# St George's Healthcare NHS Trust

# St Georges

## Quality Report

Blackshaw Road
Tooting
London
SW17 0QT
Tel: 020 8672 1255
www.stgeorges.nhs.uk

Date of publication: 24/04/2014
Date of inspection visit: 10-13 and 22 February 2014

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

## Ratings

| | |
|---|---|
| **Overall rating for this hospital** | **Good** |
| Accident and emergency | **Good** |
| Medical care | **Good** |
| Surgery | **Good** |
| Intensive/critical care | **Outstanding** |
| Maternity and family planning | **Good** |
| Services for children & young people | **Good** |
| End of life care | **Requires improvement** |
| Outpatients | **Good** |

# Summary of findings

## Contents

# Summary of findings

## Overall summary

St George's Healthcare NHS Trust a large hospital and community health service provider. With nearly 8,000 staff and around 1,000 beds on the St George's site, the trust serves a population of 1.3 million across South West London. A significant proportion of services are offered to the populations from Surrey and Sussex, totalling about 3.5 million people. St George's Hospital, Tooting site, is situated in the London Borough of Wandsworth. It is one of the country's principal teaching hospitals and is shared with St George's, University of London, which trains medical students and carries out advanced medical research. The hospital also hosts the St George's, University of London and Kingston University Faculty of Health, Social Care and Education, which is responsible for training a wide range of healthcare professionals from across the region.

St George's Hospital, Tooting, offers district general hospital services and specialist care for the most complex of injuries and illnesses, including trauma, neurology, cardiac care, renal transplantation, cancer care and stroke.

St George's Hospital has been inspected on five occasions since registration in April 2010. It was not fully compliant for all the outcomes inspected on two out of five occasions. The last inspection took place in October 2013 and the hospital was found to be non-compliant in respect of Outcome 9, management of medicines, Outcome 13 (R22) staffing and Outcome 21 (R20) records. During this inspection we reviewed the actions the trust had taken to address these issues and found that they had been rectified, apart from the staffing levels on Trevor Howell Day Unit. We found that staffing levels on this ward were maintained using bank (overtime) and agency staffing, but that this did not impact on the care experienced by patients.

Key findings from this inspection include:

### Staffing

This trust, like many others, experiences difficulty in recruiting enough nurses to cope with the increasing demands on the service and the complexity of patients admitted to the ward areas. We held a number of staff focus groups where staff stated that they had actively chosen to work at St George's hospital as they enjoyed the culture of the organisation and felt that they were able to deliver a good service to their patients. However, we noted on some wards and areas that there were significant issues with shortages of staff which impacted on patients and the care they received.

### Cleanliness and infection control

Overall, the hospital was found to be clean and good infection prevention and control systems were in place. We noted that there were some issues of cleanliness within the mortuary and the day assessment unit. However, most ward areas and departments were clean and clutter-free. The chief nurse and director of operations was the lead for infection prevention and control and this ensured that this issue had board-level commitment.

### End of life care

End of life care occurred throughout the hospital and more frequently on the oncology wards. There was a palliative care team who worked well for patients who are recognised as being at the end of their life. However, this is not replicated throughout the hospital where patients who have a terminal illness are cared for but may have medium to longer-term life expectancy. End of life care in the maternity department was exceptional.

# Summary of findings

## The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

### Are services safe?

**Requires improvement**

St George's Hospital provided safe care for many of its patients. The hospital has had two Never Events (mistakes so serious they should never happen) at this site and action has been taken to investigate and address the issues raised. We saw good systems in place to disseminate the lessons learnt from incidents through open safety meetings for all staff and tools (such as newsletters) to cascade information to teams.

There were mechanisms in place to identify and record serious incidents and there were no concerns about mortality rates. Staff knew how to escalate safeguarding concerns and most patients felt safe at the hospital. There were good measures in place for medicines management, infection control and pressure ulcer management. Most wards and departments were adequately staffed with permanent or temporary staff. Where there were staff shortages, recruitment to vacancies was in progress. We found that the critical care unit was outstanding in ensuring that its patients were safe at all times.

However while the hospital had begun to take action on pressure sore prevention and urinary tract infections improvement to ensure that patients were safe from these conditions was required. In a number of wards and departments we found that staff were not sufficiently aware of the Mental Capacity Act 2005 which was impacting on the care delivered to patients. Staff should be aware of this Act in order that patients who may lack capacity to make decisions were provided with the correct support and decisions making processes to ensure that their care was appropriate to meet their needs.

### Are services effective?

**Good**

The majority of care delivered was in line with national guidelines and best practice where this was available. The functioning of the hyper acute stroke unit on William Drummond Ward was particularly effective. Multidisciplinary team working was embedded into the culture of the organisation. Sufficient equipment, in good working order, was available to deliver care effectively.

### Are services caring?

**Good**

People were cared for in a kind and respectful manner. In the majority of cases, staff respected the privacy and dignity of patients and their family or carers. Where privacy had been compromised, such as in some outpatient clinics and wards, the trust had been asked to address these issues by CQC. People and their families were involved in their care and allowed to make informed decisions. The care of women in maternity services was considered to be outstanding.

### Are services responsive to people's needs?

**Good**

People had their individual medical, psychological, social and cultural needs assessed and met by staff. Services were largely accessible in a timely manner

# Summary of findings

and the equality and diversity of people was respected. Mechanisms were in place for people to give comments and make complaints. The arrangements in place for discharging patients from hospital were considered to be very good. However, more needs to be done so that staff understand the requirements of the Mental Capacity Act 2005 and its Code of Practice.

## Are services well-led?

Good

The trust has values which some staff were aware of and others displayed in their ways of working. The chief executive and some senior leaders were visible to staff and visited wards and departments regularly. Some services were very well-led, for example, the critical care services. However, the children and young people's, outpatient and end of life care services were not well-led. Within these services we found examples of bullying and harassment which the trust have been alerted to and have committed to take action to address.

# Summary of findings

## What we found about each of the main services in the hospital

### Accident and emergency

Good

The A&E department was providing a high quality of care and treatment within a well-managed environment. Care and treatment was provided according to evidence-based guidelines and the service took regard of the advice from appropriate national bodies.

Patients were positive about the quality of treatment that they had received. Staff interacted and treated people in a kind and respectful manner. However, there were aspects of the physical environment of the department that risked compromising the caring manner in which treatment was otherwise provided.

Patients were involved in making decisions about their care and treatment, which they said had been explained to them. The A&E department was well-led and able to respond to the wide range of needs of patients.

### Medical care (including older people's care)

Good

Patients on medical wards received care that was safe, effective, caring, responsive and well-led. There were enough nursing staff on most wards to deliver care safely. Infection control, pressure ulcer prevention and medicines management were largely good.

Discharge coordinators were based full-time on medical wards and liaised with colleagues to enable an effective discharge process. Most patients stated that staff treated them with respect and maintained their privacy and dignity.

The functioning of the hyper acute stroke unit on William Drummond Ward was considered to be good with areas of excellence. However, while the Butterfly Scheme for alerting staff to patients with dementia was in operation, dementia screening was not always clearly recorded or identifiable by staff.

### Surgery

Good

Surgical services provided safe and effective care in most areas we visited. Surgical patients told us staff were caring and they felt their needs had been met. National Institute for Health and Care Excellence (NICE) guidance was in place and internal audits indicated that there was a high level of compliance with the use of the World Health Organisation (WHO) safety checklist in most of the theatres. However, action is required in the cardiac theatre.

There was limited space in the recovery area of the operating theatres in the St James Wing. This, combined with high bed occupancy on wards, sometimes led to delays or cancellations of surgery. While this was not a good experience for the patient, it was responsive to safety concerns.

Caroline Ward, a mixed cardiology and cardiothoracic surgical ward had a number of issues which impacted on the safe, effective and well-led areas of our inspection. However, the trust was aware of the issues and was taking steps to address this.

# Summary of findings

## Intensive/critical care

Outstanding 

Patients received safe, effective and responsive critical care services in line with national guidelines. National data showed that the safety of patients in the critical care areas was outstanding and while the hospital did not have an outreach team staff ensured that patients were assessed and treated in line with their clinical need. Recent independent reports demonstrate that the critical care unit was above the national average in a significant number of areas showing positive impacts on patients care.

There were enough specialist staff to ensure 24-hour care. Patients and relatives felt that the care was of a high standard and they had been involved in decisions about treatment.

The teams were very well-led and there were systems in place to monitor the quality and safety of patient care, which was of a high standard. Staff were focused on governance arrangements for the unit and learning from audits was embedded into practice. The educational team were active and a culture of listening, learning and action was evident throughout the unit.

## Maternity and family planning

Good

The maternity service provided safe, effective, responsive and well-led services to women. The care delivered was considered to be outstanding.

Women spoke positively about the care they received and the staff who delivered it. Staff were appropriately qualified and had the necessary skills and training. There were enough staff on the wards to deliver care safely and there were no vacant posts. Infection control and medicines management were good.

There were specialist midwives for breastfeeding, risk management, safeguarding (including domestic violence), substance misuse and teenage pregnancies. A specialist clinic for women with diabetes was also available.

## Services for children & young people

Good

Children and young people were cared for by nursing staff that were predominantly trained as children's nurses. There were playrooms with toys and activities for children and young people of all ages. All areas were clean and there was a school on site for patients. Children, young people and their parents said that they were "happy" with the care and treatment provided.

Although there were some concerns about staffing levels the trust had plans in place to recruit extra staff with a view to covering those staff on long term sick leave. Appraisals were in place on most wards and staff stated that they benefitted from these. We were concerned that the service was not well-led. One senior nurse told us that they had reported their concerns regarding staffing levels using whistleblowing procedures but had been "reprimanded" for doing this. Two other staff members told us that they were concerned that some senior nursing staff were "not listened to" by senior management in the trust.

# Summary of findings

## End of life care

**Requires improvement**

End of life care was delivered by the frontline staff across the hospital. There was also a specialist palliative care team available that coordinated and led on end of life care. The care offered by the mortuary and bereavement services was considered to be excellent.

People had their treatment plans explained and relatives had been included in the care planning process. Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form was not always completed fully.recent audits in August 2013 showed that further work was required by the trust however the small sample we reviewed were still not fully completed. There were good interactions between staff and patients and families had experienced good end of life care.

Whilst the palliative care team provided support to staff and at a trust level there was a clear understanding of the service this was not understood by staff. When questioned staff could not always identify patients who may have more than a few days to live as being at the end of their life and may benefit from access to the palliative care service. Implementation of end of life care objectives and action plans were patchy or non-existent.

## Outpatients

**Good**

Some patients found staff to be friendly, professional and caring and were mostly happy with the services provided by the trust. Others were negative about the waiting times for appointments, and many patients were frustrated that they were not given information about how long they would have to wait once they were in the clinic.

There was a reliance on temporary records as medical records were often unavailable. Patients' paper records were not always kept securely and confidentiality was often breached. Although the trust was putting arrangements in place to obtain feedback from patients, staff told us that limited information was available about patient experiences. Staff knew that there was a regular problem with overbooking of clinics, but did not seem to understand why or how this could be better managed.

Local leadership was visible but despite this the outpatients department was not well-led. Communication was not always effective at all levels and staff were not clear on management structures and the responsibilities of other team members. Staff complained of bullying and some felt unable to raise concerns. The service needs to be better-led in order to bring about improvements.

# Summary of findings

## What people who use the hospital say

We reviewed many areas where people who used the hospital were able to have their say and we spoke with people at our listening event and focus groups. This information told us that, overall, the hospital was responsive to the concerns of people using the service.

The trust can be seen to be performing lower than the England average score on both the inpatient and A&E NHS Friends and Family Test. This is a government initiative to test whether people would recommend the service to their friends and family. The response rate in A&E was lower than the national average, while the inpatients response was higher. There were four wards identified by patients as "extremely unlikely" to be recommended to family and friends These include: Caesar Hawkins (medical short stay), Cheselden (vascular), Gray Ward and Richmond (acute medicine). People at the focus groups and listening events also mentioned some of these wards in negative feedback. However at our inspection patients did not confirm these views nor did we see significant areas of concern.

Out of 69 questions, the trust was in the bottom 20% nationally in the Cancer Patient Experience Survey. The areas which rated low were mainly around poor communication, lack of privacy, not being treated with respect and dignity, not having confidence in staff, patients not feeling listened to and staff not telling them all the relevant information..

The trust has an overall score of four stars out of five stars on the NHS Choices website. Staff were praised for being caring; patients were shown dignity and respect and felt involved in decisions. The hospital received four out of five stars for cleanliness. Negative themes included timeliness of care, attitude of staff, A&E wait times, unhelpful staff and lack of consistency in care. This is reflective of the CQC's adult inpatient survey 2012, where the trust performed about the same as other trusts in all 10 areas of questioning of the survey (A&E, waiting lists and planned admissions, waiting for a bed, hospital and wards, doctors, nurses, care and treatment, operations and procedures, leaving hospital, overall views and experiences).

## Areas for improvement

### Action the hospital MUST take to improve

- Ensure that all staff understand the requirements of Mental Capacity Act 2005 and how this relates to vulnerable adults in terms of best interest decisions and informed consent.
- Ensure that medical records are available within the out patents department.

### Action the hospital SHOULD take to improve

- Action is taken to address issues of bullying and harassment and support staff in raising concerns.
- Alleviate staff concerns about permanent staffing levels on the children and young people's wards.
- Ensure clarity around the end of life care pathway.
- Ensure risk registers reflect the risks in each department and ensure appropriate action is taken to address recommendations from national guidance.
- Ensure appropriate cascade of information regarding staffing and lessons learnt from incidents in all areas of the hospital.
- Ensure that staff are aware of the strategic direction for end of life care.
- Clarify the management structures and the responsibilities of other team members to staff in the outpatient services.
- Address issues of privacy, dignity and confidentiality raised within this report.
- Avoid the unnecessary overbooking of outpatient clinics.
- Ensure all staff receive appraisals and supervision and that this is documented, particularly those in children's services.
- Review the combining of cardiology and cardiothoracic patients on Caroline Ward.
- Ensure that there are adequate numbers of porters to cover the A&E department, particularly at peak times (Friday and Saturday nights).

# Summary of findings

- Prevent the breaching of single-sex bays.
- Ensure that patients are always transferred to the most appropriate ward.
- Ensure that all staff always adhere to fire safety regulations.
- Review the recording system for pain relief of patients in the children's emergency department so that it includes a space for staff to detail hourly checks.
- Review communication systems in the event of admission and discharge with community health providers.
- Ensure that patients admitted to the Clinical Decision Unit are appropriate and in line with current protocol
- Ensure dementia screening is clearly recorded and relevant patients can be identified by staff.

## Good practice

Areas of good practice noted through the inspection include:

- The provision of a sympathetic environment within the mortuary suite.
- Outstanding maternity care, underpinned by information provided to women and partners and robust midwifery staffing levels with excellent access to specialist midwives.
- The responsive and caring environment of the Neonatal Special Care Baby Unit
- Timeliness of specialists to review patients awaiting a critical care assessment.
- Outstanding leadership of intensive care unit and high dependency unit services with open and effective team working and a priority given to dissemination of information, research and training.
- Multi-professional team working in neurology theatres.

# St Georges

## Detailed findings

**Services we looked at:**
Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; End of life care; Outpatients

## Our inspection team

**Our inspection team was led by:**

**Chair:** Gillian Hooper, Director of Quality & Commissioning (Medical & Dental), Health Education England

**Head of Hospital Inspections:** Fiona Allinson, Care Quality Commission (CQC)

The team included CQC inspectors and analysts, doctors, nurses, patient 'experts by experience' and senior NHS managers.

## Background to St Georges

St George's Hospital, Tooting, is situated in the London Borough of Wandsworth. It is one of the country's principal teaching hospitals and is shared with St George's, University of London, which trains medical students and carries out advanced medical research. The hospital also hosts the St George's, University of London and Kingston University Faculty of Health, Social Care and Education, which is responsible for training a wide range of healthcare professionals from across the region.

St George's Hospital, offers district general hospital services and specialist care for the most complex of injuries and illnesses, including trauma, neurology, cardiac care, renal transplantation, cancer care and stroke. A large number of these services cover significant populations from Surrey and Sussex, totalling about 3.5 million people.

The hospital has been inspected on five occasions since registration in April 2010. It was not fully compliant for all the outcomes inspected on two out of these five occasions. The previous inspection took place in August 2013 and the hospital was found to be non-compliant in respect of medicines management (minor impact), staffing (minor impact) and records (minor impact).

## Why we carried out this inspection

We inspected St George's Hospital, Tooting, as part of our in-depth hospital inspection programme. We chose this hospital because it was considered to be a low risk service.

## How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

# Detailed findings

- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young People
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we hold about the hospital and asked other organisations to share what they knew about the hospital. We carried out an announced visit between 10 and 13 February 2014. During the visit we held focus groups with a range of staff in the hospital, including nurses, doctors, physiotherapists, occupational therapists, porters, domestic staff and pharmacists. We talked with patients and staff from various areas of the hospital, including the wards, theatre, outpatient departments and the A&E department. We observed how patients were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held three listening events where patients and members of the public shared their views and experiences of the hospital. An unannounced visit was carried out on 22 February 2014.

Good

# Accident and emergency

| | |
|---|---|
| Safe | Good |
| Effective | |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

## Information about the service

The A&E department at St George's Hospital, Tooting is one of four major trauma centres within London providing specialist emergency care and treatment. It has both adult and paediatric A&E units with dedicated triage, assessment, treatment and resuscitation areas. There is a clinical decision unit where patients who need planned investigation and treatment for between 24 and 48 hours can be seen. There is also a medical assessment unit within the hospital (Richmond Ward) where A&E patients could be seen by acute or medical physicians before being transferred to wards or discharged from the hospital.

The A&E department operated 24 hours per day and was open 365 days a year. In 2013 the department saw around 120,000 patients, of which 22% were children. There is 24-hour consultant and nursing cover seven days per week, with access to medical specialities and other health and social care professionals.

We spoke to about 30 patients, their relatives and staff from various disciplines. We reviewed information from comment cards available throughout the hospital and in the A&E reception. We received comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed the performance information about the trust.

## Summary of findings

The A&E department was providing a high quality of care and treatment within a well-managed environment. Care and treatment was provided according to evidence-based guidelines and the service took regard of the advice from appropriate national bodies.

Patients were positive about the quality of treatment that they had received. Staff interacted and treated people in a kind and respectful manner. However, there were aspects of the physical environment of the department that risked compromising the caring manner in which treatment was otherwise provided.

Patients were involved in making decisions about their care and treatment which they said had been explained to them. The A&E department was well-led and able to respond to the wide range of patients' needs.

Good

# Accident and emergency

## Are accident and emergency services safe?

Good

### Safety and performance

The A&E department reported 9 serious incidents between December 2012 and November 2013. This was less than 4% of the total number of incidents reported at the trust. Most incidents reported within the A&E department were rated as 'moderate harm' and related to implementation of care and ongoing monitoring and review. This information did not reveal any serious concerns within the A&E department. We spoke with senior staff in the department who were aware of this information and said it was brought up at a monthly divisional meeting, where any subsequent follow-up actions would normally be discussed.

### Learning and improvement

There was a system in place for the learning from any accidents, incidents or relevant events. These were reported to senior staff using a computer software system which allowed them to be reviewed. Senior staff confirmed that, following review of reported incidents, any learning points or issues were discussed at the regular training discussions which staff attended several times a week. Junior staff confirmed that they would get feedback from any accidents or incidents and received appropriate training and updates following the review. We looked at records of recent incidents and noted that the review process had begun and appropriate interim actions were taken.

### Systems, processes and practices

When patients first arrived at the department they were prioritised using the Manchester triage system to assess their needs. Patients were then referred to the relevant part of the department to ensure that the correct staff, equipment and facilities would be available to meet their needs.

### Equipment

There were appropriate facilities and equipment available for the care and treatment of patients. Where appropriate, regular checks were made on equipment to ensure that they were in good working order and sterilised. Staff received specific training in how to use the equipment and facilities and we observed them doing so proficiently. Both the adult and paediatric resuscitation areas had appropriate facilities and staff to treat patients with urgent or immediate needs. Emergency drugs and equipment were available throughout the A&E department and there were daily checks on these to ensure that they were in date and in good working order. Staff received regular update training in what to do in the event of a medical emergency.

### Infection control

There were appropriate systems and procedures in place to protect people from the risk of infection. Throughout the inspection the department was mainly clean and tidy. People we spoke with praised the level of cleanliness. Patients who had been to the hospital before confirmed it had been in a clean condition on their previous visit. There was an infection control policy and procedure in place which staff received training and regular refresher training in. The department was cleaned on a regular basis and patient contact surfaces were cleaned between patient consultations. There were appropriate facilities for the disposal of clinical waste, including sharp items. Personal protective equipment such as gloves and aprons were available throughout the wards and we observed these being used. Hand-washing facilities and alcohol gel were also available.

There were ongoing audits of infection control standards within the department on items such as the decontamination of equipment and hand washing. Progress was charted over time and senior staff provided reminders or training to junior staff as appropriate. It was noted that department performance on hand washing was relatively low at times. During the inspection, we observed clinical staff in the triage areas did not always clean their hands in between seeing patients.

### Monitoring safety and responding to risk

Staff used an early warning score system to monitor patients' conditions to ensure they did not deteriorate. Checks on patient records showed that these scores had been completed correctly. Other risk assessments and screening tools, such as for falls or a 'recognition of stroke' tool were used as appropriate. There was a specific system in place for the assessment and monitoring of pain in paediatric patients.

On the first day of the inspection, we noted that some patients had not had a risk assessment for pressure ulcer prevention where it would have been appropriate to do so. It was also noted that pressure ulcer care had been

highlighted as a risk for the trust as a whole. Completion of the risk assessments improved on the subsequent days of our inspection and were included in all of the records we later reviewed.

The A&E department reported their risks to the overarching medicines division and these were included on the divisional risk register. Risks on the most recent register included a missed scanning of previous A&E patient card, delays in receiving x-rays and the lack of piped oxygen within paediatric A&E. Senior staff we spoke with were aware of these risks and were able to describe the appropriate actions taken to mitigate them.

However, the risk register did not include all of the risks faced by the department. Staff were able to describe other risks to us; while these were being appropriately managed, the fact that they were not included on the register meant that they would not be appropriately mitigated and accounted for across the department as a whole.

Staff were made aware of the principles of the Mental Capacity Act 2005 as part of mandatory refresher training. We spoke with staff who were aware of the circumstances when someone may have reduced mental capacity and how this would affect the decisions they made. They were able to describe the appropriate actions they would take in these circumstances. Staff were also aware of mental health issues and the circumstances in which it may be appropriate for someone to be detained under the Mental Health Act 1983. We observed staff helping and supporting people with diminished capacity. In all circumstances, they treated people with kindness and patience and involved appropriate professionals and family members.

Staff had been trained in safeguarding both vulnerable adults and children. They knew how to recognise the signs of possible abuse and knew the appropriate actions to take (including involving the local authority). Staff were able to provide examples of how they had responded appropriately to safeguarding concerns in the past. Paediatric staff were trained up to level 3 in safeguarding children.

### Anticipation and planning

At the time of our inspection, the department was operating under their 'winter plan' with raised staffing levels throughout the department. This was devised to help ease the pressure created by increased attendance at A&E over the winter months. The increased staffing levels appeared suitable to the volume and needs of patients who attended the department. Staff reported that this would be further reviewed in March 2014 as part of their ongoing workforce planning.

The A&E department was one of four major trauma centres within London. Staff received training in what to do in a major event and were able to describe how they would be alerted and respond to such an event in the department. This training included trial major event scenarios where the effectiveness of the procedures were reviewed.

## Are accident and emergency services effective?

(for example, treatment is effective)

### Using evidence-based guidance

The trust used accepted evidence-based guidance when providing care and treatment to patients. They used the Manchester triage system to assess patients when they first arrived at the department and had adapted it so that patients would be referred to different areas of the department based on their assessment results. We observed this being used appropriately to prioritise patients. The NHS Emergency Care Intensive Support Team (an external, national body which conducts analyses of the quality of care within NHS emergency departments) had completed two reviews of the department in 2013, looking at the management of the A&E department and the length of stay across the hospital. Several of the recommendations of these reports had already been adopted by the department in order to improve the quality of patient care and the overall patient flow through the hospital.

### Performance, monitoring and improvement of outcomes

The department used numerous performance indicators to monitor the quality of the service it was providing. This included the monitoring of the length of time that people waited before they were treated and admitted, transferred or discharged. There was a target for this to be undertaken within four hours of people's arrival in the department and it was noted that the department usually met this target. On the few occasions where the department had been in breach of this target, senior staff were able to describe the specific actions they had taken in order to reduce people's waiting time to within the target.

Good

# Accident and emergency

The A&E department also monitored other factors such as mortality indicators and the number of emergency re-admissions of patients following a previous emergency admission. However, recent data did not disclose any evidence of risk within the department. Staff took part in a broad range of national clinical audits through which they monitored the clinical outcomes for people with specific conditions such as strokes and severe trauma.

It was noted that the trust had designated the room in the A&E major injuries (Majors) section which was normally used for mental health assessments as a psychiatric decision unit. People with mental health needs who had not been treated and admitted, transferred or discharged within four hours of arrival were admitted to this unit.

### Staff, equipment and facilities

Staffing was appropriate to meet the needs of the department and the patients in attendance at the time of our visit. Senior staff were able to describe the process of how they had decided on these levels, based on previous attendance figures and future projections. Treatment and care were delivered by suitably qualified and competent staff who were supported in their role and professional development. We looked at copies of previous rotas as well as annual performance statistics which confirmed that the establishment levels and the skills mix for the department were maintained over time. Staff within the paediatric A&E department had all received specialist training in paediatric care and treatment. However, the document for recording pain relief of patients in the children's A&E did not include space for staff to detail hourly checks. This was not in line with current guidance, and while staff on the unit were aware of this, the recording system had not been changed

### Multidisciplinary working and support

A range of suitable professionals were available to offer advice and support staff in the department. They were used on a regular basis and in a timely fashion. As part of the winter plan, the department had a full-time registered mental health nurse who was able to undertake immediate assessments and provide care for people who attended. Staff told us that in reach mental health services were supplied by an external provider that was usually able to attend with an hour or two. However, staff did report that, when there was more than one patient with mental health needs to be assessed at a time; this caused delays in people being seen and treated in a timely way. This was because it usually took mental health staff at least three hours to assess each person.

X-ray and computerised tomography (CT) scanning facilities were available in close proximity to the department, as were the surgical theatres. A range of other professionals, such as physiotherapists and occupational therapists, were available to help in the assessment or discharge planning of patients. Some patients were admitted to the medical assessment unit (Richmond Ward) when a bed was not ready on specialist wards, but their care would still be overseen by specialist staff from those wards. A member of the community nursing team also attended the department on a daily basis to evaluate whether there were any patients on the units who could be appropriately cared for and treated in the community.

## Are accident and emergency services caring?

Good

### Compassion, dignity and empathy

Throughout the inspection, we saw numerous examples of care and treatment being carried out. In all of the observed interactions, staff treated people in a kind and respectful manner. Comments from people we spoke with included that everyone was "kind and helpful", "pleasant and attentive" and their treatment had been "brilliant all round". There were chairs available in all bays, including fold-out chairs in the paediatrics unit, so that friends and family could stay with people during their time in the department.

Patients were offered food and drink, when appropriate, most of the time. We did find some isolated cases in the A&E Majors unit where some patients had been not offered any food or drink for extended periods of time. Patients said that they were happy with the food they had been provided with. We observed appropriate use of curtains around patients' beds when care and treatment were being provided, and staff were aware of the need to maintain patients' confidentiality.

There were aspects of the physical environment of the department that risked compromising the caring manner in

which treatment was otherwise provided. Ambulatory patients were asked to queue at the triage area before they were seen, but on several occasions, we saw the queue extending so that the automatic doors remained constantly open, making the waiting area very cold.

Patients who were brought in by ambulance were initially triaged in the corridor which was used by members of the public, resulting in conversations being overheard by others. Senior staff reported that they had changed the system two weeks prior to the inspection so that patients spent less time in the corridor but noted that this had not been sustained.

### Involvement in care and decision making

We observed staff providing people with choices about treatment options and support available. Patients told us that they were able to ask questions of staff who they felt were approachable.

### Trust and communication

Patients told us that their treatment and support had been explained to them in a way that they could understand. There were information leaflets available that staff could print off which helped explain medical conditions and treatments.

### Emotional support

Nursing staff reported that they took on many of the duties of supporting or consoling upset patients and family members themselves. The trust had a bereavement service whose staff visited the department each week day to see if they could offer support to anyone.

## Are accident and emergency services responsive to people's needs?

(for example, to feedback?)

Good

### Meeting people's needs

As a trauma centre for London, the A&E department provided specialist services for major trauma victims, services for patients with heart problems and strokes, as well as a full range of adult and paediatric emergency services. When people attended the department, following triage, they were sent to the correct unit of the department according to their specialist needs and the urgency or seriousness of their condition.

Following an assessment from the NHS Emergency Care Intensive Support Team (an external body) the department was increasing the use of their rapid assessment and treatment function which included a specific provision for patients to be seen by a senior clinician to assess and implement a care plan more quickly.

While there were written criteria for admission to the clinical decision unit, it was noted that these were not being universally applied by all clinicians. Some patients were being admitted to the unit to avoid breaching the four-hour waiting time target, despite not meeting the admission criteria. This posed a risk that some patients may not be cared for in the most appropriate environment or that beds would not be available for future patients who did meet the criteria.

The main waiting area in the department was described by people as "cold" and the seating "uncomfortable". As the seating was quite low to the ground, it would pose difficulties for people with lower limb problems.

There were some posters displayed in the A&E department telling people how they could make a complaint, comment or contact the Patient Advice and Liaison Service, but when we asked for a copy of this leaflet from the reception desk, none were immediately available. There were no leaflets in the department on the services available in the hospital or about common health conditions.

The paediatric waiting area was comfortable, suitably decorated for children and toys and other entertainment and distraction materials were available. However, the paediatric assessment area was cold and staff confirmed that this was frequently the case.

### Vulnerable patients and capacity

Translators could be accessed if people needed them. However, copies of the information leaflets were available in English with those in different languages having to be requested. In addition, there was no governance framework in place to review the information in these leaflets, which meant that there was a risk that some of the information may be out of date.

Good

# Accident and emergency

### Access to services

The A&E department was open 24 hours a day, seven days a week, 365 days a year. It maintained consultant and nursing cover on site at all times. The department was accessible by both car and public transport. There was a nearby space in which air ambulances could land.

### Leaving hospital

Discharge arrangements were largely handled appropriately. Before patients were discharged from hospital, appropriate arrangements were made for any ongoing care or support they needed in the community. Patients received assessments from other appropriate professionals, such as community nurses or physiotherapists, to determine what their needs were.

The department also used a short-term assessment, reablement and rehabilitation service. This service provided support and ongoing long-term assessment services for two to six weeks following a patient's discharge from the department. The service supported people to regain their independence, prevented inappropriate readmission to hospital and responded quickly to crises in a person's home.

### Learning from experiences, concerns and complaints

There was a complaints policy and procedure in place. Posters were displayed in communal areas detailing how people could provide feedback or make a complaint. People we spoke with said that they were aware of the Patient Advice and Liaison Service (who could assist them in making any representations).They said that they were confident they could raise any concerns without their care and treatment being affected as a result. Records of complaints were reviewed and staff were able to describe the actions they had taken in response. The department also asked people to indicate whether they would recommend the department to family and friends, and senior staff monitored these results.

In order to ensure focus on improving NHS Friends and Family Test completion rates, other forms of direct patient feedback in A&E were suspended in the department. This meant that the department did not receive any other information about other aspects of the service provided as some wards did.

## Are accident and emergency services well-led?

Good

### Vision, strategy and risks

While not all staff members could verbalise what the trust values were (excellent, kind, responsible, respectful), we observed staff interacting with patients according to these values and generally displaying them in the way they worked. All staff appeared committed to providing a high quality of clinical care. Staff were aware of the risks and pressures within the department at given times. Senior staff had processes in place for considering the future demands on the department and were planning their service provision accordingly.

### Governance arrangements

Appropriate governance arrangements were in place within the department. Information was collected on both the safety of the service and the quality of care and treatment provided. Although this was through national initiatives rather than local monitoring. Plans were put in place to mitigate risks and improve quality. These were discussed at regular scheduled meetings with the appropriate senior staff. The outcomes of these meetings and any actions plans were fed back to other staff members at regular team briefings.

### Leadership and culture

There was an open culture within the department and morale was good. Junior and senior staff worked well together. Staff were clear about their roles and responsibilities towards patients, their colleagues and the department itself. Junior staff told us that they felt well supported by their managers.

However, it was noted that several action plans had been put in place but had not had long-lasting effects. These included plans to tackle the occasional low levels of hand washing by staff in the department, isolated comments from people about the poor attitude of staff and a new process for triaging patients so that they spent less time in the corridor outside the department. In all cases, while the action plans were initially implemented, they did not appear to make a lasting difference and staff tended to revert to previous ways of working after a period of time.

Good

# Accident and emergency

### Patient experiences, staff involvement and engagement

Patients' feedback on the service was acted on by senior staff. Staff we spoke with were motivated to provide a high quality of patient-centred care to people using the service and this was reflected at all levels. There were open channels of communication between staff at all levels and we were provided with examples of how leaders had used these channels to make positive changes.

### Learning, improvement, innovation and sustainability

There were processes in place for learning from accidents or incidents that took place in the A&E department as well as from its general performance. Appropriate actions plans were put in place to drive improvement. There was a process for senior staff within the department to be kept aware of the latest developments within their field and for relevant changes to be implemented. All staff underwent mandatory training to ensure that they were kept up to date in relevant core subjects.

Good

# Medical care (including older people's care)

| | |
|---|---|
| Safe | Requires improvement |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

## Information about the service

Medical services at St George's Hospital, Tooting include a wide range of inpatient wards such as general medicine, older people, stroke, coronary care, gastro-intestinal and an acute medicine unit (AMU).

We visited nine wards/units and carried out both announced and unannounced visits. The wards/units we visited were Richmond (AMU), coronary care unit, Amyand (general medicine), Caesar Hawkins (medical short stay), William Drummond (hyper acute strike unit), Brodie (neurosurgery), Dalby (senior health), Allingham (gastro-intestinal) and Wolfson and Thomas Young (neurorehabilitation).

We spoke with more than 30 patients and relatives and more than 20 staff, including doctors, nurses, healthcare assistants, pharmacists, physiotherapists, occupational therapists, house-keepers and domestics. We received comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed the performance information about the trust.

## Summary of findings

Patients on medical wards received care that was safe, effective, caring, responsive and well-led. There were enough nursing staff on most wards to deliver care safely. Infection control, pressure ulcer prevention and medicines management were largely good.

Discharge coordinators were based full-time on medical wards and liaised with colleagues to enable effective working processes. Most patients stated that staff treated them with respect and maintained their privacy and dignity.

The functioning of the hyper acute stroke unit on William Drummond Ward was considered to be good, with areas of excellence. However, while the Butterfly Scheme was in operation to highlight patients with dementia, dementia screening was not always clearly recorded or identifiable by staff.

Good

# Medical care (including older people's care)

## Are medical care services safe?

Requires improvement

### Safety and performance

An analysis of the trust's reports revealed that it was reporting patient safety incidents appropriately and in line with other trusts in England. It is mandatory for NHS trusts to report all patient safety incidents. Staff used an electronic incident reporting system to report serious incidents and were able to describe the process. The medical unit reported 17% of the total number of incidents reported by the trust to the National Reporting Learning Service. While this is not a significant number, the unit was the highest reporter of safeguarding incidents and deaths within the hospital.

The trust reported a number of conditions to the national database. These include the number of patient with pressure sores, venous thromboembolisms (VTE or blood clots), urinary infections and falls. The trust is currently reporting higher numbers that the national average in the areas of pressure sores and urinary infections. However, we found that arrangements were in place for the prevention and management of pressure ulcers. Patients were assessed by nursing staff on admission for risk using the pressure ulcer prevention tool. Patients assessed to be at risk were nursed on pressure-relieving mattresses, repositioned regularly or encouraged to do so themselves, and had a prescribed cream applied to their affected pressure areas. There was a policy for pressure ulcer prevention and management which included the aim of ensuring that no preventable pressure ulcers occurred.

However, on some wards, staff used incontinence pads and incontinence sheets with patients being nursed on pressure-relieving mattresses. The use of both these items has been shown to limit the effectiveness of pressure-relieving mattresses and therefore increased the risk of pressure ulcers developing. The tissue viability team was aware of this issue and were in the process of updating the policy to advise staff against using these items.

Medical staff assessed most patients within 24 hours of admission for the risk of developing VTE. They recorded patients' risk on their charts and prescribed treatment where appropriate. VTE status was discussed on ward rounds with the outcomes for patients recorded appropriately by medical staff.

Patients told us that they felt safe on the wards we visited. One patient said, "If I had any concerns about my care, I would report it to the nurse in charge".

### Learning and improvement

Matrons and ward managers had received training in root cause analysis to help identify the causes of any problems. They investigated serious incidents and identified areas for improvement. Senior ward staff used handover sessions, meetings, team days and emails to communicate and share learning on serious incidents.

It was noted that there were 15 patient falls on Richmond AMU, a 58 bedded unit, in January 2014. During the unannounced part of our inspection, it was revealed by staff that this number of falls may have been related to unsuitable slippers given to patients by the hospital. The type of slippers have been changed and the trust is monitoring to see whether there is a corresponding reduction in the number of falls on Richmond AMU.

During our inspection, we attended a patient safety forum which highlighted when a smart infusion pump was used incorrectly and a patient had received an incorrect dose of medication. This incident was investigated and lessons were currently being disseminated to other areas in the trust. The trust had previously introduced smart infusion pumps to administer a set dosage of intravenous (IV) medicines in order to reduce the risk of administration errors. The trust's medicines management policy states that all IV medicines to be administered within five minutes must be administered with a smart infusion pump via the drug library (the list of drugs and preset doses) on the pump.

### Systems, processes and practices

### Environment

The hospital environment largely facilitated the effective delivery of care. However, there was not enough space between beds in the bays on William Drummond Ward (hyper acute stroke unit) and Brodie Ward (neurosurgery) to safely deliver care. On Brodie Ward, there were six beds in each of the three bays and most patients required hoists to transfer them to and from their beds. We observed that

manoeuvring hoists in these cramped conditions could potentially lead to injuries to patients and staff. We were told, however, that this ward was due to move to other premises on the hospital site within the next few months.

In addition, we observed and staff told us that the environment on Wolfson and Thomas Young was not conducive to the rehabilitation of patients because it was an antiquated ward environment that was not purpose-built. Senior staff told us that the ward was scheduled to be moved to purpose-built premises on the Queen Mary's Hospital site in September 2014.

There was enough medical equipment to safely deliver care, including gloves, aprons, hoists, blood pressure machines, and so on.

### Infection control

Standards of cleanliness and hygiene were maintained across the medical wards in order to protect people from the risk of acquiring healthcare-associated infections. The chief nurse and director of operations was also the trust's director of infection prevention and control. This ensured that there was someone with the executive authority and responsibility for ensuring that strategies were implemented to prevent avoidable infections at all levels in the organisation. There were arrangements in place for nursing patients in isolation to reduce the spread of infection should they acquire infectious illnesses such as MRSA.

The wards were visibly clean. Alcohol hand sanitizers were available outside the wards, bays, side rooms and at the bottom of patient beds. Information on infection control was displayed at strategic points both within and outside the wards and departments. Personal and protective equipment such as gloves, and aprons were available to staff in sufficient quantities.

There were cleaning schedules which domestic staff followed. We observed domestic staff cleaning the wards and adhering to the principles of infection control, such as cleaning side rooms which had been used to treat patients in isolation. There were arrangements for deep cleaning, carried out on ward areas and side rooms where patients had been treated for an infectious illness.

### Medicines management

Safe and effective arrangements were in place for the prescribing, ordering, administration and recording of medicines. Some wards had ward-based pharmacists, who were involved in the multidisciplinary ward rounds. Medical and nursing staff told us that pharmacists provided valuable clinical input. There was an extensive stock list of medicines held on the wards. Most of the medicines prescribed were dispensed on the ward, to avoid delays in starting treatment. This included discharge medicines. There were suitable arrangements in place to ensure that there were no delays in patients receiving their medicines, including the pharmacy staying open at weekends and a resident pharmacist being available 24 hours a day.

Medicines were all securely stored and there was controlled access to all areas where they were kept. Medicines requiring cold storage were kept in separate medicine fridges and their temperatures were monitored by staff. Records showed that fridges were maintained within the safe temperature ranges for storing medicines. Emergency medicines were kept on the wards. We saw evidence that these were checked regularly and replaced promptly if any were used. There was evidence of routine checking of controlled drugs.

At our previous inspection in August 2013, we noted that the temperature of medicine storage areas were not being monitored consistently and that some medicine storage areas were above the safe range. The trust had taken prompt action to resolve this. Pharmacy technicians had visited all areas, provided training in temperature monitoring procedures and an air conditioning unit had been installed in the medicine storage area of one ward. This had been effective in resolving the issues noted at the inspection.

Although the trust was reporting a higher number of medicine incidents compared with other trusts, this was due to the culture of encouraging reporting to aid quality improvements. Medication incidents were monitored and classified. We were provided with information which showed that no patient had suffered severe harm due to medicine incidents in the first three quarters of 2013/14. Medicine incidents were escalated and investigated promptly. A number of medicine incidents on the trust's reporting system revealed that appropriate action had been undertaken to reduce the risk of incidents recurring.

Nursing staff reported that they have had to complete medication competencies. Medication records were

completed in full. Two patients on Richmond AMU reported that staff asked them about their allergies and always checked their details and medication before administering medicine.

Critical aspects of medicines management, such as dispensing times, errors, medicine incidents, assessment of VTE risks, medicines storage and controlled drugs, were audited regularly. These audits showed that the trust was performing well. Inpatient and outpatient dispensing times were monitored. The trust provided evidence which showed that the majority of inpatient medicines were dispensed within 60 minutes, while outpatient medicines were dispensed within 40 minutes. Dispensing errors were monitored closely and these audits showed that the number of errors was low. Another audit by the trust showed that in the last quarter (2013), 93% of patients had their medicines reconciled within 24 hours, exceeding the target set by the National Patient Safety Agency of 70%.

The trust carried out an extensive audit in 2013 on the safe and secure handling of medicines which showed that intravenous fluids were stored appropriately in 89.6% of clinical areas. The findings of the audit were presented to the trust's patient safety committee meeting in May 2013, together with an action plan to address the risks; we saw that further improvements had been made following this.

### Monitoring safety and responding to risk

There was monitoring and auditing of safety incidents such as infection control, medicines management and pressure ulcers. We saw a snapshot audit of pressure ulcer prevention (September 2013). This covered several areas other than the medical wards, but we found that the pressure ulcer prevention documentation had become embedded into the admission procedure carried out by nurses when patients arrived on the wards. This audit also found that, while 92% of patients with or at risk of a pressure ulcer had a pressure-relieving mattress, only 20% had a repositioning chart completed. The audit reminded staff that the use of pressure-relieving mattresses did not replace the need to reposition patients.

All wards we visited displayed safety and risk information on a board in the corridors that was visible to patients and visitors. Information displayed included number of infections, falls, pressure ulcers and unplanned absences by staff on a monthly basis.

There were adequate staffing arrangements to enable safe practice across the medical wards. Matrons and senior ward staff were involved in the recruitment of ward staff to ensure that permanent and temporary staff were appropriately qualified and competent at the right level to carry out their roles. Staffing levels, skills mix and nurse to patient ratios were mostly good on the areas we visited. Most wards had a qualified nurse to patient ratio of 1:6 during the day and 1:8 at night.

Rotas confirmed that most wards were adequately staffed and the majority of staff expressed satisfaction with the current staffing levels and skills mix. The exception was staff on Wolfson and Thomas Young who stated that insufficient staff in the weekday mornings meant that patients were often late for therapy sessions. This was because most patients had to wait for staff to assist them with getting out of bed, washing and dressing.

Where staff vacancies existed, permanent staff did bank (overtime) shifts or temporary bank workers filled in for staffing shortfalls. There was also a trust rapid response team which was used to fill staffing gaps at short notice. Temporary agency staff were also used, but only as a last resort. Staff told us that they were supported by their managers to book additional staff if required, for example, to nurse a patient on a one-to-one basis, based on clinical need. Vacancies were being recruited to and the overall staffing numbers on the medical wards had increased over the past few months.

We noted during the unannounced visit at night that there were not enough porters in A&E to take patients to and from the x-ray department. Doctors and radiographers sometimes had to carry out portering functions, particularly at peak times (Friday and Saturday nights).

There was a varied understanding of the Mental Capacity Act 2005 and its deprivation of liberty safeguards. Staff received training on the Act as part of the safeguarding vulnerable adults training. Some staff knew what the requirements of the Act were, while others were unclear. We saw evidence that people were presumed to have the capacity to make specific decisions – that is, where they wanted to live, in accordance with the Act. All requests for capacity assessments were referred to medical staff to be completed, which is not a requirement of the Act. Capacity assessments completed by medical staff were documented in patients' notes.

Good

# Medical care (including older people's care)

One area of confusion around the requirements of the Act was when to make referrals for best interest decisions and the involvement of an Independent Mental Capacity Advocate. One doctor told us that they thought that referrals for best interest decisions were only required when people had a learning disability.

There was a policy on safeguarding vulnerable adults in place that staff knew how to access. Most staff had attended or completed online training on safeguarding vulnerable adults, which covered how to recognise and report safeguarding incidents.

There were two learning disability nurses in post who covered the hospital and were contactable between 8.30am and 6pm. They assessed people with learning disabilities and gave advice to staff on their management. Applications to deprive people of the liberty were made in accordance with legislation. There were an average of four to five applications per year to the relevant authority and we were told that the last two were refused. The lead nurse for adult safeguarding completed deprivation of liberty screening and gave advice to staff on the least-restrictive practices preferable.

### Anticipation and planning

Patient records were accurately maintained and used effectively to improve the safety and quality of patient care and treatment. Multidisciplinary records were used effectively. Records were mostly completed in full and were dated, timed and signed by the relevant staff. There was a clear audit programme in place to ensure that care was safe.

## Are medical care services effective?

(for example, treatment is effective)

Good

### Using evidence-based guidance

The coronary care unit followed National Institute for Health and Care Excellence (NICE) and other national guidelines in caring for patients with cardiac problems. Rotablation was available to patients with blocked coronary arteries. This is a treatment where a catheter is inserted into a narrowed artery to pulverize hardened plaque within it. In addition, over 500 angioplasties were carried out per year in order to treat narrowed coronary arteries found in heart disease. This is in line with national guidance.

Examples of the daily use of NICE guidance included the availability of a smoking cessation nurse and nurse practitioners in cardiology to assess patients for acute cardiac syndrome.

The functioning of the hyper acute stroke unit on William Drummond Ward was considered to be good. The ward followed most of the Royal College of Physicians best practice guidance for caring for patients who had suffered a stroke. For example, patients were offered a minimum of 45 minutes of occupational and or physiotherapy for a minimum of five days per week. Staff morale was high on the ward and they told us that it was "an excellent place to work". The ward staff had up-to-date knowledge about the speciality and were well-led by the ward manager. However, only 60–65% of patients who had suffered a stroke were admitted to the unit for assessment and treatment within four hours. This was mostly related to delayed repatriation of patients to their local hospitals.

Rehabilitation patients on Wolfson and Thomas Young Ward were transferred to another ward if they needed treatment for any acute medical care, including intravenous antibiotics for one or two days. This disrupted the care of the rehabilitation patients and was not evidenced-based.

The trust was found to be performing within expectations or better for all of the indicators from the 2011/12 Myocardial Ischemia National Audit Project. With the question around the proportion of eligible patients with an initial diagnosis of nSTEMI who receive primary angiography within 150 minutes of calling for professional help being better than expected. Mortality data showed that this hospital had no outliers.

### Performance, monitoring and improvement of outcomes

There were arrangements for monitoring compliments and complaints through the nursing scorecard for all wards and departments. This information was published each month.

Some cardiology patients were cared for as outliers on Caroline Ward, which was predominantly a cardiothoracic surgical ward. Doctors told us that the decision to place cardiology patients on this ward was based on discussions

between clinical teams and the bed manager. For example, a patient's medical condition should be stable before they were transferred from the coronary care unit to Caroline Ward. While cardiology patients were reviewed daily by the registrar, we were told that they received a "less good service" by being on a predominantly surgical ward.

### Staff, equipment and facilities

There was a cascade system of supervision and appraisal (individual performance review). Senior staff supervised and appraised more junior staff. Supervision tended to happen on an ad hoc basis and was rarely recorded. One band 6 nurse told us, "I would supervise staff while delivering care together". Staff told us that their performance review occurred on an annual basis and was documented. Staff lists were displayed in one ward office with the proposed dates of their supervision and performance review meetings. Staff knew who and when they were meeting for their end of year review. On some wards, there were regular away days for team building, effective communication and training events.

There were processes for performance and professional management of staff. Practice nurse educators were based on some wards to support staff training, preceptorship practical experience and training and mentoring of newly qualified as well as more senior staff. Mandatory training for all clinical staff included safeguarding vulnerable adults, infection control, pressure ulcer prevention and manual handling. Medical supervision of trainees was good. Most staff of all disciplines told us that they felt well supported by their managers and that there were adequate training opportunities. Support plans were developed for nursing staff if there were practice issues identified as part of an investigation, such as administering drugs.

### Multidisciplinary working and support

We saw good examples of multidisciplinary team working. Ward rounds occurred twice daily on some wards to ensure that the entire team were updated about changes to patients' care plans. Multidisciplinary team meetings involved consultants, junior doctors, nurses and the therapy team. Multidisciplinary patient records were adequately maintained.

The social therapy and rehabilitation team was available on most wards and comprised occupational therapists, physiotherapists and local social workers. In conjunction with discharge coordinators and other members of the multidisciplinary team, the team was involved in facilitating the safe and effective discharge of patients. There was good communication and engagement between all members of the multidisciplinary team.

## Are medical care services caring?

Good

### Compassion, dignity and empathy

Most patients stated that staff treated them with respect and maintained their privacy and dignity. Interaction between staff and patients, relatives and other staff was professional and respectful on most occasions. Patients' comments included: "excellent care", "very kind", and "staff always introduce themselves and explained what they are going to do".

Patients knew what their care plan was and felt that they had been able to "have their say" in their treatment. In one record, it was documented that a female patient did not wish to receive personal care from male nurses. This request was facilitated by the ward staff in order to respect that person's choice and maintain their dignity. However, at one of the listening events prior to the inspection, Asian women had highlighted the concern about not being given the choice in the gender of the staff who carried out their personal care. Muslim women, in particular, had stated that it was important that they received personal care from female nurses. They stated that they often felt too vulnerable to assert their preference in this respect. Generally however, we found that there was clear evidence that, if patients wanted their personal care delivered by a staff member of the same sex, this was facilitated by staff. The fact that the majority of nursing and healthcare assistant staff were female meant that it was not usually a problem to accommodate female patients' requests in this regard.

Staff maintained patients' privacy during personal care some of the time. Curtains were drawn around beds during personal care activities and some curtains had 'do not enter' signs sewn into them as a visual reminder to staff. Staff respected closed curtains and asked permission if they needed to enter. However, on several wards, we observed gaps in curtain panels when they were drawn, resulting in patients' privacy being compromised.

Good

# Medical care (including older people's care)

Patients commented that several wards, including Richmond AMU and Allingham Ward, were very noisy during the night time. They felt this was related to staff talking and the general activity of patients being admitted. We noted during the unannounced visit at night that the tone of some staff voices and activities, such as wheeling a trolley, could disturb patients' sleep.

Call bells were noticed to be placed within reach of patients and staff responded in a timely manner most of the time. The exception was on Allingham Ward, where more than one patient reported having to wait several minutes before staff responded to their call bells. We observed staff treating patients with compassion and respect on most of the wards. However, on Allingham Ward, we observed that one patient was ignored by a member of staff when they were calling out for assistance. This was an isolated event.

Staff were aware of the religious and cultural needs of patients. All areas had single-sex bays in accordance with NHS policy. However, on Amyand Ward, this was breached on one occasion this month (February 2014) and on three occasions last month. All wards, apart from Wolfson and Thomas Young, had side rooms with en suite facilities. Guidance was available to inform staff of the specific requirements following the death of a person and staff gave examples related to the Buddhist, Jewish and Muslim faith requirements. Staff used private rooms to have more personal conversations with people when necessary.

### Involvement in care and decision making

The trust actively engaged with patients and their relatives and encouraged them to give their feedback on the safety of services. Many patients and their relatives participated in the NHS family and friends test and results were closely monitored. Good results were received from the hyper acute stroke unit, Richmond AMU and Amyand Ward. The majority of patients were either 'likely' or 'extremely likely' to recommend the medical wards to their family and friends. Matrons monitored lower test results and patient comments in order to track the reasons for them. We saw cards, emails and tweets which were very complimentary about patient experiences of care on Richmond AMU. Matrons used feedback results to highlight good practice to staff but also to identify areas for improvement.

Staff involved patients in discussions about their care. One patient told us that the consultant had provided the ward's contact details to their daughter. Another told us the consultant had met with their family to discuss ongoing care needs and discharge arrangements.

### Trust and communication

Nurses were described as "excellent" on Amyand Ward by one patient. On the neurorehabilitation ward (Wolfson and Thomas Young); each patient had their own weekly diary of activities that informed them of their rehabilitation programme. We observed nursing and other staff speaking to patients with respect. Most wards had noticeboards with the names and pictures of the ward-based staff members. Patients were allocated a named nurse during their stay on most of the wards. The patient's named nurse and the name of their consultant was written a board by their bedside.

### Emotional support

Most patients we spoke with told us that they were satisfied with the care and treatment that they received at the hospital. Comments included: "it is an excellent hospital; the best for certain types of illnesses". One patient told us that they were treated "kindly" by the nursing staff. Psychologists were available to offer support to rehabilitation patients with cognitive impairment.

## Are medical care services responsive to people's needs?

(for example, to feedback?)

Good

### Meeting people's needs

A doctor told us that the readmission rate on Richmond AMU was approximately 4%. The trust had implemented a weekly 'frequent attenders clinic' for people with chronic conditions who presented at A&E regularly.

Patients were medically assessed on admission, diagnostic tests were carried out as appropriate and treatment prescribed where necessary. Nursing staff used standard risk assessment tools to identify patient needs. Patients were assessed for the risk of falls, pressure ulcers and malnutrition. Staff carried out 'intentional rounding' (or

around-the-clock care) every two to four hours on most patients. This included documenting the patient's condition, for example, whether they were continent, in pain or discomfort, and their fluid intake.

Staff ensured that the nutritional and hydration needs of patients were met and that these supported positive outcomes of care. Nutritional status was assessed on admission. Dieticians were involved when appropriate and volunteers assisted with serving meals on some wards. A 'red tray' system was in place to indicate which patients required assistance with feeding. Hot drinks were taken around to patients at regular times and water was freely available.

Menus were available and were either left with patients to make their choices or the housekeeper asked them for their choices. Menus were only available in English and patients who do not speak English could not always choose their meals due to the language barrier. Also, menus were available on a two-week rotation. This meant that there was limited choice for longer-term patients. One patient told us that they found the food "very palatable" but "boring" after a while.

Staff had access to interpreters through the Patient Advice and Liaison Service.

### Vulnerable patients and capacity

There was some awareness of dementia care and treatment. Staff told us that dementia screening was carried out when appropriate, but it was not always clear from patient records that this had been the case. On one ward during the unannounced visit, staff were not clear whether or not one patient had been diagnosed with dementia.

There was a lead consultant and clinical nurse specialist in dementia available. Dementia awareness was part of the mandatory training programme for clinical ward staff and the Butterfly Scheme was in operation on the wards we visited. This scheme aims to improve patient safety and wellbeing by teaching staff to offer a positive and appropriate response to people with memory impairment. A discreet butterfly symbol next to patients' names alerted staff to patients who needed assistance.

### Access to services

There were capacity issues in cardiology for patients requiring specialist care. Although there were five cardiology wards, patient flows were challenged by medical patients in cardiology beds as well as delayed repatriation of patients back to their local district general hospitals. Contributing to these challenges of capacity and patient flows was the fact that the hospital was a tertiary referral centre for cardiology and carried out a high number of angioplasties each year to treat the stenotic (narrowed) coronary arteries of the heart found in heart disease. The trust held escalation meetings three times a day to look at occupancy issues, predicated discharges, A&E activity, elective admissions, and so on. These meetings were attended by representatives of all divisions in the hospital.

### Leaving hospital

There was evidence of proactive discharge planning, referral to other organisations, transitional arrangements and appropriate support networks. The discharge process was carried out in a holistic and multidisciplinary fashion. Discharge coordinators were based full-time on medical wards and liaised with colleagues both within and outside the organisation as part of the discharge planning process. This role added value to the discharge process by reducing the number of delayed discharges and preventing hospital re-admissions. There was a vacancy for a discharge coordinator of Richmond AMU. This post had not been filled for a few months, despite being advertised. This meant that discharge from this ward was not as coordinated as it could be and impacted on the staff providing care on Richmond AMU.

Discharge coordinators worked with social services in local boroughs to facilitate safe discharges. The safeguarding lead told us about implementing lessons learnt from failed discharges and that the challenge was repatriation of patients to non-local boroughs. Patient records were reviewed and most had a proposed date of discharge and identified the initial thoughts about the support required. Staff had established links across community services (formal and informal networks). The London Boroughs of Wandsworth and Merton had hospital-based social workers who contributed to the discharge process.

There was evidence of family involvement in discharge planning and patients confirmed this. Staff told us that discharge planning "starts on admission" and patient records showed evidence of discussions about discharge planning with patients and their families. Discharges were

all discussed in the multidisciplinary ward rounds. The social therapy and rehabilitation team was involved in discharge planning, transport was booked online and discharge medicines were prescribed by medical staff.

An electronic patient discharge system was in use. Patients were supplied with a copy of their discharge summary, which listed all of their discharge medicines and whether any had been changed since their admission. We saw from prescription charts that patients were counselled about their medicines before they were discharged and that they were given a contact number for the medicines information pharmacist should they have queries about their medicines once they left the hospital. A facility to blister-pack medicines was also available onsite if people needed their medicines supplied in this way. Out of hours, there were pre-packed medicines available for patients to take home.

### Learning from experiences, concerns and complaints

There was evidence that the provider learnt from people's experiences, concerns and complaints to improve the quality of care. One example of change was when people fed back that the reception desk at the entrance to Richmond AMU was often unmanned. They did not know where to go for assistance as the six ward clerks working on the ward were often away collecting notes. The area now uses a large sign to inform people to walk down the corridor to the nurse's station for assistance if the desk is unmanned.

## Are medical care services well-led?

Good

### Vision, strategy and risks

Most staff we spoke with knew what the trust values were and these were displayed on office noticeboards. There was a strategy for visible nursing leadership, with different grades of nurses wearing different coloured uniforms. Posters on the wards identified uniform colours and roles. Staff understood the risk areas of the department and knew the actions taken to minimise the risk to patients.

### Governance arrangements

There were clear governance and reporting structures from wards to board level. Staff displayed an open, honest approach to complaints and wanted to learn from them. There was evidence that some wards celebrated success and good feedback. Staff were aware of the trust's whistleblowing policy and most told us that they would use it if they had to.

Staff were aware of divisional managers and communication was cascaded up and down the structure. Matrons shared performance data and learning from incidents at handovers, unit meetings and one-to-one meetings.

### Leadership and culture

Staff told us that the senior leadership of the trust were "doing well". Most stated that their immediate line managers were "supportive". Senior managers visited the wards on a regular basis and were proactively involved in rectifying problems. Matrons led on quality issues but other staff members had delegated responsibilities for areas such as infection control and safety thermometer (a tool for measuring and monitoring performance) audits.

Staff we spoke with knew the name of the chief executive and chief nurse and said that there was "better communication" from executive team members in recent times. Some staff told us that senior leaders were "more involved" in the operation of the hospital and visited wards and departments regularly.

At a local level, Richmond AMU and the hyper acute stroke unit were well-led. The lead consultants and senior nursing staff were visible on the clinical areas.

### Patient experiences, staff involvement and engagement

Staff were able to express their views and engage with the values of the trust through the Listening into Action programme, where staff from all departments, levels and roles, come together and talk openly about what matters to them and what changes should be prioritised. Staff we spoke with were aware of the programme but not all had been able to attend a session to date.

### Learning, improvement, innovation and sustainability

Regular teaching and supervision for junior doctors on Richmond AMU took place. 'Hot cases' were discussed on a daily basis and formal teaching took place every Monday. There was evidence of relatively low staff vacancy and sickness rates, a positive indication of the sustainability of recent improvements that had been made.

Good

# Surgery

| | |
|---|---|
| Safe | Requires improvement |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

## Information about the service

St George's Hospital, Tooting provides both general and specialist surgery for adults and children. Specialist surgery provided includes: cardiothoracic, neurosurgery, head, neck and maxillofacial (mouth, teeth and jaws), plastic surgery, renal (kidney) and bariatric (weight loss) surgery. (We did not inspect paediatric and neonatal surgery). In the main hospital there are 25 inpatient theatres and 5 day surgery theatres, of which 13 are operating theatres, including a 24-hour emergency theatre, three cardiac theatres, three neurosurgical theatres and an anaesthetic service for invasive procedures in the cardiac catheter suite.

The day surgery unit is a standalone unit adjacent to the main hospital. There are five theatres and over 9,500 procedures a year take place there.

We visited the pre-operative care centre, the surgical admissions lounge and the theatres for general surgery, cardiothoracic surgery, neurosurgery and for day surgery. We also visited 10 of the associated surgical wards which were Keate (plastic), Gray and Cavell (general), McKissock and Brodie (neuro), Holdsworth high dependency unit, Gunning (trauma and orthopaedics), Benjamin Weir (cardio), Caroline (cardiothoracic), Florence Nightingale (ear, nose and throat) and Vernon (urology).

We spoke with 26 patients and 34 staff, including healthcare assistants, nurses, junior doctors, consultants, senior managers, therapists and porters. We observed care and treatment and looked at care records. We received comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed the performance information about the trust.

## Summary of findings

Surgical services provided safe and effective care in most areas we visited. Surgical patients told us staff were caring and they felt their needs had been met. National Institute for Health and Care Excellence (NICE) guidance was in place, and the safety of patients was maintained through the effective use of the World Health Organization (WHO) surgical safety checklist in most theatres however action is required to address the shortfalls in cardiac theatre.

There was limited space in the recovery area of the operating theatres in the St James Wing. This, combined with high bed occupancy on wards, sometimes led to delays or cancellations of surgery. While this was not a good experience for the patient, it was responsive to safety concerns.

Caroline Ward, a mixed cardiology and cardiothoracic surgical ward, had a number of issues which impacted on the safe, effective and well-led areas of our inspection. However, the trust were aware of the issues and were taking steps to address this.

Good

# Surgery

## Are surgery services safe?

Requires improvement

### Safety and performance

The hospital used a standard early warning score system to trigger escalation of patient care. If patient scores were over four, the frequency of observations was increased and the nurse in charge notified. If necessary, there was appropriate escalation to medical staff during the day, or the advanced nurse practitioner in the first instance at night. We observed the daytime process in action on one ward where a patient was being transferred to the intensive care unit.

There may be some under reporting of incidents. For example, on Gunning Ward, we noted details of an error in a patient's prescription chart. The error on 28 January had been picked up by the pharmacist on the same day and rectified so the patient did not receive an incorrect dose of medicine. The pharmacist had discussed the error with the prescriber at the time; however, it was not reported as an incident on the computer software programme until we raised the issue during our visit on 13 February.

### Learning and improvement

There was a system in place to record serious incidents through computerised logging. Staff reported that they usually had feedback about incidents that occurred and, if necessary, the procedures were changed. We were confident that learning was shared in the areas where incidents had occurred but were not so sure that they were shared more widely across the trust. For example, we found that a Never Event (serious preventable incident) of wrong site surgery in one theatre was not known about by staff in all theatres. The trust had reported two Never Events between December 2012 and November 2013.

### Systems, processes and practices

The WHO surgical safety checklist was used in all theatres and we observed good processes in all areas, except the cardiothoracic surgeries. Audits showed that there was lower compliance from cardiothoracic surgeries with the WHO checklist. Sign in and out completion rates in most theatres were 99-100% but in cardiac theatre this was 89%. One surgeon in the cardiac theatre refused to take part in the WHO checklist.

Not all anaesthetists and surgeons in the cardiothoracic surgeries took part in the pre- and post-list team briefings, which in cardiac theatres was only 14% in the last quarter's audit. Other theatres scored generally in the 90% range.

### Equipment and environment

Facilities were generally good. All theatres had advanced airway equipment, cardiovascular monitoring devices and ultrasound for central and peripheral nerve blocks and venous access. The trust was working to standardise equipment, notably defibrillators. We saw that the trust's risk register for surgery also highlighted old ventilation systems and other plant failure as causing downtime in surgery, and that this risk had been escalated in the light of failures in 2013. While the ventilation system was old it did not pose a safety risk for patients apart from potential cancellation due to breakdown. There were other equipment risks on the risk register, such as insufficient transport ventilators within the hospital. This was a risk to patients' health and should be rectified as soon as possible because of the frequency of patient transfers within St James and Atkinson Morley Wings.

Staff on the wards told us that there was sufficient equipment to safely deliver care. If additional equipment was requested, it usually arrived the following day. If equipment was needed sooner, staff would normally borrow it from a nearby ward.

The day surgery unit was well designed, aside from the lack of facilities for private conversations, which affected a small number of patients.

There were insufficient beds in the general surgery recovery area for the seven theatres that this area served. As an interim measure, three recovery beds were being added to the surgical admissions lounge area. However, in the longer term, major building plans had been approved to increase capacity. The impact on current patients was that some patients, particularly those admitted at the end of the day, might have to be transported unconscious to other theatre blocks for recovery, which presented a safety risk. Other patients might spend the night in a recovery area rather than be moved to a ward due to lack of beds on the ward areas.

Good

# Surgery

## Medicines management

Medicines were being managed safely. We looked at medicines storage and supplies, records relating to patients' medicines and spoke with pharmacy staff, patients and nurses.

There were safe and effective arrangements in place for the prescribing, ordering, administration and recording of medicines in the wards we visited. The prescription chart used by the trust was well-designed and included sections to record patient's allergies, medicine histories, sources of information, venous thromboembolism (VTE or blood clots) status, and bleeding risks. Prescription charts were completed accurately and fully.

The day surgery unit had excellent processes for patient throughput, and offered a service that patients perceived as "personalised".

## Infection control

Patients were protected from the risk of infection because theatres and ward environments were clean. Equipment had cleanliness stickers to identify that they had been cleaned. Personal protective equipment was available to staff in all areas and there were sufficient hand-washing sinks on wards. Hand hygiene audits were regularly carried out and we observed good hand hygiene during our visit. Hand hygiene alcohol gel was available at all ward entrances. There were information leaflets for patients and visitors on infection control.

## Monitoring safety and responding to risk

Resuscitation trolleys in all areas visited had been checked daily and were complete and in date. Records of the checks showed consecutive entries.

The safety thermometer used by trusts compares various data items around infections, falls, embolisms and pressure ulcers form individual trusts against the England national average. This thermometer is used to evaluate how a trust is performing.The trust had higher than average results for new urinary tract infections in patients with catheters. Staff told us that catheter care was being closely monitored. The aim was to remove catheters as soon as possible after surgery.

The trust's proportion of patients with new pressure ulcers was above the England average. Staff on the wards were well aware of procedures to respond to pressure ulcers and we saw 'pressure care bundles' in patients' notes. Staff told us that equipment such as pressure-relieving mattresses were available and easily accessible.

In relation to medication, when patients were identified as being at risk of VTE, appropriate medicines were prescribed. There were no omissions on the prescription charts we looked at. People's allergies were documented, including the type and severity of the reaction. This meant that there were robust arrangements in place to protect people from being given medicines that they were allergic to.

Staff on wards showed an awareness of the Mental Capacity Act 2005. If someone on a ward was confused, there would generally be an extra member of staff to help care for them. Mental capacity assessments completed by medical staff were documented in patients' notes. Medical staff also carried out mini mental state examinations to assess the mental health of vulnerable adults, when symptoms indicated that there might be a concern.

There were systems in place to protect people from the risk of abuse. Safeguarding training was mandatory for all staff. Staff were able to describe the safeguarding process and some were able to provide examples of where they had made a referral to social services.

## Anticipation and planning

There were good safety checks for patients having elective surgery. Most patients admitted for elective surgical procedures had robust assessments by staff in the pre-operative care centre. Where risks were identified, such as a risk of pressure ulcers, there were specific 'care bundles' (additional assessment and monitoring documents) to ensure appropriate management when patients had surgery and in their aftercare.

## Are surgery services effective?

(for example, treatment is effective)

Good

## Using evidence-based guidance

Patients received care in line with national guidelines. The majority of patients felt that their care and treatment had been effective from consultation to successful surgery and

discharge. Patients were mobilised as soon as possible in order to minimise the risk of deep vein thrombosis (DVT). An acute pain team was available and visited wards on a daily basis, in order to manage patients' pain effectively.

The trust was found to be performing worse than expected for two of the 2011/12 National Bowel Cancer Audit Project indicators. The National Bowel Cancer Audit Project aims to improve the quality of care and survival of patients with bowel cancer, and meets the requirements as set out in the NHS cancer plan, NICE guidelines and the report of the Bristol Royal Infirmary inquiry. The audit measures completeness of records for these patients.

The trust was found to be performing within expectations for all but two of the Royal College of Physicians 2010 Audit of Falls & Bone Health in Older People indicators.

### Performance, monitoring and improvement of outcomes

Staff in the day surgery unit told us that they had a high rate of non-attendance and were seeking to improve this by contacting people the day before their surgery. In the event of non-attendance, staff booked patients from other theatres to fill spaces.

We saw monitoring dashboards showing the performance of different theatres which were reported to the trust board, allowing for cross-trust comparisons. The figures for quarter three 2013/14 showed poor VTE prophylaxis and poor response to complaints across the surgical specialities and helped staff identify where improvements were needed. Action plans were in place to address these deficits.

### Staff, equipment and facilities

There were enough appropriately trained staff to provide care safely. The trust monitored staffing levels on wards daily and managers reported staffing levels by 10am each day. If the staffing level was judged to be unsafe, a case would be made for additional members of staff, based on the acuity of patients' needs on that ward that day. This demonstrated that wards were able to adjust their staffing needs for different clinical conditions and we saw an example of this on one ward.

On Caroline Ward, a surgical registrar told us that they were almost entirely ward-based, constantly reviewing the surgical patients. This meant that they were unavailable for other duties. If patients required urgent operations, they would inform the consultant and action would be taken as appropriate. The doctor told us that there was a lot of "pressure"' on doctors and that the ward was in "critical need" of more nurses. The issues had been raised with the ward manager.

Staff in most areas had completed mandatory training. The specialities where completion rates were lower were in plastic surgery, ear, nose and throat, and neurosurgery. In the day surgery unit, we were told that staff had little time for training other than that which was mandatory. Ward nurses and some healthcare assistants reported having good training opportunities.

All wards we visited reported regular staff meetings, and also valued the e-newsletter as a source of information and updates.

### Multidisciplinary working and support

Members of the multidisciplinary team, including physiotherapists and social workers, were involved in reviewing patients when appropriate. Multidisciplinary ward rounds took place daily on wards. Patients told us that they saw their consultants and doctors on ward rounds most days and most felt well-informed about their progress.

Discharge coordinators liaised with members of the multidisciplinary team including physiotherapists, occupational therapists and social workers and ensured that patients could be discharged at any time, as long as the appropriate support packages were in place. Occupational therapists carried out assessments, including exercise bike and stair tests, to ensure that patients were fit enough to be discharged from hospital. Discharge coordinators covered all wards at the hospital.

There were effective working relations between doctors, anaesthetists and nurses in all theatres. We noted reports of low staff morale, and poorer team working in the cardiothoracic theatres and Caroline Ward.

## Are surgery services caring?

Good

### Compassion, dignity and empathy

We observed, and patients told us, that they were treated with kindness and respect by staff. Patients said they were

Good

# Surgery

pleased with the care that they received. One patient told us that staff looked after them well and described the ward environment as "very quiet". Another patient told us that they had an "excellent experience" and had no complaints.

Patients' privacy and dignity were maintained. The curtains were closed around patients' beds when examinations or care were being carried out. We noted that female patients known to be Muslim were asked whether they would accept personal care from male staff, but other female patients were not routinely asked for their preference.

Patients' opinions about the food varied. Some patients said it was "like a hotel"; others complained their choices were not always available. Many told us that they were offered enough food to eat and water to drink. People with special dietary requirements for health, religious or cultural reasons were accommodated.

### Involvement in care and decision making

The hospital used the NHS Friends and Family Test to obtain feedback from patients and displayed the results on their noticeboards. Where results had been less positive than expected, the wards developed action plans to improve the patient experience where possible. Results from the test indicated that noise at night was a problem on some wards, particularly where the nursing stations were very close to patient beds. We saw that quiet closing bins had been put in place in some areas. This reduced the noise at night in these areas.

Patients in theatre were treated with dignity and staff checked that patients had fully understood their planned procedure. This ensured that patients gave informed consent. Where patients' surgery had to be cancelled, they were given a full explanation.

Patients told us they were able to ask questions at every stage of their treatment.

### Trust and communication

Nursing staff told us that patients sometimes felt that they did not have enough knowledge about what was happening next. Patients waiting for discharge did not always understand the reasons for delays. In addition, patients waiting for surgery did not always understand why they were not treated in order of arrival. We saw staff reassuring patients who were concerned about delays and whether they would have their surgery as planned.

One patient commented that doctors did not always communicate effectively with nurses. His prescription from the doctor for sleeping tablets had not been noticed by nurses. On Caroline Ward, there was no evidence that patients were allocated a named nurse to coordinate their care while they were in hospital.

### Emotional support

Patients told us that nursing staff were supportive. One patient mentioned that nursing staff had reorganised appointments with other providers on their behalf when it became clear that their discharge would be delayed. Patients said nurses were always busy but seemed to make time to speak to people if they needed reassurance.

## Are surgery services responsive to people's needs?

(for example, to feedback?)

Good

### Meeting people's needs

Staff responded to people's needs in a timely manner. We observed, and care plans we looked at confirmed, that staff responded appropriately as patients' needs changed. Wards that took male and female patients ensured that people were nursed in single-sex bays and signs were changed on bathrooms and toilets according to the gender mix. However, some patients mentioned that this did mean they were moved to different parts of the same ward during their stay, which resulted in a disrupted inpatient experience.

People were told how to register a complaint if they needed to. Several patients said they had no need to complain, but if they had a concern, they would mention it to the nurse in charge.

The leaflets we saw around the hospital were in English only. Most wards had patients who did not have English as a first language. Staff had access to interpreters, and these were arranged when appropriate.

### Vulnerable patients and capacity

We observed a minor issue with patient confidentiality in the day surgery area. Lack of private rooms meant that, if people needed help in completing forms, this could only be

done in a public area. We saw two people, one older person and one with a disability, having to do this (even though one person mentioned that they were uncomfortable doing this).

### Access to services

Elective surgery was regularly cancelled and this caused patients to complain, particularly new patients awaiting their first procedure. In the three weeks before our visit, the day surgery unit had 109 cancellations by patients, 155 cancellations by the hospital in advance and 38 cancellations on the day of admission. There had been 295 cancellations for people awaiting admission as inpatients in that period, and a further 31 cancellations on the day of admission. Forty-nine patients had cancelled inpatient procedures. While these figures are not statistically significant we saw from the cancellation figures for the previous year that the high level of hospital cancelled procedures prior to our visit was not unusual. We noted from the risk register records that repeated cancellations were leading to patients being in a sub-optimal condition for surgery. Senior managers told us that the trust had had to cancel elective admissions due to the pressure on beds within the hospital. While this results in a poor experience for the people on waiting lists whose surgery has been cancelled, it is necessary to maintain safety within the hospital.

We were told of a procedure cancelled recently because the correct prosthesis was not available. The patient was made to fast before the surgery was cancelled in the afternoon. We were also told that the above incident was logged appropriately, but that the person reporting it was also asked to investigate it, which was contrary to trust policy. If a pre op briefing had been completed as per WHO checklist this would have been identified and an opportunity to rectify this situation would not have been missed.

There was a theatre available for surgery 24 hours a day. The neurosurgery unit confirmed that they could manage out-of-hours emergencies within their own unit. Staff told us the portering system did not work as efficiently as it could, causing patients to wait longer than necessary for transfers.

A new surgical admissions lounge, closer to theatres and with more space than the previous location, had recently been opened which was improving the experience for patients.

### Leaving hospital

Nursing staff arranged simple discharges. Where patients had complex needs, one of the discharge coordinators would be involved. There was information on patients' care plans about the expected date of discharge. Planning for discharge began on admission and was updated during the patient's stay. Relatives were kept informed of the support that patients would need on their discharge. Patients we spoke with were aware of discharge plans and social services were also kept informed where appropriate.

The discharge coordinator we spoke with showed strong awareness of the support systems that needed to be in place to help older people return home safely after surgery and the need to avoid re-admission. The care records we looked at included effective discharge planning. Staff told us there were sometimes minor delays in discharge due to the unavailability of transport, especially in the evening, or because patients were returning to their local hospital where a suitable bed was not immediately available.

### Learning from experiences, concerns and complaints

We were told that, in order to optimise the throughput of surgical patients and avoid cancellations, a theatre coordinator moved patients between lists. Nurses on wards showed us action plans developed in response to monthly feedback from patients. On some wards action plans were displayed alongside the results of the Friends and Family Test.

Staff suggested that patients would benefit from having greater understanding in advance of possible reasons their elective surgery might be cancelled. Cancellations tended to occur because of urgent admissions from A&E and also from transfers for complex surgery from other hospitals. We were told that the trust policy was that patients who had had their surgery cancelled would be re-booked within a month.

## Are surgery services well-led?

Good

### Vision, strategy and risks

We spoke to the senior managers in theatres and on the wards and felt that they had a good understanding of the performance of their respective departments.

Good

# Surgery

## Governance arrangements

Staff meetings on wards and in theatres enabled staff to discuss and understand changes to policies and practice. Most staff believed that they worked in supportive teams. The governance arrangements enabled senior staff to review incidents and trends over time, and to identify areas of risk. We were told that communication among staff was mostly good.

## Leadership and culture

We observed good leadership in most surgical services at ward and theatre level. However, there was a lack of staff cohesiveness on Caroline Ward and in cardiothoracic surgery. Senior management awareness of performance and behavioural issues was evident. We spoke to several senior managers about this issue, including the chief nurse, head of nursing and matron. They were all aware of the issues on Caroline Ward and said that these were being addressed.

## Patient experiences, staff involvement and engagement

Patients commented positively on the care and support they received from staff in helping them to become independent as soon as possible after surgery. Patient views about their time in hospital were collated and displayed on each ward and these showed that the trust was keen to involve patients and relatives in developing a caring culture.

## Learning, improvement, innovation and sustainability

Opportunities for training varied across departments. Some healthcare assistants were supported to undertake their nurse training, while others felt that this opportunity was limited due to lack of time. Junior doctors in some surgical specialties were not receiving appropriate support and were not gaining the experience they needed.

Outstanding ☆

# Intensive/critical care

| | |
|---|---|
| Safe | Outstanding ☆ |
| Effective | Good ● |
| Caring | Good ● |
| Responsive | Good ● |
| Well-led | Outstanding ☆ |

## Information about the service

The critical care service at St George's Hospital, Tooting is made up of three intensive care units (ICU) attached to the different theatres and three high dependency units (HDU). There are 34 ICU and 19 HDU beds in total. In general intensive care, there are 12 ICU and six HDU beds. In cardiac critical care, there are 13 ICU and four HDU beds, plus two side rooms. Neuro critical care has nine ICU beds, five HDU beds and two side rooms. There was a step down facility from HDU to a high visibility unit on some surgical wards. This was an area in the ward which was visible to staff where patients from HDU were placed so that staff could keep an extra watch on them.

We spoke with three patients and six staff, including nurses, doctors, consultants and senior managers. We visited all of the critical care units, observed care and treatment and looked at records. We reviewed the performance information about the trust.

## Summary of findings

Patients received safe, effective and responsive critical care services in line with national guidelines. National data showed that the safety of patients in the critical care areas was outstanding and while the hospital did not have an outreach team staff ensured that patients were assessed and treated in line with their clinical need. Recent independent reports demonstrate that the critical care unit was above the national average in a significant number of areas showing positive impacts on patients care.

There were enough specialist staff to ensure 24-hour care. Patients and relatives felt that the care was of a high standard and they had been involved in decisions about treatment.

The teams were very well-led and there were systems in place to monitor the quality and safety of patient care, which was of a high standard. Staff were focused on governance arrangements for the unit and learning from audits was embedded into practice. The educational team were active and a culture of listening, learning and action was evident throughout the unit.

Outstanding ☆

# Intensive/critical care

## Are intensive/critical services safe?

Outstanding ☆

### Safety and performance

Patient safety data was submitted to the Intensive Care National Audit & Research Centre (ICNARC) which monitored the trust's performance against other organisations nationally. The critical care service performed very well by comparison with other services in England. The ICUs had low rates of re-admissions and low length of stays. The ICNARC data showed that fewer people died than might have been expected given the area, age and health of the population. Staff reported incidents and received feedback on the outcome of investigations that had been carried out.

### Learning and improvement

Staff on the units had sufficient skills and experience and were all trained in intensive care. There was a high level of trainee doctors on the units who were well-supervised by consultants. Trainee doctors reported that they had good inductions. Trainees all had copies of the hospital's ICU handbook so had a good shared understanding of processes and procedures and attended a two week series of morning lectures.

### Systems, processes and practices

We noted that, unlike many hospitals, the hospital did not have a critical care outreach team. Their target was for a specialist registrar to see patients as soon as possible and within 30 minutes of an ICU request. Staff told us that patients were usually seen within 15 minutes. The clinical director for critical care was undertaking a full review of the service to compare it against the published standards for outreach from the National Outreach Forum which demonstrated a will to ensure best practice in the units.

There were drug infusion folders and other folders setting out relevant protocols for doctors, and policies were easy to locate on the intranet.

When patients' conditions deteriorated during the night, the procedure was for staff to escalate care to the night site practitioner team in the first instance, who will call for ICU assistance if required. The general ICU worked closely with the cardio and neurological ICUs.

### Environment and equipment

The units were well-designed and well-equipped. Technicians tested and maintained the equipment. There were daily routine checks recorded which monitored a range of equipment, such as batteries, glucose meters, oxygen cylinders and portable ventilators. Most equipment was already standardised between the units, and for ventilators which were not yet standardised, a standardisation programme was in place.

### Infection control

Patients were cared for in a visibly clean environment with equipment marked with stickers saying "clinically clean". Hand-hygiene gel and hand-washing sinks were available and used, and curtains around beds were changed regularly and dated. The rate of hospital-acquired infection was low. Infection through central venous catheter insertion had been reduced to 0.2% per bed per day (from 1.5%) by use of full barrier precautions on insertion and by removing these catheters as soon as patients were ready.

### Medicines management

Arrangements for medicines management were safe. Cardiac and anaphylaxis packs (for severe allergic reactions) were kept in each theatre, were labelled with expiry dates, and were in date. The equipment and medicines on the resuscitation trolleys were checked daily. The temperature of the medicines fridge was monitored daily and records showed that medicines were stored within the safe temperature range. Some injectable medicines were drawn up into syringes in advance of being used, which is the recommended practice in this environment. Pre-prepared syringes were clearly labelled with the drug name to reduce the risk of administration errors. Patient records were comprehensive and completed in full.

### Monitoring safety and responding to risk

A range of systems and processes were in place to monitor the safety of patients. For example, the results for the ICU and HDU units' performance on pressure ulcers, Clostridium difficile (C. difficile) infections and MRSA were on display. Staff told us that there could be delays in step down to HDU if there were no beds on the wards. Patients were sometimes nursed elsewhere for a short time after discharge from ICU rather than on the most appropriate ward.

Outstanding ☆

# Intensive/critical care

### Anticipation and planning

Plans had been approved for an increase in bed capacity in the recovery department and the associated recruitment of additional nursing staff. We were told that 100 additional nurses for critical care had been recruited in the past 14 months. This extra recruitment was in recognition of the need for additional critical care nurses due to the increasing need of complex tertiary work.

## Are intensive/critical services effective?
(for example, treatment is effective)

Good

### Using evidence-based guidance

Patients received care and treatment in line with, or exceeding, national guidelines. Critical care services followed the National Institute for Health and Care Excellence (NICE) critical illness rehabilitation (CG83) guidance.

### Performance, monitoring and improvement of outcomes

The units' data supplied to ICNARC enabled them to compare their performance with similar units nationally. There were weekly informal mortality meetings. We observed comprehensive handover meetings between shifts which ensured that staff were thoroughly briefed on patients' progress and conditions.

### Staff, equipment and facilities

Each ICU was covered by a consultant who was a specialist in intensive care medicine. There were 350 nursing posts working across critical care. Patients on ICUs received one-to-one nursing care, while on HDUs there was one nurse for two patients. Staff sickness on the units was low at 3–4%. A band 6 nurse worked on rotation through the different units. Doctors remained on specific units. Staff reported that they had received training when there were changes to processes or equipment. Nearly all nursing staff – 99% – -had completed their most recent annual appraisals.

There were different ventilators used in the different units, but there was a programme in place to standardise equipment across all ICUs.

### Multidisciplinary working and support

The critical care units were all staffed by multidisciplinary teams and staff told us that the teams worked effectively together. A dedicated physiotherapist worked on critical care and undertook daily ward rounds with the doctor, a senior rehabilitation nurse and a speech and language therapist. Physiotherapy was available every day and speech and language therapy was available Monday to Friday. An occupational therapist, pharmacist and a clinical psychologist were available to provide additional support. Dieticians advised on nutrition for patients to optimise their recovery.

## Are intensive/critical services caring?

Good

### Compassion, dignity and empathy

Patients said they were treated with care, consideration and compassion. Staff displayed a caring and professional manner and made time to speak to patients and relatives. We noted that staff were not easily able to respond to the wishes of Muslim women to be cared for by female doctors.

### Involvement in care and decision making

Staff respected people's rights to make choices about their care. Patients said they were satisfied with the amount of information they had been given and family members told us they were involved in their relatives' care.

### Trust and communication

Communication with the specialist wards onto which patients transferred was good. There was evidence of clear and comprehensive ICU notes on patients' files on the wards. Relatives reported that staff were proactive in keeping them informed.

### Emotional support

There were sufficient staff to answer people's questions and to meet their emotional as well as their medical needs. Relatives spoke highly of the support given by staff. In the special survey carried out on discharge from ICU, 91.4% of patients said that there were staff to talk to for support. When necessary, staff involved the palliative care team to provide support to patients and families.

Outstanding ☆

# Intensive/critical care

## Are intensive/critical services responsive to people's needs?
(for example, to feedback?)

Good

### Meeting people's needs
Patients were closely monitored in the units and staff responded promptly to changes in their needs. Patients' needs had been assessed and observations were recorded in a timely way. Observations were carried at least hourly or more often if required. All units used the early warning scores observation chart which triggered calls for increased medical intervention. Pain relief requests were responded to promptly.

There was 24-hour cover by speciality junior doctors.

The units had clear criteria against which to review referrals to ICU and a follow-up nurse was employed in ICU to facilitate transfer to wards.

### Vulnerable patients and capacity
Staff showed an awareness of the Mental Capacity Act 2005. Where patients could not fully understand or be involved in decisions about their care, staff ensured that decisions were made in their best interests, involving the family, carer or support networks. Facilities for relatives in the general ICU were not as good as in other areas. For example, there was no overnight accommodation, and offices or seminar rooms had to be used for private discussions.

### Access to service
Patients or their relatives were given comprehensive information about a person's condition and how to manage it. Translation services for people who did not speak English were available when required.

### Leaving hospital
Most patients were not discharged home directly from critical care services, but transferred to other wards in the hospital first. There were some delayed transfers because hospital beds of the correct specialty were not available. For patients being transferred to other wards at night (after 10pm) staff were required to complete incident forms. There were several of these late transfers in January 2014. This had an adverse effect on the service's ability to be responsive to all patients requiring intensive care, but there were approved plans in place to rectify this situation. Late transfers were also undesirable because of lower staffing levels on wards at night.

### Learning from experiences, concerns and complaints
There was positive feedback from the general ICU discharge survey in January 2014 (this survey was used instead of the Friends and Family Test because most patients were transferred to wards rather than to their homes). All patients would recommend the units to their family and friends and agreed that their care was discussed with them while on unit. Of the respondents, 95% were satisfied that they had enough privacy.

## Are intensive/critical services well-led?

Outstanding ☆

### Vision, strategy and risks
All the units had clear, shared objectives across their respective teams. Medical, nursing and therapy staff told us that they felt part of a supportive team and had a good understanding of the department's performance

### Governance arrangements
There was a strong culture of clinical governance supported by multiple audits. All staff we spoke with confirmed that the consultants were approachable. There was a clear management structure, with teams working together effectively and striving to provide an excellent service.

### Leadership and culture
The ICU was a consultant-led service and there was a strong consultant presence in each unit. Discussions within teams were open and transparent in both formal and informal meetings to discuss concerns and improvements to care. Staff retention was good and staff said they enjoyed working there. Sickness rates were low. Doctors and nurses worked effectively together, and there was excellent multidisciplinary team working.

### Patient experiences, staff involvement and engagement
Patients and relatives reported favourably on their experiences of care and the kindness and professionalism of staff. There had been no complaints reported in the past

year, and scores in the General ICU Discharge survey were high, for example: 97.8% for being treated with dignity and respect and 96.4% of relatives felt their relatives' care had been discussed with them while they were on the unit.

### Learning, improvement, innovation and sustainability

There was a range of audits carried out to help improve the service. Some audits were internal, for example, on infection control, while others were provided to ICNARC. This helped staff ensure that their services were in line with good practice. The units received electronic data analysis reports showing how they compared with other similar services, which helped staff understand more about the care that they delivered. The data analysis aimed to assist staff in decision-making, resource allocation and local performance management.

The units had an active educational team and staff had 12 scheduled days a year for mandatory training. Staff reported "excellent" teaching on the units. There was also a strong research culture, an example of which was participation in the VANISH clinical trial, testing Vasopressin versus Noradrenaline as initial therapy for patients in septic shock.

Good

# Maternity and family planning

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Outstanding |
| Responsive | Good |
| Well-led | Good |

## Information about the service

St George's Hospital, Tooting maternity service includes one 12-bed unit (Carmen Suite) which provides midwife-led care for women with no underlying risks. This unit has two delivery rooms and birthing pools. There is also a separate consultant and midwife-led delivery suite, with 14 delivery rooms, two operating theatres and Lilac Suite, which is a separate en suite room for bereaved women and their partners and family. In addition, there is a 32-bed antenatal and postnatal ward (Gwillim) which had eight single rooms that were allocated depending on need. A feeding room, daily baby clinic and new-born hearing screening were available on this ward. There were just over 5,000 births during the year July 2012 to July 2013, slightly less than the previous two years.

We visited all maternity areas and spoke with 14 parents and nine members of staff, including matron, doctors and trainee doctors, midwives, one healthcare assistant and five student midwives. We observed care and treatment and looked at some records. We reviewed the performance information about the trust.

## Summary of findings

The maternity service provided safe, effective, responsive and well-led services to women. The caring way in which the care was delivered was considered to be outstanding.

Women spoke positively about the care they received and the staff who delivered it. Staff were appropriately qualified and had the necessary skills and training. There were enough staff on the wards to deliver care safely and there were no vacant posts. Infection control and medicines management were good.

There were specialist midwives for breastfeeding, risk management, safeguarding (including domestic violence), substance misuse and teenage pregnancies. A specialist clinic for women with diabetes was also available.

Good

# Maternity and family planning

## Are maternity and family planning services safe?

Good

### Safety and performance

Maternity services had maintained a low rate of elective and emergency caesarean section rate in the last year (2013). Rates of hypoxic ischemic encephalopathy (infant neurological injuries caused by caused by low oxygen) were low.

### Learning and improvement

Serious incidents were reviewed weekly by senior staff. Systems were put in place to learn from these incidents and prevent similar occurrences. All serious incidents were discussed at the weekly perinatal mortality and morbidity meeting. These were described as "blame free discussions". Midwives said that they received feedback from the 'risk midwives' and lessons learnt were disseminated through a staff newsletter. This meant that they were aware of previous issues and incidents and the systems put in place to prevent any recurrence.

### Systems, processes and practices

There were good systems for reporting safeguarding concerns and staff we spoke with, including students, were aware of the named midwife and how to contact them. The resuscitation trolleys (used to transport emergency medication) were seen to be appropriately stocked, clean and covered. They were checked daily by staff.

### Infection control

Patients we spoke with said the areas were clean. The wards visited were visibly clean and well maintained, except for the day assessment unit. In this unit we saw computer equipment was stored in a corridor which had an 'out of order' label dated October 2013 and was seen to be covered in dust. Packets of maternity pads were open and left out. The documentation for one trolley stated that it had not been cleaned since September 2013. However it was seen to be clean. Also, we saw staff who were not following the 'bare below the elbow' rule which was against the trust infection control policy. Hand gels were situated at the entrance of the wards and staff washed their hands and used hand gels as required. The findings from hand hygiene audits were displayed and no issues had been raised.

We received information before our inspection indicating that the fridge in the mortuary on Lilac Suite was not clean. We saw it needed cleaning on the first day we visited. Staff took action and this area was included in the midwives' cleaning schedule to ensure it was kept to an appropriate standard thereafter.

### Medicines management

Medicines were managed safely on Gwillim Ward. Arrangements were in place to obtain medicines promptly. Prescription charts were completed in full, including women's allergies. A separate, more detailed risk assessment for venous thromboembolism (VTE) – blood clots had been completed for all women on this ward.

We noted that, due to the design of the ward, the medicines storage area did not have controlled access. However, this did not pose a risk as medicines were stored securely within locked cupboards and trolleys. Nevertheless, we were told that there were plans to relocate medicines to a more secure area. The temperature of the medicines fridge was marginally out of safe range on the day of our inspection. This had already been noted by pharmacy staff and a procedure was in place to deal with temperature variances. The contents had been quarantined so that patients were not placed at risk. The pharmacist allocated to the ward was rectifying this issue.

### Monitoring safety and responding to risk

There were sufficient staff to meet the needs of women on the wards. Consultant cover was provided for 98 hours a week. Funding was being sought to increase this to 144 hours by April 2014, to provide better care for women. There were no staff vacancies. One matron reported that recruitment had improved in the last two years. There was a midwife-to-birth ratio of 1:27. Staff skills mix was addressed in daily allocations to ensure the service operated effectively. These ensured patients' needs could be met. Staff were happy to be working at the trust, and said that they would recommend it to colleagues as a good place to work and would recommend it to family and friends as a good place to have a baby.

Midwives, doctors and students understood when to escalate incidents. They were aware of the reporting systems in place and how to complete electronic data incident forms used by the trust. Systems were in place for these forms to be reviewed by managers and actions were taken to alleviate or minimise risk.

Good

# Maternity and family planning

The London Fire Brigade (LFB) visited the trust in February 2013 and gave an enforcement notice in the Lanesborough Wing, stating the trust had failed to comply with the Regulatory Reform (Fire Safety) Order 2005. Work should have been completed by May 2013, although the LFB had not re-visited to check whether the appropriate actions had been taken. We saw that fire extinguishers were checked, there was a daily check of fire exits, and staff we spoke with had completed fire safety training. We noted that a floor-cleaning machine was blocking a corridor, and a door to a cupboard containing pipes was left open on one of the wards. Fire doors were propped open, even though they had a sign on saying 'keep closed'.

### Anticipation and planning

Plans were in place to cap the number of maternity patients admitted to the unit, in agreement with local commissioners, to enable staff to provide appropriate care and treatment to women.

## Are maternity and family planning services effective?

(for example, treatment is effective)

Good

### Using evidence-based guidance

Maternity care was provided in line with current legislation, standards and guidance. St George's is a centre for the management of morbidly adherent placentas (an abnormality in the adherence of the placenta which can cause haemorrhaging). The maternity service used an electronic foetal heart monitoring system to reduce the risk of unnecessary intervention. This system required a high level of staff training, both initially and ongoing, and included a test every three years. The maternity monitoring dashboard showed that the service was working to reduce elective caesareans. Indicators seen showed that the service was in line or above the national average. This has a positive impact on the care of women.

### Performance, monitoring and improvement of outcomes

Regular audits were carried out, for example, on the equipment used. Staff said they received both positive and negative feedback verbally from women, but that negative feedback was not always displayed on the ward.

### Staff, equipment and facilities

There was a good preceptorship practical experience and training programme for midwives (this is a support and development system for newly qualified staff). Students reported good links between the wards and the university, although some raised issues about the lack of time to get assessments completed, delays in getting work signed off, or having to swap mentor in order to get work signed off. Students felt that they were given good opportunities to get involved in a variety of activities and were supported to learn by midwives. All midwives were allocated a supervisor who they met with annually. The recommended ratio of one supervisor to 15 midwives was achieved throughout 2012 and 2013. Information about midwives supervision was displayed around the wards so that patients were aware of the support systems in place. Study days were incorporated into the off-duty rota which ensured staff were released to keep up to date with training and best practice. The number of midwives and doctors having completed their mandatory training was above the trust's target.

There was sufficient equipment for staff to carry out their roles safely. One issue on the risk register from 2011 was an identified need for new delivery beds. While this remained on the risk register, systems were in place to improve the situation, including staff completing training in manual handling, repairs being carried out when needed, and using electronic incident reporting to log treatment delays that were due to equipment.

### Multidisciplinary working and support

Staff reported good links with health professionals in other areas of the hospital and in the community. Daily and weekly meetings were held on the wards. There was good communication between midwives and doctors and good team work overall. Staff told us that colleagues were supportive of each other.

## Are maternity and family planning services caring?

Outstanding

### Compassion, dignity and empathy

Women told us that they were "very well looked after" and that "midwives are outstanding in their care". Other comments included: "I'm glad I chose St George's", "I can't

Good

# Maternity and family planning

fault it", "all questions were answered", "feel really safe" and "outstanding care received from midwives". Women told us that they were happy with care they received and would recommend it to others. We saw that doors were closed to give women privacy and maintain their dignity. Boards with women's names on them were out of sight of patients and visitors to maintain confidentiality. We saw call bells being answered by staff promptly and women told us that this was normally the case.

### Involvement in care and decision making

The CQC maternity Survey showed that the hospital was performing in the upper half of the maternity survey. Women and their partners were involved in decisions and given the information they needed to help them decide the best options for them. Information leaflets were available on the wards and at antenatal clinics. One woman and her partner said they attended the twins and triplets clinic and saw the same staff each time. They stated that this was "very good", "very helpful" and "meant we didn't have to repeat things again and again".

Partners were made to feel welcome and there was the option to stay overnight if necessary, which would mean that they would be there to support and help if needed. However, one woman told us that she was not told that her partner could stay, so felt she was not given the option. Some also felt that they should have been allowed more than two visitors at a time, although she understood the risks of overcrowding and raised noise levels which could affect other people.

### Trust and communication

Most women told us that communication by staff was good and that they were often given the information they needed, when they needed it. One woman said that they were given clear information about when to attend to have their labour induced. They said that they were seen by the midwife as soon as they arrived at the unit and were happy with the way that they were informed about the process. However, one woman said that she felt communication from the consultant could have been improved and that would have made her experience more positive. Another woman said that she was given conflicting information about breastfeeding, particularly around frequency.

Midwives were allocated to care for specific women on their shifts. One woman told us that "when a new midwife came on duty, they introduced themselves, wrote their name on the board and discussed my plan of care with me".

### Emotional support

Comments received from women and their partners included: "antenatal care was very good", "they give you lots of support", "midwives are responsive", "fantastic care", "could not fault a thing", "it's a friendly environment", "they were supportive with breastfeeding", "they answer your questions" and "accommodation is provided for partners".

The Lilac Suite, where bereaved mothers were cared for, was sensitively situated at the entrance of the ward. This meant that people did not have to walk through areas where there were photographs of babies and where babies were being born. One couple told us about their experience of losing a baby and the positive support they received from staff during this time. They said, "They did everything they could" and provided "great support".

## Are maternity and family planning services responsive to people's needs?

(for example, to feedback?)

Good

### Meeting people's needs

Women were offered a choice of food and portion sizes looked sufficient. "Excellent food choices" was one comment we received. Staff said they provided food to cater for the various ethnic and cultural backgrounds of women who used the service, including Asian, Caribbean and Halal diets.

People we spoke with said that their requests based on cultural grounds were accommodated. Two examples were identified: one woman said, "we are only supported by female staff"; another said, "male partners only stay in some rooms".

There was a bariatric room available in response to an increase in the number of women with a high body mass index, which increases health risks during pregnancy.

Good

# Maternity and family planning

### Vulnerable patients and capacity
Staff had completed training in safeguarding vulnerable adults and were aware of the need to report issues and concerns to the relevant people. If there were issues regarding a woman's capacity to make decisions, they would be supported and appropriate actions would be taken.

### Access to services
Maternity services were provided to women living in the London Borough of Wandsworth and surrounding areas and were accessible. Women could see midwives in the community and antenatal classes were provided.

### Leaving hospital
Information leaflets were given to women before they left the hospital which included answers to common questions, such as where they should go in an emergency, or what to do if they were concerned about their own or their new baby's health after they left the hospital. Midwives often gave advice to women about their discharge medicines because the pharmacist was not available on the wards all the time.

### Learning from experiences, concerns and complaints
Good systems were in place for monitoring concerns and complaints. Themes from complaints were a standing agenda item at maternity risk meetings, labour ward forums and supervisors' meetings.

## Are maternity and family planning services well-led?

Good

### Vision, strategy and risks
Staff were aware of the trust's values. A maternity monitoring dashboard was used to measure performance against a set of quality and safety indicators. This was reviewed monthly with a copy sent to all medical staff and midwives and was reported to the Trust Board.

### Governance arrangements
There were clear reporting lines from staff through senior managers to the Trust Board. Information was disseminated to all staff across the trust from the board and divisional senior managers.

### Leadership and culture
Some staff told us that they had seen the chief executive working on one ward as a healthcare assistant and 'walking around the wards'. This gave the chief executive direct insight into what life was like for patients and the opportunity to speak with staff on the frontline.

Effective medical and midwifery leadership was demonstrated during our visit and there was an effective consultant presence on the delivery suite. On staff member told us that "even when busy the ward is managed well".

### Patient experiences, staff involvement and engagement
People gave feedback to the wards about their experiences. Some left postcards with their comments at the end of their stay. Senior staff said that they planned to address the issues raised by people and would outline what they had done in response to comments made.

### Learning, improvement, innovation and sustainability
There were simulation training sessions for all staff, which included how to respond in emergency situations.

Good

# Services for children & young people

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

## Information about the service

St George's Hospital, Tooting, children and young people's service has five inpatient wards (65 beds over three wards), an eight-bed intensive care unit, a neonatal unit with special care baby unit, a high dependency unit and intensive care unit, a 15-bed day surgery ward, outpatient clinics and a child development centre. There is also a separate children's assessment unit.

We visited three wards (Frederick Hewitt, Nicholls and Pinckney) and the neonatal unit. We talked to 11 parents and their children, 13 members of staff, including nurses, student nurses, matrons, play specialists, doctors, consultants and support staff. We observed care and treatment being provided.

We received comments from our listening events, from people who contacted us to tell us about their experience and 10 comment cards from parents on the neonatal unit. We reviewed the performance information about the trust.

## Summary of findings

Children and young people were cared for by nursing staff who were predominantly trained as children's nurses. There were playrooms with toys and activities for children and young people of all ages. All areas were clean and there was a school on site for patients. Children, young people and their parents said that they were "happy" with the care and treatment provided.

A number of staff were concerned about staffing levels and whether the needs of some children with complex needs were always fully met. Not all staff were aware of the plans in place to recruit staff to vacant posts and the cover arrangements for staff on long-term sick leave. Systems for all staff to receive supervision and appraisals were not in place in all the wards.

We were concerned that the service was not well-led. One senior nurse told us that they had reported their concerns regarding staffing levels using whistleblowing procedures but had been "reprimanded" for doing this. Two other staff members told us that they were concerned that some senior nursing staff were "not listened to" by senior management in the trust.

Good

# Services for children & young people

## Are children's care services safe?

Good

### Safety and performance

Staff we spoke with said that there were good systems for reporting child safeguarding concerns. They had completed training to the required level and were confident about the actions they should take if they were concerned. There were named staff available to give advice, information and support to staff around child protection issues or concerns. A safeguarding newsletter had been introduced to the children's emergency department and we were told that five consultants were focusing on safeguarding in that department.

A computer software system identified if a child was on a child protection plan and if they were known to social services. Staff said there were good links with the children's emergency department and they were usually informed by a phone call if there were concerns about a child who was to be admitted to the wards. The safeguarding children annual report identified the number of referrals that were made to the local authority, to the Child and Adolescent Mental Health Service (CAMHS) and the number of child protection medical assessments completed.

### Learning and improvement

Staff told us that the induction for new staff covered learning from incidents and gave examples of data being used to identify trends and how this learning was disseminated on across the trust. Nurses described what they would report as an incident and were aware of the processes to be used. They also told us that they received information about incidents and issues in the form of 'lessons learnt' to help prevent similar matters from recurring in the future.

### Systems, processes and practices

### Equipment

Nurses said they had access to sufficient equipment to carry out their job. The resuscitation trolley on Pinckney ward was checked regularly, but the top of the trolley was untidy and cluttered, which may have posed a risk if staff needed to find and use equipment in an emergency. Records of the resuscitation trolley on Frederick Hewitt ward showed it had been checked every other day through January but less frequently in February 2014. A separate record indicated that it was cleaned daily and a full check was completed every week.

### Infection control

All areas we visited were visibly clean and well maintained. Young people and parents we spoke with said the areas were cleaned daily and kept clean. "It's very clean" was a comment made by several people we spoke with.

There were clear policies and procedures for cleaning rooms and bed areas when someone had an infectious illness. Staff said the contract cleaners responded to their requests. We saw two areas on one ward being given a 'deep clean' during our visit which reduced the risk of cross-infection for children and young people as well as their parents and carers.

The infection control measures in place in the special care baby unit were seen to be excellent and the environment was clean. One parent said, "the nurses are always cleaning things and washing their hands". Hand gels were situated at the entrance of the wards. We saw that staff washed their hands and used hand gels before they went to see a child or young person and when they left the room or area. The findings from hand hygiene audits were displayed and no concerns were highlighted.

### Medicines management

Medicines were being managed safely on the areas we visited. Arrangements were in place to obtain medicines supplies promptly and were prescribed and given to children appropriately. All medicines were stored securely, within locked cupboards and trolleys, in order to prevent unauthorised access. Regular daily checks were carried out on controlled drugs in order to prevent misuse. Staff checked and recorded the medicines fridge temperature regularly and there was a procedure in place if the fridge was out of safe temperature range.

### Monitoring safety and responding to risk

There were six nurse vacancies on one children's ward and two members of staff on long-term sick leave on another ward. These posts were being covered with bank (overtime) and agency staff. The ratio of staff to children was one nurse to five children. A number of staff were concerned about staffing levels and whether those children with

Good

# Services for children & young people

complex needs were always fully supported. While staff had raised this as a concern, it was not on the trust's risk register. We were told that the chief executive was aware of the concerns regarding staffing on the children's wards.

Two student nurses told us that, on their first day on placement, they were only agency staff working on the ward. This meant that they did not meet their mentor until their second day on placement. Parents we spoke with said they felt that, at times, there were not enough staff on the wards. One parent said, "I am concerned about the quality of care provided on the weekends and at night"; "our confidence has been knocked". Another comment by a parent was, "Agency nurses seem less knowledgeable than normal staff with regard to the use of equipment". While the use of agency staff does not necessarily make the ward unsafe it is of concern as it does not always provide consistency of care for children and young people. On our unannounced visit we found that the wards were staff with high numbers of agency staff but that actual levels of staffing was appropriate to meet the needs of children and young people.

There were vacancies on the neonatal unit that were being managed by the use of agency staff. This issue was on the trust risk register with an action plan in place to support the unit while staff were recruited.

### Anticipation and planning

We were told how some areas of some wards were closed when required to ensure appropriate care and treatment was provided. Children and young people were diverted to other dedicated wards within the hospital. The trust has plans to develop the children's services, in line with increased demand in certain areas.

## Are children's care services effective?

(for example, treatment is effective)

Good

### Using evidence-based guidance

We were given examples and told how staff used records and audits to provide good quality care.

### Performance, monitoring and improvement of outcomes

Patient trackers were used to seek children and young people's opinions of the services provided. We were told that comments received were discussed at ward meetings. Staff were using the productive ward programme to improve quality across the wards. A 15-step challenge was completed. This was an initiative to encourage patients and staff to work together to look at what was working well and what improvements could be made to the patient experience. We were told that families spoken with at the time were "happy" 'and that the only issues raised were around noise levels and the suitability of beds for some children.

### Staff, equipment and facilities

There were specialist nurses based on one of the wards and parents made positive comments about the support they provided and the confidence they instilled in them.

Staff training records indicated the trust's target for mandatory training of clinical staff were being met for equality and diversity, fire safety, health and safety, moving and handling, safeguarding adults and children. However, they were not being met for conflict resolution, infection prevention and control, information governance and (on one ward) for resuscitation. Information in a board governance meeting indicated that staff attendance at child protection training had fallen below the trust's target and an action plan was being developed to ensure that staff had accessed this training.

### Multidisciplinary working and support

Staff reported good links with health professionals in other areas of the hospital and in the community. There was a daily 'board round' when all professionals involved in a child or young person's care met and discussed the individual's care and treatment requirements. This ensured all involved in a child's care were up to date with changes. Staff said that they worked well as a team and were supportive of each other.

## Are children's care services caring?

Good

### Compassion, dignity and empathy

Children and young people said staff respected their privacy most of the time, adding, "as much as is possible with only a curtain around the bed". Staff said that they usually called through before entering a closed curtain, to

ensure they maintained the individual's privacy. However, one young person said "one member of staff just walked in through closed curtains without announcing themselves first".

There were a number of rooms where staff could have conversations with children, young people and their families away from the shared bays, and to allow for privacy if they needed to deliver 'bad news'. A patient said, "Staff gave me information about the ward and showed me around, even though we came here in the middle of the night". One parent told us that they had overheard staff commenting (in a negative way) that they were not staying with their child which made them feel "upset".

Other comments from parents included: "Staff care passionately about what they are doing" and "Staff are lovely". Another parent told us, "Staff have been professional, empathetic, efficient and supportive; their care has been fantastic and we have always felt our child is safe and cared for".

### Involvement in care and decision making

Parents we spoke with said that they were involved in the care and treatment provided and were kept informed of what was going to happen. We saw some good examples of parents being invited to participate in care, treatment and medication administration.

Comments from children, young people and their families included: "They explain things all the time" and "They explained everything in lay terms" which helped people understand what they were being told. One parent said, "They answer all my questions and make me calm at this stressful time". Another said, "They involved us completely in our child's care", "I can ring at any time and they will update me".

### Trust and communication

Information about each of the wards and the services provided was available to children, young people and their families through a booklet, information displayed around the wards and in the parents' rooms.

Children and young people and their parents said that staff talked with them appropriately. Parents reported "good levels of communication" saying that they were asked and informed about "everything".

One parent said, "When my child was first admitted, I didn't know what to expect. Staff were fantastic, letting me know everything and explaining things to me", and, "the care that has been given is amazing, I couldn't have asked for better".

### Emotional support

Staff on one ward provided palliative care for some children. They had access to a specialist palliative care team within the hospital and told us there were policies and procedures in place. Staff told us that part of their role was to promote good general health care for children and their parents, and not just provide treatment for the reason they were admitted.

## Are children's care services responsive to people's needs?

(for example, to feedback?)

Good

### Meeting people's needs

Staff had access to translators when required, although there were often family members who could help with translating. Staff acknowledged that it was not always appropriate to use family members as translators and assured the team that this was only done in an emergency. Training sessions were provided for parents and carers to support them in managing their children's healthcare when they were discharged home.

There was a varied menu that catered for children's cultural and religious dietary requirements. Children were given a choice and 'meal vouchers' were provided in certain circumstances. This allowed them to use other catering facilities on site at the hospital in order to have variety and to encourage a normal social life. Some children and parents said that the food was "good", "tasty" and "sufficient", while others said that the food was "basic" and "OK".

One parent told us that they had experienced long delays in their child's treatment while waiting for medication that was not routinely kept at the hospital. They also said staff did not have the training in how to use some specific equipment, which meant they had to travel to another London hospital on occasions and this impacted on their family life.

Good

# Services for children & young people

### Vulnerable patients and capacity

Staff were aware of issues relating to parental consent and were clear that parents gave written consent before operations were carried out. Staff were also aware of the Gillick competency and Fraser guidelines which help to decide whether a child aged 16 or under is able to consent to their own medical treatment, without the need for parental permission or knowledge.

The trust has worked with the local mental health trust to develop policies and guidance for staff around working with young people with eating disorders. Staff were clear that they would use other professionals to help them provide the most appropriate support to young people while they were a patient at the hospital.

Staff told us that they had good links and response from CAMHS when needed. One-to-one staffing was used when required to ensure that young people's safety was maintained if they were considered to be a risk to themselves.

### Access to services

The wards were accessible with clear directions from the main reception. A number of parents we spoke with were frequent visitors to the hospital due to the medical conditions their children had. Other children had been admitted to one of the wards from the children's emergency department and it was their first visit. Both types of visitor said they were given information about the service, what to expect and where things were on the ward.

### Leaving hospital

Discharge meetings were held with the relevant health professionals for children and young people who had been on a ward for a long time and would be receiving healthcare support in the community. This ensured that parents had the information they needed to care for their child at home and were aware of the actions to take in the event of a concern or an emergency. Staff completed a discharge checklist which ensured everything was in place before a child left the wards.

There were sometimes delays in discharging children from the wards due to the unavailability of somewhere safe to discharge them to. While staff were clear that the wards were not the best place for children and young people if they were medically fit to be discharged, they accepted that, in some instances, it was the best place for them as an interim measure.

Community health providers told us that they would like communication between the wards and themselves to be improved. They would like to be informed when a child in their care was admitted to hospital and when they were to be discharged. If they had this information, they would be able to prioritise their visits and not schedule a home visit when a patient was in hospital.

### Learning from experiences, concerns and complaints

Ward managers on one ward sent staff a newsletter with important information and updates. This included information about serious incidents, learning from incidents, study days and mandatory training levels.

Nursing staff and consultants were aware of how to deal with complaints at the ward level and where to refer patients to if they were not satisfied. Issues dealt with at ward level were recorded and the head of department was informed. Most parents were aware of how to make a complaint, although one parent was not. One parent raised concerns with us about the attitude of a nurse and we referred this matter to senior staff on the ward.

We saw a number of 'thank you' cards and letters from children and their families. These indicated that parents were happy with the care and treatment that had been provided to their children. The play specialists were starting to provide cover on Saturdays, following feedback received from children and their parents.

## Are children's care services well-led?

Good

### Vision, strategy and risks

Staff were aware of the trust's values and were clear that their focus was patient safety. There were development plans for the future of children services, addressing the current and projected need and use of the wards. Some parents and children had been asked their opinions on the development plans.

### Governance arrangements

There were reporting lines through senior staff and department leads to the board. Systems were in place for staff to receive information through staff meetings.

Good

# Services for children & young people

### Leadership and culture

One senior nurse told us that they had seen the chief executive on one of the children's ward and that he held staff forums. However, these were at a time when many staff would be busy and may not be able to attend. The chief executive walked around the neonatal unit in December 2013 and was informed about the important matters of the day.

Not all staff were aware of the plans in place to recruit staff to vacant posts and the cover arrangements for staff on long-term sick leave. This left staff feeling concerned for the future. One senior nurse told us that they had reported their concerns regarding staffing levels using whistleblowing procedures but had been "reprimanded" for doing this. They confirmed that patient safety remained their priority and that they would speak out in future if they had concerns.

Two other staff members told us that they were concerned that some senior nursing staff were "not listened to" by senior management in the trust. A few members of staff were concerned that there would be repercussions for them by speaking with us about their concerns. This was apparent by comments, including, "Is this recorded?" and "Will I be named?"

Systems for all staff to receive supervision and appraisals were not in place in all the wards. However, we were told that junior staff on one ward received regular supervision and an annual appraisal, although this was not always the case for senior staff.

### Patient experiences, staff involvement and engagement

There were systems in place to seek children's views of the services provided, although we were told by staff that some frequent attendees did not want to keep completing them. Play specialists were sometimes asked to take questionnaires to children and young people in order to help improve completion rates.

### Learning, improvement, innovation and sustainability

There was a plan in place for the redevelopment of the children's wards which was due to commence in 2014–2015. This would improve the environment; provide more space on the wards, and more beds to enable the service to treat more children. Some staff had visited other children's hospitals to see what was working well and how things could be adapted for St George's. We were told that patients and groups of children from local schools had been asked their opinion on the development plans. This meant that the local community was involved in the future of their hospital.

Requires improvement

# End of life care

| | |
|---|---|
| Safe | Requires improvement |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Requires improvement |

## Information about the service

The trust's end of life care service included palliative care services as well as inpatient and outpatient chemotherapy and radiotherapy for symptom and pain management. End of life care was also delivered by frontline staff on other wards throughout the hospital.

We visited the three oncology wards/departments as well as the A&E department. We also asked questions to staff in other areas about end of life care. There was one patient who had been identified as receiving end of life care on the general wards during our visit.

We spoke with six patients and relatives, and a range of staff, including the end of life care lead, occupational therapists, radiotherapists, nurses and doctors. We observed care and treatment being given to people and looked at four care records. We spoke with staff in the bereavement offices and the mortuary. We received comments from people from our listening events and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

## Summary of findings

End of life care was delivered by the frontline staff across the hospital. There was also a specialist palliative care team available that coordinated and led on end of life care. The care offered by the mortuary and bereavement services was considered to be excellent.

People had their treatment plans explained and relatives had been included in the care planning process. Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form was not always completed fully.recent audits in August 2013 showed that further work was required by the trust however the small sample we reviewed were still not fully completed. There were good interactions between staff and patients and families had experienced good end of life care.

Whilst the palliative care team provided support to staff and at a trust level there was a clear understanding of the service this was not understood by staff. When questioned staff could not always identify patients who may have more than a few days to live as being at the end of their life and may benefit from access to the palliative care service. Implementation of end of life care objectives and action plans were patchy or non-existent

Requires improvement

# End of life care

## Are end of life care services safe?

Requires improvement

### Safety and performance

St George's Hospital, Tooting is situated within the South West London Primary Care Trust cluster which was performing in the bottom 20% of all clusters nationally for 11 of the 26 questions in the National Bereavement Survey (VOICES) 2011. The areas that the cluster did not perform as well on were around the privacy and dignity shown by hospital nurses, quality of hospital doctors, pain relief and patient's ability to choose where to die. The trust had also undertaken an audit called FAMCARE in 2013 which showed that people were satisfied or very satisfied with the care and treatment they received at the hospital. The trust meets its CQUIN targets in respect of end of life care.

There were no serious incidents reported regarding patients receiving end of life care. Serious incidents would be investigated by the palliative care team if they involved patients at the end of life. We did observe one 'near miss' on Trevor Howell Day Unit. The notes on the end of one patient's bed were not those of the occupier, but of the patient in the next bed. This was pointed out to staff who immediately rectified the issue.

The trust undertook an audit of 277 DNA CPR forms completed between 2011 and 2013. The audit identified that only 20% of DNA CPR forms were completed accurately.A further audit undertaken in August 2013 by the trust highlighted that DNACPR forms were not being completed in resepct of patients and families involvement in the decision. Action plans are in place and a re-audit is expected in April 2014. We reviewed the DNA CPR forms for four patients and found that, while discussions with patients and their families had been recorded, other parts of the forms had not been completed, such as information on the decision not to resuscitate the patient. Further training was being rolled out to clinical staff on medical wards. The completion of these forms ensures that all involved in the care of the patient are aware of the patient and families wishes in respect of care at the very end of their life.

### Learning and improvement

According to published figures from the National Cardiac Arrest Audit Report, 36% of patients who had a cardiac arrest while an inpatient survived the event. The trust had planned to use this information when reviewing do not attempt cardiopulmonary resuscitation (DNA CPR) forms.

### Systems, processes and practices

### Equipment and environment

The lift to the mortuary was broken and had not been working for an extended period of time. This meant there was no disabled access. Mortuary staff said that this was an estates issue and that they had made many previous attempts to get it remedied without success.

There was good access to and availability of general equipment (beds, hoists, commodes, pressure-relieving mattresses, and so on) for people fast-tracked to return to their homes for end of life care. There was a water leak through a light fitting in the maternity bereavement room which made it unsafe. This was raised with the matron who contacted an emergency engineer and the matter was dealt with.

One of the aims of the palliative care team was to provide an integrated palliative and end of life care specialist service across the trust. We were told that the mortuary deals with an average of 10 deaths a night. The mortuary was the centre for post-mortems for 13 hospitals. It also stored bodies for the Westminster coroner. In line with best practice and trust policy, DNA CPR forms were located at the front of patient records for quick access in an emergency.

### Monitoring safety and responding to risk

Some concerns were raised by staff around staffing levels on the oncology units. There was no evidence that staffing levels were unsafe, and nurses in the focus groups we held during the inspection confirmed this. However, nurses had to work long hours and senior staff (for example, matrons) had to do more hands-on work rather than lead their respective teams. Vacancy rates were higher than they were elsewhere in the hospital; however, we were told many times by staff that active recruitment was taking place.

In two focus groups during the inspection, nurses stated that, although recruitment was taking place, very few applicants were getting through the assessment phase to actual interview. Staff consistently stated that they would prefer to keep their "standards high". While there were

Requires improvement

# End of life care

recognised staffing issues on the oncology units which had the potential to affect the quality of care for patients at the end of life, the trust had implemented measures to improve staffing levels.

Staff had undertaken online training in safeguarding vulnerable adults and the Mental Capacity Act 2005. We found that there had not been a best interest meeting before a nasogastric feeding tube was inserted in a patient who was at the end of life. Trust-wide data showed that there were around 50 referrals for independent mental capacity advocates each quarter. We had conversations with four qualified nurses and two student nurses about the Mental Capacity Act. We were concerned that they did not exhibit full understanding of the implications of the Act on patients to whom it applied.

### Anticipation and planning

When a patient was deemed to be reaching their end of life, the palliative care team was contacted to support the patient and the staff with the development of an individualised care plan.

## Are end of life care services effective?

(for example, treatment is effective)

Good

### Using evidence-based guidance

Evidenced-based practice in the trust's end of life care was evident. This included practice recommended by the Bereavement Council, the National Council for Palliative Care, the national quality standard for end of life care for adults and National Institute for Health and Care Excellence (NICE) guidance on supportive and palliative care for adults with cancer.

There are also national quality markers for end of life care which the hospital measured its self against. The performance data included patients preferred place of death. In this marker the hospital ensured that preferred first and second place of death was recorded and that most patients (75%) died in thier preferred place.

In preparation for the trust's NHS Litigation Authority assessment of risk standards in April 2012, the palliative care team were asked to review how successful the NICE quality standard for end of life care had been implemented. Much of the information provided related to the use of the Liverpool Care Pathway for end of life care and the working of the palliative care team, who stated that the trust-wide application of the standard would need to be investigated further. This work had not been undertaken. Therefore, the trust had not identified and evaluated the effectiveness of its practice in line with the NICE quality standard.

The Liverpool Care Pathway has been withdrawn in line with national guidance and the trust had implemented the London Cancer Alliance care plan We reviewed the records of four patients at the end of life and these contained evidence of appropriate evidence-based prescribing.

### Performance, monitoring and improvement of outcomes

A cross-section of staff in A&E, the Trevor Howell Day Unit and the Marnham and Allingham wards, were very positive about the palliative care team, saying that they were effective, supportive, available seven days a week and able to provide some training to staff. The Cancer Patient Experience Survey 2013 rated the trust in the bottom 20% of all trusts nationally in 39 out of the 69 questions asked. This poor rating does not seem to be borne out by our findings during this inspection. The trust's end of life care audit in August 2013 showed evidence of proactive review and monitoring of end of life care within St George's Hospital, Tooting.

### Staff, equipment and facilities

Staff stated that they had sufficient equipment to treat patients. We saw that patients on end of life care plans received medication through a syringe pump (to control amount given) and that these were regularly available for use.

### Multidisciplinary working and support

There was a multidisciplinary team approach within the palliative care team, which also had good links with local community hospices. The team monitored and reviewed information held about patients that had been referred to the service.

Clinicians and members of the palliative care team confirmed that there was multidisciplinary team working in caring for patients at the end of life. Minutes of recent meetings confirmed this, with the meetings including representatives from hospices that provided community care. There were also regular 'death and dying' meetings with staff from the mortuary, palliative care team, chaplaincy and head of nursing.

Requires improvement

# End of life care

We saw evidence in patient notes of multidisciplinary team working. Allied health professionals, such as physiotherapists and occupational therapists, told us that they felt part of the team and appeared to be patient-focused.

## Are end of life care services caring?

Good

### Compassion, dignity and empathy

The services offered by the mortuary and bereavement services were considered to be excellent. The mortuary was clean and the care was compassionate and caring. All faiths were respected and catered for.

The mortuary had separate waiting and viewing rooms and also toilet facilities. The viewing room contained a double couch so that people could sit together. Bodies could be viewed either through a window or via a camera link. There were many personal touches in the mortuary which we felt were positive and made visitors have a more personal and respectful experience. There was also a procedure for viewing bodies out of hours. These facilities were considered to be excellent.

There were separate mortuary facilities for deceased babies which contained 'Moses baskets' and a bath where bereaved parents could bathe their deceased child. This was considered to be good practice. There was a dedicated bereavement midwife who saw bereaved parents/relatives in an area away from new mothers and babies which showed sensitivity to the situation.

The bereavement officer was very knowledgeable and proactive in seeking ways to make the bereavement process easier and as caring as possible, putting bereaved families at the heart of their work. There were issues regarding the lack of space in the chemotherapy day unit, which impacted on patients' privacy and dignity. Staff on the wards also told us that, due to space restrictions and the lack of side rooms on some wards, sensitive conversations could be overheard as patients were sometimes only separated by curtains. One of these was overheard by the inspection team during our visit.

### Involvement in care and decision making

In one listening event prior to the inspection, people of the Islamic faith told us that it was important that the bodies of the deceased were handled by a person of the same gender. Also, it was important that close relatives were able to wash and prepare the body after death. However, they said that the hospital had often carried out this task before families had a chance to be involved and this caused distress. This was not in line with the trust's policy which facilitated family involvement in care after death.

Patients told us that treatment plans had been explained and most relatives said that they had been included in the care planning process. However, we were also told by a patient's relatives that they had not been involved in the decision to carry out surgery. The patient had a completed DNA CPR form, which did not show evidence of family involvement.

### Trust and communication

There were good interactions between staff and patients. Staff were seen talking with patients, discussing their symptoms and asking about how they were feeling. This was polite and exhibited care and concern. One porter's behaviour was 'exemplary' by the dignified and safe manner that they transferred a patient.

### Emotional support

Staff in the oncology outpatients department told us that active identification of patients who required end of life care was mainly considered by inpatient medical wards and beyond their remit. Staff on the palliative care team said that their team included a counsellor who worked three days a week and access to a psychologist. The bereavement officer identified people for follow-up counselling and psychology as appropriate. Families told us they had experienced good end of life care from the St George's community services team, specifically highlighting very good bereavement counselling when children had died.

## Are end of life care services responsive to people's needs?

(for example, to feedback?)

Good

### Meeting people's needs

Consultants told us that they knew what actions to take and how to escalate any clinical concerns for patients at the end of life. We observed the proper use of the national

Requires improvement

# End of life care

early warning score (NEWS) for acutely ill patients on the oncology ward, A&E and surgical wards. The palliative care team was available seven days a week and ensured that patients' end of life wishes and their preferred place of death were recorded on their care plans.

Staff in the mortuary confirmed that it was the trust's policy for ward staff to prepare bodies before they were transferred to the mortuary. This included ward staff washing the bodies, removing tubes and needles, and so on. This policy met with the requirements of local Islamic community who had raised this during a listening event and for whom this was important. However, one family felt that this had not been implemented.

Staff told us that there was reasonable access to a translation service through a contracted provider during weekdays. However, there were shortcomings in the translation service due to the range of languages (about 140) spoken locally. Staff exhibited an awareness of the need for a clear understanding and sensitivity in explaining some matters to patients, and acknowledged that it was not always appropriate to use the contracted provider or family members as translators.

### Vulnerable patients and capacity

Staff were aware and sensitive to the needs of patients in their care. They recognised that this group of patients were particularly vulnerable at this point in their life. Staff supported patients in making decisions by providing them with information and involving families where patients wanted this.

### Access to services

Visiting times were very flexible for visitors of patients at the end of life. We were told by a patient's relative that car parking at the hospital caused unnecessary stress. They said that they found it very difficult to park in order to see their relative who was terminally ill. They also stated that it was very difficult to get wheelchairs to and from the car park.

### Leaving hospital

Staff on the Trevor Howell Day Unit said that the discharge process for patients to return to their homes was seamless. However, staff on one of the care for the elderly wards told us that they had problems getting equipment for patients being discharged who were not being fast-tracked or terminally ill.

### Learning from experiences, concerns and complaints

The head of nursing for patient experience dealt with about 100 complaints a month and less than 8% of complainants were unhappy with their response. The annual complaints and improvements and Patient Advice and Liaison Service report for 2012/13 showed a 54% reduction in complaints in relation to oncology and palliative care in the previous year.

## Are end of life care services well-led?

Requires improvement

### Vision, strategy and risks

Staff were unaware of the overall trust's end of life care strategy, but knew how to contact the palliative care team. The chief nurse is the board lead on end of life care. A steering group meet three times a year to review performance and quality of care and to implement the national end of life strategy. This is then reported to the trust board. The trust publish guidance and updates on the trusts intranet. However in discussion with staff they were unaware of the the vision and strategy of this group and ultimately the senior managers at the trust.

### Governance arrangements

Concerns had been raised previously regarding the identification of bodies in the mortuary. The clinical governance committee reviewed the practice and implemented policies to remedy the issues. Triple identification was now implemented and we were told that this now worked well. Governance structures for end of life care were not clear, even to senior leaders in the trust. Best practice and learning from end of life care may therefore not be shared as widely across the trust as it should be.

### Leadership and culture

The chief nurse told us that end of life care was "everyone's business" and that all staff were involved when appropriate. While structures and reporting systems downwards from the palliative care team worked well, there was a lack of strategic direction for end of life care from the top of the organisation.

The deputy chief nurse and chair for the end of life strategy group told us that there was no specific action plan to address the points from the National Bereavement Survey

Requires improvement

# End of life care

(VOICES) 2011. This was because the survey was an audit which covered the South West London Primary Care Trust cluster and it was unclear what applied specifically to the trust. Further audits and surveys had been undertaken which did have action plans in place which reflected the service within the hospital.

### Patient experiences, staff involvement and engagement

Staff described end of life care as being for those "actively dying and in the last days and hours of their life". We were, therefore, concerned that patients who were terminally ill but were expected to live for a longer time were not given access to end of life care in the same way.

### Learning, improvement, innovation and sustainability

A consultant told us at one of the focus groups that they were positive about training available to staff on end of life care and use of DNA CPR in the community and hospital. The trust's clinical strategy 2012–2022, refers specifically to end of life care and states 'We will work towards the goal that 75% of all predictable deaths should occur in the patient's preferred setting rather than hospital as the default.' We found that the hospital was currently achieving 77% of patients dying in their first or second preferred place of death. Two sets of minutes of the steering group for 2013 were reviewed these reflected action plans in place to meet the national end of life strategy. The hospital worked towards the quality markers set by the local commissioning groups who had their own local strategies for end of life care. The hospital does not have its own strategy but works to meet the national end of life strategy. We felt that responsibility for learning and improvement for end of life care was devolved to the palliative care team itself and strategic direction from the senior leadership in the trust was lacking.

Good

# Outpatients

| | |
|---|---|
| Safe | Requires improvement |
| Effective | |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

## Information about the service

St George's Hospital, Tooting outpatients department runs a wide range of outpatient services. There were over 700,000 attendances in 2013 and the trust provides over 60 clinics a week across different specialties. The outpatient clinics are located throughout the trust, including services provided in the main hospital building within the Lanesborough and St James Wings and at Queen Mary's Hospital in Roehampton. We visited the outpatient clinics for general surgery, orthopaedics, gynaecology, oncology, haematology, phlebotomy, neuro-rehabilitation and the children's outpatient services at the Dragon Centre.

We spoke with 13 patients and 20 staff, including medical and nursing staff, healthcare assistants, managers and administrators. We received comments from our listening events, staff focus groups and from people who contacted us about their experiences. We also reviewed the trust's performance data.

## Summary of findings

Some patients found staff to be friendly, professional and caring and were mostly happy with the services provided by the trust. Others were negative about the waiting times for appointments, and many patients were frustrated that they were not given information about how long they would have to wait once they were in the clinic.

There was a reliance on temporary records as medical records were often unavailable. Patients' paper records were not always kept securely and confidentiality was often breached. Although the trust was putting arrangements in place to obtain feedback from patients, staff told us that limited information was available about patient experiences. Staff knew that there was a regular problem with overbooking of clinics, but did not seem to understand why or how this could be better managed.

Local leadership was visible but, despite this, the outpatients department was not well-led. Communication was not always effective at all levels and staff were not clear on management structures and the responsibilities of other team members. Staff complained of bullying and some felt unable to raise concerns. The service needs to be better led in order to bring about improvements.

Good

# Outpatients

## Are outpatients services safe?

Requires improvement

### Safety and performance

There were two reported incidents in 2013 which resulted in severe harm to patients. Many staff we spoke with were unable to tell us what response had been made by the trust or how this was communicated with the team members to improve the services.

Staff were aware of how to respond to safeguarding concerns and what constituted abuse. Clinics had a safeguarding lead and most staff knew who they were. However, some staff in the paediatric outpatient clinics at the Dragon Centre told us they would tell the doctor if they had identified safeguarding concerns, rather than inform the safeguarding children's team.

### Learning and improvement

Matrons reported on indicators within the outpatient areas, focusing on patient's safety incidents, sickness absence, staffing levels, attendance and cancellation rates. We were told progress was made in a number of these areas in recent months. Staff were not aware of the monthly scorecard details and these were not visible in the clinic areas.

### Systems, processes and practices

Clinicians did not always have access to patients' medical records for their appointments. A staff member told us that 120 records did not arrive for a number of clinics the week before the inspection, and that this was a regular occurrence. A patient told us that a senior staff member told them that they could not be seen because their notes were not available: "I was asked to wait until she can fit me in. I don't know how long this will take". Nurses and healthcare assistants spent a substantial amount of time looking for records and completing incident forms every day. Staff told us they informed the management regularly that it was a problem, but had not seen any change. This meant that a number of patients were undergoing fairly complex procedures without clinicians having reference to their notes, which put them at risk of receiving unsafe care.

Since October 2013, the trust had taken some action and had plans to improve records management. Actions taken included a new system of electronically tracking records throughout the trust. However, staff told us this made records more difficult to locate and that a number of staff were not trained to use the new system. This and other measures taken had not yet translated into improvements in practice.

### Environment and infection control

The premises we visited were visibly clean and staff were aware of infection control procedures.

### Monitoring safety and responding to risk

There were some mechanisms in place to capture incidents and identify risks. However, these were not always used as a learning tool. For example, one manager told us that they had frequently recorded incidents related to missing medical records on the trust's database but there was no adequate response or action taken.

Safe staffing levels with appropriately qualified and experienced staff was a challenge. Staff absences due to sickness had led on occasions to clinics being cancelled. However, measures to reduce staff sickness levels were effective and the trust's data showed that long-term sickness rates in the department had reduced in the last six months of 2013. Staff had worked hard to reduce the impact of staff absences on patients.

In some clinics, vacant posts were filled by temporary staff or staff who were acting up in another position. Over 20% of posts were vacant, but the trust was unable to provide us with information about how this impacted on individual outpatient clinics. Although bank (overtime) staff were used infrequently, other nurses were working extra shifts to cover for staffing shortages. The department's temporary staff expenditure was six times higher than the trust's target, peaking at 23% in 2013. Matrons told us the trust had started to recruit more staff and we noted that there was a plan to address this issue.

We found that outpatient clinic staff in some areas did not understand the details of Mental Capacity Act 2005 and how this related to vulnerable adults in terms of best interest decisions and informed consent.

### Anticipation and planning

Most patients who became acutely unwell in the outpatients department were transferred to A&E and triaged (prioritised). Some clinics had local arrangements, for example, there were three allocated beds on Amyand Ward available to fast-track patients from the lymphoedema clinic.

Good

# Outpatients

Staff told us that allocated appointment slots of 10 to 15 minutes were insufficient for patients with complex conditions. Booking lists were prepared by the central outpatients department and staff told us that they were not "organised efficiently" and failed to consider the knock-on impact on the clinics.

## Are outpatients services effective?
(for example, treatment is effective)

### Using evidence-based guidance
Some senior medical staff told us that junior medical staff were actively engaged in research and audit. Other staff told us that they intended to audit and peer review their services in the coming year. Overall it was difficult to evaluate how effective services were in practice and to demonstrate how they were improving in line with best practice guidance.

### Performance, monitoring and improvement of outcomes
Staff suggested that the central booking service was not working effectively. There were standard operating procedures for all bookings and processes to help clinics to run smoothly but staff felt that these were not always being followed.

### Staff, equipment and facilities
Some staff had recently completed web-based mandatory resuscitation training. Despite this, several junior nursing staff could not show us how to use resuscitation equipment in some outpatient clinics. The trust's training data showed that a number of staff had yet to attend resuscitation training. A few allocated fire wardens in the department had also not attended the required annual update training. In some areas, staff spoke in high regard of the access to opportunities for development. For instance, staff working in the lymphoedema clinic told us that specialist external training had been arranged annually to allow them to further their skills and to maintain their continuing professional development.

### Multidisciplinary working and support
Patients told us that doctors and nurses were skilled and knowledgeable. Healthcare assistants and nurses from associated wards were allocated to work in outpatient clinics based on their skills and experience. The benefit of multidisciplinary team working to ensure that patient care was coordinated effectively was recognised by staff. There was good senior medical support available to junior doctors in the clinics. Joint clinics were held in some specialties to improve their effectiveness. Staff were confident that diagnostic tests and results from other specialties were received promptly so that patients received timely feedback about their care.

## Are outpatients services caring?

Good

### Compassion, dignity and empathy
Most patients told us that they were satisfied with the service they had received. Comments included: "Amazing care, the nurses are lovely" and "Had excellent service". Many patients said they experienced a very caring approach by staff and found staff willing to help. Staff maintained positive and caring interactions throughout the outpatients department during our inspection. For example, nursing staff offered cups of tea to patients who had experienced delays. A specialist urology clinic for patients who had recently stopped using a catheter had its own waiting area.

### Involvement in care and decision making
Patients told us they were allocated sufficient time with staff when they attended clinics. They were encouraged to ask questions, were involved in making decisions about their care, and able to give their informed consent if required.

### Trust and communication
Clinical staff came to waiting areas to call patients to be seen. However, the open reception area did not always allow adequate privacy. Staff in clinic A and at the Rose Centre (breast screening service) told us it was difficult to maintain privacy in clinic rooms as voices could be overheard. Also, the sign at the clinic's reception desk alerting visitors to respect privacy and dignity was disregarded by many as it was not prominent. In the phlebotomy clinic, doors were not closed and we could see patients having the procedure carried out which breached their privacy. A curtain was available but was not used. These issues of lack of privacy in some clinics should be addressed by the trust.

Good

# Outpatients

**When a patient did not speak English, staff accessed interpreting services available over the phone or in person.**

### Emotional support

We were told that psychological services can be accessed in emergency situations by telephone, otherwise referrals were made to access on-site psychiatric or psychological support.

## Are outpatients services responsive to people's needs?

(for example, to feedback?)

Good

### Meeting people's needs

Patients' appointments were prioritised according to their clinical needs. Some staff felt the central booking team did not give sufficient time for complex patients and that clinicians had to work around the schedule they were given by management. Conversely consultants told us that they had an open door policy, but acknowledged this had an impact on waiting times.

### Vulnerable patients and capacity

Staff told us they spent time discussing treatment options and plans with patients. They were aware of the requirement to obtain people's consent when necessary.

### Access to services

The trust was meeting the Department of Health standards of two weeks for urgent cancer referral waiting times and the 18-week referral-to-treatment pathway. Performance information for October 2013 showed that patients were waiting about seven weeks for an appointment against a standard of about five weeks. The trust was meeting the national 95% performance target for patients to be treated within 18 weeks for all areas, with the exception of trauma and orthopaedics.

A high number of patients who did not attend their booked appointments for some clinics limited timely access to clinics by others. We identified good practice whereby the department was actively working to improve overall attendance rates through reminder calls, messages and texts.

Senior medical staff we spoke with told us that they planned to ensure clinics were rarely cancelled by their specialty. Trauma and orthopaedics and plastic surgery had higher than average outpatient cancellations every month. Senior nursing staff told us that the liver clinic had a high patient non-attendance rate and that this was monitored monthly by the matrons. Other staff were unaware of these details and so were not provided with information to manage this situation proactively.

Some patients told us that they were informed of waiting times for consultation on arrival at outpatient clinics. Several patients told us they had good experiences in certain clinics, including phlebotomy, with few delays and results reported on the same day. Waiting times for consultation varied between clinics on a day-by-day basis, dependent on unpredictable factors, such as clinical emergencies that took doctors away from clinics and patients who did not turn up or cancelled appointments. Some patients were seen promptly, while others had to wait more than three hours. This made it difficult for them to plan around their appointments. The waiting times for individual clinics were not listed, instead an overall waiting time was displayed. This was misleading as there were patients waiting for a variety of services.

Some of the clinics overran and staff told us of cases where clinics overran by up to three hours. Despite this being an ongoing issue, the trust had taken limited action to minimise the inconvenience to patients. A number of clinics were open for longer hours into the evening and staff told us of plans to increase evening opening times to suit patients' needs. For example, there was now a weekly evening rapid access clinic for colorectal services.

### Learning from experiences, concerns and complaints

Complaints information was displayed in a number of the clinics. The trust reported that, of the complaints received regarding the outpatients department between April 2013 and October 2013, the majority related to communication. A patient said, "I would consider a formal complaint but I don't know the process". Minutes of the October 2013 patient experience committee stated there was an increase in complaints in the trauma and orthopaedics and urology specialties. The minutes stated there were no common themes and that the management team were working with outpatient staff and clinicians to address and improve these issues.

Good

# Outpatients

## Are outpatients services well-led?

Good

### Vision, strategy and risks

The trust's priorities for 2014/15 included improving patients' experience in outpatient clinics. The department's management had undertaken a full service review in order to identify measures to improve the patient and staff experience. Existing problems with technology, access to records, the environment, booking clinics and staffing had been identified.

There were trust-wide and speciality-specific risk registers which identified areas of high, medium and low risk to patients and staff. Risks for the department had been identified – for example, the lack of privacy and dignity in some clinics – but it was unclear how the action taken will mitigate this risk. The trust also identified delays in children's outpatient services as a risk, which was first escalated in 2008. It stated that the introduction of the electronic record-keeping and triage systems would resolve this risk.

### Governance arrangements

Consultants told us the service was well-led and spoke positively about clinical governance meetings and governance structures. However, non-medical or nursing staff were not aware of recently investigated serious incidents. Most non-medical staff were not sure who was ultimately responsible for the quality and oversight of outpatient services across the trust.

### Leadership and culture

Staff did not have a clear overview of the management structures and responsibilities of the senior management team. There was a system in place to monitor the quality of the service, although we found that the trust did not take appropriate action to address continuing failures. For example, the trust had not taken prompt action in response to the ongoing issues and identified risks related to medical records not being delivered on time. In addition, staff reported that clinics were consistently overbooked but there was no evidence that action had been taken to address this issue.

Medical staff told us they felt confident to directly approach the chief executive if they had concerns and spoke of good working relationships with general management. A number of staff told us that the chief executive was visible, but that the other senior managers in the management structure were less so.

Some clinical staff in one of the clinics we visited told us they experienced bullying from a senior member of staff and told us they felt unable to raise concerns. Some did not feel valued or listened to and were allegedly told not to speak openly with CQC inspectors. Senior managers we spoke to told us they were not aware of any reports of bullying or harassment within the department. The trust's policy for dealing with bullying and harassment states that senior management staff should provide support to any member of staff who experiences harassment, should remind staff of behaviour that could be seen as harassment and not to dissuade employees from making a complaint.

### Patient experiences, staff involvement and engagement

The trust as a whole was in the bottom 20% of trusts in the Cancer Patient Experience Survey 2013 that asked whether patients felt they were told sensitively that they had cancer, were given the right amount of and clear information about their condition and available treatment and had got enough emotional support from the hospital. The majority of patients who were informed of their cancer diagnosis felt that staff were "reassuring". Comments included: "The clinical nurse specialist explained diagnosis and treatment, giving the diagnosis was very well done". One patient told us of their negative experience and said, "The delivery of bad news is insensitive" and "I came in for what I thought was a routine appointment only to be told that the cancer had spread".

Staff were aware of the electronic devices used by patients to provide feedback, but were unaware how often results were produced and what was done with them. Some senior clinical staff reported last receiving formal patient feedback in July 2013.

### Learning, improvement, innovation and sustainability

Senior management staff told us there were intentions to introduce the productive outpatients programme, in order to streamline all areas of the outpatients department across the trust.

This section is primarily information for the provider

# Compliance actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers<br>People who use services and others were not protected against the risks associated with obtaining the consent of patients with limited capacity as not all relevant staff understood the requirements of Mental Capacity Act 2005 and how this relates to vulnerable adults in terms of best interest decisions and informed consent. Regulation 23 (1) (a) **(b)** HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records<br>People who use services and others were not protected against the risks associated with not having medical records available in the outpatient department to provide appropriate care based on previous history. Regulation 20 (2) (1) HSCA 2008 (Regulated Activities) Regulations 2010 Records |