

Derby Teaching Hospitals NHS Foundation Trust

London Road Community Hospital

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Derby Teaching Hospitals NHS Foundation Trust serves a population of over 600,000 people in and around Southern Derbyshire.

The trust has two hospitals, the Royal Derby Hospital, an acute teaching hospital and London Road Community Hospital. Derby Teaching Hospitals NHS Foundation Trust is one of the largest employers in the region with a workforce in excess of 8,000 staff.

Derby Teaching Hospitals NHS Foundation Trust is registered to provide the following Regulated Activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Maternity and midwifery services
- Surgical Procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury

London Road Community Hospital was inspected on 16 and 17 August 2016.

This inspection was a focused follow up inspection of following our comprehensive inspection in December 2014. There had been compliance actions issued against this provider at the time of our last inspection, these were issued under 2010 regulations, which were superseded by new regulations in 2014. These are now known as requirement notices. At this inspection, we inspected the key question of safe in medical care (including older people's care) and the key question of effective in end of life care to ensure the service was compliant with the requirement notices we issued at our last inspection. We did not rate the trust overall.

Our key findings were as follows:

- Care and treatment of patients at the end of their lives was effective and delivered in line with legislation and evidence based standards.
- Staff had good access to both the specialist palliative care team and access to comprehensive online information to support them to deliver care to patients at the end of their lives.
- Decisions made regarding cardiopulmonary resuscitation were made in line with the trust's policy and the Mental Capacity Act 2005 in the majority of cases.
- There was a good track record in safety, and an open culture, for reporting incidents and evidence of lessons learnt.
- Staffing levels and skill mix were planned, implemented and reviewed to keep patients protected from avoidable harm.
- Staff took appropriate steps to reduce the risk of hospital-acquired infections. Equipment was readily available and medicines were managed and stored safely.

However

- There was a lack of storage across all of the wards and bathrooms were being used as store rooms.
- Solutions and items which had the potential to cause harm to patients were not always stored appropriately.
- Staff were not familiar with the major incident and business continuity plan and their roles within these.

Professor Sir Mike Richards
Chief Inspector of Hospitals

London Road Community Hospital

Detailed findings

Services we looked at

Medical care (including older people's care); End of life care.

Detailed findings

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Background to London Road Community Hospital

London Road Community Hospital is part of Derby Teaching Hospitals NHS Foundation Trust. The trust serves a population of over 600,000 people in and around Southern Derbyshire. It is one of the largest employers in the region with a workforce in excess of 8,000 staff.

London Road Community Hospital was inspected on 16 and 17 August 2016.

This inspection was a focused follow up inspection of following our comprehensive inspection in December

2014. There had been compliance actions issued against this provider at the time of our last inspection, these were issued under 2010 regulations, which were superseded by new regulations in 2014. These are now known as requirement notices. At this inspection, we inspected the key question of safe medicine and the key question of effective in end of life care to ensure the service was complaint with the requirement notices we issued at our last inspection. We did not rate the trust overall.

Our inspection team

Head of Hospital Inspections: Carolyn Jenkinson, Care Quality Commission.

Our inspection team was led by: Helen Vine, Inspection Manager.

The team included CQC inspectors and a variety of specialists; including, an end of life care specialist nurse, specialist diabetic nurse and a respiratory nurse specialist.

How we carried out this inspection

Before our inspection, we reviewed a wide range of information about Derby Teaching Hospitals NHS Foundation Trust and asked other organisations to share the information they held. We sought the views of the local clinical commissioning group (CCG), NHS England, Health Education England, General Medical Council, Nursing and Midwifery Council. We also spoke with the local Healthwatch team.

The announced inspection took place on the 16 and 17 August 2016. We spoke with a range of staff throughout the trust, including, nurses, junior and middle grade doctors, allied health professionals, administrative and housekeeping staff.

Detailed findings

Facts and data about London Road Community Hospital

The London Road Community Hospital is part of Derby Teaching Hospitals NHS Foundation Trust. It is a community hospital located in Derby city centre, and

provides rehabilitation and intermediate care, inpatient facilities and some outpatient services. The hospital employs around 700 staff and treats around 184,000 per year.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	N/A	N/A	N/A	N/A	N/A
End of life care	N/A	Not rated	N/A	N/A	N/A	N/A

Notes

Medical care (including older people's care)

Safe

Good



Overall

Information about the service

Derby Teaching Hospitals NHS Foundation trust provides medical care (including older people's care) at London Road Community Hospital (LRCH) as part of the integrated care division. The integrated care division is split into three business units, for the purposes of this report we are looking at the rehabilitation and older people business unit.

The trust has 662 inpatient medical beds across two sites Royal Derby Hospital (RDH) and London Road Community Hospital (LRCH); 86 beds are located across four wards at London Road Community Hospital. During our inspection we visited four clinical areas. These included; wards, three, four, five and six.

In the period January 2015 to December 2015 there were 1,387 admissions to London Road Community Hospital.

This inspection is a focused follow up inspection following a comprehensive inspection in December 2015 and will only look at the safe domain.

During our inspection of this hospital we spoke with two patients and 22 staff. This included, junior and senior nurses, health care assistants, doctors, GPs, allied health professionals such as physiotherapists and support staff such as receptionists.

We considered the environment and looked at nine medical and nursing care records and six patient observation charts. Before our inspection, we reviewed performance information from and about the trust.

Summary of findings

Safety of medical services was good.

- We found a good record in safety with a reduction in the number of falls over the last two years. Although pressure ulcer numbers had increased slightly, we could not find a cause for this and staff were appropriately caring for these patients.
- Openness and transparency about safety was encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents.
- Staffing levels and skill mix were appropriate to keep patients protected from avoidable harm.
- Systems, processes and standard operating procedures in infection control, medicines management, patient records and monitoring, assessing and responding to risk were mostly reliable and appropriate to keep patients protected from avoidable harm.

However;

- There was a lack of storage across the wards and bathrooms were being used as storerooms.
- Solutions and items which had the potential to cause harm to patients, were not always stored appropriately.
- Staff were not familiar with major incident or business continuity plans.

Medical care (including older people's care)

Are medical care services safe?

Good



We rated safety as good

- Performance showed a good track record in safety, although pressure ulcers rates had increased slightly, falls had reduced. Improvements to safety were evident and changes were monitored.
- Openness and transparency about safety was encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents.
- Staffing levels and skill mix were appropriate to keep patients protected from avoidable harm.
- Systems, processes and standard operating procedures in infection control, medicines management, patient records and monitoring, assessing and responding to risk were mostly reliable and appropriate to keep patients safe.

However we found;

- There was a lack of storage across all of the wards and bathrooms were being used as store rooms.
- Solutions and items which had the potential to cause harm to patients were not always stored appropriately.
- Staff were not familiar with the major incident and business continuity plan and their roles within these.

Incidents

- There were no never events in the service 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 256 incidents reported by the rehabilitation and older people business unit at London Road Community Hospital (LRCH) in the reporting period March 2015 to June 2016. The top two incident themes related to pressure ulcers (inherited and hospital acquired) and falls. The majority of incidents were graded as low or no harm incidents. We reviewed a selection of incidents and were assured incidents were graded appropriately.

- There were a total of 11 serious incidents between Jun-15 and May-16. The majority of incidents were reported under two incident types – pressure ulcers (nine incidents – 39% of all incidents) and slips, trips and falls – 11 incidents (48% of all incidents). The number of serious incidents reported remained similar over time with 12 reported in the period June 2014 to May 2015. 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.
- We reviewed two of the serious incidents and found there had been a full investigation, learning from the incidents had been recorded and agreed actions completed.
- Incidents giving cause for concern or following a specific trend were discussed in team meetings, shared via email or staff newsletter. We saw a root cause analysis had been shared with the ward team on one ward and staff signed to confirm they had read this. This gave staff the opportunity to learn from incidents. Ward meeting minutes we reviewed confirmed incidents were discussed with ward teams.
- Staff were aware of, and appeared knowledgeable and confident about reporting incidents. All trust staff had access to the online reporting system. Staff said agency nurses could access the electronic system; however there were no agency nurses on the ward at the time of our visit and so we were unable to discuss this with them.
- Staff gave us examples of when they might report incidents such as a pressure ulcer or falls. Staff said there was a no-blame culture in the ward and they felt empowered to report incidents without fear of reprisal. Staff described receiving feedback from incidents if they requested it. Staff gave us examples of feedback from the falls team after reporting a patient fall.
- We saw policies, systems and processes in place to respond to National Patient Safety Alerts (NPSA), for example, the trust had a safety alert liaison officer (SALO) who emailed the alerts to the identified division or business unit contacts or to the allocated lead the alert to complete an action plan. We saw an example of an action plan in relation to an alert sent in February 2016, all actions had been completed within five weeks of receiving the alert. NPSA alerts are issued to

Medical care (including older people's care)

healthcare providers to update them about critical safety incidents and to provide guidance. Staff on the ward confirmed if they received an alert it would come through email, and be displayed on the staff notice board.

- Minutes we reviewed showed there were monthly mortality and morbidity meetings to share learning from the deaths of patients in the division. The meetings were open for all staff groups to attend, however nursing staff said they did not attend due to the workload on the ward. They said any information they needed to be aware of would be shared through the matron and cascaded to the ward teams.
- Staff were aware of their responsibilities and principles with regard to duty of candour regulation. The duty of candour is a regulatory duty which 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 were able to provide examples of when an incident had occurred and how they had informed the patient and their relatives of the incident made an apology and explained how the trust had responded to the incident. We saw evidence of an incident where duty of candour had been appropriately followed.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CAUTI) and venous thromboembolism (VTE). A VTE is a blood clot, which forms in a vein, often in the leg, which can cause harm to patients.
- In the period June 2015 to June 2016 1,159 patients were surveyed in the NHS Safety Thermometer, 92% of patients received harm free care. On a monthly basis this ranged from 89% (in March 2016) to 96% (in May 2016).
- In the period June 2015 to June 2016, small numbers of less than one percent of patients had a fall resulting in harm and a similar small number of less than one percent were recorded as having a new VTE. Two percent of patients were recorded as having a CAUTIs.

- Pressure ulcers were recorded in just under six percent of patients, however harm free care looks at all pressure ulcers (old and new), and therefore some of the pressure ulcers recorded may not have been acquired whilst at the hospital.
- Information about the incidence of pressure ulcers, infections and falls with harm was prominently displayed on all the wards we visited this meant patients and the public could see how the ward was performing in relation to patient safety. The information identified the number of days since the last pressure ulcer, falls with harm and infection rates. Information was shared with ward managers about the performance of their ward and, when required, actions needed to improve performance.
- There was a total of six hospital acquired pressure ulcers reported in the period June 2015 to May 2016 this showed an increase over time compared to three in the period June 2014 and May 2015. The highest numbers of pressure ulcers were reported on ward four (four incidents). During our inspection we did not note any concerns in relation to patient care which attributed to this increase, appropriate assessments were carried out, care plans and equipment were in place. Staff monitored this closely through the ward assurance process.
- There were a total of nine slips, trips and falls between June 2014 and May 2015 compared to two between June 2015 and May 2016, showing a decrease over time.

Cleanliness, infection control and hygiene

- There were 9 cases of Clostridium difficile (C. difficile) infections between June 2015 and June 2016. C. difficile is a bacterium affecting the digestive system; it often affects people who have been given antibiotics and has the capability of causing harm to patients. The trust target was to have a C. difficile rate of no more than or 53 cases per year. There had been a reduction in the cases over the last year.
- There were no cases of MRSA bacteraemia recorded between June 2015 and June 2016. MRSA is a type of bacterial infection and is resistant to many antibiotics.
- Meticillin-susceptible Staphylococcus aureus (MSSA) differs from MRSA due to the degree of antibiotic resistance. Between June 2015 and June 2016 there were 3 recorded cases of MSSA bacteraemia. This number had increased slightly compared to the East

Medical care (including older people's care)

Midlands average however a review of the cases attributed to the trust had not identified any trends. Each case had a root cause analysis undertaken. These were reviewed at the trusts' Healthcare associated Infection (HCAI) review group. Learning from these cases was discussed and monitored at the trust Infection Control Operational Group and Infection Control Committee and was incorporated in staff training.

- 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 and precautions to take.
- All the wards we visited were visibly clean. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place and we saw the completed schedules, which were up to date. There were clearly defined roles and responsibilities for cleaning the environment.
- The trust carried out monthly mini infection control audits to check compliance against infection control policies. Areas assessed included hand hygiene provision, clinical practice for example were staff 'bare below the elbow' and was medical equipment clean.
- In the period July 2015 to June 2016 the results for the trust mini infection control audits across all medical areas were on average 96% slightly better than the trust target of 95%.
- There was a system for the cleaning and decontamination of equipment for example 'I am clean' stickers; however on several occasions we found these stickers were not present on commodes. Staff said if there was not a sticker on it, they would clean it prior to its use.
- We observed patient-care equipment to be visibly clean and ready for use.
- During the reporting period July 2015 to June 2016, hand hygiene compliance across all of the rehabilitation and older people's wards was on average 96% above the trust target of 95%.
- Data provided by the trust showed 100% of all staff in this core service had completed level one infection control training above the trust of 95%.
- Staff were 'bare below the elbow' to allow effective hand washing, however on one ward we saw one member of staff had a wrist watch on, the member of staff was not providing hands on care at the time. We discussed this with the ward sister who addressed this immediately.

- Protective equipment, such as gloves and aprons, were available and we observed staff using this appropriately. We also observed staff washing their hands between patients.
- Cleansing hand gel was available at the entrances to each area and in each room; patients and visitors were encouraged to use it by staff. Posters were prominently displayed encouraging staff and visitors to cleanse their hands and the process to follow to do this effectively.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste including the disposal of sharps such as needles and environmental waste, however we saw on ward four the used linen trolley was overflowing and multiple bags of used linen were on the floor, this posed an infection risk.
- We saw there was a policy for MRSA screening. The policy outlined in what circumstances patients should be screened for MRSA with specific swabs and timescales. Staff were aware of and appeared familiar with this policy.

Environment and equipment

- The wards lacked storage space and we found large items of equipment, such as hoists and mattresses stored in patient bathrooms. Staff said if a patient wished to bathe then they would remove the equipment prior to this.
- We checked three resuscitation trolleys. The resuscitation equipment had been checked daily by staff and was safe and ready for use in an emergency. Single-use items were sealed and in date, and emergency equipment had been serviced.
- Fire-fighting equipment had been maintained and tested.
- Equipment was available for bariatric patients, for example larger commodes, hoists and chairs. A bariatric patient is defined as a patient who weighs over 159 kg (25 stone) or with a Body Mass Index (BMI) of 30 or over.
- We found there was a safe and effective system for the repair, servicing and maintenance of medical equipment. We checked 22 different pieces of medical equipment across all wards which included vital sign machines, blood glucose monitoring equipment, scales and hoist and found all but one piece of equipment (bladder scanner) to be in date with routine servicing. The bladder scanner was not in use at the time.

Medical care (including older people's care)

- The trust had access to sufficient equipment to meet patients' needs such as pressure relieving equipment; staff said they did not have problems accessing this.
- We found on wards four and five the storage of solutions, which had the potential to cause harm to patients for example cleaning tablets, was not compliant with Control of Substance Hazardous to Health (COSHH) requirements. COSHH is the law and requires employers to control substances that are hazardous to health. We spoke to the ward sister on ward six about this, who confirmed it had not been risk assessed and the cupboard had never been locked. We escalated our concerns further to the trust senior management team who assured us this would be looked at by the health and safety team.
- On ward five we found shaving razors were not stored securely and may pose a risk to patients and or visitors to the wards. We escalated our concern to nursing staff but we did not observe whether they took any action to mitigate the risk. We contacted the trust after our inspection and they were able to confirm the actions they had taken to remove this risk.
- We saw two bags of patient's lost property stored under the sink in the sluice on ward six. This was not an appropriate storage area for patient property.
- We saw an unused wrapped pressure relieving mattress on the floor in the patient dining room on ward six; this posed a risk to patients who may use this area.
- On ward four we saw toothbrushes and toothpaste were kept in the sluice, this was not an appropriate area for storing this equipment.

Medicines

- Medicines were stored securely on all wards we visited and appropriate emergency medicines were available. The nurse in charge held the keys for medication cupboards, controlled drug (CD) cupboard and fridge, all of these were locked.
- Medicines requiring storage at temperatures below eight degrees Celsius were appropriately stored in medicine fridges. Records confirmed fridge temperatures were monitored daily to check medicines were stored at the correct temperatures.
- We looked at the electronic prescription records for seven patients on the ward. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear

and fully completed. The records showed people were getting their medicines when they needed them as prescribed. Records of patients' allergies were recorded on the prescription chart.

- Nurses were responsible for administering medication. We observed nurses following the hospital policy when administering medicines to ensure the safety of patients. This included checking the patient's identity.
- We reviewed the storage and administration of controlled drugs (CDs) on three wards. Controlled drugs are prescription medicines controlled under the Misuse of Drugs legislation. We found them to be stored appropriately and records were accurately completed.
- Doctors told us they were aware of the local microbiology protocols for administration of antibiotics and prescribed in line with them, they showed us how they accessed the protocols through the trust intranet.

Records

- We looked at nine patient records across all of the wards. Records were paper based. Patient records were written and managed in a way which kept patients safe. All nine records we reviewed were accurate, complete, legible and up to date.
- Records were stored securely in ward offices, which were locked.
- Patient records showed assessments were carried out in a timely manner and documented correctly. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Safeguarding

- There was an internal system for raising safeguarding concerns and staff were aware of the process and could explain what constituted abuse and neglect.
- Staff received safeguarding training as part their mandatory training. Overall completion rates for the core service of medicine were 85% (level one) achieving the trust target of 85% and 81% (level two) below the trust target of 85%.
- We saw the trust policy for Female Genital Mutilation (FGM), it explained the process to be followed within the trust in relation to data gathering and reporting to the Department of Health (DH) on incidence of cases. Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons.

Medical care (including older people's care)

- FGM training was provided as part of safeguarding training and updated three yearly.

Mandatory training

- Mandatory training for all groups of staff was comprehensive; modules included moving and handling, infection control, fire safety and resuscitation.
- Mandatory training data for nursing staff showed a completion rate of 87% against a variable trust target of between 75% and 95% dependent upon the subject. Completion rate for medical staff was lower at 72%.
- Overall compliance rates for mandatory training across all staff groups which included administration and clerical, estates and ancillary staff and allied health professionals was 88%.
- 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; however this was not in part of a specific sepsis policy. Sepsis is a severe infection which spreads in the bloodstream;
- Staff had not received training in screening and application of a sepsis protocol, however at the time of our inspection; the trust had just started to roll out sepsis training.

Assessing and responding to patient risk

- We saw this site used a paper based observation system, which incorporated a nationally recognised early warning score (EWS) assessment tool. EWS have been developed to 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. This meant there was a system in place to monitor patient risk.
- We reviewed six patient observation charts and found nursing staff adhered to trust guidelines for the completion and escalation of EWS, frequencies of observations were appropriately recorded.
- We saw a patient, who had scored a high EWS, had received a sepsis screen and a prompt medical review. The patient was transferred to the Royal Derby Hospital, as their condition had deteriorated. This provided assurance staff used the EWS appropriately to manage the deteriorating patient.
- We saw staff used a recognised communication tool to provide structure to the communication process when

patients were transferred and care handed over. The Situation, Background, Assessment and Recommendation (SBAR) tool is recommended by NHS innovation and improvement for use in a variety of situations including patient transfer.

- We reviewed the nursing records of seven patients. 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.
- We saw evidence nurses reviewed and repeated these risk assessments. Staff took action on the results of these risk assessments; for example, patients who were at risk of pressure damage were nursed on pressure relieving mattresses. Patients at high risk of falling were nursed in cohort bays with increased nurse or health care assistant observations. A member of staff remained in the bay at all times. This reduced the risks of patient falls.
- A policy for resuscitation was available to all staff. The purpose of the policy was to ensure staff were aware of their responsibilities with respect to the immediate management of the deteriorating or collapsed patient within the trust including immediate on-site car parking areas.
- We saw an assessment and management tool for patients at risk of self-harm. The purpose of the tool was to provide information, best practice guidance and support for staff assessing, treating and deciding on best courses of action for patients.
- We saw yellow stickers used in the medical notes, which outlined patient management plans, escalation of patients concerns, and discharges. This ensured risk to patient management were minimised, and allowed effective communication amongst multi-disciplinary team members.

Nursing staffing

- During our inspection we observed staffing levels 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 and the Royal College of Nursing: Safe staffing for older people's wards. There were sufficient numbers of trained nursing and support staff with an appropriate skills mix to ensure patients were safe and received the right level of care.

Medical care (including older people's care)

- The trust had a staffing assurance tool which was updated twice daily and ensured there were sufficient staff on duty to meet the needs of the patients at the time.
- The trust used a red, amber, green (RAG) system to identify nursing shortfalls. This was reviewed at daily staffing meetings and appropriate actions taken to address shortfalls. The trust had an additional workforce allocated each day consisting of four registered nurses and four health care assistants who could be deployed to areas where additional staffing was needed. This meant the trust were able to constantly identify where additional support was required and provide it.
- The expected and actual staffing levels were displayed on notice boards in each ward we inspected and these were updated on a daily basis. During our inspection we found these to be an accurate reflection of staffing on the day.
- Ward establishments had been set following a review of acuity using an acuity tool. Staffing establishments varied across the medical wards but were sufficient to meet the needs of the patients at the time of our inspection.
- Wards caring for patients undergoing rehabilitation and or older people used the Northwick park acuity model. Northwick park acuity model is a model more specific to rehabilitation/ long stay patients. We saw examples of when ward establishments had been increased based the findings of the Northwick park acuity tool, for example wards four, five and six had an increase in registered and non-registered nurses. The trust told us due to the continued cohort bays and patients requiring increased supervision there may be a need to increase the staffing levels again.
- The trust monitored the planned versus the actual nursing staffing levels. In the period January to June 2016 the actual daytime registered nurse levels at versus the planned registered nurse levels were on average 88%. Night time actual nursing staffing levels were on average 95%. Planned staffing levels are the number of nursing hours planned for a shift, based on numbers of staff agreed with the ward in advance. Actual staffing levels are the number of nursing hours actually worked on a shift.

- Bank and agency nurses were used to maintain staffing levels on medical wards. Information received from the trust for the reporting period January to June 2016 showed a total of 922 registered nurse shifts had been filled by agency bank staff.
- Nursing staff handovers occurred at each shift change and included discussions about patient needs.

Medical staffing

- There were suitable arrangements for medical cover to support the wards Monday to Friday 9am to 5pm; for example ward four was covered by advanced clinical practitioners and an associate specialist doctor.
- Wards covered by GPs had a daily morning visit to review patients.
- Consultants carried out ward rounds three times per week.
- Out of hours and at weekends the wards had access to an external provider. In the event of a medical emergency the wards told us they would contact 999.
- We saw the trust had recruited a large amount of clinical practitioners and the plan was for all wards to be covered by advanced clinical practitioners from February 2017.

Major incident awareness and training

- There were arrangements in place to respond to emergencies and major incidents. We saw a major incident plan in place specific to medicine. The major incident plan was supported by individual action cards. We discussed major incident planning and business continuity with a number of staff including senior nurses, who were unfamiliar with the plans. They told us they could be accessed through the trust intranet, in the event of a major incident they said they would call the on-site manager and await further instructions. We did not see major incident plans, action cards or business continuity plans on the wards we visited.
- The trust provided us with a presentation 'winter learning' which was a view of winter pressures 2014/ 2015 and 2015/2016. This would form the basis of the plans for winter 2016/2017.

End of life care

Effective

Not sufficient evidence to rate



Overall

Information about the service

At the London Road Community Hospital, patients needing end of life care are cared for at the hospital on the general wards. The four wards at this hospital are rehabilitation wards and would not usually care for patients in the last hours or days of their lives, although there could be circumstances where this happened.

The department of palliative care medicine, included specialist palliative care services which are hospital based and a community based team. The community palliative care team provided cover at the London Road Community Hospital.

From January to December 2015 there were 2330 in hospital deaths at Derby Teaching Hospitals NHS Foundation Trust.

Trust wide from April 2015 to March 2016 1529 referrals were made to the specialist palliative care team. (SPCT). Of these 1284 were cancer related and 313 were non cancer related.

During our inspection we spoke with four members of nursing staff. We reviewed one patient record where end of life care was being provided and looked at eight do not attempt cardiopulmonary resuscitation (DNACPR) orders. Before our inspection we reviewed performance information from and about the hospital and trust policy documents.

The hospital was last inspected in December 2014 and the report published in March 2015. This inspection identified aspects of care that did not meet some of the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In end of life care this solely related to patient records, where we found do not attempt cardiopulmonary resuscitation (DNACPR) order forms were not completed accurately in line with trust policy.

This inspection was a follow up inspection and focused on the effectiveness of end of life care at London Road Community Hospital. Since our last inspection community

end of life care services provided from this location have been re-commissioned and are no longer provided by this trust. This meant a reduction in end of life care provision at this location.

End of life care

Summary of findings

We rated the effectiveness of the end of life care services as inspected but not rated because very few patients died at this location and trust level outcomes data were not broken down to site level.

- The service was delivering end of life care based on the five national priorities which had been identified as key for effective patient care. Care was based on best practice and current guidance. The service participated in national audit programmes and was therefore able to evaluate its performance against national performance.
- Training programmes had been established and tailored to meet the needs of the staff and staff feedback demonstrated the training was effective in providing them with the required knowledge to deliver good care to patients at the end of their lives.
- Changes had been made since the previous inspection which ensured when a decision was made on whether cardiopulmonary resuscitation (CPR) was an appropriate treatment, patient records were completed in line with trust policy and decisions made in compliance with relevant legislation.

Are end of life care services effective?

Not sufficient evidence to rate 

We rated effective as inspected but not rated because there were very few patients died at this location and trust level outcomes data were not broken down to site level.:

- Individualised personal care planning was used for patients in their last days or hours of life to deliver evidence based care and support to patients and their families.
- An education programme was in place and being provided to staff at the hospital which enabled them to become increasingly confident and competent to deliver care to patients at the end of their lives.
- National audit findings led to improvements being made to care delivery.
- Staff had access to the specialist palliative care team and to a comprehensive on line information toolkit. This contained detailed information to support all staff in delivering care to patients at the end of their lives.
- When decisions were made on whether cardiopulmonary resuscitation was an appropriate treatment for a patient, these were documented in line with the trust's policy and made in compliance with the Mental Capacity Act 2005 in the majority of cases.

However:

- There was limited evidence that patient outcomes at this hospital had been reviewed and used to inform improvements in the service.

Evidence-based care and treatment

- In 2013 a national independent review of the Liverpool Care Pathway, identified failings in the pathway and recommended individualised care planning for patients approaching the end of the life. At this hospital a personalised care planning documentation was available for staff to use which based on the five priorities of care set out by the leadership alliance for the care of the dying person. The five priorities of care were recognise, communicate, involve, support, plan and do.
- We asked one member of staff about the individualised care planning document and they were aware of this

End of life care

and knew when it would be used. They explained the personalised care plans were quite new to the hospital and they had not had cause to use one yet for a patient in the last days or hours of their life.

- Policies, procedures and documentation used on the wards were based on nationally recognised guidance. We saw evidence that care planned would be delivered in line with the National Institute for Health and Care Excellence (NICE) Quality Standard QS13. Systems were in place and resources available to provide timely specialist palliative care and advice
- A member of staff explained the AMBER care bundle was used to assist in the planning and delivery of patient care. AMBER is an acronym of **a**ssessment, **m**anagement, **b**est practice, **e**ngagement and **r**ecovery uncertain. This nationally recognised care bundle provided a structured approach to patient care where there was uncertainty about the patient's recovery. It was designed to manage the care of hospital patients who are facing an uncertain recovery but who are at risk of dying in the coming months. This ensured appropriate treatment was provided and ensured regular patient assessments were completed.
- The trust was signed up to the national programme for transforming end of life care in acute hospitals, so more people are supported to live and die well in their preferred place. A service improvement framework was provided for trusts to make local change, for example, the implementation of the evidence based AMBER care bundle, and advance care planning. Documented work plans supplied by the trust demonstrated there was commitment to continue to develop end of life care in line with these and other national best practice guidelines.
- The specialist palliative care team assisted in the management of patients who had an advanced, progressive or life threatening illness and where their care required specialist assessment, advice or treatment. From April 2015 to March 2016, 1529 patients had been referred to the trust's HPCT, of these 1284 (84%) had been diagnosed with cancer.
- Between the first of April and the 31st of July the community specialist palliative care team received three referrals from the London Road Community Hospital, all three referrers were contacted by the triage nurse within 24hours.

Pain relief

- Nursing staff were able to refer patients with complex pain management needs to the specialist palliative care team. There was also a pain team in the trust which staff could contact for advice. Palliative care consultants were available via an on call system out of hours.
- Patients were prescribed anticipatory pain relief as part of their personalised care plan. The need to evaluate the effectiveness of any medication that was administered was also contained within the care plan. Anticipatory prescribing of pain relief is when pain medicine is prescribed just in case it is needed at a later date to ensure there was no delay in pain relief being given.
- From reviewing a patient prescription chart we confirmed that anticipatory prescribing was in line with NICE guidance as it was individualised.
- A nurse explained they were able to access the standard syringe drivers to administer pain relief when required.

Nutrition and hydration.

- A mouth care and oral assessment tool was used as part of the individualised care plan to help identify potential reasons why a patient may not be able to eat or drink and to initiate treatment where required. This detailed assessment included the condition of lips and tongue and dental hygiene.
- A nationally recognised tool was used to assess patient's risk of malnutrition. Support was available from the dieticians if this was required and nutritional supplement drinks were available on the wards.
- One of the anticipatory medicines which was made available to patients was to prevent symptoms of nausea and sickness.
- In the national care of the dying audit published in 2016 the trust scored obtained results above the national average (eating assessment 61% and drinking assessment 67%) for their assessments of patient's ability to eat (74%) and drink (79%) within the last 24 hours of their life. In the same audit 26% of patients were supported to eat during this timeframe this was less than the national average of 36%.

Patient outcomes

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- Staff collected patient outcomes data which was monitored to enable improvements to be made in palliative and end of life care for patients and their families and the trust contributed data to national audit programmes.
- The trust submitted annual data to the national council for palliative care, this national data was used to provide information on hospice and specialist palliative care service activity.
- The trust had identified areas for improvement in response to their performance in the national care of the dying audit, published in 2016. Actions had been taken to address the four organisational key performance indicators that had not been met. All four indicators related to the trust's communication training. Training at the time of the audit did not cover specific skills for communicating with patients in the last hours or days of their life. Since April 2016, evidence based, nationally recognised communication training workshops had been provided and further training planned for October 2016.
- The trust did not meet three out of the five clinical indicators in the national audit, Two of these were just below the national result. These were whether it was documented in the last episode of care that the patient would probably die within the coming hours or days and whether that information had been discussed with the patient's nominated person. The third indicator the trust did not meet related to insufficient documented evidence that their visitors had been asked about their needs. The trust met two of the clinical indicators these were whether there was documented evidence that the patient had received the opportunity to have their concerns listened to and whether a documented holistic assessment had been made of the patients' needs We saw evidence that visitors' needs had been discussed and staff spoke of recognising and meeting these needs
- The palliative care team carried out an annual audit on patient's known to the team and whether they expressed a preferred place of care. From April to August 2015, 302 patient records were reviewed. A discussion had taken place regarding preferred place of care with 256 patients (85%) out of the 42 cases (14%) where this was not discussed 18 patients were too unwell to discuss their preferences. These results were similar to previous years. Two hundred and forty seven of the patients had passed away and 120 had passed away in their preferred place of care.
- The trust obtained information on patient outcomes by asking bereaved relatives to complete a bereavement questionnaire about their and their relative's care experience. From April 2015 to April 2016, 1833 questionnaires were sent to families, 195 (11%) were returned. One hundred and twenty four of these (64%) said a discussion had taken place about a preferred place of care. As a result of the low response rate, the questionnaire sent to bereaved relatives has been shorted.
- The trust's admission document now included a prompt for staff to enquire where their preferred place of care was and to document if they had an advance care plan or advanced directive in place. An advance care plan is a documented plan of a patient's wishes regarding their care; they are often made in anticipation of a future deterioration in a patient's condition.
- In the national End of Life Care Audit: Dying in Hospital, based on data from 80 patients submitted from May 2015, there had been recognition when a patient was dying in 81% of the records. Senior medical staff were noted to take responsibility for recognising a patient was dying. Training commenced in April 2016 for medical and nursing staff on recognising when patients are dying, this ensured all patients were recognised and appropriate discussions took place as early as possible.
- A ward accreditation programme was being introduced at the hospital. Ward staff were assessed to establish their level of knowledge and records were audited as part of the accreditation process. At the time of the inspection the trust were at the start of the process and no wards had been accredited.
- As part of the national transformation programme, an end of life care work programme had been developed which was used to support and assess service and quality improvement. Key areas of work included, staff education, documentation and information technology to support an electronic record system. Following the inspection the trust informed CQC that they were delivering training to medical staff to improve the standard of patient discharge letters.

Competent staff

- The community palliative care team was led by a consultant in palliative care medicine with 10 clinical nurse specialists. The clinical nurse specialists and palliative medicine consultants provided formal and informal training to staff.

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- All the community palliative care team had received an appraisal within the previous 12 months.
- There was a dedicated facilitator in post to implement the AMBER care bundle across the trust which meant the training and implementation of the care bundle was consistent.
- There was an on-going end of life education programme to equip staff throughout the hospital with the skills and knowledge required to provide care to patients at the end of their lives. The training programme was role specific and included a general overview of the trust's approach to care in the last days of life, through to a full training programme on the priorities for end of life care for more senior and specialised roles.
- The training programme had commenced in April 2016. Data provided by the trust showed as of July 2016, of the 956 staff requiring essential to role end of life training, 204 (22%) had received recognising dying training, 191 (20%) had received symptom management, 527 (56%) had received care planning training and 71 (8%) had received communication skills training.
- Staff competence was assessed and training attendance monitored as part of the trust's implementation of the national transforming end of life care in acute hospitals programme. We saw the assessment document used to establish whether wards had achieved the required standard to be accredited. The required standard ensured a high level of knowledge.
- A nurse explained there were at least two end of life link nurses on one ward who cascaded their learning to the rest of the team. Training on end of life care was available for the ward staff. We saw where bookings had been made for end of life care training for September 2016. Nursing staff were prioritised for training depending on where they worked. Link nurses were a high priority for the training.
- Link nurses were based on each ward to enable information to be cascaded effectively to all staff. There was more than one link nurse from each ward and these were from varying levels of seniority on the ward. This was to ensure information was cascaded throughout the teams.
- There was a quarterly end of life care link nurse meeting. We reviewed minutes of a meeting held in June 2016 and confirmed that there was representation at the meeting from a ward at this hospital. Topics of discussion included their role in supporting the ward team in their training as part of the programme for transforming end of life care across the trust and wards achieving accreditation.
- The trust's Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) had recently been reviewed. We saw examples of educational materials used to train staff which included relevant practical examples to help staff apply these legal requirements correctly. MCA and DoLS training was delivered as part of staff mandatory safeguarding training. Training was delivered by face to face sessions and via e learning packages. E learning training was a 30 minute training session which had been tailored specifically to meet the trust's training needs and included information on restraint.
- Training on do not resuscitate orders was provided in the resuscitation training sessions. There was a prompt on the staff intranet to alert staff there had been amendments to the trusts do not attempt cardiopulmonary resuscitation DNACPR documentation.
- Training attendance records supplied by the trust for training sessions held on the Mental Capacity Act showed staff at the London Road Hospital had been able to access the training.
- Registered nurses received training to ensure their competence in using equipment commonly used to administer medicines to patients receiving end of life care. Records supplied by the trust showed ward staff had been assessed as competent in using standard syringe drivers. Training updates were provided every three years. A senior member of staff on one of the wards we visited confirmed the staff were able to use syringe drivers.
- Senior staff told us end of life care training had now been included in the induction training for medical staff starting at the trust.
- Ward staff had the opportunity to work alongside the clinical nurse specialists to develop their skills in symptom management. One clinical nurse specialist had part of their role (0.4WTE) assigned to the regional training programme for medical students.
- Five of the clinical nurse specialists within the community palliative care team were non – medical prescribers, and funding was in place for the other five clinical nurse specialists to have completed their

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training by 2019. In addition to prescribing new medications, the role enabled existing patient medications to be reviewed and stopped if they were no longer appropriate.

Multidisciplinary working

- Key leaders of the specialist palliative care service explained they had direct links with the regional specialist nurse in organ donation (SNOD) and attended meetings held by the regional organ donation committee. The regional SNOD was available to provide advice and support to staff, patients and families throughout the hospital
- Two staff we spoke with explained the specialist palliative care team were involved in patient care if specialist advice was required.
- One member of staff explained the dietetic service could be accessed through a referral to the Royal Derby Hospital team.
- At the time of our inspection the trust did not have an electronic palliative care coordination system. (EPaCCS) This is an electronic patient record system which provides health professionals both in the hospital and community, including GPs access to a patient's care records. At the time of our inspection the trust was involved in discussions with all relevant partners about the format this shared online record of care should take. In the meantime general practitioners would need to be updated about the care a patient had received in the hospital as they did not have direct access to the care records via an on line system.
- When a patient with a personalised end of life plan of care was discharged the patient's GP would be notified by letter about the discharge and their plan of care. If a patient passed away the GP surgery would be informed, this was included in the personalised care plan document for care after their death.
- Patients previously known to the palliative care team would automatically be flagged up on the hospital record system if they were readmitted. Where patients were admitted who were receiving or required end of life care and would benefit from specialist care but were not known to the palliative care team a referral would need to be made by the medical team

- Medical notes were a paper record. All members of the multidisciplinary team wrote in the medical notes, this ensured all health professionals had access to all the information and plans of care were shared and coordinated.
- Patients referred to the specialist palliative care team remained under the responsibility and care of their admitting doctor. The palliative care team advised on the patient's care, but did not take over, the patient's total management.

Seven-day services

- The community palliative care team, Monday to Friday 9am to 5pm and one member of the team was on duty on a Saturday 9am until 5pm.
- During this time the team provided face to face specialist advice, information and support to patients and staff throughout the hospital and community.
- Outside of these hours requests for advice/support are directed to the out of hours advice line operated by the Nightingale Macmillan Unit which is part of the Specialist Palliative Care Service.
- There was a consultant in specialist palliative medicine on call 24 hours a day seven days a week. The on-call consultant was contactable via the hospital switchboard.
- Physiotherapists and occupational therapists provided planned care to patients during the weekdays. At weekends there was an on call system in place for urgent physiotherapy treatment.
- The chaplaincy service was available at all times. Out of hours they were contacted via the hospital switchboard and staff we asked were aware of how to contact the chaplaincy service.

Access to information

- Staff had access via the trust's intranet to the Derbyshire Alliance for End of Life toolkit. The toolkit had been developed within the local region and provided a substantial resource of relevant, evidence based, current information on planning and delivering care for people in their last months, weeks and days of life.
- The two staff we asked knew there was information on the trust intranet to support them to plan and deliver care to patients in the final stages of their life.
- One member of staff knew about the Derbyshire Alliance Toolkit and located it via the intranet. Once on the

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intranet staff were automatically directed to the toolkit without needing to search for it by name. There was detailed information on the symptom management including pain relief available via the trust intranet.

- Without exception all the eight do not attempt cardio pulmonary resuscitation (DNACPR) forms we reviewed were located at the front of the medical notes which made them easy to locate.
- Staff explained they would be informed at handover of patients who were not for resuscitation. Where patients were admitted during the shift they would refer to the patient's medical notes for information on the patient's resuscitation status. We saw a copy of the nurse handover sheet and this contained a record of which patients were not for resuscitation. The nurse provided us with these details and this correlated with the resuscitation status in the patient's medical notes we reviewed.
- On one of the wards we visited the medical notes were stored within a clinical room where access was restricted by a coded lock. Patient's nursing care plan documents were kept in patient areas and were readily available to staff.
- We saw the end of life care resource folder on one ward. The staff knew where this resource was and knew what information it contained.
- Patients who had previously received care from the hospital palliative care team would be flagged on the electronic records system should they be re admitted to the trust. Where patients were not previously known to the team, then the team relied on the patient's medical team referring them for an assessment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed eight do not attempt cardiopulmonary resuscitation (DNACPR) forms. These forms were all easily identifiable, being red, located at the front of the medical notes, and were legible and accessible to staff. Senior staff at the trust staff informed us the DNACPR forms had been reviewed and amended. The forms now incorporated a two stage assessment required by the Mental Capacity Act to determine whether a patient had mental capacity and if not, why this was the case.
- The two stage test on the form specifically related to the one decision, whether a patient had the mental capacity to hold discussions about their DNACPR decision.
- Of the eight DNACPR forms we reviewed, two had a documented decision that the patient had mental capacity at the time the decision regarding resuscitation was made. On the other six forms, where a decision had been documented that the patients didn't have mental capacity, four had the two stage mental capacity assessment fully completed. On the remaining two forms, each had one stage of the two stage assessment not recorded on the form.
- On one form a patient had been admitted to the hospital with an existing DNACPR in place from the community. In line with trust policy a new DNACPR form had been completed and placed in the front of the patient notes. From the information on the form and in the patient notes it was not clear whether the patient's mental capacity had been reassessed or if a discussion had taken place with the patient's family. We raised this at the time of inspection and the staff member had a very good understanding of the trust policy. The following day we were updated that a review of the patient's current condition had taken place on admission and that the patient's family had been kept up to date.
- Where possible discussions had taken place with patients about their resuscitation status and these were documented on the forms. Records of discussions which had taken place with relatives were recorded on all of the forms where patients had been assessed as lacking mental capacity in relation to the resuscitation decision.
- The trust carried out quarterly audits of DNACPR forms. In January 2016 as part of a trust wide audit, five DNACPR forms from two wards at the London Road Hospital were reviewed. All had been signed by a consultant and discussions from speaking with patients and family were recorded. These results were comparable with our findings on inspection. During the trust DNACPR form audits that have been completed during 2016 there have been no DNACPR forms in use at this hospital to include in the audits on the days they have taken place.
- Patient admission documents had been recently amended to prompt staff to consider if a patient may lack capacity in relation to a specific question at the time of their admission. That question was whether they were able to understand the information being provided to them about what the nursing care may entail.
- At the time of the inspection we saw one patient had a Deprivation of Liberty Safeguards (DoLS) authorisation

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in place. We reviewed the associated documentation in the patient's medical notes and saw that a Mental Capacity Act assessment had taken place and a best interest checklist had been completed.

- Trust managers spoke of being aware and taking note of the Department of Health Guidance issued in October 2015 on DoLS. This document provided specific guidance on taking a proportionate and sensitive assessment when considering whether a DoLS application was required for patients cared for in their last days of life. The patient admission documentation had been amended to include a prompt for staff to consider whether a patient was under a Deprivation of Liberty at the time of their admission.
- There was a documented trust procedure if a patient lacked capacity and a best interest decision needed to be made. By following this procedure and using the trust documentation staff would ensure the correct person would make the decision by taking into account any advance decisions made by the patient.
- Consent training was provided to all junior medical staff. The trust provided us with a copy of the training material which was comprehensive and relevant for their role.
- On the front of the patient's record of care documentation there was a statement it could only be read by their family and friends with the patient's permission.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The trust should ensure they are compliant with Control of Substance Hazardous to Health (COSHH) requirements.
- The trust should consider how they store equipment across all wards.
- The trust should ensure staff are familiar with the major incident and business continuity plan and their roles within these.
- Consider how to ensure patient outcome data is collected and monitored to show end of life care services are meeting the needs of the patient specifically at London Road Hospital.
- The trust should continue to prioritise training in end of life care for all staff to enable them to provide appropriate care for patients at the end of their lives.