

# The Hillingdon Hospitals NHS Foundation Trust

## The Hillingdon Hospital


### Inspection report

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Date of inspection visit: 01 November 2022  
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### Ratings

#### Overall rating for this service

Inadequate 

Are services safe?

**Inadequate** 

Are services effective?

**Requires Improvement** 

Are services caring?

**Good** 

Are services responsive to people's needs?

**Requires Improvement** 

Are services well-led?

**Inadequate** 

# Our findings

## Overall summary of services at The Hillingdon Hospital

**Inadequate** ● → ←

We did not look at sufficient evidence to change the rating. Our rating of this location stayed the same.

This was a focused inspection it does not change the rating given at our previous comprehensive inspection in July 2018. Concerns raised by patients through our National Call Centre Service triggered an unannounced inspection to look at care of the elderly in medical wards at Hillingdon Hospital NHS Foundation Trust. In particular, safeguarding, environment and equipment, nursing staff, records, medicines, incidents, nutrition and hydration, pain relief, multidisciplinary working, compassionate care, understanding and involving patients and those close to them, complaints and culture. We found the following:

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service kept good care records. They managed medicines well.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service made it easy for people to give feedback.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not always have enough staff to care for patients and keep them safe.
- We observed telephone calls going unanswered.
- Staff did not always adhere to the policy to keep medical records secure.
- We saw no evidence of learned lessons learnt from incidents amongst front line staff outside the ward from where the incident occurred.
- We were not assured how staff were able to communicate effectively with patients with confusion, learning difficulties or hearing impairments.

# Medical care (including older people's care)

**Requires Improvement** ● → ←

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## Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

## Action the service **MUST** take to improve:

- The service must ensure that all governance processes are robust and reach staff at the front line to improve the quality of the service delivered.

# Medical care (including older people's care)

- The service must ensure that all relevant incidents and learning are disseminated to all wards and ensure shared learning. This will help prevent silo working.

## Action the service SHOULD take to improve:

- The service should ensure that all records are kept secure at all times.
- The service should consider prioritising answering phone calls or relaying important information to relatives at an agreed time and date.
- The service should ensure that patients with communications barriers are communicated with effectively and appropriately, using appropriate tools and methods.
- The service should ensure service users are treated with dignity and respect.

## How we carried out the inspection

The team that inspected the service comprised of a CQC lead inspector, team inspector and a specialist advisor. The inspection team was overseen by Nicola Wise, Head of inspection.

We inspected medical care at Hillingdon Hospital NHS Foundation Trust on 01 November 2022 using our focused inspection methodology. We inspected medical care in particular the care of the elderly due to a string of concerning enquires raised by the public.

The inspection was unannounced to obtain a true vision of the care in the medical wards.

During the inspection the team visited Beaconsfield East Ward, Hayes Ward, the Departure Lounge and The Stroke Unit. We were unable to visit Franklin Ward due to a COVID 19 outbreak. We looked at five patient care records and spoke to six patients. We spoke to three ward managers and 15 other staff members including healthcare assistants, registered nurses, junior doctors and consultants.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

## Is the service safe?

Good   

We did not look at sufficient evidence to change the rating. Our rating of safe stayed the same.

## Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, we had received some enquires and allegations which led us to examine this area further. The trust had taken mitigating actions to strengthen safeguarding.**

# Medical care (including older people's care)

We received information of concern relating to personal care of an elderly patient. We raised this enquiry with our point of contact at the trust. We were told that this was investigated, and shared learning was disseminated to staff. When we questioned staff about this incident in other wards, they had no knowledge of this incident. This included consultants, junior doctors registered nurses and healthcare assistants. However, we did observe separate male and female bays on the wards, and staff we spoke with on other wards knew the male to female ratio for providing personal care.

Staff received training specific for their role on how to recognise and report abuse. Staff we spoke with were able to explain what was meant by safeguarding, were able to give examples of abuse and knew how to report a safeguarding concern. Staff were aware that information regarding safeguarding was available on the trust's intranet.

There was an increase in the number of hospital acquired pressure ulcers in the months leading up to the unannounced inspection. This was highlighted to the trust. However, in the month of October 2022, this number had reduced significantly as compared to previous months. The Trust had reported 28 hospital acquired pressure ulcers or moisture lesions with no category 3 or 4 pressure ulcers in October 2022. Staff we spoke with had good knowledge of pressure sore prevention and care. Specific training and teachings were carried out by the tissue viability nurses for all staff.

Several enquiries made note of unexplained bruising on patients once they had returned to their place of residence. Staff we spoke with showed us evidence of body mapping on admission, updates during the hospital admission and told us that body mapping was repeated on discharge. We looked at five patient care records at random and saw good documentation on body mapping.

We received some enquires regarding the quality of discharge from patients, relatives, care home providers, London Ambulance Service and the local authority. We looked at the Departure Lounge on the morning of the inspection which had two patients waiting to go home. The central discharge team had made new discharge booklets which entailed a range of information such as: the patients estimated date of discharge, transport arrangements and medication information.

They also started a discharge checklist. The checklist had been co-produced with patients and was organised, containing useful information, which could be scanned quickly, with space to provide extra, detail if required. The checklist included mobility of the patient, communication needs and dietary requirements. The checklist ensured that the Departure Lounge could document that they were receiving appropriate handovers for their patients and could demonstrate the care provided to the patients whilst they were in the Departure Lounge. This work was influenced, in part, by learning from a complaint.

The trust had patient flow co-ordinators (PFC) in the wards to assess the needs of patients prior to discharge. Staff reported seeing PFC's every morning during ward rounds.

Staff we spoke with commented that communication was good with patients regarding discharge but needed to be improved with patients' relatives.

Discharge team staff had built good communication and rapport with the local authority and local care homes. Staff stated that difficulties would often arise outside the Hillingdon borough and with care homes that they were not familiar with. Difficulties included obtaining out of borough packages of care. The discharge team was yet to create an action plan to help resolve these difficulties. The trust was part of a take home and settle scheme to ensure that elderly patients discharged had what they needed at home such as food and contact numbers. Patient flow coordinators had been introduced to some wards but not all. Since this introduction communications between the ward the discharge team had improved.

# Medical care (including older people's care)

We looked at the readmission rates by ward from April to October. These were all below the national average. We saw that Beaconsfield East had a 15.5% readmission rate, Franklin Ward had 13.10% readmission rate, Hayes Ward had 14% and The Stroke Unit had 9%. Hillingdon hospital had a readmission rate for all patients aged 75 and over at 17.6%. Readmission rates measure the level of clinical quality, high readmission rates indicate poor clinical quality and low readmission rates indicate high clinical quality. The latest national average for readmission rates for 2021/2022 for patients aged 75 and over was at 18%.

## Environment and equipment

### **The design, maintenance and use of facilities, premises and equipment kept people safe.**

We received comments about environments in which patients were housed overnight. This included medication and sharp instruments left in reach of patients living with dementia. Some of these patients were known to have violent outbursts. We looked at three patient wards and found patient environments to be safe and free from sharps and objects that could cause injury. On inspection we did not find any medication or sharp instruments left within reach of patients.

## Nurse staffing

### **The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix as per Trust policy.**

Medical staff made comments on shortness of staff in some of the wards we visited. This was corroborated with a senior charge nurse we spoke with who told us that staffing numbers were manageable but not to establishment.

In the month of October 2022 Franklin ward had a vacancy rate of 2.1%, Beaconsfield East had a vacancy rate of 7% and The Stroke Unit had a vacancy rate of 15.9%. There were no vacancies in Hayes ward.

In the month of October 2022, Franklin Ward had 16 unfilled Registered Nurses shifts, one unfilled Registered Mental Health Nurse (RMN) and 14 unfilled Healthcare Assistants (HCA) shifts. Beaconsfield East had five unfilled Registered Nurses shifts and one unfilled Healthcare Assistants shift. The Stroke Unit had 14 unfilled Registered Nurses shifts, one unfilled Registered Mental Health Nurse and 14 unfilled Healthcare Assistants shifts. Hayes ward had three unfilled Registered Nurses shifts and 76 unfilled Healthcare Assistants shift.

In the month of October 2022, Franklin Ward used 54 bank staff to cover Healthcare Assistant shifts, eight bank staff to cover Registered Mental Health Nurse shifts and 31 bank staff to cover Registered Nurse shifts. Beaconsfield East used 26 bank staff to cover Healthcare Assistant shifts, and 44 bank staff to cover Registered Nurse shifts. The Stroke Unit used 98 bank staff to cover Health Care Assistant shifts, 24 bank staff and nine agency staff to cover unfilled Registered Nurse shifts. Hayes ward did not use bank or agency staff in the month of October 2022.

One to one care was not always possible in the wards we visited. We were told that there was one HCA for two patients that required one to one care, these patients were cared in the same four-bedded bay to mitigate the risk. The trust informed us that the requirement for one to one care is assessed using the 'enhanced observation assessment tool.' This tool determines the level of risk and suggests the appropriate level of enhanced observation required to mitigate this risk. The tool may advise that patients are cohorted and cared for in higher ratios. Staff we spoke with told us that support was offered by the manager to address shortages.

# Medical care (including older people's care)

Staff that we spoke with informed us that registered nurses would often be moved between wards to achieve the correct skill mix ratio. Where staffing levels fell below planned establishment this was recorded and escalated as per trust policy.

We had asked the trust to tell us how they were tackling resourcing and high vacancy rates on some wards impacting one to one care. The trust informed us after the inspection that the vacancy rates for registered nurses have been addressed in line with the trusts international recruitment plan. Nurses already working at the trust as a health care assistant had received their Nursing and Midwifery Council registration pin in October, which meant that they were now a registered nurse.

## Medical staffing

**The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.**

We saw enough medical staff on the wards to keep patients safe. Medical staff we spoke with included junior doctors and consultants.

Medical staff were knowledgeable about their patients and were present on the wards.

## Records

**Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.**

Enquires received by the CQC informed us that medical records were left unlocked in their storage cabinets and open unattended at the nurse's station. Whilst on inspection we found some record cabinets unlocked and unattended, however the majority of records were found to be secure. All records at the nurses station were not left unattended.

## Medicines

**The service used systems and processes to store medicines.**

We received an enquiry regarding the whereabouts of medication. We raised this with the chief nurse at the time we received the enquiry. During our inspection however, we did not see any medication left in reach of patients unsupervised.

## Incidents

**The service did not manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team but not the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**

All staff we spoke with knew what incidents to report and how to report them. Staff were able to raise concerns and report incidents and near misses in line with trust policy.

# Medical care (including older people's care)

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff met to discuss the feedback and look at improvements to patient care. The trust had monthly bulletins, posters, learning videos, events, quality boards, quality rounds, weekly ward visits, monthly patient safety stands, and patient awareness week. Despite this, staff were not aware of incidents that happened in other parts of the hospital or in wards that differed from their own.

All staff we spoke to were not familiar with the incident where a patient under one-to-one care had allegedly fallen. This included consultants, junior doctors, ward managers, registered nurses and other healthcare professionals. The trust, however, shared evidence of how the information and thematic learning from falls related incidents is shared with all staff using a variety of methods, including Quality Boards, Quality Rounds, Divisional Unplanned Care monthly newsletter, nurses 'induction pack and monthly trust wide Team Brief. The monthly rate of inpatient falls for the trust remains significantly below the national average of 6.6 per 1000 occupied bed days with a rate for 3.3 per 1000 occupied bed days for November 2022.

Staff were also unfamiliar with an incident relating to personal care of an elderly patient. This incident had been declared as a serious incident. However, it was identified that this case went via the complaints process with a full response provided with actions implemented to ensure that a similar incident would not occur again. Therefore, this incident was undeclared as a serious incident. Duty of candour was applied, and the incident was dealt with as a complaint. The de-escalation of the incident was agreed with the local clinical commissioning group. The incident was still being investigated to ensure that all actions had been identified and embedded.

## Is the service effective?

Good   

We did not look at sufficient evidence to change the rating. Our rating of effective stayed the same.

## Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**

Enquires received between June and September 2022 indicated that patients had received poor nutrition and hydration, with many patient relatives stating that food and drink were left out of reach for patients. During the inspection we saw that patients could reach their food and drink and also had assistance with eating where required. We inspected the wards during a morning tea round and again at lunch time in the afternoon.

## Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.**

Enquires received by the CQC indicated that pain relief was not always administered in a timely and efficient manner.



# Medical care (including older people's care)

We asked patients whether or not they were experiencing pain and if they had pain relief. Patients we spoke with were happy with the pain relief offered and told us that their pain was manageable. Medical records we looked at confirmed that patients were receiving regular pain relief as per prescribed.

## Multidisciplinary working

We saw staff working well together and with other multi-disciplinaries in the ward. This included healthcare assistants, nurses, occupational therapists, physiotherapists, ward managers and doctors.

## Is the service caring?

Good   

We did not look at sufficient evidence to change the rating. Our rating of caring stayed the same.

## Compassionate care

**Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

The CQC received enquiries regarding overworked staff who did not have the time to care for patients. During our inspection we saw that staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness.

## Understanding and involvement of patients and those close to them

**Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**

Patients we spoke with told us that relatives often came to visit them in the ward and were made to feel welcome. Patients gave positive feedback about the service.

We looked at the friends and family test results from 01 September 2022 to 31 October 2022 for unplanned care. There was a total of 604 responses from this period. 90% of the results reported good care.

Forget me not forms were used for patients living with dementia. These forms contained personal information of the needs, likes and dislikes of the patient.

We tried to speak to a family on the ward at the time of the inspection, but they did not wish to make any comments at that time. It was therefore difficult to ascertain the level of involvement family and close friends have with a patient's care.

We were not assured how staff were able to communicate effectively with patients with confusion, learning difficulties or hearing impairments. Following the inspection the trust sent us different ways and mechanisms to aid an effective communication between staff and patients with Learning Disability (LD), dementia, hearing difficulties.

# Medical care (including older people's care)

## Is the service responsive?

Requires Improvement  → ←

We did not look at sufficient evidence to change the rating. Our rating of responsive stayed the same.

### Access and flow

We had several enquires informing of us of patient's relatives trying to get through to the ward via telephone. Patient relatives informed us that telephones often went unanswered for lengthy periods of time. We observed phone calls going unanswered several times throughout the day whilst visiting the wards. This was particular evident on Beaconsfield East Ward.

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them but did not always share lessons learned with all staff.**

Patients, relatives and carers knew how to complain or raise concerns. We received many enquires that had already gone through the complaint procedure.

The service clearly displayed information about how to raise a concern in patient areas. Patients we spoke with through enquires were well informed on how to make a complaint.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with knew of the latest complaint in their ward and could describe it in detail.

Managers investigated complaints and identified themes. Managers we spoke with were involved in the complaint process and received the relevant support from senior staff.

## Is the service well-led?

Requires Improvement  → ←

We did not look at sufficient evidence to change the rating. Our rating of well-led stayed the same.

### Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.**

We spoke to staff who informed us that they felt supported by management when they were short staffed. Management were visible on the wards and we saw good rapports between staff and management.

# Medical care (including older people's care)

The trust had developed positive relationships with local care homes and with their local boroughs. The trust had close working relationships with boroughs across North West London (NWL) directly and via the NWL discharge steering group and weekly escalation calls. The trust continues to develop relationships with boroughs outside of NWL.

## Governance

**Leaders operated governance processes, throughout the service. Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

There was a number of methods in place to cascade learning from incidents and complaints. This included, safety bulletins, posters, drop in events, information boards known as quality boards, quality rounds, verbal testing of governance, information stands in the canteen, patient safety awareness week, and learning videos. We saw that information shared in these processes varied and included incidents, complaints, medications safety, pressure ulcers and much more.

Incidents, complaints and shared learning were shared at divisional and speciality meetings, monthly team briefs, ward handovers and at the senior nursing and midwifery and allied health professional meeting. However, we found examples where the effective sharing of information about incidents had not happened.

The Senior leadership team met regularly to discuss incidents, complaints and shared learning at patient safety meetings, medication safety meetings, health and safety, falls steering group, pressure ulcer networking group, mortality and morbidity group and at the urgent care centre governance meeting.

We looked at the governance and quality meeting minutes from November and October 2022 for unplanned care. We saw that there was a large attendance from senior team members and standard items of discussion. This included but was not limited to incidents, risks, audits and health and safety.

The trust had clear governance structures in place for the dissemination, sharing and learning of incidents. However, upon talking to front line staff we were not assured that processes for sharing and learning were robust or that information was filtered down to this staff group. Staff we spoke with also reported silo working.

# Our inspection team

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This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance