Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

St George's Healthcare NHS Trust, Tooting site

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Date of Inspections: 31 January 2013
30 January 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Meeting nutritional needs	✖ Action needed
Safeguarding people who use services from abuse	✔ Met this standard
Cleanliness and infection control	✖ Action needed
Staffing	✖ Action needed
Supporting workers	✔ Met this standard
Records	✖ Action needed

Details about this location

Registered Provider	St George's Healthcare NHS Trust
Overview of the service	St George's Healthcare NHS Trust provides healthcare services in southwest London. It took on most of the provided services from Wandsworth PCT on the 1 October 2010, so now provides acute, specialist and community services from five main locations. The Trust has over 7,000 and serves a population of 1.3 million across southwest London. St George's Hospital in Tooting is the main site for the trust, and is an acute teaching hospital.
Type of services	Acute services with overnight beds Acute services without overnight beds / listed acute services with or without overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 30 January 2013 and 31 January 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information we asked the provider to send to us and were accompanied by a specialist advisor.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

We visited the Accident and Emergency department, paediatrics, maternity, stroke and rehabilitation, care of the elderly and the renal units. We spoke with a number of patients, relatives and members of staff in these areas during our visit.

People we spoke with told us they felt they were treated well and they were kept informed about their care. People commented that "Although we have been waiting awhile, they keep us informed and check we are OK and the treatment was very good".

When asked about staff, a patient in A&E said "They can't do enough for us, even though you can see how busy they are". The women we spoke with on Maternity were pleased with their care and spoke very highly of the midwives in particular.

People identified issues with the choice of food provided and we noted others with the cleanliness of some wards and departments, the attitude of staff in a care of the elderly ward and staffing levels in a paediatric ward.

You can see our judgements on the front page of this report.

What we have told the provider to do

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent

judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

People's privacy, dignity and independence were respected in some areas of the hospital.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We visited the Accident and Emergency department, paediatrics, maternity, stroke and rehabilitation, care of the elderly and the renal units.

The majority of people we spoke with told us that they were treated well. They said that they felt respected by staff. We observed most of the doctors and nurses spoke to people by their name and talked to them in a respectful manner. The women we spoke with explained that they had a choice about where their maternity care would be provided.

Comments from patients and their relatives included: "Although we have been waiting a while (in the accident and emergency department), they keep us informed and check we are ok". "They've been very good at explaining things as they go, and the doctors and nurses have told me what they are doing". "They drew the curtains when they came in to see me". "The staff are beyond expectation, even the cleaning staff". "Excellent care, I'm very happy". One young person said, "The nurses talk to me, explaining what they are doing, one carer is very good, they are finding information and telling me about my condition" and "when I first came in, they were good, explaining what they were going to do". A relative said, "The nurses are really patient transferring mum from her bed to the chair".

In some of the areas we visited people's privacy and dignity were respected and staff we spoke with demonstrated a good awareness of how to maintain people's privacy and dignity. Curtains were drawn around beds and staff knocked before entering cubicles. The staff we spoke with demonstrated a good awareness of how to maintain people's privacy and dignity. However, in other areas observed some practices that did not respect people's privacy or dignity.

The reception and triage areas in the accident and emergency department were not private, meaning that conversations about people's medical conditions could be overheard.

We saw one staff member open a cubicle door, keeping it partly ajar, whilst a patient was using a commode and the person was visible to other people.

Whilst staff were attentive during lunch and in the afternoon in the care of the elderly wards, little interaction took place between staff and patients during the morning. One patient called out intermittently but the staff did not attend to them, despite the fact that three staff were just outside the bay.

On two occasions we saw a senior member of staff walk away from a patient with vision and hearing impairment whilst the patient was in mid conversation with them. During another incident, the patient asked a cleaner if they were a nurse. The member of staff responded that they were not without any further explanation. When the patient asked again who was there later the staff member responded "Only me darling".

Staff made no attempt to support one patient whose night dress had been pulled up exposing the lower part of their body.

Most patients said that they were kept informed and involved in what was happening with their care and treatment. People told us that they were able to ask questions and felt that any language problems were addressed with the use of friends, other staff or language line interpreting. One person, whose first language was not English, said, "The staff were very kind, explaining everything and went back over it, until I understood". However, we observed that patient information displayed in some areas was only available in English. In one department the patient information boards were cluttered and information was hard to read.

In order to help prepare parents and children for their operation, they were invited to a club to experience the processes and procedures that they would undergo. Staff said this helped children to feel more relaxed.

Two women, in maternity, who had been treated at a number of different hospitals, commented that they had received continuity of care and that communication between the different hospitals was good. However, two parents on Fredrick Hewitt (paediatrics) ward felt that they had only received basic information on arrival at the ward. In Jungle (paediatrics) Ward parents told us that they had had to wait a day for treatment, due to a lack of anaesthetists and they felt that there was a lack of communication between departments and other hospitals.

Patients were given a survey to complete when they were discharged that asked for their comments about their care and treatment. The results of the survey were used to identify any improvements to the service. We spoke with one person who confirmed that they had completed a survey after their previous stay in hospital.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

In some wards and departments people did not experience care, treatment and support that met their needs and protected their rights.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We visited the Accident and Emergency department, paediatrics, maternity, stroke and rehabilitation, care of the elderly and the renal units.

Most people we spoke with were happy with their care and treatment. Patients told us how they had been treated with compassion and understanding, describing the staff as "Wonderful" and "On the go but always caring". Parents of children told us that they felt their child was safe receiving care and treatment.

Some of the things people told us were: "They can't do enough for us, even though you can see how busy they are". "Within minutes of arriving the nurse checked my child and did a quick assessment". "We've used the (accident and emergency) department before and the staff are professional and understanding". "I've received excellent care and treatment here". "The treatment was very good". "Wonderful care, they have done really well with me."

Multidisciplinary teams of staff worked together to provide care and treatment. We joined one team for a meeting which was professional, comprehensive and everyone involved knew the patients as individuals. Nursing and multi disciplinary teams working relationships was positive and a common goal was efficient and effective discharging of patients. Goal setting was shared and each discipline respected each other's challenges. In the stroke and rehabilitation unit, the consultants held a clinic for relatives to ask questions regarding care and treatment plans.

In the Renal Unit people undergoing long term dialysis saw a doctor every three months and discussed any health issues with the nurse before every dialysis session. Observations were carried out before and after each session. The people we spoke with all felt they had received a good standard of care either when they came in for dialysis or as an inpatient. The matron explained that staff were in regular contact with community services when people required additional support to ensure the correct care package was in place.

We observed staff admitting and discharging patients, providing detailed accounts and treating patient's injuries and ailments. There was good communication between the staff and with the patient.

The in patient departments had facilities for patients and their visitors to meet. The hospital had a house available for families whose child was staying at the hospital. The hospital allowed one parent to stay with each child at all times. Some parents slept on sofa beds which they said were uncomfortable.

There was a well equipped playroom with two Play Specialists for inpatient children. The play specialists also worked with children in their rooms. There was a classroom for the older children. The staff and parents we spoke with felt there was good communication with patients and parents.

The Trust's senior staff told us about some of the schemes that they had introduced to improve care and treatment. For example, work to improve prevention and treatment of pressure areas and a scheme to make sure people with dementia had the care and support they needed. However, we saw that these schemes were not working in some departments. In the accident and emergency department, the staff were unaware of the need to offer pressure relieving equipment to patients who had waited a long time. The staff in the accident and emergency department did not know about the scheme to support people who had dementia. Although, they were aware of the patient passport, a scheme supporting people with learning disabilities, and gave brief details about this. On Dalby Ward and the Stroke Unit that provided care for older person's the system to identify people with dementia was not in use. A senior staff member said this was because of difficulties securing consent from patients. Some staff we spoke with said they had received dementia training, but said that it could do with updating.

On an older person's ward, we observed that there was little interaction between people using the service and any conversations were limited to being between staff and patients, particularly in the mornings and these were minimal. One person told us, "The treatment was not as good as I thought it would be, it seems to have a lot lacking and there are a lot of areas for improvement" and "There are some pockets of excellence and equally poor care". Another person told us that there was nothing for them to do and that they had "Little contact" from staff. We saw a number of patients either sleeping or dozing in chairs in hunched, uncomfortable positions who periodically jolted awake. One person was asleep with their head resting on their arm which was leaning on a portable table. On one ward bay there was a 15 minute period when no staff entered the bay to check that patients were comfortable and safe.

In the adult accident and emergency department, while there were a number of triage cubicles, only one nurse was available to screen arriving patients, which often meant people were queuing and waiting to be seen before booking in at reception. At times this made the immediate entrance to the hospital emergency department congested.
In one ward we visited it was noted that only four blood pressure machines were available and this caused long waiting times whilst equipment was cleaned between each patient.
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A number of women on the maternity unit referred to the staff's approach to their male partners as disappointing particularly in relation to their care during labour and when they transferred from the delivery suite to the antenatal ward. The women we spoke with felt this impacted on their care and would like to see a more open approach to partners. Several partners stated that they were told there were no facilities for men.

Meeting nutritional needs ✖ Action needed

Food and drink should meet people's individual dietary needs

Our judgement

The provider was not meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration in some areas of the hospital.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We visited the Accident and Emergency department, paediatrics, maternity, stroke and rehabilitation, care of the elderly and the renal units.

Feedback from the patients regarding food was varied. Parents said the food for their children was plentiful and varied although long stay patients found that there was not enough variety. Parents could access the ward kitchen to make drinks and toast for themselves. Halal food was served on request. Breastfeeding mothers were given a meal. A patient we spoke with said "the food is good" and "I get enough to eat". Another person said, "The food is good" and "They respect my religious and cultural needs". Some patients we spoke to said the meals provided were "Okay" and "Not too bad".

However, the women in the maternity department described the food as ''Stodgy'' and that they would like more vegetables. They told us that they were without access to food for a 14 hour period from 6pm to 8am. They said they were hungry as they attempted to breastfeed their newborn babies. Many of the women said they went to the shop within the hospital to buy food or would ask their relatives to bring them in food.

The staff in the accident and emergency department said "We try to offer patients refreshments where their condition allows and if they are permitted to eat and drink". We spoke with one patient who was waiting for results to be returned in the Urgent Care Centre (UCC). The patient and a relative told us that they had been waiting for some time, but that staff had offered the relative a snack and a drink. Another patient, who had been waiting several hours, had not been offered any refreshments. Patients in the Clinical Decision Unit (CDU) received breakfast and a hot meal. We saw several hot ready prepared meals being cooked including vegetarian and Halal options. There was also a choice of biscuits, crackers, jams and hot and cold drinks. Some patients said that they had received drinks when they first arrived on the unit, although one person told us that they had not received an evening meal the night they arrived and had not eaten until breakfast the next morning.

On the paediatric wards we observed a mixture of hot and cold foods, sandwiches,

vegetable sticks and yogurts offered. Alternative food was available from the hospital canteen and a discount voucher was given if there was not enough food on the trolley for a patient or if they missed the meal.

In the morning on an older people's ward patients were provided with drinks on trolley trays by their bedside. Some patients could not reach them. Staff left the drinks there and did not encourage people to drink. There was a nutritional board that identified which patients required assistance with their meals and the types of meals and assistance they required. The ward operated a tray colour coded system to identify the types of meals for for the individual patients. During lunch staff took time to explain what the meals were and assisted patients to eat and enjoy these in an unhurried way.

We saw a range of records relating to people's nutritional needs, including assessments and monitoring charts. These were up to date. However, we saw that where people's assessments indicated a nutritional risk, there was not always a plan to support them in this respect. In the rehabilitation department, information about people's nutritional needs were not dated and there was a risk that different staff supporting people would not know if this information was the most recent or not.

The people undergoing dialysis were given tea and biscuits during treatment and a sandwich if required. The renal wards had a set menu with a number of options available but some of the patients who had regular or a long term inpatient stay felt it did not provide enough variation. We discussed this with the dieticians, who told us they would visit the ward to discuss this with the patients.

The staff we spoke with discussed the nutritional training they have received. Volunteers offered additional support for patients on the Stroke Unit during mealtimes. The volunteers received training and their competency was assessed.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People using the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

The people we spoke with, told us that they felt safe receiving care and treatment in the Accident and Emergency Unit. They described staff as "Professional and supportive". One parent said "The staff are well trained, they are often very busy, but they know how to care for sick children".

We spoke with staff and they all gave examples of how they had worked with vulnerable adults and made referrals to social services and the safeguarding lead at the hospital. Staff received regular training on protecting children and safeguarding vulnerable adults and were aware of their responsibilities. Most of the staff we spoke with understood the terms mental capacity, deprivation of liberties and best interests and were able to give accounts and examples of when these terms were used to manage and protect vulnerable people in their care.

One staff member told us that there was pressure for beds and that in some of the units, people were at risk. Staff described to us, a frail older person, unable to see or hear and unable to cope at home, having no family support and discharged without a review of their social care needs. We were told "They were sent home, despite being confused, yet the drive was to get them out in time for a care worker to visit at 4pm, they had no one, it was pressure of beds and they were considered social". Staff said "We expected to see them back and wondered what became of them".

In the Paediatric wards there were suitable security arrangements were in place which meant staff let patients, parents and visitors onto the wards.

The staff we spoke with had completed training in safeguarding (child protection) and completed an annual refresher course. They were aware of their responsibility to report issues and concerns and were aware what constituted abuse. They said the named nurse for safeguarding was available to give them support, information and advice and visited

the wards each day.

Systems were in place to identify if a child was on a child protection plan. We were told that the ward had 'good links' with paediatric A&E and midwives to receive information about safeguarding.

A member of staff on Jungle Ward said "It's a constant issue, not a one off; you need to look for it all the time".

It was noted that the blind cords on Nichols and Ocean Wards in the bathrooms were not secured to the wall.

On Pinckney ward we saw that some electric plug sockets in the play room did not have covers to prevent children from putting their fingers in them.

In Maternity there were evidence-based guidelines in place and there was a named midwife with responsibility for safeguarding of adults & babies within the maternity service. Safeguarding was included in the mandatory training programme for all staff. A database was maintained to record when staff had completed both mandatory training and annual refresher sessions on safeguarding. People using the service were risk assessed on an on-going basis during their pregnancy and maternity staff were involved in case conferences when safeguarding issues were identified. The staff that we spoke with all confirmed that they had received training and understood what the safeguarding processes were.

When we visited Dalby Ward the people using the service did not comment on the safeguarding procedures in place.

Staff told us they had received safeguarding training that was mandatory. The staff we spoke with confirmed that they would be confident enough to contact senior staff or the safeguarding nurse if they had any concerns.

When we visited the Stroke and Rehabilitation Wards the staff explained that there were good relationships between the safeguarding nurse and the multi disciplinary teams and knowledge about the safeguarding referral process was robust from the emergency department through to the wards.

The matron on the Renal Unit confirmed that all staff had completed Safeguarding Children training as well as training on Safeguarding Vulnerable Adults. Staff completed annual refresher courses on safeguarding.

If there were any concerns relating to safeguarding the matron confirmed that they would comply with Trust policy and contact the hospitals safeguarding team.

Cleanliness and infection control ✖ Action needed

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was not meeting this standard.

People in some areas of the hospital were cared for in a clean, hygienic environment.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We visited the Accident and Emergency department, paediatrics, maternity, stroke and rehabilitation, care of the elderly and the renal units.

Some patients told us that they were happy with the cleanliness of the hospital. One person said, "I've been impressed at how clean everything is here, especially when you can see how busy it is". People told us that staff treating them wore disposable gloves and used anti-bacterial hand gel before treating them and one person commented "It's very clean; the staff used disposable gloves when they took my blood", while another person remarked "Everything was clean when I came into the cubicle".
In some departments the patient areas were kept clean and cubicles were tidy and kept stocked. Cubicle curtains were washable and staff confirmed there was a regular programme for cleaning these.
There were anti bacterial spray points located throughout the hospital. We checked soap and hand gel dispensers and hand towel holders. We found these to be available, in working order and well stocked. There were numerous hand washing posters close to clinical areas and hand washing facilities.
Clinical staff wore short sleeve tops so they could clean their hands and forearms more easily. They were seen to wash their hands and use hand sanitisers frequently when engaging with patients. Staff wore aprons when required.

Cleaning and domestic staff were assigned to specific departments. We observed them cleaning floors and surfaces and emptying general waste bins regularly throughout our inspection.

We checked clinical waste disposable bins and sharps bins, used to dispose needles and syringes, and found these to be used appropriately and not being overfilled.

We noted that in the triage area of the Accident and Emergency Department there were no sinks or hand basins for triage assessment nurses to wash their hands, making it difficult for staff to maintain hand hygiene in a busy area of the department. We saw staff having to rely on hand gels between patient triage.

We saw three non-working sinks, two in the Clinical Decision Unit, and one in the children's emergency unit. While observing in the paediatric emergency unit, which was very busy during the inspection, we saw one examination trolley that had recently been used with a substantial amount of spilled blood on the trolley bed rails. We were unable to explore this further as a staff member took the next patient into the room before it had been cleaned.

In the accident and emergency department we saw that clean disposable suction heads were not always covered with their protective coverings and on two occasions we saw suction heads had fallen to the ground with the risk of contamination. We looked at examination trolleys across the whole unit, these were generally clean, but there was dried blood on the outside plastic of one portable suction unit.

On Jungle Ward there was no storage for a cleaning trolley so it was left in the ward, beside a trolley with food snacks and drinks.

Staff explained that toys in paediatric areas were regularly washed and sterilised to reduce the risk of infection.

An infection control audit was being conducted on Pinckney Ward during our visit. We saw shower curtains in the bathrooms on this ward had black mould on the bottom of them but otherwise all areas of the ward we saw were clean.

We saw that the three maternity wards we visited were very clean. However, staff explained that there had been a number of re-admissions of women who had surgical procedures undertaken in the obstetric theatre. We saw a copy of a report commissioned by the maternity service on the obstetric theatre carried out by the hospital infection control team. The report dated 25 January 2013 identified that both obstetric theatres were dusty, had blood splashes on equipment and equipment in need of repair. This had been escalated through the Trust governance processes. During our visit we saw that the equipment in the theatres were dusty and a stool had a damaged seat.

The patients' with infectious diseases stayed in isolation rooms due to the risk of infection. However, on Dalby Ward, the doors to these rooms were left open. One of the doors was broken and would not stay shut, staff used a chair to try to keep this door closed. During a five hour period we saw a door to another isolation room frequently remained open.

In the stroke unit, we saw that there was visible dust on equipment and a range of trolleys. One trolley was very dusty with layers of built up dust. We saw patient washing bowls were 'stacked' which contravenes accepted infection control practice. Bedside tables were dirty and dusty. Some mouth-care equipment had been left uncovered and some had been covered but water bottles and solution were not labelled or dated. Syringes had been left opened at some bedsides. The beds had a range of equipment behind them and in some cases this equipment was not infection control protected, for example suction equipment was not covered.

During our visit to Norman Tanner Ward we saw that the window sills and air vents were very dusty. The tables and trolleys being used were also dusty and stained. The rubbish bin next to a sink in one dialysis area was rusty and dirty. In one side room used the dialysis of two patients there were five dialysis machines stored in front of the treatment area and there were rusted pipes. In a bathroom shared by four inpatients there was ivy growing through the window frame into the bathroom.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs on nine occasions during January 2013.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We visited the Paediatric Department. On Fredrick Hewitt Ward children were cared for by enough qualified, skilled and experienced staff, although there the staff establishment only covers 13 of the 17 beds available.

We were told that following a reconfiguration last year, the ward had a staffing establishment for 13 patients, although they had kept 17 beds and at times these beds were all used. This meant they was reliant on bank and agency staff which had an impact on staff because agency staff were not able to carry out certain nursing tasks including giving medication. There were two vacant posts, two staff on maternity leave and two staff on long term sick leave. Where possible the ward used regular agency staff for consistency of care.

The Trust provided patient and staffing levels for this ward for January 2013 and we have noted that on nine occasions during the month the number of staff on duty did not meet the level specified by the Trust.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

The provider had worked continuously to maintain and improve high standards of care by creating an environment where clinical excellence could do well.

In the Accident and Emergency department we spoke with several patients and relatives and they told us they felt staff were skilled and competent to manage their care. One patient said "I've been here before; the staff are very good I've got confidence in what they do". Someone else remarked "St Georges has always been a good hospital; they've not let me down so far".

We spoke with a variety of staff of different skills who explained the regular training that they received, which included moving and handling, safeguarding adults and child protection. They also had to complete annual fire safety training and E- MAST, an electronic learning system. We did not see evidence on the training matrix of hand hygiene and infection control training although staff spoke about infection control and audits that were conducted.

We talked to staff about inter-department training and in-service updates. They told us that they received regular specialist training and updates related to their work. Staff also spoke about the commitment of the department to training. One staff member told us "The Trust takes training seriously and there is always something on offer here". Two further staff described their training and development needs and told us how they valued the opportunity to learn.

Staff explained that the transition between the minor injuries unit and its change to the Urgent Care Centre had been turbulent, with staff feeling that they had not received sufficient training or support and that they had to "Learn on their feet" although staff also felt that this was gradually improving. Staff from the Urgent Care Centre (UCC) were regularly requested to cover paediatrics and this was also a controversial point with staff from the UCC commenting on their lack of paediatric training and experience.

In the Paediatric Department we spoke with a number of staff across the paediatric wards and they all commented that they felt they were in supportive teams and worked well together.

One grandparent told us "Staff are beyond expectation, even cleaning staff"

There were nurse mentors in place to provide support for student nurses. Newly qualified staff had preceptors for their first six months. One nurse confirmed that they had had a preceptor (a nurse who provides support to a recently qualified colleague) and felt that the process worked well.

There were staff vacancies on three wards with one new staff member due to start and a planned recruitment day. On Pinckney Ward the staff we spoke with felt there were enough people to provide care.

Vacancies, staff holidays and training was covered by bank staff and part time staff doing overtime.

Staff we spoke with said they were "Happy to be working here" and "It is a nice place to work". Many of the staff we spoke with had worked at the Trust for a long time.

The staff we spoke with said they had lots of opportunities for training. We were told that all staff were up to date on their mandatory training and the staff we spoke with had completed the required training.

The patients and parents we spoke with during our visit did not raise any issues in relation to staffing.

In Maternity newly qualified midwives had a preceptorship programme foundation year when they were supported to achieve a number of competencies including an orientation programme, administration of medicines, IV cannulation, IV drug administration, perineal suturing and epidurals. The newly qualified midwives we spoke with explained that they were actively supported by their clinical instructors (preceptors) and the supervisor of midwives. They confirmed that they were actively encouraged to seek support at anytime.

Qualified staff had access to a number of training sessions which included skills relating to clinical issues that could occur during labour and after the birth. Other training available included the early recognition of severely ill pregnant women, eclampsia, care of women following operative interventions, infant feeding, fetal monitoring, maternal resuscitation, neonatal resuscitation, infectious diseases, sickle cell and Thalassaemia, newborn blood spot and blood results, fetal anomaly screening and mental health. Completion of these training sessions was recorded on the database.

On Dalby Ward some staff we spoke to said they received regular one to one supervision whilst others said they did not. They all confirmed they got annual appraisals. Staff felt they supported each other well at ward level and were passionate about the care and support they provided. They felt support from higher management could be improved. When asked how often they saw members of the management team on the wards, staff commented "Senior management do visit if a problem has been flagged up" and "Sometimes we are listened to". The main areas of concern raised where surrounding having sufficient to staff at different times of the shifts and particularly when emergencies arose.

On the Stroke Ward the rates of staff appraisal were high and on the acute stroke unit all staff had received an annual appraisal. Senior staff explained that there was minimal use of agency staff on the wards. We did not see that staffing levels were an issue and it was

not raised by staff.

Training and core competencies were identified as important to the staff and STARS (Stroke Training and Awareness Resources) were being included into the ward staff training.

The matron in the Renal Unit explained that staff completed a range of annual training courses. Staff had regular one to one sessions with their managers and all band 7 nurses had monthly one to one sessions. Over 90% of the staff within the renal service had completed an annual appraisal.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained in specific clinical areas.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Staff records and other records relevant to the management of the services were accurate and fit for purpose although we did find this was not the case in some areas we visited.

During our inspection in the Accident and Emergency Department we looked at two patient records and saw that medication and medical details had been clearly documented, along with observations of people's body temperature, heart rate, breathing and blood pressure. Medication had been recorded, signed and records were complete and legible. These were kept in the central area, for the purpose and attention of medical and nursing staff that which might need to access them rapidly while patients were receiving treatment.

We asked to see records of audits across three key care aspects. We found that while local cleaning and stock checking schedules were available in the Majors area of Accident and Emergency, these were not always fully completed, including checks of the resuscitation trolley, room cleanliness and stock and equipment checks of the examination rooms. There were gaps in the documenting of these checks, making it difficult to ascertain whether the check had been completed or not.

We looked at the quality of information and literature provided to patients upon discharge from the Urgent Care Centre. We were shown a series of health education materials on how to manage a variety of injuries and ailments. The instructions and guides were clear and included diagrams and jargon free advice. These were also stored electronically but printed copies were also available. The guides, however, were all written in English and there was a lack of continuity in how discharging patients received both verbal and written advice with some patients receiving information while others did not recall having been offered post treatment advice.

During our inspection we visited the Paediatrics Department. On Frederick Hewitt Ward we looked at the records for one patient and saw they included a basic information sheet, consent to treatment form and the Trust disclaimer that was signed by the parent/guardian. There was also a referral form signed by the GP and pre and post operative observations

completed and signed by staff. The records were stored in a metal cabinet which was located behind the desk. This cabinet was open throughout our visit, although there were staff around the area.

On Jungle Ward the notes were left on top of the counter at the nurse's station and was not stored in a cabinet.

The patient notes on Pinckney Ward were kept in open pigeon holes in front of the nurse's station. The notes had no front cover, the area they were stored in was not lockable and the area was not always staffed during our visit.

During our visit to the Maternity wards we spoke to 16 women (two in delivery suite, two in antenatal and 12 in the postnatal ward) and we asked them what the clinician (midwife or doctor) had stated was their plan of care and it was cross-referenced with their medical records. All the records identified a clear plan that was consistent with their understanding.

The Trust had developed patient held maternity notes that women brought to each antenatal appointment. There was information contained within the notes regarding their own care and that of their baby. There were contact telephone numbers for the maternity service printed within the notes should they require them at any stage of their care. Women were actively encouraged to participate in the development of a birth plan and there was space available within the notes for them to record their own wishes. The Maternity Notes were comprehensive and returned to the service following the birth of the baby. Women were risk assessed throughout their pregnancy, birth and postnatal period. A care plan was recorded in the records. An additional set of records were started when the patient was admitted in established labour.

During our visit to Dalby Ward we noted that the record keeping on the ward varied. Documentation such as patient care plans was kept up to date with relevant information. Other quality assurance documentation fluctuated. There was a weekly quality and safety round that was required to be completed by a member of the senior management team corresponding to matron level. This covered various aspects of care in the ward corroborated by observation, record checking and talking to patients and staff. They were not completed every week and we could not locate any record that the checks had been carried out over the Christmas period. The quality assurance documentation we saw contained percentage performance indicators, but not improvement progress or action plans to achieve this.

During our visit to the Stroke and Rehabilitation Unit we noted that the records were not visible on the wards and there were inconsistencies in how notes were stored. In the acute ward they were in a lockable room and in other areas within the unit the notes were left on wards with open to access. Staff mentioned that they were able to access notes. This may have been difficult to ensure easy access in practice consistently. We saw only one computer screen on the wards with patient identifiable information on.

On the Stoke Unit we reviewed a set of notes where the falls care plan was incomplete and the patients score for falls risk did not match the notification board on one ward, thus indicating a falls risk lower than identified in the assessment.

In the Renal Unit we looked at the notes of three inpatients and they were up to date with the medication and medical details clearly recorded. The observations of people's body

temperature, heart rate, breathing and blood pressure were also recorded.

We saw there were information leaflets available on the wards and in the waiting areas. The notice boards also had a lot of information regarding how to make a complaint, support services and infection control.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: Not all patients were treated with dignity and respect by staff. Some interaction was inappropriate and privacy not maintained. Regulation 17 (1) a
Regulated activities	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: During our visit we noted that some people using the service did not have their individual needs, welfare and safety ensured as some staff were not responding to them appropriately. Regulation 9 (1) b (i)

This section is primarily information for the provider

Regulated activities	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	**Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010** **Meeting nutritional needs**
	How the regulation was not being met: Some people using the service indicated that they felt the meal options provided were not meeting their nutritional needs or provided choice. Regulation 14 (1) a
Regulated activities	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: During our visit we saw that the building in some areas had not been cleaned appropriately and increased the risk of infection. Regulation 12 (2) c (i)
Regulated activities	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: During our visit we saw that the equipment in some areas had not been cleaned appropriately and increased the risk of

This section is primarily information for the provider

Treatment of disease, disorder or injury	infection. Regulation 12 (2) c (ii)
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: On nine occasions during January 2013 Fredrick Hewitt Ward did not have the required number of staff to provide suitable support and care of patients. Regulation 22
Regulated activities	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The quality assurance records on Dalby Ward and in the Accident and Emergency Department were not fully completed. Regulation 20 (1) b (ii)
Regulated activities	Regulation
Diagnostic and screening procedures	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**

This section is primarily information for the provider

Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	**How the regulation was not being met:** The confidential patient records on the Paediatric wards and on the Stroke and Rehabilitation Unit were not stored securely. Regulation 20 (2) a

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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