King's College Hospital NHS Foundation Trust

Orpington Hospital

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inadequate**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Orpington Hospital

Requires Improvement 

We carried out a focused responsive inspection visit to two Older Adult Medicine wards at Orpington Hospital on 11 July 2022. This was as a result of receiving concerning information about standards of care.

We spoke with eight patients, one relatives and 17 staff. A range of information was reviewed by us on site and as provided from the trust after our visit. We looked at seven records related to patient treatment and care. We made observations of staff interactions with patients and one another, how the multidisciplinary team worked, and the general environment.

We found:

- Staffing levels did not always enable staff to provide the standards of care they aspired to.
- Not all staff had a full understanding of how to protect patients from abuse. Care and treatment was not always delivered in a responsive manner and did not always reflect the preferences of patients. Patients were not always treated with dignity and respect. Staff did not always feel valued and listened to. As a result, they did not always report matters of concern via the incident reporting system. There were missed opportunities for managers to be informed of these, to investigate and learn from the issues.
- Medicines were not always managed safely.

However:

- Staff had training in key-skills and safety related subjects. Infection risks were well managed, and the environment was suitable for patient's needs.
- Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from these.
- Staff ensured patients had enough to eat and drink and ensured their pain levels were assessed and managed. They treated patients with kindness and respected their privacy. Staff provided emotional support to patients, their families and carers.
- There was good multidisciplinary working and sharing of information. Key services were available seven days a week.

Medical care (including older people's care)

Requires Improvement

Our overall rating for this part of medical services took into account the previous ratings from the inspection carried out in 2015, which were as follows: Safe, rated as requires improvement; Effective, rated as good; Caring, rated as good, Responsive, rated as good, and Well-led, rated as good.

Please see the summary above for further information.

Is the service safe?

Requires Improvement

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing and associated staff received mandatory training in a range of subjects and were responsible for completing this. The mandatory training was detailed and met the needs of patients and staff. Training compliance rates were stated to be 94.2% for Churchill Ward and 93.2% on Elizabeth Ward. Staff said they were given time to complete their training.

Mandatory training did not include recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. There was separate training for this subject area and we noted that 26 (86.6%) staff on Churchill Ward had completed training, and 22 (76%) on Elizabeth Ward.

Managers monitored mandatory training and alerted staff when they needed to update their training. The training schedule identified upcoming dates for training to be completed.

Safeguarding

Staff had training on how to recognise and report abuse, despite this, not all staff recognised and understood how to protect patients from abuse. When required, the service worked well with other agencies to protect vulnerable adults from potential harm.

Nursing staff received training specific for their role on how to recognise and report abuse. There were a small number of nursing staff who were not up to date with their safeguarding training, one on Churchill Ward and four staff on Elizabeth Ward.

The training management system identified those staff who' training was due in the immediate or near future. We spoke with staff on two medical wards. Most were able to respond to our questions and were able to explain and provide examples of safeguarding, and how they would escalate their concerns. One registered nurse did not fully understand what safeguarding was.

Staff made consideration of potential safeguarding matters and we heard staff discussing the need to make a referral for one patient on Churchill Ward. Staff knew how to make a safeguarding referral and who to inform if they had concerns. However, staff were not considering how their inability to respond to patient request for toileting amounted to a form of avoidable abuse to them.

Medical care (including older people's care)

Staff working on the medical wards had access to a safeguarding adult policy. This was in date and contained all the necessary information to assist them. We noted the trust had a Joint Safeguarding Committee, which met quarterly and provided an annual report and quality update to the Patient Safety Committee, a subset of the Trust Board. The trust also reported safeguarding activity to the Lambeth, Southwark and Bromley Safeguarding Adults Boards.

Cleanliness, infection control and hygiene

The service-controlled infection risks well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Cleaning services were undertaken by an external company and followed specific schedule, using designated equipment. This reflected the standards required of the Health and Social Care Act 2008: code of practice on the prevention and control of infections.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Staff followed infection control principles including the use of personal protective equipment (PPE). PPE procedures had been updated to reflect the increase in Covid-19. Staff had been made aware of a new directive on the day of our inspection, which was to recommence the wearing of face masks, due to the rising coronavirus rates. We observed staff wearing the appropriate PPE and disposing of this correctly. Staff were seen hand washing in between patient activities and used hand sanitisers as necessary.

We were provided with a copy of the infection prevention and control guidance for staff to follow about respiratory virus, including SARS-CoV-2, which was detailed and helped staff to work within safe and expected practices.

During the inspection we observed staff using infection control procedures to make sure equipment and the environment was clean. Patient equipment was cleaned after patient contact and labelled to show when it was last cleaned. Commodes and bed pans were clean and ready for use for the next patient.

There was a good access to hand wash facilities and hand sanitisers agents, although some dispensers near ward entries were empty.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment safely. Staff managed clinical waste well.

Patients could reach call bells, but we observed and heard from patients directly, that staff did not always respond quickly when called. On Elizabeth Ward we had to alert staff to a call bell that had been ringing for over four minutes and ask them if they could answer this. There was no urgency from staff to respond to this.

The design of the environment followed national guidance and there was access to separate male and female bed areas, appropriate bathing and toileting facilities. Hand hygiene facilities were easily accessible.

Staff carried out daily safety checks of specialist equipment and we saw evidence of electrical safety checks on equipment items. Staff carried out daily safety checks of specialist equipment, such as the resuscitation trolleys. We saw evidence of these checks having been completed on the wards visited.

The service had suitable facilities to meet the needs of patients' families. Staff on Elizabeth Ward reported having to share storage facilities between another ward and having to share equipment, including a patient weighing hoist, which meant it was not always readily accessible.

Staff disposed of clinical waste safely and we observed there was a range of different waste management systems in use, which reflected safe practice and national guidelines.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The NEWS2 tool for assessing the status of patients was in use and formed part of the patients' records. Scoring was applied for physiological assessments, such as, blood pressure, pulse, pain and temperature. There was a process to follow for escalating matters of concern to ensure the patient received the right help and support.

Staff were able to explain how they used NEWS2 and how they monitored and escalated concerns.

Staff completed risk assessments for each patient on admission, using a recognised tool. Nursing notes we reviewed showed these assessments were routinely reviewed and updated. However, for one patient record we reviewed on Elizabeth Ward, 24-hour 15-minute observation checks had not been consistently completed between the dates 26 June 2022 to 6 July 2022.

Electronic patient records were updated to reflect any risk assessment changes. Paper-based risk assessment such as those related to skin integrity, falls assessment and nutritional assessment were used as part of the patient's care. There were some gaps in the recording of intentional rounding checks in records at varying times on different dates. Intentional rounding is a structured process whereby nurses carry out regular checks, usually hourly, with patients using a standardised protocol to address issues of positioning, pain, personal needs and placement of items.

Staff knew how to deal with patient related risks, for example, falls and pressure ulcers. Evidence showed these assessments were discussed at handover meetings and any concerns discussed with the doctors.

Staff shared key information to keep patients safe when handing over their care to others and key information was shared during shift changes.

Orpington Hospital did not have in-reach psychiatric support available. For urgent assessment, patients may be transferred to Princess Royal University Hospital (PRUH) for review by the Bromley Mental Health Liaison team. Senior clinical advice and support was available through the site manager.

Staff shared key information to keep patients safe when handing over their care to others. We observed the handovers between shifts on two of the wards inspected. The information provided was detailed and enabled staff present to undertake their responsibilities safely.

We observed a separate multidisciplinary board round, which also provided the opportunity for each patient to be discussed in detail and included aspects of their discharge, ongoing health and social needs.

Medical care (including older people's care)

Staffing

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 did their best to adjust staffing levels and skill mix, but it remained a challenge at times.

Staff on Churchill and Elizabeth Wards reported that they did not always have enough nursing and support staff to keep patients safe. As a result, patients did not always get care in a timely manner, with examples of nursing staff not responding in good time to requests for toileting. This had resulted in patients passing urine or defecating in pads they had been provided with.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants (HCA) needed for each shift in accordance with national guidance. However, they could not always cover at short notice for such matters as sickness, and as a result, pulled staff from other wards, which then had a knock-on impact.

We saw information which showed several occasions since the start of January 2022 and the time of our inspection when staff reported their concerns about staffing levels. On each occasion reported the situation was described, the impact, and the action taken at the time. This included for example, the practice development manager and acting ward manager to assist and cover breaks.

Staff told us they were routinely moved across to another location to help fill shifts. Most staff we spoke with said under-staffing was a big issue within the department particularly on Elizabeth and Churchill Ward and the lack of support. Staff told us they were sometimes unable to provide the care they wanted to. For example, delayed response to call bells and getting patients ready in the morning.

Student nurses on Elizabeth Ward were being used as part of the nursing figures for the day, mainly for the HCA role.

Staff told us they had concerns around staffing, particularly for patients who needed one to one care or were frail. These patients required more care, sometimes making it difficult to give the time to other patients.

The nursing staffing levels were budgeted against bed number and patient acuity. Staffing was made up of a supervisory ward leader, three registered nurses and four unregistered nurses (both day and night).

Staff told us staff were often given to the PRUH site after the start of their shift, and they felt like this site was ‘often forgotten’ about and given less priority. Following the inspection, the chief nurse told us they had activated an immediate stoppage of the move of staff between the two sites, except in extreme situations.

The trust told us the two wards employed 70.44 whole-time equivalent (WTE) nursing staff and had 62.75 WTE in post. There was an active recruitment programme in progress, and this included internationally educated nurses. Despite this, staffing continued to be a challenge to the trust.

Medical staffing

The service did not always have 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.

Medical care (including older people's care)

The trust told us the Orpington Adult Medicine Care Group employed 10.4 WTE consultant grade medical staff and had 9.4 WTE in post.

The service did not always have enough medical staff to keep people safe on Elizabeth Ward. Where medical staff were filled by locum doctors, they were subject to all the relevant checks on their skills, competencies and medical credentials, and were a valuable part of the workforce.

Nursing staff said medical staff were accessible and responsive. Consultants were on call during the weekends and evenings.

We saw information which highlighted the concerns of doctors, who found themselves arriving for a shift and finding they were on their own with only the consultant. They indicated not having a second junior doctor or senior house officer on the rota. Whilst help was requested, this did not always arrive until several hours later. Other incidents related to reduced medical staffing levels had been reported via the trust incident system.

Risks related to the medical staffing arrangements were discussed at governance meetings. We noted a moderate risk rating for care of the elderly wards and for medical cover in general at Orpington Hospital. Actions were being taken to try and improve the situation, although this remained a challenge.

Records

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

We reviewed seven patient electronic records and found these to be detailed. All staff with access to the records could easily do so, via their own log in. Entries made by members of the multidisciplinary team, such as occupational and physiotherapist, speech and language, dietitians were, of a very high standard. Medical staff contributed to the records following assessments and consultant reviews.

We reviewed bedside assessment and observational charts on Elizabeth and Churchill Wards. Assessments, such as falls, skin integrity, wound care and food charts had been completed. Care plans had been included and updated. In Elizabeth Ward we found notes had been completed but for one set, the 15-minute observational check sheets were not in order and had not been consistently completed. We found gaps in the intentional rounding records in two of the four records reviewed on Churchill Ward.

Care plan records were a standard document, in which staff would add in any specific details. Most plans reviewed had not been personalised with additional information, such as preferences, likes or choices.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines

The service used systems and processes to safely prescribe and store medicines. Safety processes for administration of medicines and recording this were not always safe.

Staff had a medicines management policy to adhere to. They followed systems and processes to prescribe medicines safely, for example, checking the patient names and allergy status during medicine rounds. There were, however, safety concerns related to observing patients to ensure they took their medication as soon as given to them and the recording of this in the electronic records. Whilst we observed safe practices during the medicine administration round on

Medical care (including older people's care)

Churchill Ward, we were told by a member of non-registered staff on Elizabeth Ward that they were sometimes asked to give medicines to patients, rather than the trained nurse. This practice is unsafe and does not reflect professional standards required of registered nurses. Further, we observed a nurse who had not directly given the medicines to the patient completing the electronic patient record to indicate they had taken their medicines at the prescribed time. The record was being completed six-hours after the timing for the medicines. This unsafe practice poses a risk to patients, as there is the potential to give a second dose of medicines, if another member of staff sees nothing recorded for the correct time.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff stored and managed all medicines and prescribing documents safely. Secure medicine trolleys were used for the medicine rounds. Patient own medicines were also stored in a locked cabinet at the bed side. Medicine prescribing records were held electronically. Medicine cupboards were secure and there were top-up days for medicines.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The consideration of take-home medicines was made during handover and patient board meetings.

There were periodic audits of staff compliance with medicine safety and security, and we were provided with the results for quarters covering 2021 to the most recent. Results were rated as red, amber and green according to the score against the target. There had not been any reds and only two amber scores out of the last 72 assessments.

Pharmacy staff completed a trust-wide audit to determine whether all wards and clinics were adhering to National safety alerts, which are key to ensure the safety of patients and healthcare professionals. Churchill and Elizabeth Wards were fully compliant with the audit indicated as being for quarter two, 2020-2021. The controlled medicines audit for quarters three and four 2021/22 showed full compliance on Elizabeth Ward and one fail on Churchill Ward.

Incidents

The service was not able to manage all patient safety incidents well. Staff did not always recognise and consider reporting some safety related incidents and near misses. Where incidents were reported these were investigated, lessons learned were shared with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff did not always raise concerns and report incidents and near misses in line with the trust policy. Although staff knew how to raise concerns and report incidents, we were not assured this was always done or that they always considered some situations in the context of a re-portable matter. For example, staffing concerns and the impact on the ability of staff to respond to patient needs were not always reported. Occasions where patients care had not been optimised were not routinely reported. Staff told us they did not always report through the internal system their concerns around the skills and competence of colleagues. There were missed opportunities to help improve the experiences of patients and to learn from these matters.

As staff were not reporting all types of incidents, they did not regularly meet to discuss the feedback and look at improvements to patient care. Further, those staff that had reported matters said they had not received any feedback on the incident.

Medical care (including older people's care)

Other incidents that were reported, such as falls, or pressure ulcers were reported and investigated. Staff said feedback on these types of incidents was via email and shared at staff handovers, the latter we observed happening. We also viewed a folder with incident investigation reports contained therein. We saw information on an incident related to sepsis and the training arising from this, providing evidence that changes had been made as a result of feedback.

Staff reported serious incidents clearly and in line with trust policy. There was a process for investigating and responding to serious incidents, including action plans to prevent similar occurrences.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations and contributed to the terms of reference and raised questions they wished to have a response to.

Incidents were discussed within governance meetings and data was presented to attendees. This included learning and where matters had been responded to as duty of candour- being open and honest with patients and their families.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and procedures were accessible on the trust intranet, copies of which we were able to view on-line.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

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. The service adjusted for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Supplementary nutritional drinks were provided and where required, thickening agents to drinks or food, where a person was at risk of choking.

There was a strong emphasis on making sure patients had additional drinks in the hot temperature experienced at the time of the inspection.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. These records formed part of the ongoing monitoring of patient well-being. Information related to nutritional status was handed over at shift changes and in the patient board rounds.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Signage was placed above patients' beds to indicate where the staff needed to be alerted to special needs, such as the need to add thickening agent to fluids.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Records of their recommendations were clearly stated in the patient electronic record.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The NEWS2 record was used to assess and monitor pain levels.

We heard nursing staff ask patients if they had pain during the medicines round. Patients told us they received pain relief soon after requesting it, and most said their pain was managed well. One patient had experienced variable pain levels and reported that at times this made it difficult to mobilise. There was access to the pain team, and we heard discussion about involving them in assessing a patient.

Staff prescribed, administered and recorded pain relief accurately; however, they did not always consider the best times to use pain relief as part of meetings the individual needs of a patient. For example, pain relief was not always given prior to mobilising or having the opportunity to have an assisted shower or toileting.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There was a full induction programme for new staff. We observed a new member of staff being mentored by the practice development nurse and they were able to describe the programme of induction they were following.

There was a variance in the response from staff regarding development opportunities. Some staff were unable to tell us what development opportunities they could pursue while others were able to provide examples of the support they had been given. For example, a health care assistant was being supported to apply for a nursing associate position, whilst another registered nurse said it was difficult to apply for courses.

One senior nurse said they had not received the appropriate management training since they had started their position a year ago. An occupational therapist told us training had been put on the back burner since the pandemic, although they did have the opportunity to discuss this in their appraisal. Self-directed training had been taken up by this individual, and they would like to do more but staffing levels impacted on the time to do so.

The practice development nurse (PDN) worked between two of the wards at Orpington and others at Princess Royals University Hospital. They explained that there was a high risk of patient falls due to the age and health status of patients on Elizabeth and Churchill Wards. They provided the teaching related to falls avoidance to staff.

The PDN told us staff received training in dementia care, mental capacity and deprivation of liberty safeguards.

Medical care (including older people's care)

A staff member highlighted concerns around lack of training. When this member of staff first started, they said there was good induction period and supervision, but now this was no longer being done. They said there was a lack of training and new starters did not have the adequate necessary training to be able to carry out their roles.

The clinical educators supported the learning and development needs of staff. The PDN was responsible for ensuring all new starters had support and access to relevant training and key skills. They were taught about equipment, medical gases, blood glucose monitoring and the electric patient records, amongst other topics. Student nurses had mentors to support them during their placement. In place of mentorship were practice assessors or supervisors.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed good involvement with the multidisciplinary team (MDT) during the patient board meeting on Churchill Ward, and a constant presence of the MDT on the medical wards. This enabled appropriate interventions to be identified and enacted for patient needs.

Each patient needs were discussed holistically and there was a good understanding of each patient from all staff. The patients care pathway was reviewed by relevant consultants.

We attended the nursing handover in Elizabeth Ward. Although information was detailed, the meeting was disrupted several times and people were having conversations nearby due to the meeting taking place at the nursing station and the ward being busy.

Staff worked across health care disciplines and with other agencies when required to care for patients. Arrangements were put in place to meet current and ongoing care needs. Patients had their care pathway reviewed by relevant consultants as part of the routine review and within the patient board round.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Staff said they were able to get support from doctors and other disciplines and departments when required

Is the service caring?

Inadequate

Compassionate care

Staff did not always respect patient's dignity or consider their individual needs.

Medical care (including older people's care)

We heard and saw most staff acting in a caring and compassionate manner towards patients, speaking in a kind and considered manner. The personal choices and preferences of patients, however, were not always fully considered and were at times, based around convenience to staff. As a result, we were not assured patients dignity was being respected.

Patients were provided with continence aids as staff could not always respond quickly to requests for the use of the toilet or commode. Staff and patients told us delays in responding to call bells had resulted in patients having to pass urine or defecate on pads, which distressed them considerably. Complaints information provided to us did not identify any similar matters having been raised by patients or their families to the trust, although concerns had been raised with the Care Quality Commission.

Patients who wished to use a commode or toilet in preference to a bed pan were not always supported to do so. A patient described how they were sitting in the bedside chair and wanted to use the toilet, the staff put them back to bed to use a bed pan, rather than assist them to transfer onto the commode or be wheeled on a commode to the toilet.

Staff were not always responsive to patients who used their call bell. In Elizabeth Ward we had to ask staff if they could answer a call bell as it had been ringing for over four minutes. There was no urgency or awareness from staff that the call bell was ringing.

One patient told us staff got irritable at times and they “didn’t want to get into trouble.” This was a similar comment made by another patient on a separate ward.

A patient told us care was generally good, they told us they had been upset by an incident where a staff member was rude. The matter was handled well, with the student nurse raising with the ward manager, who explained the matter would be dealt with.

A patient who had been on one of the wards for a week told us they were receiving good care, although they would have liked to be better informed of treatment plan. They told us the “majority of staff are nice and are doing their best, but it is busy.”

Another patient told us they had seen a member of staff shouting at a patient during the morning of our inspection, and how they found this very disrespectful.

Relatives commented favourably on the care given to their loved ones. We were told, “staff are very nice and doing the best they can – very caring.”

Other comments included: staff were generally caring and “I am kept informed of care because my carer comes in regularly to update,” “care is as expected with the resources available,” and “I have a good rapport with staff – they are friendly and engaging.”

A patient on Elizabeth Ward told us the atmosphere was better than the ward they had been on at PRUH. Staff were said to be nicer, call bells were answered, and staff were doing their best, but it was busy.

Whilst we heard and observed most staff behave in a discreet and responsive way when attending to patients, we did see some variation in the level of verbal engagement. For example, some staff who were providing one to one care were kind considerate and interacted well with patients. We observed some staff who were allocated to bays, did not always interact well with patients, just standing and not talking to patients for long periods of time.

Medical care (including older people's care)

Staff followed policy to keep patient care and treatment confidential. Privacy curtains were used around each bed space and side room doors were closed during patient care activities or private conversations.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff responded to questions and were seen to support patients when they raised points. Additional help was offered when patients brought a question to staff's attention.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed a patient who was distressed being cared by a staff member. They protected their privacy by drawing the curtain and spoke to patient in a calm and reassuring manner.

Chaplaincy staff attended the ward and were accessible when needed.

Understanding and involvement of patients and those close to them

There was variation across the three wards about the level of support to patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff on Elizabeth and Churchill Wards did not always ensure patients and those close to them understood their care and treatment. Some patients did not always know what was happening about going home and were not informed about their care. One patient told us they did not feel informed of their care until they asked a member of staff. A member of staff had told them that patients were not usually informed of their care plan unless they specifically ask for it.

One patient told us they would like to be informed of timetable of when the physio team was expected to arrive so they could prepare. They said they would like to be better informed of their care and treatment plan.

Other patients felt better informed, with one patient telling us they were kept informed of care because their carer came in regularly to update. Another told us they were well-informed of their care, and they had a timetable for their physio sessions.

The relative of a patient who had been transferred from the PRUH to Churchill Ward, told us they were not informed of the transfer or told why. They added, there was poor communication around this and "I don't feel well-informed or involved in care and treatment."

On Elizabeth Ward, one relative told us the staff were caring and kind, however, that communication was not always the best and they were not always provided with up-to-date information. They also noted that there was a lack of staff at the weekends.

A 'give feedback on care' form was received a few days after the inspection visit and this indicated that the family of a patient on Elizabeth Ward were dissatisfied with the level of information provided and attitude of a member of the nursing staff they had spoken with on the telephone.

Medical care (including older people's care)

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. We saw physiotherapist and occupational therapists working with patients in an inclusive manner. One drew out a map of how to manoeuvre into toilet and these staff were encouraged patient autonomy, with information about next steps and instructions throughout their treatment.

We saw there were meetings arranged with family members and patient participation.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There was information available to give feedback via a QR code. The patient advice and liaison team were accessible, with various contact methods.

Staff supported patients to make advanced decisions about their care. Several patients had 'do not attempt resuscitation' orders in place and we saw the associated documents used to record such decisions.

Staff supported patients to make informed decisions about their care, and advocacy services were used as required. We heard discussion about the arrangements for this for one patient, with a view to arranging their discharge.

Is the service responsive?

Insufficient evidence to rate

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Arrangements related to patient admission and discharge were overseen by ward leaders and other coordination staff. There was a focus on optimising patients health status to enable them to be discharged either home or to a suitable ongoing care facility.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Bays were separated by gender and there was cohorting in place, where a member of staff needed to be constantly present for patient safety.

The facilities and premises were appropriate for the services being delivered, with suitable bed areas, side rooms, toilets, and bathing areas. Ceiling hoists were identified as being available on one ward. There was access to day rooms and lifts between floors. Within the day room on Churchill we saw a good range of games and activities available for patient use. An activities coordinator arranged activities across the wards, such as movement to music and newspaper groups.

The service had systems to help care for patients in need of additional support or specialist intervention. Patients living with dementia had their individual needs assessed and considered when planning and delivering treatment and care. This is me booklets were completed and used for individuals with dementia needs.

Where additional safety measures were required such as low beds, bed rails and closer observation, these requirements were acted upon.

Therapist, social workers, and other allied health professionals were involved in the delivery of care and planning for discharge home.

Meeting people's individual needs

The service did not always consider patients' individual needs and preferences. Staff did, however, make reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Wards were designed to meet the needs of patients living with dementia. A range of historical pictures were placed on walls and there was access to resources in the day room.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The patient flow board was used to identify individuals with specific needs, such as the use of the butterfly or at higher risk of falls.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Translation services, if needed were booked via King's Language Line and could be booked 24 hours in advance.

One patient told us "I like being outdoors and getting fresh air", and that one of the HCA took her outside the hospital in a wheelchair, which they appreciated.

A patient who had been in hospital a few weeks said the care "has been okay", but they felt like some things were sometimes overlooked. For example, they had not yet been helped with getting dressed, which would usually have already taken place. Care was said to depend on the member of staff. Call bells were answered, but sometimes patients had to wait longer than expected (5-10 minutes sometimes maybe longer).

Another patient told us they had not had their hair washed since coming into hospital five-weeks previously. The patients care plan did not contain details of their preferences or choices related to bathing or hair washing. Care plans in general were not personalised with specific details to demonstrate consideration of patients' preferences or wishes.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff use an iPad and computer system (Saffron) which detailed patient's dietary requirements. Staff told us they were able to cater to patient's individual and cultural needs regarding preference around meal choice.

Patients did not always find the quality of food to be as they would like. One patient said the food was "poor" adding, that their family often had to bring in food. This patient stated they did not get assisted with eating, despite having difficulties in using their hands.

Medical care (including older people's care)

We observed breakfast and lunch time meal services and saw some patients required extra help, as identified by a red tray. Most staff did not sit next to the patient to assist with feeding and stood over them or to the side of the bed, sometimes with bed sides remaining up. We asked a member of staff if they preferred to sit next to the patient and they stated chairs were too low to allow feeding patient comfortably.

A patient complained of the quality of pureed food, indicating it “all tasted the same” and they wanted something different. The staff member explained this was not possible.

A nurse was seen taking the time to mash up whole foods into smaller pieces for patient to allow her to enjoy the food , as they did not like the mandatory special diet of pureed foods. . Another patient was heard asking the nurse if they could choose something different to eat and they were supported to do so.

Is the service well-led?

Inspected but not rated

Culture

Not all staff felt respected, supported and valued. Whilst they were focused on the needs of patients receiving care, it was not possible to always provide the standards to the level they wished to do so.

The values of the Trust were: Kind, respectful and team. Staff told us they did not feel valued, and morale was low. Most staff said they felt the hospital was not considered as an equal to the other two locations. Staff said they were continually asked to work at another location often at short notice and this affected their wellbeing.

Elizabeth Ward had opened at very short notice during the pandemic and because of this, it was felt by staff that there had not been the right resources or planning. Some staff said the morale was particularly low from Band 6 staff downwards.

The service promoted equality and diversity in daily work and provided opportunities for career development and promotion.

The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff said there was an open culture where they could raise concerns, the issue was they did not feel they were being listened to or actions were not taken to make improvements. They were not reporting all issues or concerns through Datix because of this. Staff shortages were the biggest concern amongst staff and the workload and pressures meant staff were tired, which had an impact on their wellbeing.

Patients told us they could speak to a staff member if they had a concern, similarly relatives felt able to speak to staff.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Medical care (including older people's care)

There were several governance meetings where information related to the service and more widely was discussed. Performance information, incidents, complaints amongst other subject matters were reported on and discussed. Meeting minutes showed that there was good attendance.

Information was shared at handover meetings with staff and areas of focus were covered in these meetings too. For example, focus on reducing falls, pressure ulcers and infection prevention and control measures.

Management of risk, issues and performance

Leaders used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff did not always recognise and report some risks.

There was a lack of awareness around risks and identifying issues of concern at less senior graded staff. The director of quality governance told us they had spent time trying to identify risks and ensure the patient pathway worked. Local risks were said to be covered as part of Princess Royal University Hospital and south sites. Red risks could be raised at meetings, and these would then be escalated upwards through the governance arrangements.

A senior member of nursing staff on Elizabeth Ward was not able to tell us what the local risk were or if there was a medical specialty risk register. It was not clear if risks had been identified and what, if any, measures were being taken to mitigate risks.

Nursing staff were aware of patient risks and told us the processes they could use to escalate risks, especially if a patient deteriorated.

Occupational therapists (OT) were aware of the main risks, and stated staffing was one of these. Although the two wards had a full complement of OT, they said there was a 20% vacancy rate in the wider OT team. They told us recruitment processes were lengthy, which coupled with the different pay enhancement for the location, didn't make it as attractive to the central London hospitals.

Areas for improvement

- The trust should ensure that medicines are managed in accordance with safe and professional practice standards. **Regulations 12(1), (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**
- The trust should ensure that staff provide care and treatment in ways which have regard and respect for the individual needs of patients, and in a manner, which is not degrading. **Regulations 13 (1) (2) (4) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**
- The trust should ensure there are enough staff on duty to enable the delivery of patient care needs in a responsive manner. **Regulations 13 (1) (2) (4) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

Our inspection team

Our inspection team consisted of an inspection manager, an inspector and assistant inspector. We had a specialist advisor with medical care expertise. The inspection was overseen by Nicola Wise, head of hospital inspection.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment