection prevention control and falls. Audit results were shared across the division of medicine through the ward assurance dashboards.

- Patients on the Emergency Assessment Unit (EAU) were seen and reviewed by a consultant twice daily. Once transferred to the medical wards from EAU patients were seen, as a minimum, twice weekly by a consultant unless their clinical condition determined a more frequent review, for example, if they were a new admission, they were acutely unwell or they were medically fit for discharge. At all other times patients would be seen by a specialist registrar (SpR).

Pain relief

- The Faculty of Pain Medicines Core Standards for Pain Management (2015); Standards 2 and 3 were implemented across the medical wards and relevant clinical areas, for example, nursing care records included care plans for pain. A pain tool was available for patients who could not verbalise and/or may have a cognitive disorder and pain was assessed and documented on all 21 electronic patient observation charts we reviewed.

Medical care (including older people's care)

- During our inspection we spoke to six patients specifically about how their pain had been managed during their stay in this hospital. All six patients told us their pain had been assessed and managed appropriately. One patient told us their pain had been repeatedly assessed and that pain relief was given in a timely manner.
- A review of 15 medication prescription charts demonstrated patients were given pain relief where appropriate at regular intervals.
- Nursing metrics data was collected for all inpatient areas across medical care services. Through the use of a nursing audit tool, matrons of the service were able to look at the completion of documentation for pain management. The ward assurance dashboard for medicine dated April 2015 to April 2016 showed the average completion rate across 14 ward areas was 96%. This was better than the trust target of 90%.
- On ward 43 the PQRST method was used to assess a patient's level of pain. The PQRST (P-provokes, Q-quality, R-radiates, S-severity, T-time) method of assessing pain is a valuable tool to accurately describe, assess and document a patient's pain. Nurses were able to help patients more accurately report their pain by using specific PQRST assessment questions.

Nutrition and hydration

- A nationally recognised screening tool was used throughout medicine to identify adults who were malnourished or at risk of malnutrition. Staff used this tool to inform care planning and identify any specific dietary requirements. In 26 out of 30 nursing records we reviewed we saw where patients had been appropriately assessed on admission using this tool. However, nutrition care plans were not always appropriately updated during a patient's admission. For example, a patient on ward 23 had not had a reassessment despite experiencing a weight loss of 2.8 kilogrammes over a four-day period and on ward 34 a patient had experienced a weight loss of three kilogrammes over a nine-day period.
- Nursing metrics data was collected for all inpatient areas across medical care services. Through the use of a nursing audit tool, matrons of the service were able to look at the completion of documentation for nutrition.

The ward assurance dashboard for medicine dated April 2015 to April 2016 showed the average completion rate across 14 ward areas was 95%. This was better than the trust target of 90%.

- A red tray system was in place at the hospital to ensure that the nutritional requirements of patients were fully met. Patients who needed help with eating were served meals on red trays and those who needed encouragement with their fluid intake to prevent dehydration were given a water jug with a red lid. During our inspection we saw where patients with either a red tray, or a water jug with a red lid, were offered the appropriate level of assistance.
- Food record charts were in use to actively monitor a patient's dietary intake. We saw where these had been completed appropriately.
- Registered nurses on the stroke unit had completed swallowing assessment training so could undertake a preliminary swallowing assessment to ensure, at weekends and out of hours, patients were not left without adequate nutrition for any period of time.
- Where there was any indication of a patient's difficulty in swallowing food or fluid staff followed a nil-by-mouth starter regime until an assessment could be carried out by a specialist practitioner. This meant patients could receive tube feeding with a nasogastric feeding tube within 24 hours of their admission. A nasogastric tube is a narrow tube passed into the stomach via the nose.
- There were systems in place to monitor patients' hydration. A hydration chart measured input where there were general concerns or monitoring required. A fluid balance chart was used if there was an identified risk or intravenous fluids were being used.
- During our inspection we saw examples where these charts had been used and completed appropriately. Of the 20 nursing care records we reviewed where fluid balance or hydration charts were in use, with the exception of two patients (Stroke Unit and EAU), all had been fully completed.
- Specialist nutrition nurses were available at this trust for advice and support where required and were part of a weekly nutrition ward round with ward nurses, dietetics and a gastroenterologist for those patients with complex nutritional needs.

Patient outcomes

- The trust had one open mortality outlier alert. This is when there have been a higher number of deaths than

Medical care (including older people's care)

expected for a defined condition. The trust received notification from Dr Foster Intelligence that they had shown a higher than expected hospital standardised mortality ratio (HSMR) in the area of fluid and electrolyte disorders. Dr Foster Intelligence is a provider of healthcare information in the United Kingdom, monitoring the performance of the National Health Service and providing information to the public.

- There were 13 deaths whose primary diagnosis of admission was coded under fluid and electrolyte disorders, against a calculated expected number of 9.05. The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect.

- The medical and nursing notes for all 13 patients were reviewed, along with their pathology and radiology results and their observation charts. Each case had been reviewed to see whether the primary diagnosis (in this case fluid and electrolyte disorders) was appropriate and to look at the care of those patients and their cause of death.

- Results of the review were discussed at the trust mortality group (TMG) in July 2015. At that point all the patient notes had been reviewed and the outcomes identified. The final report was presented at the TMG on 10th November 2015. The review indicated all cases were unavoidable deaths and where an electrolyte imbalance had been identified there was a significant underlying cause. We were therefore assured the trust had appropriately investigated and addressed this outlier and were satisfied this case could be closed.

- The latest published Summary Hospital-level Mortality Indicator (SHMI) for January 2015 to December 2015 was 0.99 and within the expected range when compared nationally. The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

- The trust submitted data to the Sentinel Stroke National Audit Programme (SSNAP) which aims to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. From January 2016 to March 2016 SSNAP scored the trust overall at level B, on a scale where level E is the worst possible. The trust varied in performance

against individual indicators. The trust's speech and language therapy indicator had been rated D from October 2015 to March 2016, while performance against the standards by discharge and occupational therapy indicators had been rated A from April 2015 to March 2016 and discharge processes had been rated A from July 2015 to March 2016. Results had improved since 2014 where SSNAP had scored the trust at level D overall. Access to speech and language therapy had been rated as E during that reporting period.

- The trust provided a 24 hour stroke thrombolysis service (this is a treatment where drugs are given rapidly to dissolve blood clots in the brain). The trust standard was that all patients admitted following a stroke were thrombolysed within one hour of admission to the emergency department. Between January 2016 and June 2016, 30 patients admitted to this trust were thrombolysed. Of these 15 patients (50%) were thrombolysed within one hour. Out of hours cover for the thrombolysis service was provided on a rota by this trust and a neighbouring NHS trust. Where the neighborough trust was providing cover there had previously been difficulties with the consultant on call accessing patient test results in order to commence thrombolysis resulting in a delay to treatment. An action plan had been put in place and thrombolysis times had improved as indicated in the Sentinel Stroke National Audit Programme (SSNAP) for January to March 2016.

- The trust participated in the Heart Failure Audit. Results from the 2014 audit showed Kings Mill Hospital scored worse than the England average in three out of four in-hospital care indicators and better than or the same as the England average in four out of seven discharge indicators. Two discharge indicators, where the hospital performed significantly worse than the England average, related to referral to the heart failure service.

- Following the 2013/2014 heart failure audit report, the cardiology team reviewed the findings and used the results to benchmark their practice against the national average and other hospitals. An action plan was not developed. Due to 2013/2014 being the first year where all hospitals were required to enter all coded heart failure admissions the hospital could not benchmark against previous data.

- Kings Mill Hospital took part in the 2015 National Diabetes Inpatient Audit (NaDIA)). Results demonstrated the hospital had four scores better than and 14 scores worse than the England average. The indicators

Medical care (including older people's care)

regarding medication errors and management errors were significantly worse than the England average at 52% and 38% compared to 38.1% and 23.9% nationally. The data showed overall patient satisfaction had improved from the previous year (76%) at 82% but remained worse than the England average of 84.3%. We did not see where an action plan had been developed to address these results.

- The hospital performed well in the 2013/14 Myocardial Ischaemia National Audit Project (MINAP) audits. MINAP is a national clinical audit of the management of heart attack. In 2013/14, almost 99.6% of patients who had sustained a heart attack (NSTEMI) were seen by a cardiologist or a member of their team, compared to 93.7% nationally and 90.8% were referred for, or had, an angiography compared to 72.6% nationally. Angiography is a type of x-ray used to examine blood vessels. In total, 12.2% of NSTEMI patients were admitted to a cardiac unit or ward compared to 52.6% nationally, this was the only standard to fall below the England national average.

- For the period December 2014 to November 2015 medical patients at this hospital had a higher than expected risk of readmission for non-elective admissions in respiratory medicine and a higher than expected risk for all elective admissions. The elective specialty, clinical haematology, had the largest relative risk of readmission. However, Clinical Haematology is a specialty where readmission is part of the plan for many patients. For example when patients have received chemotherapy they may be readmitted for neutropenic care when their white blood count falls. Chemotherapy is a type of cancer treatment.

- At the time of our inspection the endoscopy unit was not accredited by the joint advisory group (JAG). This is a national award given to endoscopy departments that reach a gold standard in various aspects of their service, including patient experience, clinical quality, workforce and training. However, following a Joint Advisory Group (JAG) accreditation visit on 29 July 2016 the endoscopy unit at King's Mill Hospital had met all of the required JAG accreditation standards and was therefore awarded full JAG accreditation for one year.

Competent staff

- There were arrangements in place for supporting and managing staff. This included one-to-one meetings, appraisals, preceptorship, clinical supervision and revalidation.

- Nursing appraisal rates in medical care services for the reporting period end May 2016 averaged 84.8%. Six clinical areas were significantly below the trust target of 90%. The lowest scoring areas were the Emergency Admissions Unit (EAU) at 67.8%, ward 34 at 69.6% and ward 44 at 74.1%. Nursing staff told us they found appraisals meaningful and were able to identify and access learning and training opportunities.

- Clinical supervision is a formal process of professional support and learning. Following our inspection we asked the trust to provide information confirming whether registered nurses in medical care services were accessing clinical supervision. The trust told us they did not keep formal records of staff undertaking clinical supervision. Staff were directed to clinical supervision at various points in their career at induction, proud to care days and Preceptorship. There was no specific time allocated on duty rosters for clinical supervision. Work was underway to improve the effectiveness and efficiency of rostering to help provide the allocated time for staff to undertake clinical supervision if they wished. The trust currently had 17 clinical supervisors. However a number of supervisors only undertook supervision in their own area and did not wish to be made available trust wide.

- Ward managers reported regular one-to-one meetings with their matron and weekly and monthly group forums with the chief nurse. All the ward managers reported positively about these meetings, seeing them as valuable for their development and supportive in their day-to-day work.

- Workshops and additional training through the trusts training and development department were available to support and guide staff through the revalidation process. One nurse told us they had recently accessed this. Revalidation is the process that all nurses and midwives need to go through in order to renew their registration with the Nursing and Midwifery Council (NMC).

- All new permanent staff joining the trust attended a corporate induction (orientation day) course prior to starting their employment. After completing the corporate induction course, all new staff were given a

Medical care (including older people's care)

local induction into their working area by their line manager. All staff changing role or departments within the trust had a local induction into their new area and completed a local induction checklist.

- The trust was committed to listening to and supporting trainee doctors. There were monthly Junior Doctor Forums (JDFs) in all divisions and three Joint JDFs per year. This had been recognised as an area of improvement during a Quality Management Visit by Health Education East Midlands (HEEM) in November 2015. One junior doctor we spoke with told us they had accessed these forums and found them useful.

- Following a recommendation by HEEM to ensure equality for all junior doctors the junior doctor rota had been redesigned to increase the opportunity to attend teaching sessions. None of the junior doctors we spoke with raised concerns about attending teaching sessions and gave examples of attending grand rounds (an important teaching tool of medical education and inpatient care) and regular Thursday afternoon teaching sessions. One junior doctor told us fluid and electrolytes had been discussed at a recent grand round they had attended.

- At our last inspection of the trust in June 2015 staff were not always appropriately trained to provide the care and support needed by patients at risk of self-harm.

- Following an incident in October 2015 a bespoke self-harm and mental health awareness training presentation was developed by the health and safety and practice development teams. The purpose of the mental health awareness sessions was to provide all clinical staff with the necessary information and knowledge about how to identify, provide a safe environment for care and summons the required specialist help and support required for the patients needs. This also included anti ligature training. Since our previous inspection of the trust in June 2015, the Trust had delivered mental health awareness training to over 90% of front-line clinical staff. To sustain staff education, training on mental health was included in mandatory training from April 2016 onwards. The plan was for 90% of staff to have received this training by April 2017. By June 2016 12% of staff had completed the mandatory mental health training.

- Nursing staff in all the ward areas we visited told us they had either had or were booked on the training and most felt more confident in caring for patients with a mental health illness. However, three members of staff on ward

36 told us of a recent serious incident regarding an attempted suicide. Whilst they had received training around mental health awareness since this incident they did not feel confident caring for this group of patients. As a result, any patient admitted to this area with a known mental health illness were placed on enhanced observation. Enhanced observation involves allocating a nurse to place a patient under continuous observation.

- A Registered Mental Health Nurse (RMN) based on ward 52 provided ward based training around vulnerable adults and capacity.

- After one year in post on ward 23 registered nurses were trained to undertake electrocardiogram (ECG), a test used to check the heart's rhythm and electrical activity. This was in addition to holding a certificate in Immediate Life Support (ILS) and attending a cardiac skills study day. All band six staff (six in total) were Advanced Life Support (ALS) trained and had completed the English National Board (ENB) 124 Coronary Care Nursing course.

- On ward 52 we were told all unregistered staff had completed the Care Certificate. The Care Certificate is a set of standards that social care and health workers follow in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

- At our last inspection of this trust in June 2015 we were concerned patients requiring critical care at level two on Ward 43 were not cared for by staff with a relevant qualification in critical care nursing and not therefore meeting the Guidelines for Provision of Intensive Care Services (GPICS) standard: a minimum of 50% of registered nursing staff will be in possession of a post registration award in critical care nursing. These services were not led by a Consultant Intensivist and as such, in accordance with current guidance, did not have to meet GPICS. However, at the time of our inspection we saw where registered nurses on ward 43 had received training on non-invasive ventilation (NIV) in line with mid Trent Critical Care Network. NIV refers to the provision of ventilatory support through the patient's upper airway using a mask or similar device. Staff were trained in-house by the nurse consultant for Intensive Care and were required to complete competency packages.

Medical care (including older people's care)

- Information received following our inspection showed as of July 2016 14 out of 16 (87.5%) registered staff had completed this training. This meant staff had the skills, knowledge and experience to deliver effective care and treatment.
- In stroke services, stroke specific training was available to all staff. An in-house three-day programme was available to prepare staff for working within the Hyper-Acute area of the unit. Hyper acute refers to those patients in the early stages of stroke onset.
- Nurses on the stroke ward were competent in completing basic swallowing assessments, which meant that patients were assessed quickly and able to eat if it was assessed as being safe for them to do so.
- Tracheostomy care training on ward 42 was delivered by the trust critical care outreach team.
- The endoscopy unit was a JAG accredited training centre. On the day of our inspection we saw a training event taking place for local and external staff.

Multidisciplinary working

- There was an effective multidisciplinary team (MDT) approach to planning and delivering patient's care and treatment. We saw involvement from nurses, medical staff, allied health professionals (AHP) and specialist nurses. All staff we spoke with told us there were good lines of communication and working relationships between the different disciplines.
- Medical records demonstrated an MDT approach to the delivery of patient care. In all the care records we reviewed we saw input from for example: physiotherapists, consultants, dieticians, nurses, speech and language therapy (SALT) and specialist nurses.
- MDT board rounds took place in all the clinical areas we visited. We attended three board rounds during our inspection. We saw a MDT attendance from doctors, nurses, physiotherapy, speech and language therapy, occupational therapy, a discharge coordinator and specialist nurses. Board rounds were an opportunity to discuss patients' care pathways including any discharge plans and were an opportunity to identify those patients who were particularly vulnerable for example, patients living with dementia or a learning disability and those patients identified through the sepsis pathway.
- A Rapid Response Psychiatric Liaison Team (RRLPT) could be accessed for guidance and support as required for those patients who voiced suicidal thoughts or intent to self-harm. This service was provided by a neighbouring trust but based on the Kings Mill Hospital site. Whilst there was no formal service level agreement between the two trusts for this service, information received following our inspection included a letter from the provider of RRLPT which stated RRLPT would support hospital staff where detention of a patient under The Mental Health Act was being considered.
- A ward-based pharmacist was available to attend the ward round for those patients considered to have complex medication needs. Pharmacy would also be available to see all new admissions, patients for discharge and those patients with a known Acute Kidney Injury (AKI). Acute Kidney Injury (AKI), previously known as acute renal failure, is a sudden loss of kidney function.
- The number of consultant-led ward rounds varied across the ward areas. On ward 52 consultants were present at weekends, nursing staff on this ward would provide the consultant with a list of those patients requiring a weekend review. Wards 23 and 24 reported daily consultant-led ward rounds. On ward 42 a twice-weekly consultant ward round took place. However, if a patient was acutely unwell the consultant would see them. We saw this took place during our inspection where an acutely unwell patient was reviewed by the consultant despite it not being a consultant ward round day. In all ward areas nursing staff told us consultants would be present at weekends to see all new patients, those patients who were acutely unwell and those patients fit for discharge.

Seven-day services

- Discharge summaries were sent electronically to the patient's GP on discharge to ensure continuity of care within the community. Where patients lived out of county paper copies were sent both with the patient and by post to the GP.
- Therapy services such as physiotherapy, speech and language therapists and occupational therapy operated Monday to Friday 9am to 5pm. An on-call physiotherapy service was available out of hours as required.
- Speech and Language Therapists (SALT) were employed under a Service Level Agreement (SLA) with a nearby trust. An SLA is a contract between a service provider and the end user that defines the level of service expected from the service provider. SALT provided cover 8am to 4pm Monday to Friday. There was no SALT provision out of hours.

Medical care (including older people's care)

- A team of eight nurses trained in thrombolysis provided 24 hour cover, seven days a week on the stroke unit. Where patients were known to be suffering a stroke the local NHS ambulance provider would contact the stroke unit to advise them of the patient's arrival in the Emergency Department (ED). The thrombolysis nurse would be available to meet the patient upon arrival in ED and accompany the patient throughout the acute phase of their treatment.

- There was an acute Gastrointestinal (GI) bleed consultant on-call, available to endoscope patients who were acutely unwell. Out of hours endoscopies were carried out in theatres with theatre staff providing procedural and recovery support.

- Pharmacy support was available Monday to Friday on all ward areas with additional pharmacy support available on the Emergency Assessment Unit (EAU) 9am to 5pm at the weekends. A pharmacy technician was also available on EAU Monday to Friday during daytime hours.

- A Frailty team was available seven days a week on EAU to identify, treat and coordinate care for those patients identified as having a complex cognitive disorder. For example, Parkinson's or dementia.

- A Critical Care Outreach team (CCOT) was available to the wards during daytime hours (7.45am to 8.45pm), seven days a week. The team worked closely with the nursing and intensivist teams in the intensive care units within the hospital and supported ward staff in the detection and management of critically ill and deteriorating patients. The aim of CCOT was to ensure deteriorating patients received appropriate and timely treatment in a suitable area.

- An integrated pain team for acute and chronic pain supported by a consultant anaesthetist was available 8am to 6pm Monday to Friday and 8am to 1pm Saturday. There were plans to extend this to Sundays for seven day cover. Out of hours cover was provided an on-call anaesthetist.

- On ward 52 (Woodland Ward) an activity coordinator was available eight hours a day, four days a week in addition to a Registered Mental Nurse (RMN) available 7.30am to 3.30pm, Monday to Friday.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results.

- There were arrangements in place to make sure that diagnostic imaging and endoscopy referrals and results occurred in a timely manner. Access to diagnostic test requests and diagnostic test results were made through an electronic communication system. Where results were abnormal medical staff told us they would receive a phone call advising them of the abnormality, this included radiology results.

- The trust monitored the length of time in which radiology treated an individual patient from the point of referral. For example, results for June 2016 against a trust target of 98% showed urgent x-rays requested between the hours of 8.30am and 10pm were completed within four hours in 90.3% of cases; this had improved from October 2015 where 67.2 % were completed within four hours. Urgent X-Rays requested between the hours of 10pm and 8.30am were completed within four hours in 81% of cases, an improvement from October 2015 where 53.3 % were completed within four hours. Urgent Computed Tomography (CT) referrals made before 11am were scanned the same day in 97.8% of cases. CT is an imaging procedure that uses special x-ray equipment to create detailed pictures, or scans, of areas inside the body.

- Results for June 2016 showed the average time to process blood samples (from the Emergency Assessment Unit) from receipt to the results being ready varied between 33 minutes and 110 minutes with most results available in less than one hour.

- Nursing staff used the SBAR tool to frame conversations requiring a doctor's immediate attention and action. The tool consisted of standardised prompt questions within four sections (Situation, Background, Assessment, Recommendation). This ensured staff shared concise and focused information and allowed staff to communicate assertively and effectively and reduced the need for repetition. We saw this in use during our inspection.

- Written guidelines were displayed in the clinical areas providing details for accessing physiotherapy services and included guidelines for accessing emergency physiotherapy.

- A hands-free mobile communication system was in use through medical care services. Staff were able to communicate with each other and across departments through the use of a hands-free device worn around the neck. We saw this in use on a number of occasions

during our inspection. This meant calls and critical information instantly reached the most appropriate member of staff. For example, should a patient be identified as deteriorating a call could be made to a member of the critical care outreach team or a member of the medical team whilst the nurse remained with the patient.

- For patients transferring between the emergency department or the emergency assessment unit and the medical wards, handover was given through the nursing staff and the medical notes. We spoke with two doctors who felt this process was not always effective. They gave us an example of where the blood results for a patient with an acute kidney injury had not been communicated to the medical staff on the receiving ward, this patient was transferred to a critical care area the following day. On ward 41 a doctor told us they may not always be aware when a patient had been transferred onto the ward. No other concerns were raised regarding medical handovers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A Deprivation of Liberty Safeguards (DOLs) policy (for adults 18 years and over) was available to all staff at the trust. The purpose of the guidance was to inform staff about the procedural arrangements for working with patients with impaired mental capacity who were 18 years and older and for whom care or treatment was given in circumstances that might amount to Deprivation of Liberty.
- During our inspection we saw three patients receiving care whilst being deprived of their liberty. We saw that the deprivation of liberty safeguards and orders by the court of protection authorising deprivation of a person's liberty were used appropriately.
- At our last inspection of the trust in June 2015 staff did not always understand the requirements of the Mental Capacity Act 2005 in relation to their roles and responsibilities. At our inspection in July 2016 some staff were able to explain the practical application of the Act. Where patients did not have capacity we mostly saw where staff had taken appropriate action. This included best interest decisions and a two-stage test of capacity. However, we remained concerned that a number of staff did not understand the requirements of the Mental Capacity Act 2005 in relation to their roles and responsibilities.

- On ward 52 we reviewed six sets of nursing records and saw where a patient's capacity had not always been suitably assessed. In three records where the patient had been identified as not having capacity a two-stage test of capacity had been completed appropriately. However, in a further three sets we found; one patient had been identified as "lacks capacity for nutrition", a two-stage test of capacity had not been completed; a patient living with dementia had not had an assessment of their capacity and another patient also living with dementia had a two-stage test of capacity completed despite there being no assessment of their capacity documented on admission.
- On ward 42 we saw where a patient had been admitted from a provider of specialist mental health services. The patient was detained with this provider under Section 3 of the Mental Health Act 1983 (MHA). Section 3 of the Mental Health Act allows for the lawful detention of the patient for treatment in the detaining hospital, based on certain criteria and conditions being met. The patient was accompanied at all times by two carers from the patient's usual place of residence.
- Staff on ward 42 had very little understanding of their responsibilities for this patient with regards to restriction of liberty and consent to care and treatment. Approved Section 17 leave is required if a patient leaves the detaining hospital, this describes any conditions that have to be met to allow the patient be on leave, or receiving treatment away from the detaining hospital. We did not initially see this in place so staff would not be aware of any restrictions that were in place to keep the patient safe. We raised this immediately with senior staff at the trust. When we returned to the ward a short while later we saw a Section 17 leave form in place. We saw no visible assessment of the patient's capacity despite this patient experiencing episodes of fluctuation in capacity.
- On the same ward a further patient had a two-stage test of capacity completed despite there being no assessment of their capacity documented on admission.
- Nursing metrics data was collected for all inpatient areas across medical care services. Through the use of a nursing audit tool, senior nurses of the service were able to look at the completion of documentation, including MCA assessments, for those patients living with dementia. Nursing metric results for June 2015 to June 2016 demonstrated in 82% of cases (16.5% were not applicable) an initial assessment determining whether a

patient had capacity was completed on admission and reassessed upon patient transfer. An appropriately completed two-stage test and best interest checklist was completed in 18% (79% were not applicable) of cases.

- A sedation policy was available to all staff at the trust. During our inspection we did not see evidence of the inappropriate use of sedation. Nursing and medical staff were aware of this guidance and knew where to locate it.

Maternity and gynaecology

Safe	**Good** ●
Overall	**Requires improvement** ●

Information about the service

The maternity unit at King's Mill Hospital includes the pregnancy day care unit, antenatal clinic, maternity ward (antenatal and postnatal) and the Sherwood Birthing Unit. The Sherwood Women's Centre at Newark Hospital provides facilities for antenatal and postnatal care, including ultrasound. The birthing unit provides care to women during pregnancy, labour and immediately after giving birth. There are three triage bays (where women are assessed to determine if they are in established labour), nine birthing rooms, two high dependency rooms, a pool room, a bereavement room and two theatre suites. The maternity ward has 32 beds, and four of the 14 side rooms are used for induction of labour. This area of the maternity ward has a short adjoining corridor to the birthing unit to allow easy access for emergency cases.

Four community midwifery teams provide maternity services in partnership with general practitioners and health visitors. The total number of births from January 2015 to December 2015 was 3461. The hospital had one of the highest normal births and home birth rates in the country. The gynaecology service offer inpatient ward, day care and early pregnancy assessment unit facilities. They care for women with gynaecological problems, early pregnancy issues, miscarriage or those requesting termination of pregnancy. A team of gynaecologists are supported by gynaecology nurses, general nurses and support workers. During our inspection, we visited all the ward areas and departments relevant to the service. We spoke with five women, three relatives, and 24 members of staff, and we reviewed 18 medical records.

Summary of findings

We rated the safety of maternity and gynaecology services at King's Mill Hospital as good.

- The trust had systems in place for incident reporting, investigating and monitoring. Lessons learnt were shared with staff to prevent similar incidents happening again.

- There were systems, processes and standard operating procedures in place to ensure infection prevention control, records, medicines management and maintenance of equipment.

- Midwives adhered to trust guidelines for the completion and escalation of Maternity Early Warning Scores (MEWS); frequencies of observations were appropriately recorded and where patients had met the trust criteria for sepsis screening, patients were screened appropriately.

- Care records were completed and updated appropriately to minimise risks to patients. For example, risk assessments during pregnancy, labour and after birth.

- Safeguarding procedures were in place with clear lines of reporting. Staff were aware of these procedures and their responsibilities to safeguard women and babies.

- Daily checks were completed for the checking of emergency and resuscitation equipment.

- Staffing levels and skill mix on the maternity and labour ward and gynaecology ward were planned, implemented and reviewed daily to keep women safe. Staffing shortages were acted upon appropriately.

- There was adequate consultant obstetric cover in the delivery suite at 60 hours a week, which was in line with Royal College of Obstetricians and Gynaecologists RCOG guidelines (2007).

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good 🟢

We rated the safety of this service as good.

We found:

- Staff reported incidents. These had been reviewed and lessons learned. There was a process for the investigation of serious incidents. Women were protected from the risk of avoidable harm.
- Staff checked essential lifesaving equipment and emergency trolleys.
- Routine observations were performed when required and when findings indicated a risk to a woman's health, the right actions were taken.
- Midwives completed appropriate training to ensure they were trained and competent to care for women having high dependency care.
- Medicines were managed and stored safely.
- Midwifery, nursing and medical staffing vacancies had been addressed. Staffing was planned and implemented to keep women safe.

However:

- Training statistics were just lower than the agree trust target of 90%, all staff were allocated to training days in the forthcoming year.

Incidents

- The number of reported serious incidents from June 2015 to May 2016 was eight. We reviewed the data of stillbirths for the year which was less than the national average of 4.7 per 1000 births.
- At our last visit in June 2015, the trust had an external review of their serious incidents process. All of the serious incidents were reopened and further actions were added to complete. We looked at the last six serious incident reports and found the quality assurance process had been improved and the medical director signed off the serious incidents when the actions were completed. To ensure the improvement was sustained the trust's central governance had the lead oversight of the service.

- There were no Never Events reported in this service. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Specific cases and incidents were discussed at the weekly maternity and gynaecology trigger management meetings. We reviewed the trigger log minutes from the meeting where there were multidisciplinary staff in attendance. Cases were discussed and learning actions agreed. We saw evidence of incidents being signed off as completed. Incidents were escalated to the trust scoping meeting to be reviewed to ensure external scrutiny took place.
- Staff were able to explain the incident reporting system. There was evidence that incidents were reviewed and discussed appropriately. Learning from incidents was shared in a number of ways: displayed on ward notice boards and communicated to staff at handovers, ward meetings and via a newsletter. Staff were able to give an example of learning from an incident for example a woman had a delayed venous thromboembolism assessment and was diagnosed with a deep vein thrombosis (a clot in a vein in her calf.) Staff were informed of the importance of completing the assessments, notes were audited for compliance and the results demonstrated an improvement.
- We reviewed minutes of governance meetings locally from the maternity ward and observed that the top ten incidents and top risks were discussed and shared with staff. The birthing unit Labour Ward Forum minutes identified newly reported incidents and these were discussed and shared with staff.
- Gynaecology ward meetings shared information with staff regarding incidents and lessons learnt. For example, preventative care pathways to prevent patients developing pressure sores.
- The birthing unit rooms contained folders with emergency documentation sheets to enable staff to facilitate immediate documentation of an incident. For example incidents such as post-partum haemorrhage (excessive bleeding after the birth) and shoulder dystocia (difficulty with delivering the body of the baby)
- Maternity mortality and morbidity meetings were held monthly. We reviewed the presentations from one meeting and saw that staff reviewed cases in detail.

Maternity and gynaecology

Areas of improvement were highlighted together with learning outcomes on an action plan tracker. The meeting had been moved to a different day, which allowed improved obstetric attendance. We saw three sign in sheets, which showed good attendance with between 15 and 22 professionals at the meetings.

- Staff told us of learning and actions following a review of fetal heart rate monitoring using a cardio tocography (CTG) monitor (which records babies heart rates). A number of coordinators and the lead obstetric consultant had attended a CTG masterclass. The review concluded that additional CTG training was required for midwives and obstetricians. The service was in the process of starting this in September and this would enhance the training already provided on the mandatory study days. Staff told us they anticipated it taking a year for all staff to complete the CTG training day. Midwives in the hospital would be prioritised to attend first.

- The service had updated and launched the trust's Intrapartum (during labour and birth) guidance, with stickers to use to assist staff with the hourly review of the CTG in labour. We reviewed records which showed inconsistences with how staff classified the CTG and how this was documented. Staff told us that they were developing a guideline for antenatal CTG monitoring because they did not have guidance.

- We attended the weekly CTG meeting, which had good attendance by midwives, junior medical staff and consultant obstetricians. Cases were discussed and staff asked to classify sections of the CTG. This demonstrated appropriate multidisciplinary learning from incidents.

- The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. Staff we spoke with had a good understanding of the regulations and their responsibilities under the duty of candour. We reviewed six reports the duty of candour process had been followed.

Safety thermometer

- The maternity safety thermometer was launched by the Royal College of Obstetrics and Gynaecology (RCOG) in October 2014. This is a system of reporting on harm free care. The recommended areas of harm included

perineal or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety, Apgar score of less than seven at five minutes, and admissions to neonatal units. (The Apgar score is an assessment of overall new-born well-being). The ante/post-natal ward had achieved 100% harm free care from June 2015 to June 2016.

- The gynaecology service, ward 14, had consistently recorded 100% harm free care within the expectations of the nursing safety thermometer from June 2015 to June 2016.

Cleanliness, infection control and hygiene

- All of the areas we visited were visibly clean and there were ample hand gel dispensers with instructions on how to cleanse hands. Staff followed good hand hygiene and were bare below the elbow to help prevent the spread of infection.

- Hand hygiene audits showed 100% compliance between April 2016 and June 2016 for maternity and gynaecology services.

- Equipment was labelled when cleaned, signed and dated. The birthing rooms and pool room had notices, which indicated if the room had been cleaned, required cleaning or was in use.

- Infection control audits for quarter one April 2016 to June 2016 were greater than 90% except for one occasion for needles and sharp object disposal, which was 87%. The trust target was 92% so they were compliant with all of the audits except one. This meant that people were protected from infection.

- There were reliable systems in place for the management and disposal of clinical waste and sharps in accordance with the trust policy.

- Between July 2015 and June 2016 within the maternity and gynaecology services directorate there had been no cases of hospital acquired Methicillin-resistant Staphylococcus aureus. (MRSA) MRSA is a type of bacterial infection and is resistant to many antibiotics. There were no cases of Clostridium difficile infection. Clostridium difficile is a bacterium affecting the digestive system; it often affects people who have been given antibiotics.

Environment and equipment

- In order to maintain the security of women and babies, doors to maternity inpatient wards and delivery suite

areas were locked and visitors were required to use a CCTV buzzer system to gain entry. Staff had swipe cards, which enabled them to enter areas they were authorised to enter.

- All staff we spoke with told us adequate equipment was available to run the service safely.
- We looked at Cardiotocography (CTG) equipment on the labour ward. CTG equipment can be used to monitor a baby's heart rate and a mother's contractions while the baby is in the uterus. The CTG equipment we looked at was clean and had been checked and labelled when the date of the next maintenance check was due.
- Staff checked the adult resuscitation trolleys and baby resuscitaires daily (a resuscitaire is a warming platform used to assist in the resuscitation of new-born babies). We observed that the checklists were completed, dated and signed. This meant safety equipment was available in the event of an emergency. The two high dependency rooms on the birthing unit were spacious and well equipped.
- All areas we visited were spacious and uncluttered; storage areas were well stocked and labelled.
- Adequate equipment was available to run the service safely; each birth room had piped oxygen and Entonox, (a gas that provides pain relief). All equipment we looked at had been safety tested and was in date.
- There were pool evacuation nets for water birth evacuation. Training for pool evacuation had been given to staff supporting women having a pool birth.

Medicines

- Medicines were stored, managed, administered and disposed of safely. We observed safe procedures when staff administered medication to women.
- Controlled drugs (CDs) were stored appropriately in all of the areas we visited. CDs are medicines, which have extra security controls over them. They are stored in a separate cupboard and their use recorded in a CD register.
- The trust had paper prescription and medication administration record charts. We reviewed ten prescription charts, five from maternity records and five from gynaecology records. The records were clear and fully completed; they showed women were getting medicines when they needed them.
- Allergies to any medicines were recorded on the woman's prescription chart.

- Staff were able to refer to their medicines management policy, the up to date British National Formulary (BNF) or ask for pharmacy support if necessary.
- Medicines used by community midwives were stored correctly and medicines management and checking was discussed with teams. One to one discussions were added to quarterly safeguarding supervision meetings.

Records

- Patient records were kept securely in all areas we visited.
- Hospital records were paper format. Midwives gave mothers their records to keep with them and bring to every appointment. Mothers were given the personal child health record, often called the red book, before they were discharged home. The red book was used to record the child's health and development.
- We looked at 13 maternity records. All were legible, dated and signed and individualised care plans were evident in the records. At our last inspection in June 2015 we identified the service had not documented the woman's name and hospital or NHS number being documented on each page in the majority of hand held records. This posed a risk of detached pages not being returned to the correct records. We found this continued to be an issue at this inspection.
- The gynaecology ward audited records monthly to continually evaluate practice. We reviewed five sets of records, all were legible, dated and signed and individualised care plans were evident in the records.
- The service performed regular audits of records to monitor compliance of accurate record keeping. These were monitored monthly on the quality improvement plans. Staff told us they also reviewed records on the midwives mandatory study day.

Safeguarding

- There was a designated safeguarding midwife for maternity services who provided support and supervision. Midwives told us that they were able to raise concerns and knew how to report a safeguarding incident. Staff received three monthly safeguarding supervision. Community midwives were able to discuss their caseloads.
- Staff were aware of the female genital mutilation (FGM) guideline and could explain the process if identified

which was in line with national guidance. Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons.

- Attendance for level three safeguarding children training was 88% between April 2015 and June 2016. This was just below the trust's target compliance rate of 90%. Staff who had not attended were allocated to training days.
- Attendance for adult safeguarding level two by midwives and nurses was between 97% and 100%. Attendance by medical staff was poor at 64%; with the recruitment of two consultants, the service expected an improvement in attendance.

Mandatory Training

- Staff were supported to attend training days. The midwives told us that they had spacious facilities to accommodate simulated training.
- All midwives were expected to attend the Maternal AIM Course. The course was developed following the Confidential Enquiry in to Maternal Death 2011. The day embeds the Airway, Breathing, Circulation, Disability, Exposure approach to assessment and management of maternal women who have deteriorating illness. Between October 2015 and June 2016, 86% of hospital midwives 23% of community midwives had attended. A further four courses had been booked and the outstanding staff allocated days. The Maternity Care Assistants were allocated to the Health Care Assistant AIM Course 82% had attended.
- The AIM course is in addition to a multidisciplinary emergency skills and drills training day. Each year topics change and sepsis was on the curriculum for 2015 to 2016. Attendance for 2015-16 was between 97% and 100%.
- The trust mandatory training showed 94% of midwifery staff had completed training from April 2015 to June 2016. Information governance e-learning completion was 88% from April 2015 to June 2016. Time to complete this was included on the midwives' issues training day.
- Gynaecology training was managed by the trust wide practice development team and recorded on the trust wide statistics. The ward leader told us that the staff were up to date with their training. As of June 2016, 99%

of nursing staff had completed training. Twenty six percent of the specialist gynaecology nursing team had attended training, it was a very small team and staff had been booked on dated to complete training.

- Medical staff reported good trust induction training with the medical director being present on day one. Locum doctors attended half a day induction and were supervised during their placement.
- Medical staff told us they were supported to attend mandatory training and cardiotocography weekly meetings and junior medical staff were able to attend weekly training sessions. Between April 2015 and June 2016, 70% of the medical staff had attended mandatory training.

Assessing and responding to patient risk

- Early warning scores were used to monitor patients and identify when their condition may be deteriorating. Early warning scores enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.

- The modified early warning scores (MEWS) chart was completed fully in all of the records we reviewed.
- The service used neonatal early warning scores (NEWS) to record baby observations. We reviewed three charts, which were completed fully.
- The modified early warning scores (MEWS) chart was audited by the service monthly. We reviewed results from December 2015 to April 2016. Completion of the chart and a medical plan was evident in all charts; completion of the charts was also monitored at the weekly Sepsis Task Force Audit meeting.
- The gynaecology ward used an electronic system for recording patient observations, which recorded and monitored the frequency of national early warning score (NEWS) observations. It alerted staff if observations were overdue and we reviewed electronic recordings for five women, all were recorded fully and managed correctly.
- At our last visit in June 2015, midwives were not trained to care for women who required level two high dependency care (which is women who had become acutely ill and needed one to one care). We observed training records and midwives had received training, which prepared them to identify the deterioration of women with high risk conditions and those who

required level two high dependency care. Staff told us they had good relationships with the critical outreach team who supported the service to care for these women.

- We found at our last visit in June 2015 women waking up from an operation were cared for by midwives who were not trained. Midwives no longer provided care for these women on the birthing unit immediately after a general or local anaesthetic. Women were recovered by the anaesthetist and operating department practitioner (ODP) and remained in theatre until they could breathe on their own. Midwives then took over the woman's care and transferred her to their room on the birthing unit. If a local anaesthesia was used, they returned immediately to their room.

- We observed good communication and teamwork in theatre on the birthing unit. The theatre staff followed a document based on the World Health Organisation (WHO) safety check list. This ensured each stage of the patient journey, from ward through to anaesthetic procedures, operating room and recovery was managed safely. We found the checking procedures in the operating theatre to be in line with the five steps to safer surgery process. This tool was used to reduce harm to women who had surgery.

- We requested monthly audits of compliance but were told that the service did not collate this data. We were able to review computerised data for nine days. Out of 30 operations on three occasions, the time the woman left theatre was not documented.

- We looked at 13 maternity records risk assessments. They were fully completed. This meant women were protected from being at risk of certain conditions for example pressure sores or deep vein thrombosis.

- We looked at five patient nursing records in the gynaecology department. All risk assessments were fully completed.

Midwifery staffing

- Midwifery staffing was recorded on the maternity dashboard as being 1:28 to birth ratio establishment and 1:30 to birth ration in post.

- The birthing unit had closed once in the last year due to inadequate staffing. Senior staff told us staff worked extra shifts to provide cover as needed. Expected levels and actual levels of staffing were displayed on notice boards in all ward areas.

- The birthing unit did not use an acuity tool to determine staffing levels in response to the amount of care the women needed. An acuity tool calculates the required staff needed on each shift based on one to one care for women depending on the level risk to ensure safe care. To determine safe staffing numbers the service used The Birthrate Plus® methodology (based on an assessment of clinical risk and the needs of women and their babies during labour, delivery and the immediate post-delivery period, utilising the accepted standard of one midwife to one woman in labour, to determine the total midwife hours, and staffing required, to provide midwifery care to women). Based on this methodology the service vacancy level was two whole time equivalent (WTE) midwives.

- The trust employed coordinators to ensure the smooth running of the department and allocated midwives to women. A number of coordinators told us that one to one care for women in labour was available all of the time. When we spoke with the midwives, they said they were able to provide one to one care every shift and they would escalate to the senior midwife if they felt practice was unsafe. We spoke with three women who confirmed they felt safe during labour.

- We reviewed seven weeks of staff rotas for June/July 2016 and saw the shifts generally met the preferred ward and birthing unit staffing level of nine or ten midwives and three support workers per shift.

- Midwives told us they were moved regularly from the maternity ward to help on the birthing unit. and felt this had an adverse effect on the care given to mothers and babies on the maternity ward. Staff reported told us they reported this as an incident but felt that there were no plans for long term resolution. We were unable to review how many times staff were moved because the incident was logged as short staffing and not staff moving. Staff said without unqualified staff they could not manage on a shift.

- Coordinators were not supposed to be included in the staffing numbers to be able to carry out their coordinator role. However, this did not always happen, and although midwives were allocated to care for women safely, sometimes the coordinator was responsible for the care of a woman not in labour.

- Sickness absence for 2015 was 4.5%, worse than the target of up to 3.5%. The service had confirm and challenge meetings to discuss the rate. Sickness was covered by staff taking extra shifts. The service did not

use agency staff. A text messaging system was used to ask off-duty staff if they could work an extra shift. Staff we spoke with said they did not mind because it was optional.

- There were four community midwifery teams with a manageable caseload of around 75 women each. Community midwifery staff (CMW) were requested to cover the birthing unit when it was short staffed or if there were a high number of women attending the unit. Home birth rate running total from April 2016 was 4.1%, which is higher than the national average of 2.3%

- The community midwives on call time was from 7.00pm to 9.00am, which meant that the community midwife could be on duty for 14 hours. The senior team told us that this had been agreed with staff side and human resources before it was implemented. Community midwives we spoke with told us that they did not have any problems with these hours, it would be very rare to work the full 14 hours and they could escalate if they were too tired to continue working.

Nursing Staffing

- The gynaecology ward had been separated from the surgical day unit following the restructure of the divisions. The ward leader and staff told us this had allowed them to have their own identity and felt more supported in the women's and children's directorate.

- Planned staffing was two registered nurses and three health care assistants for the day shift and two registered nurses with two health care assistants for the night shift. We reviewed off duty rotas that confirmed staffing planned was achieved. There were sufficient staff to meet patients' needs. It was rare for the ward to use agency staff. The ward team leader was not given any women to look after which meant she could supervise and support staff.

Medical staffing

- The quality dashboard showed there were 60 hours a week of dedicated consultant cover on the birthing unit and on call within a 30 minute commute outside of those times. This was in line with national recommendations based on the number of babies born on the unit each year. Medical staffing rotas were printed and very accessible to the midwives and nursing staff.

- The service had increased their whole time equivalent (WTE) Consultant posts. Two locum consultants were in post and two recruited consultants were due to start with the team September 2016.

- There had been a consultant allocated to take the lead for fetal medicine and the pregnancy day care unit. This enabled clinical oversight of the department and improved team dynamics.

- There were 28.7 WTE medical staff in total. There was a higher proportion of junior staff at the trust compared to the national staffing skill mix proportions. This was offset by the lower proportion of staff at higher grades. Junior staff told us that higher grades of staff were available whenever they needed them. The total number of medical staff was less than when we inspected in 2015. The birthing unit coordinators told us if they needed medical staff, there were no delays.

- Anaesthetic cover was available on the birthing unit from 08.00 to 19.45 with experienced staff and registrar cover overnight through an on call system.

Handovers

- A new safety huddle meeting had been developed with staff from all areas of the directorate, meeting on the birthing unit to discuss the activity in unit for that day.

- There were two midwifery handovers a day at 07.00am and 19.00pm. Multidisciplinary team handovers on the birthing unit followed the midwives' handover. We observed two effective handovers. The staff used a comprehensive handover sheet prepared electronically by the lead of the shift handing over. The handover sheet included the names of women, all staff on duty, home births and babies. Messages and important information such as incidents and changes in practice were passed on to staff shift by shift. Support workers were involved in the handover.

- We observed the gynaecology accountable ward handover sheets, which were developed to improve patient safety. It provided evidence of a comprehensive handover between nurse to nurse.

- Nurses signed a handover sheet, which indicated they had received the information needed to accept the patient. In all of the records we reviewed the handover sheet was fully completed.

Major incident awareness and training

Maternity and gynaecology

- There were arrangements to respond to emergencies and major incidents. A trust-wide major incident plan was in place to guide staff in responding quickly and effectively to any major incident.

- All staff knew there was a major incident policy and instruction book accessible to use if necessary.
- The service practiced neonatal and obstetric emergency drills with staff on the birthing unit.

Outpatients and diagnostic imaging

Safe	**Good** 🟢
Overall	**Requires improvement** 🟠

Information about the service

The Diagnostic and Outpatient Division is responsible for the delivery of outpatient services. The King's Treatment Centre provides most of the outpatient services at Kings Mill Hospital. Kings Mill Hospital provides clinics for a wide range of specialties, including orthopaedics, ophthalmology, respiratory, gastroenterology, cardiology, ear nose and throat (ENT), sexual health services, and podiatry.

Between July 2015 and June 2016, 413,473 people attended outpatient appointments. During these appointments patients were assessed, treated, monitored, followed up or referred to in-patient treatment. We did not inspect diagnostic imaging services.

During our inspection, we spoke with 11 patients and 39 staff members. Staff we spoke with included medical, nursing, allied health professionals, administrative and clerical, reception and patient appointment booking staff. We checked 14 pieces of equipment including resuscitation equipment.

We observed care and treatment and looked at four patient records. We reviewed information provided by the trust during and after the inspection.

Summary of findings

We did not rate all domains for outpatient services. We rated safety as good. We found:

- Staff knew how to report incidents. They gave us examples of the types of incidents reported and we saw investigators identify actions and learning. The trust regularly monitored and assessed all incidents for severity of harm. Staff received feedback and learning from incidents through team meetings and emails.
- Staff adhered to infection control policies including hand hygiene and 'bare below the elbows'. The majority of equipment we saw was tested and checked regularly. Staff checked emergency resuscitation equipment daily and staff knew how to access it in an emergency.
- Medicines were stored securely in locked cupboards, in locked rooms, with access limited to clinical staff. Controlled drugs were stored appropriately in locked fridges and cupboards. The outpatient service had processes for securely storing and handling patient records. Staff locked records in storerooms and trolleys
- Since our last inspection, the outpatient service had made significant improvements in reviewing patient outcomes and reducing the number of overdue appointments. The trust had changed the way they booked appointments and had introduced regular risk assessment, audits and monitoring to ensure the patients most at risk had appointments.

However we also found:

- The inspection team had concerns regarding staffing and booking arrangements for ophthalmology. Ophthalmology had the largest numbers of incidents reported and largest numbers of patients overdue for an appointment. Staff raised concerns regarding the conduct of medical staff in clinics and the availability of some equipment.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good ●

Overall, we rated safe for outpatient services as good.

We found:

- Staff knew how to report incidents. They gave us examples of the types of incidents reported and we saw investigators identify actions and learning. Staff said they received feedback and learning from incidents.
- Staff adhered to infection control policies and we observed the majority of staff clean their hands before and after treatment of patients. We observed all staff were bare below the elbows in line with trust policy.
- The majority of equipment we saw was tested and checked regularly. Emergency resuscitation equipment was checked daily and staff knew how to access it.
- Medicines were stored securely in locked cupboards, in locked rooms, with access limited to clinical staff. Controlled drugs were stored appropriately in locked fridges and cupboards.
- The outpatient service had processes for securely storing and handling patient records. Staff locked records in storerooms and trolleys. Staff knew of their responsibilities recording protecting patient confidentiality.
- Since our last inspection, the outpatient service had made significant improvements in reviewing patient outcomes and reducing the number of overdue appointments.
- Staff had processes for escalating and managing deteriorating and seriously ill patients.

However we also found:

- The inspection team had concerns regarding staffing and booking arrangements for ophthalmology. Ophthalmology had the largest numbers of incidents reported and largest numbers of patients overdue for an appointment. Staff raised concerns regarding the conduct of medical staff in clinics.
- Locum doctors did not receive a thorough induction programme when joining the trust.

Incidents

- Between June 2015 and May 2016, the outpatient service reported 457 patient related incidents. Of these, 451 (98.6%) were classed as causing no or little harm to patients. Incidents included appointment and booking errors, transport delays, patient incorrectly identified and equipment failure.
- There were no never events reported for this service for the period of June 2015 and May 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were five serious incidents for the period June 2015 to May 2016. Three of them related to delayed diagnosis of patients, one medication and one surgery complication as a result of inaccurate documentation. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, they warrant using additional resources to mount a comprehensive response. Data from the trust showed staff conducted investigations, identified root causes and took immediate action. Staff knew about the incidents and told us senior nurses shared learning through team and one to one meetings.
- A statement from the trust said a series of incident reporting training sessions were held within outpatient department during April and May 2016. However, attendance was not recorded for these sessions.
- Data from the trust showed incidents in ophthalmology accounted for 11.4% (52) of all incidents, more than any other department between June 2015 and May 2016. The majority of incidents involved booking errors, documentation (wrong or missing), and patients not informed of cancellations. We spoke with bookings staff who said this was due to using a different booking system. Ophthalmology was due to move to a new process shortly after our inspection.
- During our previous inspection, the trust had not systematically and routinely reviewed or assessed a significant number of incidents for severity of harm caused to patients. We reviewed all incidents reported between June 2015 and May 2016 and saw all incidents had been assessed for severity of harm. Therefore, the trust had reviewed and improved their process of assessing and reviewing incidents.

Outpatients and diagnostic imaging

- The majority of staff knew how to report incidents and were encouraged to do so. Clinical and support staff we spoke with described the incident reporting system and felt comfortable using it. They gave us examples of reported incidents and changes to practice as a result. For example, administrative staff knew about incidents relating to letters sent to patients advising them to attend the wrong location for clinics. This led to changes in the electronic system to ensure letter templates were linked to specific clinics at different locations.

- Data from the trust showed managers and staff implemented actions and identified learning from investigations. The majority of staff received feedback on learning from incidents in monthly team meetings and through staff bulletins. We saw learning from incidents highlighted on staff notice boards and in minutes of team meetings.

- The Diagnostic & Outpatient division did not have mortality and morbidity meetings for Kings Mill Outpatients. The medical and surgical specialities undertook all activity in the outpatient department, and mortality and morbidity meetings took place within those specialties.

The Duty of Candour

- The Duty of Candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.' We saw from incident investigations incident investigators had involved patients and their families through the investigation process.

- Staff understood the duty of candour and the need to be open and transparent. Staff gave us examples of when they had used duty of candour or when they had been open and honest with patients and their relatives when things went wrong. Staff gave examples of when they were open and honest with patients including mistakes in booking or appointment cancellations, missing patient records and incorrect treatment.

Cleanliness, infection control and hygiene

- The departments we visited were visibly clean and tidy, with uncluttered clinics, utility rooms, corridors and doorways. We saw completed cleaning rotas for different areas, which confirmed the required cleaning had taken place.

- Nursing staff followed trust policies on infection control and hygiene in the clinics. We observed staff using appropriate hand washing techniques and personal protective equipment, including aprons and gloves. Hand alcohol gel dispensers were readily available in clinics and patient waiting areas.

- We observed medical staff cleaning their hands before and after clinic sessions. However, we observed one consultant did not wash hands before and after seeing patients in clinic.

- We observed all staff were bare below the elbow, in keeping with trust policy to help prevent the spread of infection.

- We saw items of equipment had 'I am clean' stickers when staff had cleaned them. Staff completed cleanliness audits for clinic environments and equipment. We saw staff wiping down equipment after use and before the next patient arrived into the clinic.

- The outpatient service conducted regular infection prevention and control (IPC) audits, for example in relation to the environment and hand hygiene. The latest audits supplied by the trust showed there was a staff compliance rate of 98% with hand hygiene procedures. Outpatient departments scored 95% for the overall cleanliness of the environment.

- Staff undertook IPC and hand hygiene training as part of their mandatory training programme. Data from the trust showed 89% of staff completed both IPC and hand hygiene training. All staff we spoke with knew their responsibilities regarding infection control and hand hygiene.

Environment and equipment

- An external company checked, tested and maintained equipment. The majority of equipment we saw during our inspection was in date, tested and checked within the last year. The majority of staff said they had no concerns regarding the maintenance and availability of equipment.

- The trust used audits to check equipment availability and monitor when equipment needed a maintenance test. These audits showed the majority of equipment was tested and checked in line with maintenance requests and the annual service programme. The equipment not seen by the maintenance company was equipment given to patients to use at home for

example, nebulisers and continuous positive airway pressure (CPAP) machines. The trust had processes to recall equipment to hospital through home visits, rebooking appointments, and telephone calls.

- There were protocols for specific pieces of equipment throughout the department, which staff could access on the trust's internal computer systems.
- Clinics had access to emergency resuscitation equipment and staff checked the equipment daily to ensure the equipment was well maintained and safe to use. Staff knew where the nearest resuscitation equipment was and how to obtain it. The outpatient environment in the King's Treatment Centre enabled staff to transport resuscitation equipment between clinics quickly. This was because there was one corridor, which ran through all outpatient departments enabling quick access.
- Staff attended medical devices training as part of their mandatory training programme. Medical devices training helped staff keep up to date with how to use medical equipment. Data from the trust showed 87% of staff had completed this training.
- Staff in ophthalmology said they had a shortage of certain equipment including occluders (a cover used to put over the eye when being examined) and a logmar cabinet (used to hold eye charts to test patient's vision). Managers knew of the shortage of equipment however, they had delayed replacing the equipment. There was no explanation from managers as to why this had happened.
- Eye clinics had theatres in order to perform minor surgical procedures on patients. We checked two theatres and both were visibly clean with all equipment checked, tested and dated. The theatres had piped oxygen and staff said theatres could be used to provide oxygen if needed.
- The design of the outpatient clinics meant the reception area was separated from clinic waiting areas. Therefore when patients arrived and receptionists confirmed personal details they could not be heard by other patients waiting. This helped to preserve patient confidentiality.

Medicines

- Medicines were stored securely in locked rooms and cupboards with access limited to clinical staff. Staff kept

accurate and up to date medicines checks and monitored fridge temperatures when medicines need to be stored at certain temperatures to maintain their effectiveness.

- A medicines management audit for clinics one to eight, dated July 2016 indicated 70 to 80% compliance with trust policy. All clinics identified a lack of specialist syringes e.g. for enteral (oral) use only.
- Controlled drugs (CDs) are medicines requiring additional security. We saw CDs were stored and locked in fridges or cupboards. We noted from records staff checked them daily and the CD check records were complete.
- Nursing staff explained any medications to patients and gave them advice about how to take them and any likely side effects. They gave patients information leaflets to support this.
- Nursing staff attended medicines management training as part of the mandatory training programme. Data from the trust showed 93% of staff were up to date with medicines management training. This was better than the trust standard of 90%.
- Outpatient services had processes in place for the management of prescription pads (FP10). Clinics stored pads securely in locked rooms and clinical staff signed them out so there was an audit trail of who had used them. Staff logged the numbers of each prescription before sending them to pharmacy. Consultants signed FP10s back at the end of each clinic.

Records

- The trust had created a centralised patient records area, which could store more records. Outpatient services had clear procedures for receiving records and distributing them to clinics. Nursing staff checked records on arrival to ensure they were complete and had the appropriate details.
- Records were stored in locked storerooms when they arrived in clinics. Staff stored records in locked trolleys and they gave them to consultants before clinics. Records remained in the clinic room with consultants until clinics ended. This meant records were secure and not visible to the public at any time. During our inspection, we did not see any records left out in clinic areas.
- During our previous inspection we were concerned that patient records were not available when patients attended outpatient clinic appointments. We checked

records availability for three different clinics. We found there were no cases of missing notes for these clinics. Staff said the availability of records for clinics had greatly improved in the last six months. Data from the trust for the period 20 June 2016 to 1 July 2016 showed there was one missing or late patient to clinic. Outpatient clinics had processes in place in the event of patient's notes not arriving for clinics. Staff could print off information and consultant letters to GP from an electronic patient record system and create a temporary set of notes. This meant the consultant could still see and review patients and had access to information.

- We reviewed four patient records. All the records were fully complete and contained all necessary information post appointment including letters to the patient's GP. All four records had outcome or reconciliation forms included and recorded. All records were easy to read and legible. We found consultants signed, dated, and initialled records in line with General Medical Council standards in three sets of records. One set of notes had the consultant's initials and no signature.

- We observed all staff locking their computers when walking away from desks, especially in public areas. This meant staff kept confidential patient information secure and unauthorised persons could not access it. All staff we spoke with knew about their responsibilities to keep patient information confidential and secure.

Safeguarding

- All staff we spoke with in outpatients said they had completed training in safeguarding adults and children. This included nursing and non-nursing staff. Data from the trust showed 100% of nursing and non-nursing staff had completed level two training in safeguarding adults. Data from the trust showed 98% of nursing and 96% of non-nursing staff had completed level two safeguarding children training.

- Staff had access to the trust safeguarding policy. Staff we spoke with knew of the procedures to follow should they need to report a safeguarding concern. Nursing staff demonstrated good understanding of safeguarding procedures and could identify their local safeguarding lead.

- Staff knew about potential signs of abuse and knew how to escalate concerns. Staff said they would discuss concerns before making a referral to the appropriate agency or telephone the safeguarding team. Nursing

staff said they were confident in escalating concerns as needed. Staff knew how to access policies on female genital mutilation and domestic violence through the intranet or hard copies available in clinic areas.

Mandatory training

- Mandatory training included moving and handling, health and safety and equality and diversity training. The trust target was for 90% of staff to have completed their required training. All of the managers and staff we spoke with confirmed they were up to date with annual mandatory training. Data from the trust showed 92% of all staff across outpatient departments at Kings Mill Hospital had achieved mandatory training compliance.

Assessing and responding to patient risk

- In January 2015, the trust identified a significant number of patients, around 19,500 in total, where staff did not record the outcome of their outpatient appointment in the electronic system correctly or they were overdue for a review appointment. This included patients attending at Kings Mill Hospital. This meant there was a risk of patients not accessing the correct care and treatment in a safe, timely manner.

- In response, the trust started an outpatient improvement programme in April 2015. The improvement programme saw a significant reduction in the number of patients requiring recorded outcomes. By July 2016, the number of patients without outcomes had fallen to 1,038. It also saw the auditing of outcome collection for patients to ensure all patients received an outcome. During our inspection, we saw clear procedures for collecting and inputting outcomes for patients.

- During this period, the numbers of patients with an overdue appointment also decreased. This meant patients were more likely to receive safe, timely access to care and treatment. In June 2015, the outpatient service had 6,375 overdue appointments. The trust had reduced the number of overdue appointments to 2,427 at the time of our inspection. We saw staff prioritised patients most at risk through reviewing action plans, booking processes, and monitoring arrangements. We saw the majority of waits were overdue by one to four weeks.

- Ophthalmology had the most numbers of overdue appointments with 798 (33%). Reasons for this included the number of patients needing appointments, medical

staffing and flow of patients. Managers had an action plan, agreed by the trust board during the inspection. The action plan identified urgent actions staff needed to take to address this issue. The service put on extra clinics in the evening and at weekends to manage demand.

- The trust responded appropriately to urgent cases. As part of on-going changes to ophthalmology clinics, the service had introduced red packs containing patient records. Red packs identified patients as urgent or emergencies so staff could prioritise patients.

- Clinical staff observed patients and recorded physiological observations such as blood pressure and heart rate. Staff knew about the side effects of tests and kept patients under close observation. Staff used early warning scores for both adults and children to ensure they managed and cared for patients appropriately. Staff told us of incidents when patients were transferred to the emergency department when their health deteriorated.

- Staff knew procedures for escalation and calling for help when patients became seriously ill. Staff could give us examples of when they had to support deteriorating or seriously ill patients. Staff had access to resuscitation equipment and called the crash support number. Staff could call this in an emergency and dispatch a crash team to the department to treat the seriously ill patient.

- Staff could also call an alternative number if the emergency was not life threatening but they needed support to care for an ill patient.

- The outpatient clinics had admission pathways onto wards via the emergency department if they needed to admit patients. Staff we spoke with knew the processes and said they would send all patients through the emergency department before admission so doctors could review them.

- Staff undertook basic life support training as part of their mandatory training programme. Data from the trust showed 88% of staff were up to date with basic life support training.

- We saw consultants checking images, reading patient notes before clinic, and asking patients questions to assess the risk associated with medications and further treatment types. This enabled consultants to make decisions on safe care and treatment for the patient.

- We observed an interaction between two members of nursing staff discussing an ECG result and whether the

patient should put forward for surgery. Staff used NICE guidelines (CG95) Assessment and diagnosis of recent chest pain as the basis of their discussion and assessment of risk.

Nursing staffing

- Staffing for clinics was dependent upon the number of consultants running clinics each day. A trained nurse supported each consultant and in turn, healthcare assistants supported nursing staff. The matron for the outpatient service was responsible for staffing numbers and allocating the numbers of staff to clinics. We saw the majority of clinics had enough staff to ensure they ran smoothly and to time. The outpatient department did not use an acuity tool on which to base staffing rotas, this was despite research undertaken by the department sister to find a national tool.

- Managers said they did not employ agency staff, and filled gaps in staff rotas by using qualified bank staff who worked at the trust. However, some nursing staff said this did affect their workload if they had to support bank staff who were unfamiliar with the clinic environment. Data provided for the period July 2015 to June 2016 indicated an average of 360 bank staff were utilised each month, 12% (42) of these were qualified staff.

- Each clinic had a clinic coordinator. A member of nursing staff undertook the role and it rotated between staff. The coordinator had the responsibility of raising staffing concerns and ensuring clinics ran smoothly. This role was not supernumerary and therefore a member of nursing staff had additional responsibilities as well as supporting consultant clinics.

- Staff in ophthalmology raised concerns with the inspection team regarding staffing levels. Staff said there were not enough nurses on duty to meet demand and managers had reduced the hours of staff working. They said this affected the level of incidents the speciality had. Staff also said because clinics were busy they had to work more than their contracted hours and stay late. Senior nurses staffed clinics according to the number of consultants, we saw staff were busy and the clinic coordinator had to address competing demands. We escalated these concerns to senior nursing staff who said they would look at the issue.

- Relevant divisions in the trust provided specialist nursing staff for clinics.

Medical staffing

Outpatients and diagnostic imaging

- Medical Staff were employed by each clinical division and delivered outpatient clinic sessions for their speciality. Medical vacancy and sickness rates were managed within the specific division and monitored by the trust's medical task force.
- Medical consultants and registrars worked in outpatient clinics on a rota. At the time of our inspection, there were sufficient consultants to cover the clinics although some were very busy with long waiting times. Some patients we spoke with, in particular in ophthalmology, said they experienced long waits (over two hours) for their appointment.
- The trust employed locum doctors to cover clinics at Kings Mill Hospital as required for staff holidays or other leave. We spoke to two locum doctors who said they were happy working at the trust. However, we saw the induction for locum doctors was limited to half day training on computer systems. The locum doctors we spoke with said managers did not show them where they kept important equipment and they were not orientated into the clinics. We raised this with managers who said they were holding a meeting just after our inspection to discuss improving locum induction.

- Nursing and non-nursing staff in ophthalmology raised concerns regarding the behaviour of three consultants. The behaviour included raised voices and being rude to other members of staff. We raised this with managers at the trust who said they knew about a number of incidents and work was on going to address the behaviour of some consultants.

Major incident awareness and training

- The trust had a major incident plan which set out department procedures and responses to follow in the event of a major incident. Kings Treatment Centre, which delivered the majority of outpatient services, was part of the plan. Outpatient departments had clear procedures regarding cancelling clinics and using some clinic areas to treat casualties or support families and relatives. Most staff we spoke with knew about the incident plan and procedures to follow.
- Clinic managers could tell us about local business continuity plans in the case of inadequate staffing, power failure, bomb threat, IT failure, fire and flood. Staff knew about procedures to follow in the event of major impacts on the service.

Outstanding practice and areas for improvement

Outstanding practice

- Since our last inspection in June 2015 the trust had demonstrated significant improvements in the management of the deteriorating patient and the treatment of sepsis. Across medical care services staff identified and responded appropriately to changing risks to deteriorating patients. Where patients had met the trust criteria for sepsis screening, patients were screened appropriately.

- The 'EGO' pathway which had been implemented for those patients admitted with a minor orthopaedic injury who also had comorbidities that were medical care related.

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure staff understand the requirements of the Mental Capacity Act 2005 in relation to their roles and responsibilities

Action the hospital SHOULD take to improve

- The trust should ensure staff are consistent in isolating patients at risk of spreading infection to others.
- The trust should ensure oxygen cylinders are stored in a purpose-built trolley in a well-ventilated storage area and cylinders are chained or clamped to prevent them from falling over in accordance with Health and Safety Executive (HSE) guidance.
- The trust should ensure fluid/food thickening powder is managed and stored appropriately.
- The trust should ensure an on-going review of staffing numbers in order that sufficient numbers of nursing staff are deployed.
- The trust should consider reviewing the use of the bathroom on ward 53 as a storage area.
- The trust should consider providing a suitable waiting area for children in the emergency department between 9pm and 9am.
- The trust should recruit additional paediatric qualified nursing staff to the emergency department.

- The trust should ensure there are sufficient nursing staff in the resuscitation area of the emergency department at all times.
- The trust should consider a review and regular audit of consistency of staff documentation with regard to the classification of the cardiotocograph.
- The trust should consider how to improve mandatory training attendance for specialist gynaecology nurses.
- The trust should consider how to ensure sufficient numbers of medical staff working in maternity and gynaecology receive safeguarding training.
- The trust should ensure the process of reconciliation continues for outpatients without identified outcomes.
- The trust should continue to ensure patients most at risk are not unnecessarily waiting for outpatient appointments.
- The trust should continue its programme to reduce the numbers of overdue appointments for outpatients.
- The trust should review induction processes for locum doctors in outpatient areas.
- The trust should review and continue to address staffing, booking processes, and consultant behaviour in ophthalmology.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 11 HSCA (RA) Regulations 2014 Need for consent** **Regulation 11(1)** Care and treatment of service users must only be provided with the consent of the relevant person **How the regulation was not being met:** Staff did not always understand the requirements of the Mental Capacity Act 2005 in relation to their roles and responsibilities. Patient's capacity was not always suitably assessed.