Paper ref: TB (01/19) 021

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Care Quality Commission Inspection: September 2018

Response to preliminary findings as at December 2018

	CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
Medicine and Emergency Care: 4 to 6 September 2018						
CROSS-SITE ISSUES						
1.	Patient records, computer screens and boards had confidential patient information openly accessible, so potential for breaches of personal data	• The boards used in each AMU are to be covered • IG training to be reiterated through team meetings in January, as part of a site-wide conversation about patient confidentiality	November 2018 February 2019	Claire Hubbard Kam Dhami	• Unannounced in-house inspections to include observations of information governance practice. • Staff compliance with the annual mandatory Data Security Awareness Training *(formerly the IG Toolkit)*	**A**
2.	Mental Capacity Act – recording of capacity assessments were not available for some patients and DoLs were in place, so there was no assurance that processes were being followed. There was confusion/limited understanding amongst staff between the	• The Trust uses standard DNACPR forms and will review the format against best practice in other organisations, and introduce any agreed changes. • Forms to be read in conjunction with patient notes and records.	February 2019 January 2019	Paula Gardner	Patients randomly selected from the DoLS tracker held by the Safeguard Team and checked for adherence to Trust procedures and processes.	**A**

Status						
	G	Action completed and CQC concern addressed	**A**	Action on track to be delivered by the agreed date	**R**	Action off track and revised date set and stated

	CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
	difference between a DoLs and a mental capacity assessment. *(The exception to this is Medicine at City Hospital where capacity processes were found to be in place.)*					
3.	Some resuscitation trolleys were unsecure and not tamper proof. Some equipment on trolleys was out date despite signed checks by staff	Tamper proof resuscitation trolleys ordered in August 2018 to replace all site trolleys, due for deployment in January 2019.	January 2019	Paula Gardner	Governance Team audit of resuscitation trolleys in February 2019.	R
4.	Some IV fluids were not securely stored	• All areas have had their storage of IV fluids reviewed. All areas at City Hospital store their fluids in a locked cupboard with racking or shelving. Areas at Sandwell store their fluids in a locked cupboard with racking or shelving. • Digital lock replacement required for clean utility, AMUA and Sandwell ED • Sandwell ED Resus has IV fluids stored locally within the room due to clinical need. This is being placed on the risk register.	November 2018	Claire Hubbard	Pharmacy staff to visit wards and departments and inspect the place of storage every 3 months.	A
5.	Continued staff concerns with the quality and reliability of IT systems and support	The October Board established revised governance for IT having changed the management team. Performance data is widely published weekly		Toby Lewis		A

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CQC finding		Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
		across the organisation.				
		• From January IT helpdesk tickets will only be closed with employee confirmation and 100 'mystery' shoppers will advise the Board fortnightly on employee confidence in the revised systems.	February 2019		• Helpdesk compliance KPIs will provided fortnightly to relevant executive and Board committees	
		• The externally supported infrastructure programme will be implemented between October and December 2018.	January 2019		• Completion report to Board's Digital MPA	
		• Unity installation, which is cloud backed, will be take place during Q4 or Q1 of 2019.	April 2019		• Delivery of business case via implementation, go live and optimisation (post project review)	
		• Printer resolution team will visit each ward and department to close out remaining print issues.	January 2019		• In situ checklist submission from each team confirming resolution as part of go live checklist	
		• Revision of password policy will enable Trust to reduce helpdesk tickets and waits by implementing meaningful self-service.	January 2019		• Material reduction in password queries to helpdesk March 2019 vs November 2018	

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	CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
6.	Patient call bells were not always within reach or accessible	Matrons have it as part of their quality checklist	November 2019	Claire Hubbard	Unannounced in-house inspections to observe accessibility of patient call bells and response	**G**
SANDWELL GENERAL HOSPITAL - URGENT AND EMERGENCY SERVICES						
7.	Infection control and cleanliness of the department was a concern	• The department has regular cleaning. As this is a 24 hr facility there has been a discussion around increasing the frequency of cleaning. • The matron has reinforced with staff the importance of cleaning equipment between patients.	October 2018	Hillary Mallard	Visible cleanliness of department and equipment and compliance with cleaning log, plus improved PLACE scores.	**A**
8.	The specialist paediatric team did not work nights. Care overnight was delivered by non-specialist paediatric staff. There was no separate waiting area for children between the hours of 9.30pm to 9am, this could potentially compromise the safety of children.	The Trust is satisfied with the safety of children overnight, as waiting areas are observed. • Wait times for children are separately reported and the scale of staffing is being increased on weekday afternoons • Skills development is taking place to ensure that nursing staff have the required competence and confidence to look after children.	January 2019 February 2019 March	Prem John	Completed checks to confirm nurses are competent to look after children.	**A**

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	CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
		• The Trust is reviewing the interaction between its assessment units and its A&E department	2019			
9.	Ambulance handover bay – There were concerns about the safety, privacy and dignity of patients	Staff have been reminded to support privacy and dignity for patients by ensuring curtains and doors closed and patients covered appropriately	October 2018	Hillary Mallard	No complaints or PALS regarding privacy and dignity in relation to the handover bay.	**A**
Notable practice: • All patients and relatives spoken to were positive about the care delivered to them. • The response given to 'pre-alert'/'red phone' patients was good – observed an example of responsive treatment of a paediatric sepsis patient • There was an accessible domestic violence staff member in the department						
SANDWELL GENERAL HOSPITAL - MEDICINE						
10.	In AMU there was a policy to allowed mixed sex bays to be used. Whilst the policy states that this should be avoided if possible, bed configurations were not being optimised to reduce this. We have requested more information from you regarding mixed sex accommodation. We found the same concerns at City Hospital	Since early 2018 the Trust has implemented an exemption arrangement which was agreed with its commissioner and regulator. In light of CQC comments we have: • Changed internal reporting and escalating arrangements to ensure rapid moves take place as single sex beds become available • Agreed to resume breach reporting without exemption from December 1st 2018	October 2018 December 2018	Rachel Barlow	National reported breach data	**A**
11.	We had concerns around nurse staffing levels. Particularly around high agency/bank staff numbers on OPAU	• Continued work to recruit and retain nursing staff across medicine • Cross directorate balancing work introduced to	December 2018 October	Claire Hubbard Claire	Ward Quality Assurance Dashboard	**G**

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	CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
		equalise gaps based on acuity • Revised Trust-wide approach to focused care and de-escalation	2018 December 2018	Hubbard Debbie Talbot		
12.	Staff had a limited understanding around duty of candour	• Implementation of the DoC process – staff know about the policy and where to find guidance • Intranet page of Patient Safety to hold the stage 1 & 2 proformas and the template letter • Weekly reports to advise, who requires a DoC conversation	November 2018 December 2018 January 2019	Kam Dhami	100% compliance against the auditable standards in the Duty of Candour Policy.	**A**
Notable practice: • Matrons and leads appeared passionate in role						
CITY HOSPITAL – URGENT AND EMERGENCY SERVICES						
13.	Concerns about paediatric care out of hours as was found at City	The Trust has clear arrangements for the management of children in ED out of hours. We continue to discuss: a) The right model for medical staffing between ED, paediatrics and neonates b) The best way to ensure competency among staff who see some but not typically children	January 2019	Toby Lewis	TBC when model defined	**A**

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	CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
		We will define a final position for 2019 by the end of January 2019.				
14.	We saw large sharps bins full of needles and open to all by the paediatric department, staff told us they empty and re use sharps bins. These had no date or signatures were included as they were re-using them, so no audit trail was possible.	Sharps bins will be used appropriately, i.e. lids will be closed, not filled above line, disposed of correctly.	January 2019	ED GDON	Photographs of bins to be taken routinely to confirm status	**A**
15.	Safety/security concerns- doors were wide open, staff were concerned about safety so had doors open however, this had the potential for anyone to walk in the department.	• We will prevent doors being held open for longer than a defined period • We will implement revised security protocol within our A&E departments based on MAPA training	Oct 2018 March 2019	Alan Kenny Rachel Barlow	An audit of adherence to the revised Security protocol in the A&E departments.	**A**
16.	The triage room door was wide open and everyone in the vicinity could hear/see patient during an assessment	• Staff have been reminded to support privacy and dignity for patients by ensuring curtains and doors closed and patients covered appropriately	October 2018	Hillary Mallard	Unannounced in-house inspections to include observations and interviews of patient privacy and dignity.	**A**

Notable practice:

- The domestic violence lead was impressive and we saw innovation around the compact mirror and lip balm.
- BMEC – we saw significant improvements from the last inspection. These included the children's/adult waiting areas, documentation had also improved. The

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	CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
	BMEC band 7 and the new clinical ED lead at BMEC highly respected by staff.					
CITY HOSPITAL – MEDICINE						
17.	Concerns around mixed sex accommodation are highlighted (as documented under medicine at Sandwell)	Since early 2018 the Trust has implemented an exemption arrangement which was agreed with its commissioner and regulator. In light of CQC comments we have: • Changed internal reporting and escalating arrangements to ensure rapid moves take place as single sex beds become available • Agreed to resume breach reporting without exemption from December 1st 2018	October 2018 December 2018	Rachel Barlow	National reported breach data	**A**
18.	Staff acuity levels were sometimes not sufficient to meet patient's specific needs. This included agitated patients and patients assessed as needing one to one care	• We have implemented revised arrangements for identifying and supporting patients needing enhanced or focused care • We will track all red and purple patients corporately to assure ourselves that their care is being managed suitably	Oct 2018 January 2019	Paula Gardner Paula Gardner	Ward Quality Assurance Dashboard	**G**
19.	Two staff were in tears when raising concerns and frustrations about staffing levels as they considered they could not always deliver the care patients deserved or needed	• A discussion has taken place with the staff concerned to understand (a) their concerns and (b) how those concerns had not surfaced within contemporaneous risk register and incident reporting. • A whistleblowing disclosure exercise is being	Oct 2018 January	Claire Hubbard Toby	Ward Quality Assurance Dashboard	**G**

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		organised across the wards concerned to understand the full scope of anxiety among all staff groups	2019	Lewis		
20.	There were gaps in ward staff knowledge (Fire safety / DoLS) and planned training events were not always attended due to staff shortages	• The longstanding policy is to achieve 100% mandatory training compliance by the end of March 2019. This will include the specified wards. • The evacuation training events for 2019 will be shared with the CQC.	April 2019 January 2019	Raffaela Goodby Alan Kenny	100% mandatory training compliance reported on the IQPR.	**A**

Notable practice:

- There were effective board and ward rounds/discharge planning (Ward based consultants, protected daily TTO planning time)
- MTD working, resulting in improved communication/ access to prompt specialist advice

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Care Quality Commission Inspection
Children and Young People's Services and Maternity Services

Response to preliminary findings

CQC finding		Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
Young People's Services and Maternity Services: 11 - 13 September 2018						
CROSS-SITE ISSUES IN MATERNITY AND CHILDREN'S SERVICES						
21.	Ward managers do not have enough protected time to allow them to carry out their managerial roles.	Maternity, Neonatal Unit (NNU) & Paediatrics: Ongoing recruitment into current vacant posts to release ward managers to have rostered funded protected time.	Ongoing – April 2019	Rachel Carter	• Audit of funded protected time allocation for Ward Managers. • Sustained delivery of EWTT (or equivalent and clinical audit standards • Improved staff satisfaction (Your voice, local feedback-meetings)	**A**
22.	Staffing was a concern across neonates and paediatrics. Multiple occasions of staffing not meeting patient acuity within neonates and D19.	• NNU: Increased funding secured through contract change to enable staffing to meet BAPM requirements • NNU: Escalation policy deployment; flow chart to indicate need and action to restrict activity.	In progress from June 2018 – ongoing	Rachel Carter	• Staffing will meet activity and acuity with appropriate escalation to ensure staffing meets acuity (safe staffing reports, Q&S dashboard, NNU BadgerNet reporting	**A**

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	CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
		• D19: Ongoing utilisation of Paediatric Escalation Policy; flow chart to indicate need and action to restrict activity if required.			tool). • Reduction in reportable incidents associated with staffing deficits. • Improved staff satisfaction (Your voice, local feedback-meetings)	
SANDWELL GENERAL HOSPITAL - CHILDREN AND YOUNG PEOPLE						
23.	There were ligature points in the rooms used by children with MH needs. Some information has been provided to us.	• Immediate review of the area with estates and Head of Paediatric Services undertaken • Rooms altered to balance risks identified vs. predominant use of these facilities for non-MH children	January 2019	Amanda Geary	• Areas compliant to meet the needs of the supervised at risk mental health adolescents plus the acute medical admissions. • 1:1 staffing model for MH admissions to be audited monthly	**A**
24.	Resus trolleys were not locked/did not have tamper proof tags on Lyndon 1 or Lyndon ground.	Tamper proof resuscitation trolleys ordered in August 2018 to replace all site trolleys, due for deployment in January 2019.	January 2019	Paula Gardner	Governance Team audit of resuscitation trolleys in February 2019.	**R**
25.	Establishment Nurse staffing levels did not meet RCN guidelines.	External review commissioned of staffing, which found that planned establishment levels do meet RCN non mandatory guidelines	February 2019	Rachel Carter	Week by week monitoring of deployed staff vs. establishment to ensure Trust meets its own staffing guidance	**A**

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	CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
26.	Numbers of consultants and workload - working up to 13 programmed activities in addition to acting down duties (as insufficient middle grade doctors) - there was no capacity for unexpected absences.	There are 4 out of 13 consultants in paediatrics whose job plan is above 12 PAs, all the PAs above 10 being management roles that have been taken on voluntarily by consultants or via competitive interview:	October 2018	Nik Makwana	Group Job planning will launch March 2019 with individual job plans completed by July 2019	G
27.	Children were not being seen within 14 hours of admission and they was not have a 12 hour daily presence of consultant cover.	Due to the delay in Midland Met construction a review has been undertaken with an options appraisal in progress for interim plans to enable improved cover of our middle grade gaps, provide a greater time period of onsite consultant cover and aim for review of new admissions within 14 hours.	May 2019	Nik Makwana	Children seen within 14 hours of admission and presence of a Consultant over 12 hours.	A
28.	Out of date medicines including controlled drugs on Lyndon 1.	This arose through human error. • Ward staff raised repeat request to pharmacy for medications to be removed – drugs were removed • Staff reminded to report any further incidents of out of date stock not being collected by pharmacy to ensure appropriate, timely escalation. • Monitoring in progress (reported incidents)	October 2018	Punnet Sharma	• Medications in wards and clinical areas are in date. • Expired medications are removed on the day of request. • Incident reporting reflects appropriate escalation and action with evidence of monitoring through directorate risk and	G

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	CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
		• Process for checking of all stored drugs by pharmacy technicians to be reviewed.			governance meetings	
Notable practice: • Effective MDT working across the trust - all staff have said how responsive OTs, physios, dieticians, SaLT and CAMHS are when they need them. • Nurses and consultant in particular were very committed to the service and go above and beyond to support each other. • Diabetes bags were given to children with diabetes before discharge - it contained lots of information in a child friendly format.						
CITY HOSPITAL – MATERNITY SERVICES						
29.	Reduced staffing levels on occasions, particularly in the Serenity Midwifery birth centre made some staff feel anxious and vulnerable about providing sufficient levels of care to women at the centre. Staffing levels sometimes impacted on staff being unable to take breaks and attend mandatory training sessions.	• Cross cover model across maternity remains in place to balance risk between units, including labour ward and Serenity. • Group performance process to be used to track monthly data on shifts that are more than one staff member below our threshold • Renewed effort to address sickness management issues across midwifery services to ensure rostered staffing is achieved.	January 2019	Rachel Carter	Staffing meets acuity with evidence of appropriate, timely escalation. Improved staff satisfaction (Your voice, local feedback-meetings)	**A**
30.	The fridge on the antenatal ward used for storing breast milk was unsecured posing a potential safety risk. However, the service addressed this in a timely way as senior staff ordered a lock for the fridge once this concern was raised.	Replacement lock to be ordered and secured	October 2018	Rachel Carter	Fridge secure and only accessed by staff	**G**

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	CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
31.	Gases were stored without the required signage on the clean utility doors in the delivery suite. We raised this to the senior management team during the inspection, this was addressed.	Signage to be secured to doors	November 2018	Alan Kenny	Gases stored with required signage	G
32.	Staff confirmed the birthing pools in the Serenity Suite were cleaned after each use. However, there was not a system in place to record when the birthing pools had been cleaned.	• Cleaning schedule to be shared with CQC inspection team as evidence submission. • All staff to be aware that the documentation used to reflect pool cleaning is known as the 'cleaning schedule'	September 2018	Rachel Carter	Evidence submission to reflect schedule was in place	G
Notable practice: • The 'Silent Cockpit' principle was used in maternity theatres to ensure the patient was the main focus. This had been nominated for an award. • CTG monitoring was well documented and reviewed by 'fresh eyes. • Service leaders took complaints seriously and implemented changes in response to feedback. • There was a strong supportive team working culture.						
CITY HOSPITAL – CHILDREN AND YOUNG PEOPLE'S SERVICES: NEONATES						
33.	Isolation Rooms - two babies were being cared for in isolation rooms with the door wedged open due to lack of staffing to provide one to one care.	• Staffing rotas now reported and checked daily by Director of Midwifery • Cots closed pending starts for recruited nurses • Corporate tracking of intensive care training	October 2018 November 2018 October	Rachel Carter Amanda Geary Paula	Safe care for all babies in appropriate environment and staffing	A

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	CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
		numbers within the unit	2018	Gardner		
34.	Pseudomonas - recent outbreak which affected four babies. The unit has not been deep cleaned but cleaning has been increased.	• Evidence of deep clean to be shared with CQC inspection team as evidence submission • Investment agreed to expand neonatal unit in advance of Midland Met. Expected completion during 2019.	Immediate December 2019	Rachel Carter Alan Kenny	Evidence submission to reflect deep clean had been undertaken	G
35.	Safe care and treatment - two members of staff disclosed they have felt pressure to do IV checks whilst not signed as competent; one refused and the other complied.	• Discussion at Band 5 midwives forum regarding NMC and Trust guidance on safe medicine management • Communication to all midwives via effective handover regarding IV competencies in line with safe medicine management guidance • Clinical Education team to identify and work with midwives not signed off as IV competent to ensure that they meet their competencies as per the Trust guidance	October 2018 October 2018 February 2019	Rachel Carter	• Documented evidence on effective handover • Mandatory training compliance report	A
CITY HOSPITAL – CHILDREN AND YOUNG PEOPLE'S SERVICES: CHILDREN'S WARDS						
36.	Notes room - the door was not fully closed. Notes were potentially accessible to unauthorised individuals.	• Staff have been reminded of the Information Governance responsibilities. • Introduction of Unity will remove paper	In progress April 2019	Heather Bennett Toby	Staff compliance with the annual mandatory Data Security Awareness Training *(formerly the IG Toolkit)*	A

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	CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
		records from our sites		Lewis		
37.	Dirty utility - the door was wedged open and there was access to chloro tabs and liquid cleaners albeit in wall mounted cupboards that 'older' children could potentially access.	• Relevant digital locks and padlocks have been installed • Staff spoken to with regard to adherence to safe storage of hazardous substances.	October 2018 October 2018	Heather Bennett	Monthly Environmental audit by ward manager, outcome an actions monitored within Directorate Governance Report, meetings and Group Governance Board.	**A**
38.	Treatment room was open - there was access to syringes. Out of date drugs were found in the fridge. There was also a sharps bin in use that was full and contained a soup tin.	• A digital lock will be installed on the treatment room • On the fridge there is a daily checklist including checking of dates of drugs – this checklist now in place on drugs cupboards – will form part of environmental audit.	October 2018 October 2018	Heather Bennett	Monthly Environmental audit by ward manager, outcome an actions monitored within Directorate Governance Report, meetings and Group Governance Board.	**A**
39.	Out of date equipment - lubricating gel and paraffin, tubing, scissors all found to be out of date. A significant amount of stock was out of date. When asked about the process for disposal, staff said they didn't have time to do it but they would put them in the bin.	This is a ward manager's responsibility. • Out of date stock was immediately removed. • Weekly check of area implemented and will form part of environmental audit.	In progress October 2018	Heather Bennett	Monthly Environmental audit by ward manager, outcome an actions monitored within Directorate Governance Report, meetings and Group Governance Board.	**A**

Notable practice for children's and neonates:

- The staff were working well as a team to provide care and treatment in challenging circumstances.
- All staff spoken to have praised their band 7 for supporting their teams; clinically, leadership & emotionally.

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CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
• The infant feeding team was a good example of innovation and good practice. • BMEC have reacted positively to the last inspection and we have seen the improvements.					

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Care Quality Commission Inspection

Response to preliminary findings

CQC finding		Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
Community Inpatients at Rowley Regis Hospital: 18 - 21 September 2018						
CONCERNS WHICH WERE FOUND ACROSS BOTH SITES AND CORE SERVICES						
40.	Resus trolleys were not tamper proof.	• Tamper proof resuscitation trolleys ordered in August 2018 to replace all site trolleys due for deployment in January 2019.	January 2019	Paula Gardner	Governance Team audit of resuscitation trolleys in February 2019.	R
ROWLEY REGIS AND LEASOWES HOSPITALS						
41.	DNACPR - tick boxes to describe ceilings of treatment. No narrative boxes, could easily be ticked after the form was signed. Some aspects weren't sufficiently explained, for example antibiotics did not state whether oral and IV antibiotics were not to be given.	• The Trust uses standard DNACPR forms and will review the format against best practice in other organisations • Forms to be read in conjunction with patient notes and records.	February 2019 January 2019	Paula Gardner	100% compliance against the auditable standards in the Trust's DNACPR Policy.	A
42.	Care plans – core care plans used – these had limited personalisation to describe the	• New care plans templates to be issued with Unity EPR. • Dementia specific standard care plan to be	March 2019	Nicola Taylor	• Daily data assurance audits • Documentation audits	A

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	CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
	care needs in an individualised way.	developed and incorporated into Trust-wide practice. • Consistent care planning between the acute and community wards to be introduced with Unity.				
43.	MCA DoLs. Improvements since last inspection, however using basic general checklist from patient assessment documentation as capacity assessments for decisions/MCA and for DoLs applications.	• Introduce MCA standard check into the Safety Plan reporting data. • Review MCA approach Trust-wide by reference to Black Country best practice and revise approach after CLE sigh-off.	January 2019 March 2019	Paula Gardner	Safety Plan data	**A**
44.	NEWS – Where there are elevated scores the frequency and actions described are not always being followed up.	• Introduction of NEWS on line training for all staff completing clinical observations • All staff to complete mandatory training Basic life support • Implementation sepsis data collection tool • Trajectory for all senior nurses to complete health assessment module and non-medical prescribing	January 2019	Nicola Taylor	• Mandatory training reports • NEWS on line training record • Ward manager / Matron audits of documentation • Mock CQC audits completed by matrons, GDON and Chief nurse • Sepsis audit data presented weekly at Consistency of care meeting.	**A**

Notable practice:

- Improved signage/ dementia friendly environment (e.g. painted walls different bright colours).

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CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
• Family involvement – Quality listening time for all families and patients within one week of admission. Patient forum for patients and relatives on every ward monthly. • Bespoke training for EDHR has been delivered. EDHR lead visits ward and does Q & A on one to one basis, asks staff questions to test their knowledge/understanding, staff demonstrated a good understanding of EDHR in general. • Risk registers – improved since last inspection. Now at ward level – reviewed regularly. Ward managers on leadership courses, nurse associates introduced, nurse prescribers training started					

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Care Quality Commission Inspection
Critical Care: 18 - 21 September 2018

Response to preliminary findings

	CQC finding	Improvement action taken / planned to address the concern	Timescale	Lead	How will successful completion be evidenced?	RAG
Critical Care: 18 - 21 September 2018						
CONCERNS WHICH WERE FOUND ACROSS BOTH SITES AND CORE SERVICES						
45.	Resus trolleys were not tamper proof.	• Tamper proof resuscitation trolleys ordered in August 2018 to replace all site trolleys, due for deployment in January 2019.	January 2019	Paula Gardner	Governance Team audit of resuscitation trolleys in February 2019.	R
SANDWELL GENERAL HOSPITAL						
46.	One concern was that the paediatric resuscitation trolley check list was not as detailed as the adult resus trolley checklist, so it may be missing equipment and staff may not be aware.	• The checks for the equipment will be completed every Wednesday and Saturday • The checks now require the checker to sign against every piece of emergency equipment in line with the emergency checks for the adult emergency equipment. • The checks are clearly documented in the unit diary for the shift leader to allocate a member of staff to complete twice a week • Once the checks are completed for each month, the admin staff will scan the checklist onto the S drive 'Cross Site Shared' so there is	October 2018	Amber Markham	100% compliance of twice weekly equipment and expiry date checks, as evidenced by monthly audits undertaken by the Matron / Paeds team.	G

Status					
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		a permanent record available.  Paediatric Bed space Action Plan.docx				
47.	Some out of date paediatric drugs – *removed during the inspection*.	• The item identified was a flow sensor for a G5 Ventilator (not a drug) , this was actioned immediately and reoccurrence prevented by changes in equipment checking procedure	October 2018	Amber Markham	100% compliance of twice weekly equipment and expiry date checks, as evidenced by monthly audits undertaken by the Matron / Paeds team.	**G**
48.	Inaccurate dates on services stickers on equipment. Engineers had put future dates on stickers. *The manager addressed this with the company*.	• Actioned during inspection with EBME • EBME have changed their practice for labelling serviced equipment	October 2018	Amber Markham	Evidence seen confirming that EBME have changed their practice for labelling serviced equipment	**G**

Notable practice:

- The team was responsive when concerns were fed back.
- The clinical lead was extremely knowledgeable about this area and had complete oversight of the challenges faced and had suitable and appropriate plans in place to mitigate risk.
- A very flexible workforce which allowed them to accommodate the right patients into the critical care unit whilst remaining safely staffed and compliant with core standards.

Status	G	Action completed and improvement achieved	A	Action on track to be delivered by the agreed date	R	Action off track and revised date set and stated