St Mary's Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

St Mary's Hospital is operated by Isle of Wight NHS Trust. The trust is the only integrated acute, community, mental health and ambulance health care provider in England. The trust provides health services to an island population of 140,000. Acute services at the trust are provided at St Mary's Hospital in Newport, with 246 beds and 22,685 admissions each year. Services include Accident and Emergency (A&E), urgent care services (by referral only), medicine and surgery, intensive care, maternity, special care baby unit (SCBU) and paediatric services.

Community services include district nursing, health visiting, community nursing teams, as well as inpatient rehabilitation and community post-acute stroke wards. Mental health services provide inpatient and community based mental health care. Ambulance services deliver all emergency and non-emergency ambulance transport across the Island. The emergency call centre takes both emergency 999 calls as well as NHS 111 calls. The urgent care service provides an out of hours GP service including medical advice, assessment and treatment.

The trust has been in special measures for quality since 2017 and in special measures for finance since March 2019. The trust is currently rated as requires improvement, with an inadequate rating for Use of Resources. The acute services at St Mary's Hospital are currently rated overall as requires improvement.

Following the last comprehensive inspection of the trust in May and June 2019, the trust was served a warning notice under Section 29A of the Health and Social Care Act 2008 requiring them to make significant improvements by 31 December 2019 about the following concerns for the acute service delivered at the location St Mary's Hospital:

- Staff fully completing patient documentation.
- Staff following the trust's policies and procedures to support the identification and management of the deteriorating patient.
- Patients experiencing delays in their care and treatment once they were admitted to the hospital in relation to stroke care and cancellations of surgical operations due to lack of bed availability.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We carried out an unannounced follow up inspection of the trust in February 2020 and we were on site at St Mary's Hospital on 3 and 4 February 2020.

During this focused inspection, we looked at all the issues raised in the warning notice. We did not re-rate the service because we did not inspect any of the full key questions (safe, effective, caring, responsive, well led) of the acute services. Therefore, the rating for St Mary's Hospital and the Isle of Wight NHS trust remains at requires improvement.

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

We found that staff at this hospital had started to address the concerns raised at the inspection in June 2019. Requirements for significant improvement set out in the warning notice following the May and June 2019 inspection under Section 29A of the Health and Social Care Act 2008 were met. While there was evidence of significant improvement, there were still some areas the provider needed to improve.

We found the following areas where the service still needs to improve:

- Medical staff did not fully complete patient assessment documents.
- Duplication of required information throughout medical and nursing documentation increased the risk of staff not completing patient risk assessments.
- Across most services inspected, staff did not always complete patient fluid balance records.
- There were examples of some incomplete patient records in most of the wards and units we inspected.

However, we found the following areas where improvements had been made since the previous inspection:

Summary of findings

- Nursing records were fully completed for patients on the coronary care unit.
- Most staff signed and dated their entries in patient records.
- Most patient risk assessments had been completed and updated as needed.
- Most staff followed the trust's processes to identify, monitor and act upon patients at risk of deterioration.
- More stroke patients were cared for by staff with the right skills, training and experience.
- Specialist support from staff, such as speech and language therapists and specially trained nurses, were available for patients who needed it.
- Improvements had been made to promote better outcomes for stroke patients.
- In the emergency department, more staff completed hourly patient safety checks.
- Trust audits demonstrated improvements with the timeliness of patient discharge summaries.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve.

Following the comprehensive inspection in May and June 2019, the provider was issued with several requirement notices. These included requirement notices for regulations 12 (safe care and treatment) and 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We have not issued any further requirement notices as these requirement notices remain in place and will be reviewed at the next comprehensive inspection of this service.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	Requires improvement 	**This rating is from the previous comprehensive inspection. We did not re-rate this service as part of this focused inspection.** **The staff had responded to issues raised in the warning notice served:** There was improvement in how staff assessed and responded to risk. Some improvements with completion of records had been made, however there remained gaps in patient documentation.
Medical care (including older people's care)	Inadequate 	**This rating is from the previous comprehensive inspection. We did not re-rate this service as part of this focused inspection.** **The staff had responded to issues raised in the warning notice served.** There was improvement in how staff assessed and responded to risk. More stroke patients were being cared for by staff with the right skills, training and experience. Specialist support from staff such as and speech and language therapists and specially trained nurses was available for patients who needed it. Improvements had been made to promote better outcomes for stroke patients. Some improvements with completion of records had been made, however there remained gaps in patient documentation.
Surgery	Requires improvement 	**This rating is from the previous comprehensive inspection. We did not re-rate this service as part of this focused inspection.** **The staff had responded to issues raised in the warning notice served.** Although gynaecology was inspected as an additional core service at the previous inspection in May and June 2019, for the purposes of this inspection any references to gynaecology form part of the surgery core service report. Most patient charts and care plans were completed, dated and signed.

Summary of findings

Most patient risk assessments had been completed and updated as needed.
However, on Whippingham ward:
Patient charts and care plans were not completed or reviewed as patient needs changed, and staff did not date or sign the records.
Risk assessments had not always been completed and updated as needed.
Records had not always been followed through on later records and could not easily be found.

Summary of findings

Contents

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St Mary's Hospital

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery

Summary of this inspection

Background to St Mary's Hospital

St Mary's Hospital is operated by Isle of Wight NHS Trust. Acute services at the trust are provided at St Mary's Hospital in Newport, with 246 beds and 22,685 admissions each year. Services include Accident and Emergency (A&E), urgent care services (by referral only), medicine and surgery, intensive care, maternity, special care baby unit (SCBU) and paediatric services.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, four other CQC inspectors, a CQC enforcement inspector and three specialist advisors who between them had expertise in medical and surgical services. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about St Mary's Hospital

At the last inspection in May and June 2019 acute services at St Mary's Hospital was rated requires improvement for safe, effective, responsive and well led, and good for caring.

The acute services at St Mary's hospital has seven acute wards, five units and the emergency department providing acute services. The hospital is registered to provide the following regulated activities:

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

We previously carried out a comprehensive inspection of Isle of Wight NHS Trust between May and June 2019. Following that inspection, we issued the trust with a warning notice under Section 29A of the Health and Social Care Act 2008. The warning notice set out areas of concern, where significant improvement was required at St Mary's Hospital. We carried out an unannounced follow up inspection of the trust in February 2020 and we were on site at St Mary's Hospital on 3 and 4 February 2020.

During the inspection, we visited the following areas of the hospital:

- The emergency department
- The medical assessment unit
- The same day assessment unit
- The stroke unit
- Coronary care unit

We visited the following wards:

- Appley ward
- Colwell ward
- St Helens ward
- Whippingham ward
- Mottistone ward

At this inspection we spoke with 55 staff including senior nurses, health care assistants, consultants, junior medical staff, junior nursing staff, allied health professionals, managers, cleaning staff, administration staff and ward

nursing staff. We also spoke with seven patients. We observed five handover meetings, two hospital at night handover meetings and three safety huddles. Eighteen mental health assessment and 70 records were reviewed.

Urgent and emergency services:

The Isle of Wight NHS Trust currently provides one emergency department, where urgent and emergency services are delivered at St Mary's Hospital. It provides a 24-hour, seven day a week service.

The department has three adult resuscitation bays, 10 majors bays, two initial assessment and treatment bays, three minors cubicles and a mental health assessment room that is ligature risk compliant. The department has two dedicated paediatric rooms suitable for minors, majors and resuscitation cases.

Children have a separate waiting room and are treated in two rooms adjacent to the major treatment area. There are separate rooms for mental health assessment, eye examinations and application of plaster casts.

Radiology services are located next to the department.

The emergency department is led by four substantive consultants, a matron and seven sisters/charge nurses.

The unit cares for both adults and children with approximately 50,000 attendances per year (25% of these patients are children).

The emergency department is not a trauma centre, but is part of the regional trauma network and is a primary point of arrival for non-major trauma and occasionally major trauma awaiting transfer to a major trauma centre. Air-Ambulance or coastguard helicopter services assist the transfers to mainland trauma centres.

At the last inspection in May and June 2019 the urgent and emergency care service was rated requires improvement for safe, effective, responsive and well led, and good for caring.

We spoke with 15 members of staff including senior nurses, health care assistants, consultants, junior medical staff, junior nursing staff, managers and administration staff. We observed a safety huddle and eight patient records were reviewed.

Medical care services:

The Isle of Wight NHS Trust currently provides medical care mainly across six inpatient areas at St Mary's Hospital:

- The medical assessment unit which has 24 beds.
- The same day emergency care unit which provides same day care for both medical and surgical patients during the hours of 8am to 8pm.
- Appley ward which is a general medical ward of 28 beds with designated provision for respiratory, diabetes and endocrinology.
- Colwell ward which is a general medical ward consisting of 28 beds, with designated provision for care of the elderly and gastroenterology.
- The stroke unit which has 24 beds, including a four bedded hyper-acute stroke service.
- The coronary care unit which has six beds and a stepdown ward with 12 beds.

Medical patients were also accommodated on surgical wards, when there were no available beds on the medical wards.

There was a range of other non-inpatient medical services which were not inspected during this focused inspection. These included the respiratory service, the endoscopy service, the chemotherapy day unit and in-reach services for care of the elderly and rheumatology.

At the last inspection in May and June 2019 the service was rated requires inadequate for safe, effective and well led, and requires improvement for caring and responsive.

At this inspection we attended safety huddles, four nurse handovers, an evening and morning hospital at night medical handover and reviewed 30 patient records.

Surgical care services

The Isle of Wight NHS Trust currently provides surgical care at St Mary's Hospital.

The Surgery, Women's and Children's Health Care Group, includes the surgical and orthopaedic services as well as paediatric and obstetric services. The purpose of the care group is to provide clinical care and operational

Summary of this inspection

leadership to general surgery. Including breast and colorectal, urology, trauma and orthopaedics, ENT, maxillo-facial, ophthalmology, gynaecology, chronic pain, stoma, community and acute paediatrics.

Some support services are also included within the care group and include day surgery and main theatres, the pre-assessment and admission unit and anaesthetics.

Patients are cared for within the following wards, St Helens, Elective Surgery; Whippingham ward, Emergency surgery; Alverstone and Mottistone, Elective Orthopaedic Surgery.

At the last inspection in May and June 2019, the surgical core service was rated inadequate for responsive, requires improvement for safe, effective and well led and good for caring. Also, at the previous inspection in May and June 2019, gynaecology, which was inspected as an additional core service was rated inadequate for safe and effective, requires improvement for responsive and well led. The effective domain was not rated. For the inspection of February 2020, we have reported on the surgery service and gynaecology together in the surgery core service report.

We inspected four wards, St Helens, Alverstone, Mottistone and Whippingham ward.

We spoke with 11 staff including nursing staff, health care assistants, consultants, junior medical staff, allied health professionals, managers, cleaning staff and administration staff. We also spoke with four patients. We observed a safety huddle, 18 mental health assessments and 32 records were reviewed which included nursing and medical records.

Requires improvement

Urgent and emergency services

Safe

Requires improvement

Are urgent and emergency services safe?

Requires improvement

Assessing and responding to patient risk

Staff identified and monitored risks for patients. Staff identified and acted upon patients at risk of deterioration.

There had been improvement in monitoring patients in the department. Most staff completed the hourly patient safety checks , allowing them to identify and manage any risks, changes or deterioration in patients' conditions.

Of the eight patient records we looked at, staff completed hourly safety checks for seven of the patients. The records for the eighth patient showed staff recorded the safety checks between one and two hourly.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The department used NEWS2, which is a nationally recognised system to assess acutely ill and deteriorating patients. Of the records we looked at, most observations were recorded at frequencies that met the guidance of the NEWS2 system. The records showed that where indicated by the patient's NEWS2 score, patients' conditions were escalated to the relevant healthcare practitioner as per the NEWS2 guidance.

Review of incidents reported by the trust showed there had been two reported delay in treatment incidents in December 2019 that referenced staff not reacting on an identified risk to the patient.

Records

Staff kept records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care. However, they were not always fully completed.

There had been some improvement in recording the assessment, care and treatment of patients in the department. Staff kept records of patients' care and treatment. Essential medical information such as medical assessments and treatment management plans were consistently recorded in the patients care pathway document. However, medical records were not fully completed, and patient fluid charts were not always fully completed.

The urgent and emergency care pathway document was not user friendly and there was a risk that essential information was not recorded. Review of the trust's own quality assurance assessments, discussion with staff and senior leaders evidenced that they had identified that the pathway documents for medical staff were not user friendly. It required medical staff to document non-essential information and information already documented by the nursing staff. An example of this included duplicated sepsis screening on both the medical and nursing documents.

Staff told us that a new document for medical staff to complete had been developed and was being printed at the time of the inspection with a plan to pilot the document by the end of February 2020. They believed this would result in improved completion of medical records and reduce risk of essential information not being documented.

Staff did not always record details of intravenous fluids on patients' fluid input and output charts and did not always record total fluid intake. For one of the eight records we looked at, although the prescription record showed the patient had been administered intravenous fluids, there was no detail of this on the patient's fluid input and output chart. For two patients, although fluid intake was recorded on their fluid charts, these had not had six hourly totals completed as directed by the guidance on the charts.

Inadequate

Medical care (including older people's care)

Safe	Inadequate
Effective	Inadequate

Are medical care (including older people's care) safe?

Inadequate

Assessing and responding to patient risk

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. However, some patients were at risk of unidentified deterioration because staff did not always carry out patient observations in line with the guidance of this tool.

There had been improvement in how staff assessed and responded to risk, with more patient assessments completed and action taken. There had been a revised hand over at night process to aid communication across all medical staff grades and specialities.

For 28 of the 30 patient records we reviewed, the frequency of observations followed the guidance of the National Early Warning System 2 (NEWS2) used, along with trust policy. NEWS2 is a nationally recognised system to assess acutely ill and deteriorating patients Staff had correctly calculated the patients' NEWS2 scores. The medical wards all had NEWS2 link nurses to support staff in the use of NEWS2 in their area which had enabled the improvement see on this inspection.

However, for two records we looked at, the NEWS2 guidance had not been followed. For a patient on Appley ward there were long gaps in the frequency of undertaking observations. Staff had written the observations should be carried out four hourly. Observations on 31 January 2020 had been recorded at 10.50am, 5pm and then on 1 February 2020 at 6.40am. The patient was admitted with possible sepsis post chemotherapy. However, staff had not completed a sepsis screen for this patient. For a patient admitted to the coronary care unit their NEWS2 score had been incorrectly recorded as two instead of six.

At the nurse handovers we attended on Colwell ward, Appley ward, coronary care stepdown unit and the stroke unit, the registered nurses who handed over to the oncoming shift commenced their handovers with a description of the patients' current NEWS2 score. Staff on the oncoming shift were actively listening and asked relevant questions.

There remained some inconsistencies with the staff grades and specialisms for attendance at night medical handovers, to identify and quickly act upon patients at risk of deterioration. There had, however, been improvements to the communication between staff with shared documentation of the patients for handover. Junior doctors had more support than previously to identify and take action for the patients at risk of deterioration.

Following our inspection in 2019, the trust had reviewed the hospital at night medical handover processes. This included review and amendments to the members of staff required to attend the handover and the time of the handover meeting to facilitate improved attendance. The attendance records showed that the average attendance was below the required of staff as set out in their policy at the 8am meetings in October to November 2019 and was 73% for incoming staff and 61% for outgoing staff. The records showed that the average attendance of required staff at the 9pm meetings from October to December 2019 was 75% for incoming staff and 53% for outgoing staff.

Medical and surgical consultant attendance was only required at the 8am meeting. There was an on call system for junior doctors to contact consultants out of hours. The information provided by the trust showed that there was 96% attendance from the medical consultant in October 2019 and 70% attendance in November 2019. Surgical consultant attendance was 74% in October 2019 and 63% attendance in November 2019.

We attended the hospital at night handover Monday 3 February 2020 at 9pm, and Tuesday 4 February 2020 at 8am. The handover was led by the critical care outreach team, and followed a clear structure. The structure included an overview of hospital capacity, any issues, for

example, infection control and safeguarding, and an opportunity for each specialty to handover any 'at risk' patients, to support patients' safety. Staff that attended were able to raise questions about patients. At the 8am handover, the medical registrar was aware of a gynaecology patient at risk who needed to be reviewed by the stroke team , and this information was discussed. At the morning handover we attended, a medical and surgical consultant were present, to provide senior medical support. The structure allowed staff to speak up, but the meeting was more operational than a review of clinical aspects of the deteriorating patient which would have further supported junior doctors.

Since our last inspection, medical registrars had started using a paper handover template at the meeting. This included patients' biographical details, current medical problems, management plans, and a 'to do' for medical staff and nurses. This was an improvement from the previous inspection as staff now had current information about patients' conditions and management plans. However, the document used during the handover we observed was not fully completed. The only column that was fully completed for the 19 of the 20 patients listed, was what their current problems were. The medical staff explained they had started using the form on 6 January 2020, and that they were aware it was not fully embedded therefore was still a risk, for example, where patients' management plans and medical and nursing actions were not detailed, that action that needed to take place may be missed.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up-to-date. Staff did not always have access to up-to-date, accurate and comprehensive information on patients' care and treatment. However, records were stored safely and easily available to all staff providing care.

Although there had been some improvements made in the completion of patient documentation, with more of the record complete, there continued to be some gaps. For example, incomplete documentation of nutrition and fluid charts as well as falls risk assessments. This meant patients continued to be at risk of poor care and treatment because staff did not have full and current information. The timeliness of discharge summaries had improved. We reviewed some patients' records which showed they were at potential risk of coming to harm and bought these to the trust's attention. The level of completion of records varied by ward and unit with most areas having gaps in the records to some greater or lesser extent. However the coronary care unit and coronary care unit stepdown patient notes we reviewed were all fully completed.

Staff we spoke with said there had been several changes to the documentation in recent months, the latest being four weeks ago. In particular the current booklet was considered to be too long with multiple pages not really required. Staff felt this was a reason for the lack of completeness of the documentation. Senior staff we spoke with told us that due to some duplication, the medical documentation records had been reviewed and at the time of our inspection new record keeping templates for medical staff were being printed. Despite the concerns that remained with gaps in patients' records, there were clear care and treatment plans in all the patient records we reviewed.

There were gaps in records which meant there was a risk of patients not getting the correct care and treatment. For example, the trust policy for a patient with a nasogastric tube was that staff must check the tube position by aspiration at least daily. A nasogastric tube is a special tube that carries food and medicine to the stomach through the nose. Staff had recorded they had checked a particular patient's nasogastric tube position on 31 January 2020, 2 and 3 February 2020 but not on 1 February 2020. For the same patient their intravenous fluid prescription did not have the doctors bleep number, and there was a signature but no printed name, which could have resulted in a delay to contact the doctor if there had been a concern with the patient's intravenous fluid prescription.

The trust used a validated tool which gave the estimated risk for the development of a pressure sore in a given patient, but staff did not always complete it. On Appley ward, a patient's risk of developing skin damage score had been calculated as 13 on 31 January 2020. According to the trust's procedures a 'my pressure ulcer and moisture lesion prevention plan' should have been completed to manage the risk of the patient developing pressure sores. This had not been completed when we reviewed the notes on 4 February 2020.

Inadequate

Medical care (including older people's care)

The trust had undertaken recent audits of their patient record keeping since our last inspection. The findings were variable across wards and units and according to the document audited. For example: the completion of risk assessment documentation audit at November and December 2019 was 80% or greater on Appley and Colwell wards, the stroke unit and the medical assessment unit. Completion of food charts in January 2020 was on Appley ward 76%, Colwell ward 100% and 96% on the stroke unit. The hydration chart completion was 90% on Appley ward and the stroke unit, 100% on Colwell ward, 78% on the coronary care stepdown and 100% on the medical assessment unit.

The trust had undertaken work to improve the concerns about delays with patient discharge summaries not being timely since the last inspection, to better ensure the safe and effective ongoing care when discharged from hospital. Overall at the trust in January 2019 51% of discharge summaries were completed on the same day, with 64% by the third day after discharge. At January 2020 79% of discharge summaries had been completed the same day for patients, and 90% by day three.

Are medical care (including older people's care) effective?

Inadequate

Nutrition and hydration

Specialist support from staff such as speech and language therapists and specially trained nurses was available for patients who had swallowing difficulties.

Specialist support from staff such as speech and language therapists and specially trained nurses was available for patients who needed it**.** There were no delays with stroke patients swallow being assessed, this was an improvement since the last inspection. Nursing staff had been recently trained and competency assessments signed off for them to be able to assess patients' swallow mechanism in the absence of a speech and language therapist. The ward sister informed us there was always at least one nurse on duty trained and competent to assess patients ability to swallow. This was confirmed by nursing staff we spoke with working on the stroke unit during our inspection.

The trust had an inpatient speech and language therapy referral and prioritisation pathway for non-stroke patients. Patients with swallowing problems that had not had a stroke were prioritised as urgent by the speech and language therapists, who confirmed this group of patients would be seen urgently. The target response time was within two working days, as directed by the Royal College of Speech and Language Therapists. This time scale had been met for 98% of patients referred from July to December 2019. The 2% of patients not seen within the target response time, were either not nil by mouth or having nasogastric feeding, minimising the risk of these patients not getting enough to eat and drink. Patients that met urgent priority criteria included: those who were nil by mouth without an alternative method of nutrition and or hydration and patients at risk of choking.

We spoke with a speech and language therapist who confirmed they carried a bleep and checked their referrals at 8am and 1pm Monday to Friday. There was no speech and language therapy cover at the weekends or bank holidays. The speech and language therapist told us medical staff would assess and treat these patients with other support to manage their hydration and nutrition, if speech and language therapy not available. The speech and language therapist explained it was not possible for a non-specialist to assess a patients' swallow when they do not understand or know the reason for patients' swallowing difficulties. At the time of this focused inspection we did not see any patients with a swallowing difficulty that had not had a stroke.

Patient outcomes

The service participated in the national audit for stroke services and used the findings to make improvements to promote good outcomes for patients. Some improvements had been made in the stroke service.

The stroke care service had made improvement in the timely treatment of patients with thrombolysis, however compared nationally the trust had not yet consistently met the median time for patients to receive thrombolysis of 52 minutes. The time for patients to see therapists had also improved. Whilst there had been an increase in the number

of stroke patients being admitted to the stroke unit within four hours of presentation of stroke symptoms this was still behind the national target; delays for admission can result in poorer outcomes for stroke patients.

The trust continued to participate in the national audit programme for stroke services (SNAPP) and used the findings to make improvements to promote good outcomes for patients. There had also been some reduction in the time taken before patients' assessment following admission by physiotherapy, occupational therapy and a significant reduction for speech and language therapy.

Data from the audit for October to December 2019, the most recent data for the time of the inspection, showed the trust had improved from a D to an A score. This data showed the proportion of patients admitted directly to an acute stroke unit within four hours of hospital arrival had increased from 33% to 54%. This was better than the national average of 53% of patients, for the same time period, admitted directly to a stroke unit within four hours of arrival at the hospital. However, this remained below the national target of 90% of stroke patients being admitted directly to an acute stroke unit within 4 hours of arrival at hospital.

Thrombolysis is the breakdown of blood clots formed in blood vessels, using medication given to patients through a peripheral intravenous line. The stroke service had acted to improve thrombolysis start time for suitable patients. The SNAPP audit data showed that of all stroke patients admitted between October and December 2019, 100% of the patients eligible for thrombolysis were thrombolysed. From October to December 2019 the median time taken from admission to hospital to thrombolysis was 85 minutes, at the last inspection the median time was 100 minutes. On 4 February 2020 one patient on the stroke unit had commenced thrombolysis treatment 42 minutes after admission to the hospital which was within the guidelines. There were no other patients eligible for thrombolysis during our inspection.

The trust informed us that as of 30 January 2020 all the medical registrars had now attended stroke thrombolysis training. The trust was also in discussion with another trust, to consider proposals for a joint service development for stroke care for the patients' journey along the stroke pathway that included urgent assessment and treatment, inpatient hyperacute and acute stroke medical care and treatment as well as leadership.

On 4 February 2020 when we inspected there were 12 patients who had been admitted due to a stroke on the stroke unit, the other 12 patients on the unit were general medical patients. We did not see any stroke patients in other areas we inspected which is positive as the patients are more likely to get the right care and outcomes when cared for in the specialist unit.

Of the three patients we reviewed one patient had been admitted to the stroke unit in seven hours and 29 minutes, the second patient six hours and 45 minutes and the third patient two hours and 55 minutes. Therefore, only one of the three was admitted within expectations which could compromise the outcomes for some patients. The trust informed us delay for admission to the stroke unit was due to increased hospital pressures which included the number of staff available, delays in assessment and bed availability. The stroke service was following an action plan to improve the time in which patients were admitted to the stroke unit.

Requires improvement

Surgery

Safe	Requires improvement
Effective	Requires improvement
Responsive	Inadequate

Are surgery services safe?

Requires improvement

Assessing and responding to patient risk

Staff mostly completed and updated risk assessments for each patient and removed or minimised risks. Most staff identified and quickly acted upon patients at risk of deterioration.

There was some evidence of improvement in three wards since the 2019 inspection, although staff on one ward did not follow the trust process for completing risk assessments which would identify patients at risk or deteriorating in health.

Risk assessments were completed well on three of the four wards using nationally recognised tools, such as a tool to score to assess patients' risks of developing a pressure ulcer. Other risks assessed were those of mobility, moving and handling, venous thromboembolism (VTE) and the national early warning score (NEWS2); a nationally recognised system to assess acutely ill and deteriorating patients. The risk assessments were documented in the patient's records and included actions to mitigate any risks identified.

However, on Whippingham ward we saw that the patient risk assessments were not always completed, including the tool to assess patients' risk related to pressure ulcers. Other risks not fully assessed or updated were those of mobility, moving and handling, venous thromboembolism (VTE) and NEWS2.

Patients who required planned or elective surgery attended a pre-assessment clinic to ensure they were fit for the procedure. At the clinic they were swabbed as per hospital policy to assess if they had any colonisation of MRSA. When results were found to be positive the admission date was deferred, and the patient was provided with a treatment protocol to use at home, according to the hospital's MRSA policy and retested prior to the procedure.

Nursing staff we spoke with were able to describe how they would raise concerns about a deteriorating patient. Medical staff supported them if a patient's health deteriorated. The staff were able to contact a doctor or a consultant 24 hours a day for advice or to raise concerns about patient care.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, up-to-date, stored securely or easily available to all staff providing care. Staff did not always have access to up-to-date, accurate and comprehensive information on patients' care and treatment.

Although there had been improvements to patient records, on one ward patients continued to be at risk of poor care and treatment because staff did not have full and current information to ensure they provided safe care and treatment to patients. Audits were not consistently being used across the four wards, so the managers could not relay on the accuracy of the data.

A paper records system was used for both nursing and medical notes. We reviewed 18 sets of patient's records and saw that 14 were mostly completed and written clearly. However, on Whippingham ward, there were gaps and records were not contemporaneous with some having no daily updates on the patients' needs and wellbeing.

In two records we saw that support workers had completed the nursing notes. Nursing staff we spoke with told us that it was usual practice for support staff to write what care they had given to patients. We saw that support staff had written for example 'nasal gastric tube and catheter removed', in addition to the personal care that had been given the patient. Staff we spoke with told us that support

staff would not carry out these activities. The records did not have a clear record of the activities that had been carried out by a registered nurse in relation to the removal of the nasal gastric tube and catheter removed.

There was lack of consistency across the wards about what the expected standard of record keeping was for support staff. We asked ward staff whether registered nurses were expected to oversee support workers entries in the notes and counter sign them. The answer varied from 'no they would not do this' to 'yes, nurses were expected to counter sign'.

There was a risk important information was not available for nurses to plan and evaluate effective care. Medical and nursing records were stored separately and contained information about the patient's journey including pre-operative assessments, investigations, results and treatment provided. There were separate care pathways for each speciality or procedure. However not all the paperwork was secured and available within the current record. For example, previous records relating to the current inpatient stay had been filed and information that was still relevant had not been updated and added to newer records which just stated 'see book 1'.

The audit instructed ward staff that if the percentage of records fully completed fell below 85%, a local action plan was to be put in place and the audits completed weekly instead of monthly until the 85% target was reached. On Whippingham ward we saw audits had not been correctly completed, the data could not be relied on and the percentages and interpretation of findings were therefore not correct. Where the audits showed that work was needed, staff told us there were no action plans in place and the audits had not been completed weekly as per instructions.

At this inspection in February 2020 data showed and nursing staff told us there had been an improvement in discharge summaries being produced within the agreed timescales and they sent patients home with a discharge summary in most cases.

Are surgery services effective?

Requires improvement

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

We found improvement with the use of evidence-based guidance and quality standards to inform the delivery of care and treatment. Staff could access national and local guidelines through the hospital's intranet. However, on Whippingham ward although there was policy guidance, staff did not write plans to meet patient's identified needs using the guidance and standards available. For example, tracheostomy care.

Hospital policies we reviewed were assessed by the author to ensure guidance did not discriminate because of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation and/or age.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They did not use agreed personalised measures that limit patients' liberty.

We observed that there had been improvements on three of the four wards for the recording of consent to care and treatment including assessment under the Mental Capacity Act. However, on Whippingham ward in three care records we reviewed, there was no consistent documentation of Mental Capacity Act assessments or best interest meetings.

For example, where a patient had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) order there was documentation that the patient's mental capacity to make a decision had been assessed or considered. However, over the two days of the inspection, when we reviewed patient records, staff we spoke with told us, that mental capacity in some patients fluctuated. There were no plans of care in the patient's records to meet the identified changing capacity concerns. This meant patients who had fluctuating capacity were at risk of receiving inappropriate treatment or interventions.

When patients could not give consent, staff did not always make decisions in their best interest, and did not take into account patients' wishes, culture and traditions.

Requires improvement

Surgery

We observed on Whippingham ward there were several patients who appeared vocally confused and distressed. Staff on duty appeared to disregard the patient's calls, with no visible assessment of the patient's needs, for example pain relief or a drink. We witnessed some staff carrying out tasks such as personal care with no visible interaction with the patients. We saw some action had been taken to prevent patients getting out of bed for example, raising the end of the bed and having bed rails in place. When we reviewed care plans where this action had been taken, there were no appropriate assessments or best interest decisions in place to evidence why staff had taken this action.

Are surgery services responsive?

Inadequate

Access and flow

People could not always access the service when they needed it and receive the right care promptly.

We found that continued high bed occupancy across St Mary's Hospital and the need to treat, continued to delay access to the hospital. As a result, delays continued for patients to access their treatment and was still a risk of poor outcomes.

Senior staff told us they had recently implemented a plan to lessen the number of cancelled surgeries. All potential on the day cancellations for surgery, were reported to a senior member of staff who made the final decision on cancellation and rescheduling. Staff were encouraged to go to that member of staff with a potential solution. In addition, where possible, inpatient surgical procedures were changed to day surgeries to relieve the use of an inpatient bed. Staff on Whippingham ward told us there was one area on the ward where an extra bed could be situated when there was a bed capacity issue. It was the only area not near a fire exit. They told us it had last been used in December 2019.

Prior to the inspection the trust told us for the period 1 October to 31 December 2019 the short notice surgery cancellation rate for non-clinical reasons was 4%. Of these cancellations, 38% were due to the need to treat more urgent patients and 37% were due to staffing issues. The NHS constitution details that patients who have their operations cancelled at short notice on the day of surgery, should have their operation rescheduled and carried out within 28 days of the initial cancellation. The trust said seven out of 108 short notice cancellations in this period were not treated within the required 28 days.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Urgent and emergency services

- The provider must ensure staff complete patients' records. This includes medical records and patient fluid balance records. (Regulation 17)

Medical care

- The provider must ensure staff complete patient records. This includes medical records, nursing records and patient fluid balance records. (Regulation 17)
- The service must ensure where risks to patients are identified, actions are taken to lessen the risk. (Regulation 12)

Surgery

- The provider must ensure staff always complete all patient risk assessments. (Regulation 12)
- The provider must ensure staff complete patient records. This includes medical records, nursing records and patient fluid balance records. (Regulation 17)
- The provider must ensure staff have access to up-to-date and accurate information on patients' care and treatment. (Regulation 17)
- The provider must ensure patient record audits are completed accurately and the findings are used to improve practice. (Regulation 17)

Action the provider SHOULD take to improve

Urgent and emergency services and Medical care

- The provider should act to reduce duplication in patient records.

Medical care

- The provider should continue to act to make improvements in the stroke pathway for patients suspected of having had a stroke.
- The provider should continue to make improvements with staff attendance at the hospital at night handovers.
- The provider should continue to act to embed the improvements made with staff following the trust's deteriorating patient processes, including adherence to the NEWS2 process and guidance.