Ashford and St. Peter's Hospitals NHS Foundation Trust

Quality Report

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

Ratings

Overall rating for this trust

Are services at this trust safe?	
Are services at this trust effective?	
Are services at this trust caring?	
Are services at this trust responsive?	
Are services at this trust well-led?	

Summary of findings

Letter from the Chief Inspector of Hospitals

Ashford and St Peter's NHS Foundation NHS Trust provides services across north-west Surrey to a population of 410,000 people. The trust provides district general hospital services and some specialist services such as neonatal intensive care and limb reconstruction surgery from sites at Ashford and St Peter's Hospitals.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so, we rate the performance of services against each key question as outstanding, good, requires improvement or inadequate.

When we inspected the trust in December 2014 we rated it as good overall. We rated safety as requires improvement and effective, caring, responsive and well-led as good. The result of our focussed inspection did not change the ratings from the previous inspection.

We previously found that the trust was in breach of regulations four times. These related to some lack of staff awareness of emergency procedures, the learning from patient feedback and critical incident in the critical care unit, the secure storage of confidential patient records and the safe storage of medicines. We told the trust that it must give us an action plan showing how it would bring services into line with the regulations, and we have monitored this progress of this action plan with them.

At this inspection, we found that the trust had improved.

The trust had taken action to comply with the regulations for all four breaches, although the procedures for monitoring the temperature of medicines storage needed further embedding in practice. However, we had confidence that services were now delivered in line with regulations.

We will continue to monitor the performance of this service and inspect it again as part of our ongoing inspection programme.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Ashford and St. Peter's Hospitals NHS Foundation Trust

Ashford and St Peters NHS Foundation NHS Trust was formed from the merger of two hospital sites in 1998 and achieved foundation trust status in 2010.

The trust has 636 beds, of which 553 are in-patient (overnight) beds. The trust employs around 3,500 staff and provides district general hospital services to a population of 410,000 people in north west Surrey in the boroughs of Runnymede, Spelthorne, Woking and parts of Elmbridge, Hounslow and Surrey Heath. Services are provided on two hospital sites, St Peter's Hospital and Ashford Hospital.

We inspected this trust in December 2014 and we found there were breaches of the regulations that ensure the quality and safety of services. In that inspection report we identified areas where the provider must make take action to improve and become complaint with the relevant regulations. These related to some staff awareness of emergency procedures, the learning from patient feedback and critical incidents in the critical care unit, the secure storage of confidential patient records and the safe storage of medicines. We issued four requirement notices to the provider.

The plan submitted by the provider contained timescales by when actions should be completed. These have now passed. We inspected those specific areas where there was a breach in the regulations to ensure the necessary changes had been made and the service was now compliant with the relevant regulations.

Our inspection team

Our inspection team was led by Shaun Marten, CQC inspection manager, included another CQC inspector, and was overseen by Alan Thorne, Head of Hospital Inspection.

How we carried out this inspection

The trust provided us with extensive documentary evidence to demonstrate they had met the terms of the requirement notices and that the relevant regulations were being met. We reviewed this information in detail.

We visited wards and departments at both hospital sites to test and corroborate the documentary evidence supplied. We visited about nine wards and departments including the critical care unit and outpatient departments at both sites.

We reviewed checklists and other records relating to the storage of medicines, and spoke with nurses and reception staff. In critical care we reviewed patient feedback results, and minutes of meetings. We also spoke with staff about how they learnt from incidents to prevent recurrence, and used patient feedback to develop services.

Overall, the documentary evidence supplied gave us general assurance the terms of the requirement notices had been met. We tested this evidence during our visits to the wards and departments and generally found a satisfactory level of corroboration to give us assurance that the required improvements had been made..

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? **We did not rerate this service, Therefore the rating remains requires improvement.**	

Incidents

The previous inspection in December 2014 showed that people that use services and others were not protected against the risks associated with inappropriate or unsafe treatment in critical care. This was because there was a lack of the effective operations of systems designed to enable the registered person to regularly assess and monitor the quality of the service provided, and to identify, assess and mange risks relating to the health, welfare and safety of patients and others who may be at risk. There was no system in the critical care department to make changes to the treatment or care provided from an analysis of incidents that resulted in or had the potential to result in harm to the patient.

At this inspection we found that there were systems to ensure that there was analysis of safety incidents and that learning points were identified and appropriate remedial actions taken. This was because:

- An external review of critical care was completed and following this, an action plan established most recently reviewed in February 2017 showing completion on most actions. This included a specific review of governance arrangements.
- A plan of meetings was published for critical care including dates and expected outcomes. There was evidence of regular critical care morbidity and mortality meetings and that these meetings were minuted. We saw current minutes of the critical care governance meeting, which contained a report and an analysis of incidents. An agenda for the next month's meeting and minutes of the meetings were emailed to all staff on the unit.
- Minutes for meetings were stored in a shared drive available for all unit staff to access. We saw emails that showed any learnings and changes in practice were circulated to all staff on email
- We saw minutes of the shift leader meetings, which took place monthly and where incidents and learnings were discussed. The outcomes of that meeting were cascaded at the monthly unit meetings.

- An example of practice being changed was given when a trend in pressure ulcers was noted to be due to positioning of the endo-tracheal tube in intubated patients. A change of dressing was agreed, discussed with staff and implemented.
- Following an incident report, a standard operating procedure was put in place concerning the removal of dialysis catheters.
- In the staff room, we saw records of incident and audits results displayed for staff to review.

Medicines

The previous inspection in December 2014 showed that people who used the service were not protected against the risks associated with medications because

- Medicines were not stored in conditions that would ensure they remained effective and in optimum condition and on one ward staff failed to respond to maximum fridge temperature being out of an acceptable range
- Not all trained paediatric nurses were up to date with medicines management training which increased the risk of medication errors being made.
- In one clinic, there was evidence that an intravenous bag of saline was used for more than one patient and was not disposed of immediately after use.
- On some medication charts, the reason for as required medication was not clearly described.
- Medicine incidents database highlighted two occasions at Ashford hospital when there was a delay in medicine delivery, which led to missed doses of medication and delayed patient discharge.

At this inspection we found that medicines training was current, intravenous bags were single use and that medication charts described the reason for as required medicines was stated. However, although systems and processes had been put in place to ensure the safe storage of medicines at appropriate temperatures, the required schedule of checks and the recording of any remedial actions was not yet fully embedded in all areas. This was because:

- That medicine management training for women's health and paediatric staff was checked and showed 94.3% of staff had completed this training. On our visits to the wards and departments, staff we spoke to were aware of medicine management training and the need to complete this. We saw that across the trust 86.7% of staff had completed this training.
- To address the issue of multiple uses of one saline bag there was a Breast Expander Implant Standard operating procedure

issued , additionally the intravenous policy was refreshed to highlight that re-use of a single–use intra-venous fluids should not occur.There was evidence that spot checks had been carried out to ensure correct practice. An incident was reported in December 2016 when in one department a single bag of saline was found to be used on multiple occasions. A full root cause analysis (RCA) completed action plan put in place and checks made to ensure correct practice following the incident.

- An action plan was established to ensure as required medicines had a documented reason for administration. We saw two audits where this has been checked across all wards with a compliance score of 64%. We visited nine wards and departments across both hospital sites and where 'as required' drugs were prescribed reasons were given. At Ashford hospital we saw evidence of pre-printed medicine prescriptions for patients undergoing knee and hip replacement surgery and the information given alongside the 'as required ' prescriptions was of a high standard.
- We found pharmacist hours had been increased, transport provision reviewed and missed doses audited. Results of an audit dated February 2016 showed less than 1% of doses omitted were due to the medicine being unavailable and further analysis showed these omissions not to be due to unavailability of medicine. At Ashford hospital that there were no omitted doses and assurance from the staff that there were no delays in deliveries of drugs and all drugs were readily available.
- With regards to medicine storage we saw revised forms for temperature monitoring were developed and an audit of medicine storage across the trust was completed. Trust wide themes were identified and general solutions were identified. The most recent audit results available for October 2016 showed that only four out of 28 wards at St Peters were fully compliant with four checks for temperature monitoring and at Ashford only one of the 12 wards or departments were fully compliant.
- At St Peters hospital on eight wards or departments that were checked we found six that were not consistent in recording their medicine fridge or ambient room temperatures with omissions in recording temperature and a failure to take corrective action when the temperature was outside of the recommended range.
- At Ashford hospital on one ward, we found the ambient room temperature where drugs were stored to be consistently higher than the recommended range with no evidence of action being taken.

Summary of findings

Responding to patient risk

The previous inspection in December 2014 showed the trust had not taken proper steps to ensure that each service user is protected against the risks of receiving care that is inappropriate or unsafe by means of ensuring the welfare and safety of the service user. Some reception staff were unsure about their responsibilities to call for help and to be aware of the location of emergency equipment if a patient deteriorated. Some could not locate where the crash trolley (for transporting emergency equipment and medication) was and did not know the correct process for alerting the 'crash team' by telephoning 2222.

At this inspection we found that all staff could clearly describe emergency procedures and were aware of their responsibilities. This was because:

- A revised resuscitation policy included the statement that 'all existing and new staff should familiarise themselves with the location and use of emergency equipment'.
- A booklet had been circulated to all staff explaining what to do for a collapsed patient and how to summon help. The same information was circulated across the trust in poster format.
- Phone stickers showing the number 2222 were produced and circulated trust wide to be put in place on all phones. We observed these were in place checks across the trust demonstrated that phones were labelled with the stickers detailing the correct phone numbers.
- An audit process was undertaken to ensure effectiveness of measures taken and showed that staff responded correctly showing that they knew who to call and what phone number to use in an emergency.
- We found all staff in reception areas at both sites were aware of their responsibility to summon assistance in the case of patient collapse. When questioned hey were able to demonstrate the correct process and show where emergency equipment was located.

Records

The previous inspection in December 2014 showed that people who used the services were not protected against the risks associated with unauthorised access to confidential patient records. Patient records were not securely kept and some were seen to be accessible to secure areas, posing a risk. Records were left in unlocked trolleys in outpatients and ward areas.

At this inspection we found that confidential patient records were securely stored. This was because:

Summary of findings

- Lockable notes trolleys for notes for all wards and departments across the trust had been purchased. We observed these were in use in all areas.
- There was a system for managers to carry out spot checks to ensure all areas were compliant with records storage standards. We saw that results were collated and where necessary corrective action was taken.
- We observed all notes trolleys were locked on a sample of five medical wards at St Peters hospital and one surgical ward at Ashford hospital. On one medical ward one trolley lock was broken but had already been reported for repair.
- We observed all notes trolleys had staff information attached to the trolley reminding staff about the need to keep patient notes secure.
- In the outpatient department staff were aware of the need to secure patient records and a copy of the standard operating procedure was on display.
- We observed that a clinic was in progress meaning notes had to be readily available. We saw notes were available but stored in opaque folders stored upside down so patient sensitive data was not visible. The area was supervised by a member of staff.
- However, in the ophthalmology department the notes were stored in a similar way bit the corridor was unsupervised which means the records were not secured as patients were sitting adjacent to them. We noted the computer screen in this area was minimised but not locked which means the screen could easily accessed by unauthorised persons.

Are services at this trust effective?

We did not inspect this area of the service as this was a focused follow up inspection.

Are services at this trust caring?

We did not inspect this area of the service as this was a focused follow up inspection.

Are services at this trust responsive?

We did not inspect this area of the service as this was a focused follow up inspection.

Are services at this trust well-led?

We did not rerate this service, therefore the rating remains good.

Public engagement

Summary of findings

The previous inspection in December 2014 showed there was no system in critical care to regularly seek the views (including the descriptions of their experiences of care and treatment) of patients and persons acting on their behalf to enable the registered person to come to an informed view in relation to the standard of care and treatment provided to patients in the critical care department.

During the inspection, we found that there were systems to collect and act on feedback from patients and those close to them. This was because;

- A critical care step-down patient experience questionnaire had been commenced. We saw that this encouraged patients to feedback after their stay in critical care and that the form was available on the ward areas.
- There was a friends and family test for critical care and high dependency units in place. We saw that this encouraged both patients and relatives to feedback about their experience on critical care asking how satisfied they were with the unit and the reason for their response. The responses were collated and we saw evidence that it was made available for staff to see and was discussed at unit meetings. We were told that if there were any adverse comments one of the senior staff would ensure this was dealt with in line with the complaint policy
- Patient diaries have been introduced for patients in critical care. We saw examples of a patient diary and the training that staff completed to ensure their competency. The diary was used for patients intubated for 72 hours or longer and recorded anecdotal information about the patient's stay. Following the discharge patients were invited back to clinic with a nurse, physiotherapist and consultant present to discuss their experience on the critical care unit and to review diary entries if they wish. We saw that notes were made of the meeting with the patient and that feedback was given to staff. An example was given of how practice had been changed following feedback from a patient, which resulted in the nurse in charge always carrying the keys for storage of medicines as this avoided nurses asking each other for the keys as the patient could the recall overhearing nurses always asking for the keys
- A relative's questionnaire has been introduced. We saw that the room for relatives had information about the questionnaire encouraging them to comment on the care and to contribute any feedback. There was a locked collection box so that information was kept confidential.