Ashford and St. Peter's Hospitals NHS Foundation Trust

St Peter's Hospital

Quality Report

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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.

Summary of findings

Letter from the Chief Inspector of Hospitals

Ashford and St Peter's NHS Foundation Trust provides healthcare services across north-west Surrey to a population of 302,600. The trust provides district general hospital services and some specialist services such as neonatal intensive care and limb reconstruction surgery from sites at Ashford and St Peter's Hospitals.

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

We also apply ratings to the trust's overall performance. When we inspected the trust in December 2014 and published in 2015 we rated it as 'good' overall. We rated safety as 'requires improvement' 'good' for effective, caring, responsive and well led. We found that the trust was in breach of some regulations and we told the trust it must address this. We returned to the trust in February 2017 to review progress and found the trust had improved and was compliant with all regulations.

This unannounced responsive inspection was undertaken as we had received information of concern regarding standards of nursing care on medical wards at St Peter's Hospital. We followed this up with the trust who provided us with further information. However, we needed to go and test this information to ensure patients were receiving safe care. We focussed the inspection on this issue and did not inspect other services or cover all of our key lines of enquiry. The results of this responsive inspection have not changed the ratings from the previous inspection report published in 2015.

We saw several areas of good practice including:

- The strategy and initiatives to prevent and monitor pressure ulcers
- The planning and delivery of nursing care

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure fire safety is regularly reviewed and enforced.
- Ensure the safe storage and security of medicines.
- Ensure safety checks and services on patient equipment are consistently completed.

In addition the trust should:

- Support and enable all staff to complete mandatory training.
- Continue its strategy to make safety thermometer information more accessible to staff and patients.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care		As this was a focussed inspection we did not re-rate this service. We found some areas where the trust was in breach of the regulations and must take action. We had concerns about fire safety and the blocking of fire exits with equipment. Medicines were not always stored securely and emergency equipment was not always checked or serviced to ensure it was ready for immediate use. We found other areas where the trust should take action. Mandatory training levels were below trust targets and staff found it difficult to access training. Safety performance information was not readily available to staff and patients. However, we also found areas of good practice. Generally patients received care that met their needs. There were sufficient nursing staff; although there was high usage of temporary staff, there were arrangements to ensure they were inducted to the ward areas where they worked. There were robust arrangements for the prevention and management of pressure ulcers and safety thermometer performance was in line with national averages. Staff helped patients to eat and drink and to take their medicines. Patient records were generally completed in line with professional standards, although there were some omissions. Patients reported being treated with kindness and that their privacy and dignity was maintained. Managers responded promptly to area of concern we raised at the time of our inspection.

St Peter's Hospital

Detailed findings

Services we looked at
Medical care

Detailed findings

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Background to St Peter's Hospital

Ashford and St Peters NHS Foundation Trust was formed from the merger of two hospital sites in 1998 and achieved foundation trust status in 2010. Services are provided on two hospital sites, St Peter's Hospital (Chertsey) and Ashford Hospital.

We inspected this trust in December 2014 and published the report in 2015 when we rated St Peter's Hospital as requires improvement overall with breaches of Regulation10 HSCA 2008 (Regulated Activities) Regulations 2010: Assessing and monitoring the quality of service providers. Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010: Management of medicines. Regulation 20 HSCA 2008 (Regulated Activities) Regulation 2010: Records. Regulation 22 HSCA 2008 (Regulated Activities) Regulation 2010: Staffing.

We conducted a follow up inspection in February 2017 and found the trust had taken action to comply with the regulations for all four breaches, although the procedures for monitoring the temperature of medicines storage needed further embedding in practice. However, we had confidence that services were now delivered in line with regulations.

We undertook a focused, unannounced responsive inspection of the hospital in September 2017 as a result of information received. This inspection focussed on care on the medical wards.

We did not rerate this service as it was a focussed inspection.

Our inspection team

Our inspection team was led by a CQC inspector and included a CQC inspector, CQC inspection manager and a specialist advisor experienced in medicine and was overseen by Nick Mullholland, Head of Hospital Inspection (South East).

How we carried out this inspection

We carried out an unannounced, responsive inspection on 19th September 2017. The inspection was focussed on nursing care on the medical wards at St Peter's Hospital as we had received information of concern. We had previously discussed these concerns with the trust who provided evidence and assurance of the quality of care being delivered. We reviewed this evidence. However, we

Detailed findings

needed to test this information to be assured patients were receiving safe care. As this was a focussed inspection we did not inspect all of our key lines of enquiry, only those relating to our concerns.

We visited four medical wards and observed the environment and care. We looked at audit results and other information available at ward level. We spoke with 17 members of staff including registered nurses, healthcare assistants and allied health professionals. We also spoke with five patients. We reviewed 11 sets of patient records.

Facts and data about St Peter's Hospital

The trust has 575 beds, of which 501 are general and acute beds.

The trust employs around 3,300 staff and provides district general hospital services to a population of 302,600 people in the boroughs of Runnymede, Spelthorne, Woking and parts of Elmbridge, Hounslow and Surrey Heath.

The latest annual turnover was £288 million.

St Peters Hospital 52,911 inpatient admissions and 483,999 outpatient attendances from July 2016 to June 2017. In the same period there were 99,803 A&E attendances.

This trust's composite score for key indicators is within the middle 50% of acute trusts.

We use the term 'outlier' to describe a service that lies outside the expected range of performance. One example of where we use this is our mortality outliers programme. Our process involves analysing data that suggests concerning trends in the death rate for specific conditions or operations. This trust is not an outlier for mortality. The Summary Hospital-level Mortality Indicator (SHMI) in October 2017 was favourable at 56.8 against a national average of 100.

Between July 2016 and June 2017 the trust had no MRSA bloodstream infections and 23 cases of Clostridium difficile (C.diff).

Medical care

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

At St Peter's Hospital medical care services are managed by the division of medicine and emergency services. Specialties include acute medicine, gastroenterology, respiratory medicine, cardiology, endocrinology, elderly care and stroke care. Medical care services had a bed complement of about 235 inpatient beds in nine wards. The division also manages the endoscopy service and the discharge lounge. From July 2016 to June 2017 the medical service over the whole trust had 29,747 admissions, an increase of 8% on the previous year. Of these 13,768 were emergency admissions and 14,405 were in the speciality of general medicine. The average length of stay was 6.2 days.

Summary of findings

The previous rating for medical care at St Peter's hospital in the report published in 2015 was good. We did not rerate this service as this was a responsive, focussed inspection.

Medical care

Are medical care services safe?

We did not re-rate safe as this was a focused unannounced inspection, looking at certain aspects of care on the medical wards.

Safety thermometer

At this inspection we observed how patient safety information was communicated at ward level.

- The NHS safety thermometer is a local improvement tool for measuring, monitoring, and analysing patient harms and harm-free care. The NHS safety thermometer allowed the proportion of patients who were kept 'harm-free' from venous thromboembolisms (VTE's), pressure ulcers, falls and catheter associated urine infections to be measured on a monthly basis.
- We were unable to find the most recent safety thermometer information displayed on the hospital wards and staff we spoke to were unable to find that information for us. Since the inspection we have evidence that the safety thermometer information is publicly available via the Trust's website.
- We saw white boards at the entrance to the wards with headings about harm free days referencing pressure ulcers, infections and patient falls but on Cherry, May and Swift wards, these boards were not completed with up to date information. On Swift ward there was some information but it was not complete. Staff told us that information to be displayed on the safety boards was currently under review. Not having this information visible meant staff and visitors were not informed of the current safety results for that ward.
- The trust informed us that information was not displayed in some instances because the Quality Experience Workforce and Safety (QEWS) dashboard which is used to summarise ward level harms to predict future risk was under review. The proposed new dashboard is due out in February 2018.
- On Aspen ward we saw the safety board was part of a local quality improvement initiative to determine what content would be most relevant for their specific ward's quality white board. Senior ward staff told us the information needed to be appropriate and accessible to visitors and patients and that once this was agreed this would be shared with all wards.
- We were told that safety huddles were held in the morning on all ward areas these meetings enabled safety information such as staffing, at risk patients and any health and safety issues to be discussed and to be bought to the attention of the team that morning. The timing of the inspection meant we did not see a safety huddle but, on one ward, we were shown this information was documented and was kept at a central point on the ward for all staff to see.
- Following the inspection we had to ask the trust to supply us with the NHS safety thermometer information which showed monthly collection of data for harm free care which was in line with the national target. Falls with harm and new pressure ulcers was seen to be below the national average. We were told that this information was available to staff at ward level.

Environment and equipment

During this inspection we checked the environment of the medical wards to establish that appropriate equipment, including emergency equipment, was readily available for patients.

- On checking the general ward environment in Cherry ward, we found a fire exit (3A 01) blocked with a chair stored behind the door. This meant the fire exit was obstructed and contained material that could act as a source of fuel in a fire. The door to the stairwell was open and not secured and we noted that the emergency break pull was released.
- On the same ward, in patient bay '3A 24', the fire exit was completely blocked with screens, three infusion pumps, three blood pressure machines, one linen trolley, one ECG (electrocardiogram) machine and sundry other items. On the fire door to the outside corridor the break tube was found to be broken and therefore this door would not be secure and function as a fire safety measure. All these findings were reported to the staff on the ward at the time of the inspection.
- On Swift ward in Bay 4 the fire exit was blocked with an air conditioning unit, a linen trolley and chairs. This was bought to the attention of the staff at the time of the inspection. The estates and facilities staff attended the ward and indicated that it was the wards staff responsibility to ensure fire exits were kept clear. When asked staff if they knew how to operate the fire door and generally they were able to do so. As a result of finding

blocked fire exits we spoke to two members of the hospital senior management team and advised them of our findings. This meant that immediate corrective action could be taken.

- Information given to us at the end of the inspection day demonstrated that a reminder had been sent to each ward and department to review security and fire safety in their areas a month before the inspection. We saw a fire safety audit had started across all wards and departments from the 1st September 2017 but the four ward areas we inspected had not yet been audited.
- On completion of the inspection, we saw that an email notice had been sent out reminding all staff of fire safety and actions to be taken to ensure the safety of their areas. This included a link to the trust policy and commitment to complete a fire audit check across all areas.
- We saw and checked four resuscitation trolleys, one on each of the wards inspected. On Swift ward we saw that the suction tubing was not attached. This meant this was not ready for use in an emergency. We saw there was a daily checklist but there were no signatures for the dates 6th, 15thand 16th September, indicating that checks were not made on those days. The automatic defibrillator had not been tested on a regular basis in line with policy and meant that equipment might not function in an emergency. All drawers had the correct consumables and medicines in accordance with the checklist and we saw that consumables were in date.
- On Cherry ward, the resuscitation trolley checks were undertaken however the signatures were unreadable and identical for two weeks suggesting it was completed by the same person. The weekly check was not fully complete as two items had been ticked as being present, which were not. This indicated that checks were not thorough or complete and meant that the integrity of the trolley and contents could not be assured at all times, presenting a safety risk.
- On the other two wards the trolleys were cleaned and tidy, correctly stocked and checked in line with policy.
- On Swift ward we saw a checklist for oxygen, suction and sharps bins for each patient bay, although this this was not consistently completed. This meant that necessary equipment for patients might not be available when needed and there might be a delay in initiating care. In bay one we saw that the daily checklist was only completed on the 2nd July, 5th August, 12th August and 17th September bay two for acute patients the day and night equipment checklist was only completed 2nd September, 5th September, 9th September, 12th September and 17th September. We checked with a staff member who told us that if the checklists were not complete then the checks had not been done. However, when we checked the equipment at each bed space, it was seen to be correct, clean and ready for use.
- In bay three, safety equipment checks were only recorded as being made on the 12th August, 2nd September, 9th September and 17th September. A suction catheter was seen to out of its cover and lying on the floor presenting an infection risk and was therefore not appropriate for patient use.
- In bay four on Swift ward we saw there was no oxygen mask between beds one and two, between beds three and four there was no mask but there was a re-breathing bag and suction. This presented a risk of confusing or delaying staff responding to an emergency as there was no consistency in the availability of equipment.
- It appeared that all checks in all bays were made by the same person. This increased the risk that items might be overlooked by the same individual.
- We observed that certain areas of Swift ward were in need of refurbishment. In bay two we saw paint peeling off the walls and exposed wood on door frames which would present an infection control risk as surfaces were not intact and difficult to keep clean.
- On Cherry ward in the dirty utility room there was a notice saying keep the floor clear. However we saw a dirty mop and bucket. There were six yellow bags filled with, empty but used disposable bedpans, as the bedpan macerator was out of use on the day. The bags were stored on the floor and only partly secured. This presented an infection risk.
- A pair of dirty stained scissors was found in the drawer marked property bags. Liquid detergent and chlorine tablets were unsecured and could therefore be accessed inappropriately. The clinical waste bin was full. This meant that staff might not be able to dispose of waste appropriately and this would present an infection risk.
- The store room on Cherry ward was unlocked and this contained intravenous fluids, syringes and needles and giving sets. This meant that safe storage and the integrity of the stores could not be assured.

- Three items of out of date stock were found, a pair of plastic forceps dated 2015/08, a pair of sterile gloves dated 2017/04 and a culture valve dated 2017/03. Staff were advised of these items at the time of the inspection and these items were taken out of use immediately.
- On all wards we saw stickers on the equipment which indicated it had been serviced regularly, with electrical testing stickers on electrical equipment. While many health care providers continue with annual PAT testing, this is no longer mandated. The Medicines and Healthcare Products Regulatory Agency's (MHRA) 'Managing Medical Devices' (April 2015) states that healthcare organisations should risk assess to ensure that the safety checks carried out on portable electrical equipment are "appropriate and reasonably practical".
- On Aspen ward it was seen that three out of eight bilevel positive airway pressure (BIPAP) machines were not within their service date. These machines are used as a non-invasive form of therapy for patients suffering from sleep apnoea. Two sequential compression garments were also outside their required service date. This meant that equipment might not be fit and ready for use. Senior staff on the ward was informed at the time of the inspection checked and confirmed servicing of this equipment would be organised immediately and we received confirmation that this would be done.
- Aspen ward was visibly clean and tidy with appropriate storage of equipment and free from clutter. In the clinical room there were no items stored on the floor and oxygen cylinders were stored correctly. In bay one, four medical gas cylinders were seen to be waiting for collection. At the time of inspection it was seen that these were not appropriately secured to ensure safety.
- The staff we spoke with confirmed they had access to equipment they required to meet peoples' care needs. For example, they were able to access appropriate mattresses and cushions for those patients at risk of developing a pressure ulcer.

Medicines

During this inspection we checked medicines were administered safely and recorded and patients were supported in the taking of medicines.

- We saw that patients were supported appropriately to take their medicines at the time of administration on all four wards. We saw that when necessary nurses sat with patients assisted with oral fluids and ensured patients took medicines when they were given. We saw no instances of medicines being left at the patient bedside.
- We checked a total of nine medication charts and found all prescriptions were signed, dated, and allergies and omissions were documented. We saw annotations that showed prescriptions were checked by a pharmacist and appropriate interventions made.
- On Aspen ward we saw one instance where prescription charts were left unsecured in a male patient bay. We bought this to the attention of the staff and saw that these were made safe.
- On two wards we found medicine storage was not secure. On Cherry ward, the clinical room where medicines were stored had a key pad but at the time of inspection we found the key pad was fixed open and the room was not secure. Cupboards marked A and B were open and we were able to access liquid medicines such as phenytoin, intravenous paracetamol and antibiotics. We informed staff at the time of inspection and the cupboards were secured.
- Appropriate medicines were stored in a dedicated medicines fridge which was locked. We saw records on the ward, which showed daily temperature checks were undertaken. This provided assurance the hospital stored refrigerated medicines within the recommended temperature range to maintain their function and safety. We also saw recommended actions to be taken if the fridge temperatures were not in the correct range. We also checked the records for the ambient temperatures of the drug room, which showed these, had been completed correctly.
- On Swift ward the fridge was locked but the medicine fridge temperature not checked on 14th and 15th September, on the same date the ambient temperature was also not checked. The intravenous antibiotic drug cupboard was not locked and medicine cupboard labelled 'P2' was not locked despite a notice on the cupboard saying 'please ensure drug cupboards are locked at all times'. We saw that a rectal preparation of diazepam was not locked in the cupboard. A check of this cupboard showed that all medicines were in date. On the ward area we observed the drug trolley was not locked and this meant that drugs were not secured appropriately.

Records

Medical care

During this inspection we assessed if staff had all the information needed to deliver safe care and treatment and that people's care records were managed and written in a way that kept patients safe.

- We reviewed 11 patient records during our inspection. The records we saw across all four ward areas were found to be of a good standard. Nursing records were generally in line with the guidance within the Nursing and Midwifery Council (NMC) Code of Conduct 2017.
- Patient records showed staff had undertaken patient risk assessments, but these were not always consistently completed. However, overall they were legible, comprehensive and current and we judged them to contain all the information needed to deliver safe care.
- We focussed on the assessments made for pressure ulcers and found these to be present with body maps to mark any areas of concern. Repositioning charts were used to record changes of position to reduce the risk of pressure ulcers but these were not always consistently completed.
- On Aspen ward we saw examples of good nursing documentation which detailed that staff were encouraging oral fluids and patients were encouraged to be mobile. Two more patient records were checked with consent forms and seen to be correct. The nursing staff documented in the patient records that the call bell was put in reach and our observation of patients on the day of inspection confirmed this was the case.
- Review of a further set of records demonstrated a full capacity assessment done with 'this is me passport' a specialised care plan in the front of the notes. The mouth care, repositioning and pressure relieving checklists were fully completed for the previous five days. Food and drink charts and malnutrition universal screening tool (MUST) score was fully complete. Weekly Waterlow assessment with body map, falls risk assessment and other assessments were fully complete. The Waterlow assessment is a tool used by nursing staff to assist in assessing a patient's risk of developing a pressure ulcer We saw evidence of a completed Do Not Attempt Cardio Pulmonary Resuscitation form (DNACPR) form and mental capacity assessment was completed. A sepsis screening tool was completed appropriately.
- A further set of notes showed pressure ulcer checks were made most days with only one day not completed. Repositioning chart were completed. Pressure ulcer risk assessments were completed on four occasions. However, this was not in line with trust policy which states patient risk should be assessed on a daily basis. Pressure area and body map assessment completed. Falls assessment were complete. Nursing records showed evidence of delivery of personal care, mouth care and that pressure areas checked and recorded in notes.
- Two patient records checked on May ward and were clear and legible and contained appropriate documentation.
- On Cherry ward one set of notes showed twenty four hour pressure relieving and repositioning chart was completed there was clear documentation of mattress type, two sets of patient records were complete with daily pressure chart complete and all other risk assessments complete.
- Generally we found that medical records were stored securely in trolleys which had a numeric combination lock. Only authorised staff knew the access code to these locks this maintained the security and prevent unauthorised access of patient records. There was only one breach of this security on patient bay 3A Cherry ward where we saw that the notes trolley was open and records were not secured.
- On Swift ward we found a clinical handover sheet containing patient information left on the side in bay two, this was bought to the attention of the staff at the time of inspection and it was removed from the area to ensure confidentiality of patient information.

Safeguarding

- Staff were able to give examples of how to raise safeguarding concerns and an example was given when this had been done recently as a patient had been at risk of self-harm. Appropriate referral was made to psychiatric and safeguarding team. An incident form was completed and one to one care was put in place which was evident on the day of inspection.

Mandatory training

- Staff were aware that they were responsible for completing mandatory training and that the manager would check compliance and keep records of training completed.
- Staff told us that training would be cancelled due to the lack of staff and that this seen as a problem. One staff

member told us they have tried to get round this by organising training on the ward which was not always possible but there was a concern that if this was not done training compliance would not be maintained or improved.

- On Swift ward we were told that staff were not up to date with mandatory training and a member of staff told us that there always seemed to be other priorities. Direct patient care and managing patient complex needs took priority over mandatory training. We were also told that the booking system for training was not always easy to use.
- On Cherry ward we were told that it was not always possible to release staff for training and that mandatory training compliance was about 80%. A report was issued every month to show training compliance.
- On Aspen ward we were told that 40% of staff were not up to date with mandatory training.
- Following the inspection we saw evidence that overall the mandatory training compliance for the medical division was 78% and the mandatory fire safety training was also 78% against a target of 90%.

Nursing staffing

During this inspection we checked actual ward staffing compared to planned staffing and arrangements for using bank and agency staff. In general on the day of inspection we were satisfied that staffing was planned and numbers of staff and skill mix were of a satisfactory standard.

- On all ward areas staff were able to explain how clinical staffing for the ward was organised. On Cherry ward we were shown how the staffing was managed with rotas completed six to eight weeks ahead. We made several random checks were over the past month and it could be seen that the actual staffing met the required staffing for both day and night shifts.
- We were told that for 28 beds there was five trained nurses and four healthcare assistants on duty during the day. At night there were three trained nurses and three health care assistants. This meant that with four bays during the day there was one trained nurse and healthcare assistant per bay and that this was generally sufficient. Staff told us they could request additional staff if a patient with more complex needs required close monitoring and one to one nursing care.
- Clinical ward staff worked a long day from 7.15am to 8.00 pm with two coffee and two meal breaks during this time. Staff told us that generally they were able to take their breaks indicating appropriate staffing to meet patients' needs.
- Staff explained that there was a significant number of agency and bank staff used to ensure staffing numbers were appropriate. We were told that a number of these agency and bank staff were staff who worked at the hospital on a regular basis. Booking bank and agency staff was made by calling the hospital bank who would find appropriate staff and aim to fill any staffing gaps. We were told that system worked well but on occasions there were few staff available in which case there was a wider pool of agency staff that would be used.
- We spoke to staff across all four areas who told us that generally nurse staffing was seen to be a challenge but was usually adequate. Staff told us they were flexible about moving to another ward to work if that was seen as necessary. One staff member told us that staffing was a challenge but they managed and care was not affected by staffing which they saw as good.
- On Swift ward, staff were able to explain the expected number of trained staff that should be on duty and if there was a shortfall how this would be reported to managers. The managers were seen to be supportive and one staff member told us that there had been a patient recently with very complex needs and the senior staff had been supportive ensuring there were extra staff if required and working on the wards themselves if necessary. The staff member told us they enjoyed working on the ward and the staffing was better than at their previous hospital.
- On Swift ward one nurse commented that in the higher dependency bays it was not always possible to complete the work due to staffing, however in the lower acuity bays it was 'easier' to finish all work. The same staff member commented that most of the time the staffing was safe however it is more difficult at weekends.
- On one of the wards we saw on the staffing rota there was regular use of agency staff on a daily basis on both day and night shifts. On the day of inspection only one of the eight healthcare assistants on duty over the twenty four hour period was supplied by an agency.
- On Aspen ward the actual number of staff on duty met the required number of staff and we observed that a member of staff had time to sit and talk with a patient. A

staff member on this ward commented that the ward felt safe, sometimes short staffed and staff do not always get breaks but generally they felt well supported adding that there is lot of paperwork to complete and sometimes it is necessary to stay behind to complete this.

- Nursing managers told us that recruitment and retention of nursing staff was difficult and the vacancy rate on one ward for contracted registered nurses staff could be estimated to be 3%. The ward had a full establishment of healthcare assistants. A second ward had five band 5 nurse vacancies. Staff on Aspen ward said there were two band six vacancies.
- We were told there was an active recruitment campaign locally and for nurses from abroad. A number of these nurses who had just started at the hospital where supernumerary while they completed their induction programme. Staff on the ward told us that they welcomed this initiative and recognised that recruitment and retention was difficult.
- None of the four wards visited had to close beds due to staff shortages. Staff told us that they feel supported by the senior staff and there are regular meetings to check capacity and staffing requirements. There was a regular rostering meeting on a Tuesday looking at the week ahead. We were told that some extra beds had been opened at Ashford hospital which had helped capacity and staffing.
- Staff told us that they would complete an incident form if staffing was thought not be adequate and we saw there was a clear process for escalation of staffing concerns which had overview by the matrons and divisional senior nurse.
- Staff handovers were at the start and end of the shift and we saw that time was allocated for this to be completed.
- Staffing boards were not used consistently on any of the wards visited and this meant that there was a lack of transparency of information about staffing levels.
- Trust-wide the ratio of occupied beds to nursing staff was 2.41 from July 2016 to June 2017 which was slightly worse than the national average of 2.17.

Are medical care services effective?

We did not re-rate effective as this was a focused unannounced inspection, looking at certain aspects of care on the medical wards.

Patient Outcomes

- In the year April –June 2016 the rate of new pressure ulcers in medical wards (per100 patients sampled) was 0.7. In the period April 2017 to June 2017, the rate was nil and this data demonstrates improvement.

Nutrition and hydration

During this inspection we reviewed how patient's nutrition and hydration needs were supported by the nursing staff.

- The malnutrition universal screening tool (MUST) was used to assess patients' risk of being undernourished. The 11 patient records we reviewed had completed MUST assessments. A number of the patient records contained fluid and or food charts the majority of these were only partially completed. This meant that a patient's intake was not consistently monitored.
- Staff told us that they had access to a dietician and knew how to make a referral.
- Patient on the wards commented that they had access to cold fluids throughout the day and hot fluids were offered at regular intervals. At the time of the inspection we saw catering staff offering drinks to patients and ensuring these were left in reach.
- On May ward one patient told us they were offered regular fluids with their meals and were able to ask for drinks in-between meals.
- On Aspen ward we saw a healthcare assistant taking time to support a patient with oral fluids and time was taken to find a flavour of drink the patient preferred.
- In the May 2017 CQC Inpatient survey, the trust scored 7.4 out of 10 for saying they received help with eating.
- Trust wide patient-led assessment of food scored 93.5% for the period March to June 2017, better than the national average of 89.6%.

Competent staff

During this inspection we checked staff had the skills and knowledge to deliver effective care and treatment.

Medical care

- All the ward staff we spoke to had completed an induction programme. As well as the hospital induction there was a local induction programme to the ward area. Staff also told us that when working on a specialised ward there competencies that would need to be completed and we were shown evidence of this. Staff told us they had completed specialised training and competencies and felt confident in their ability to manage the patients in their care.
- There was evidence of induction completed for agency staff and these were kept on file in the ward areas.
- Staff we spoke to generally had received an appraisal; one senior member of staff had not completed appraisal training and was not sure if all the staff on that ward had received an appraisal.
- Trust-wide 80.7% of staff received an appraisal in the past 12 months in the period September to December 2016.

Multidisciplinary working

- One physiotherapist and occupational therapist was attached to each ward. The occupational therapist confirmed that their role was to assess patients against their discharge needs, functional ability and home state. Decision about discharge home was made based on the input from the patient, family, multi-disciplinary team and patient individualised assessment. This was recorded on line and the record was copied to social services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were able to explain when a Deprivation of Liberty Safeguard (DoLS) referral may be necessary and how this would be communicated to the appropriate team.
- Staff told us and the patient records we looked at showed us there were able to complete a mental capacity assessment. We saw that the patient was involved in the assessment and the patient's consent to assessment was obtained. In the case of the patient not having mental capacity staff the assessment was made with the patient's best interests considered.
- On Swift ward patient records showed that one patient was detained under section 2 of mental health act and this was fully completed with clear rationale documented. Deprivation of liberty safeguarding was fully completed. Mental capacity was assessed and the outcome of the assessment documented.

Are medical care services caring?

We did not re-rate caring as this was a focused unannounced inspection, looking at certain aspects of care on the medical wards.

Compassionate care

- The patients we spoke to across all ward areas were positive about the care they had received. The latest Friends and family test results for medical wards (October 2017) show 94.5% of patients would recommend the trust, with a response rate of 18.2%.
- In the May 2017 CQC Inpatient survey, the trust overall scored 9 out of 10 in relation to treatment with respect and dignity.
- Trust-wide, patient-led assessment of privacy, dignity, and well-being scored 89.2% for the period March to June 2017, better than the national average of 82.7%.
- One patient told us that staff understood their condition and described the staff as, "very good and compassionate".
- A patient who had been on the ward for just over two weeks told us they were well looked after but not always kept up to date with the results of tests and investigations.
- On one ward we saw a staff member sitting with a patient who was distressed; the conversation was seen to be respectful and caring. When the patient continued to be in a distressed state we saw the staff member taking advice from a senior colleague and then staying with the patient assisting them with fluids maintaining conversation until the patient appeared to be calmer.
- On Swift ward we saw staff discussing with patients their hygiene needs and staff were asking how the patient preferred to have their needs met on that day. Good observation of caring seen with staff asking a patient 'do you want a shave this morning'. Staff were seen to be helping patients to walk to the bathroom. We saw staff discussed the plan for their care that day with patients.
- On one ward we observed a doctor introducing themselves to a patient and asking permission to discuss their care. Curtains were pulled round the bed to ensure privacy and voices were lowered to maintain confidentiality.

- We saw on in the most areas of the ward that staff would stay within the bays to write the patient records and told us this enabled them to keep patients under observation.

Are medical care services responsive?

We did not re-rate responsive as this was a focused unannounced inspection, looking at certain aspects of care on the medical wards.

Access and flow

- Staff told us that they planned the patient discharge from their admission and we saw this was reviewed at the morning MDT meeting meaning that the patient changing needs were kept under review We observed the discussion included specific patient needs on discharge and what referrals needed to be made to support services.
- Staff told us that discharges are often delayed due to social services support and waiting for packages of care to be put in place but they would escalate any delays to senior management staff so that the process for discharge could be kept under review.
- In July 2017 the referral to treatment, on completed admitted pathways in medicine, within 18 weeks was 91.3%, better than the national average of 89.7%.

Meeting people's individual needs

During this inspection we checked the service took account of the needs of different people including those in vulnerable circumstances with a focus on pressure ulcer management.

- We saw on all wards that patient bays were designated high or low risk and that more acute areas were close to nurse station and staff were allocated according to their skills to the appropriate area.
- On Aspen ward we saw that bay one and two were designated the acute area and patients with more complex and critical needs were being cared for in these areas.
- On all wards we saw that nurses were allocated to work in a particular patient bay area stayed within that area and kept their patients under observation.
- Patient call bells were available at all the bed spaces and on three of the four wards we saw all patients had a call bell within reach. On Swift ward we saw that in bay one and four there were four patients that did not have their call bells within reach, meaning that if the nurse was not present in the area the patient would be unable to call for assistance.
- The tissue viability nurse (TVN) told us she covered both hospital sites and one ward at a third location. All pressure ulcers were logged on to the electronic incident recording system and we saw this was being done. This information was checked and all patients with a grade two pressure ulcer were seen by the tissue viability to nurse to ensure a plan of care was in place.
- We saw that the policy stated that a root cause analysis was done for all pressure ulcers that were grade two or above and hospital acquired. The tissue viability nurse was involved in the review of these investigations.
- On Swift ward we saw that the tissue viability nurse had been working with the ward staff as part of a quality improvement project and there was information displayed indicating the care for patients at risk of developing pressure ulcers.
- Staff we spoke to were able to tell us what actions they would take in the case of a pressure ulcer developing, what care they would put in place and how they would inform senior and specialist staff.
- Across the trust there has been an initiative called SOS meaning 'heels strictly off surface'. All staff had been given a small handheld mirror as part of this campaign that enabled them to check the heels of patients. This meant that staff were reminded to check patient who were less mobile and at greater risk.
- From April there had been an initiative to measure pressure ulcer free days and on the wards staff spoke enthusiastically of achieving this target and on one ward we saw a certificate that documented this achievement. Trust data demonstrated that occurrence of grade two and above pressure ulcers have shown a decrease across the trust and that numbers were within national measures.
- We were shown the pressure ulcer pledge that was put in place three years ago and this was seen to be a shortened and condensed version of the policy that all staff have signed up to. Staff we spoke with told us there was a positive culture about the prevention and management of pressure ulcers and there was mandatory training in the prevention of pressure ulcers.

- Staff told us it was easy to contact and get advice from the tissue viability nurse and that they were visible on the wards. There were link nurses for pressure ulcer management on all four wards and these staff had completed additional training.
- The tissue viability nurse told us she was a member of southern tissue viability group, this enabled her to benchmark practice and there was also a link with a similar nurse at a close local trust hospital.
- We observed there were low air loss mattresses, cushions, and foam mattresses available on all wards and that many patients were using these. On checking patient records, we could the assessment for a special mattress was completed and we saw that the patient had these present.
- On Swift ward patient records showed that patients were repositioned within designated time frame. Repositioning charts and daily skin checks were seen to be complete.
- We found a monthly audit of the mattresses was completed which meant that the integrity of the mattress was checked. A third party was employed to do a full annual audit of all mattresses across the trust.
- On all wards we saw that air mattresses and chair cushions were in use alongside other pressure relieving equipment. Staff told us that it was not difficult to get appropriate resources for managing patient at risk of pressure ulcers.
- On all wards we saw that fall risks assessments were completed and a bright yellow wristband was used for patients at risk of falling. This enabled staff to see at a glance those patients needing more support. On Swift ward we saw that bed and chair sensors were in place and that when the patient went to move without assistance the alarm would alert the staff that the patient needed attention.
- We saw a falls pathway for patients assessed to be at risk and this referenced the 2103 National Institute for Health and Care Excellence (NICE) guidelines Falls in older people: assessing risk and prevention.
- We saw that that a flow chart pathway for the management of sepsis was prominently displayed in ward areas. Staff spoken to told us that had received training on the recognition of sepsis and were able to explain what they would do in the case of suspected sepsis.
- We saw that a patient with challenging behaviour had been assessed by the medical team and a referral made to psychiatric team. Staff told us that referral to the psychiatric or dementia team was easily done by bleeping them or by making an online referral.

Are medical care services well-led?

We did not re-rate well-led as this was a focused unannounced inspection, looking at certain aspects of care on the medical wards.

Leadership of service

- On the day of inspection there were designated senior staff in charge of the wards and these staff were responsive to any issues we bought to their attention. Action was taken immediately and we saw that any areas of concern were escalated to the senior staff who would attend the ward areas.
- On all wards staff spoke about the strategy to improve pressure ulcer prevention and management. They were aware of the trust initiatives and were positive about the changes that had been made. They appreciated the rewards such as the certificate of pressure ulcer free days.
- During our inspection we identified concerns in relation to blocked fire exits, checking of safety equipment and safe storage of medicines. This showed that the quality monitoring and assurances processes require further improvement in order to demonstrate effective management oversight.

Culture within the service

- Staff on all wards areas told us they felt well supported by their managers and that the management team were approachable. They described the culture as open and transparent and they felt able to raise any concerns with their line managers.
- Nursing staff spoke of being well supported by the medical teams and that any staffing concerns were taken note of and that the ward team were supported to manage their workload.
- We were told that the matrons working across the medical services were visible and were always contactable.

Medical care

- Staff told us they were committed to delivering safe care and gave an example that when necessary they would work across other ward areas to ensure enough staff were on duty.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that all fire exits are kept clear and ward staff are aware of their responsibility to maintain this.
- The trust must ensure the safe storage and security of medicines.
- The trust must ensure safety checks and services on patient equipment are consistently completed.

Action the hospital SHOULD take to improve

- Support and enable all staff to complete mandatory training.
- Continue its strategy to make safety thermometer information more accessible to staff and patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Doing all that is reasonably practicable to mitigate any such risks.** **Fire exits on Cherry and Swift wards fire exits were blocked.** **Fire training rates were below the trust target.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The proper and safe management of medicines.** **On Cherry and Swift wards, medicines were not stored securely.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way.** **Safety checks on emergency equipment were not consistently completed on Swift and Cherry wards.**

This section is primarily information for the provider

Requirement notices

Some equipment had passed its scheduled service date on Aspen ward.