

We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

Southmead Hospital

Trust HQ, Southmead Road, Westbury-on-Trym,
Bristol, BS10 5NB

Date of Inspections: 22 January 2013
17 January 2013
16 January 2013
15 January 2013

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2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✓ Met this standard
Staffing	✓ Met this standard
Complaints	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	North Bristol NHS Trust
Overview of the service	Southmead Hospital is part of North Bristol NHS Trust which provides acute hospital services and community healthcare services to the people of Bristol, South Gloucestershire and North Somerset. The hospital provides maternity services and is also a specialist regional centre for orthopaedics and renal services.
Type of services	Acute services with overnight beds Diagnostic and/or screening service
Regulated activities	Diagnostic and screening procedures Family planning Maternity and midwifery services Nursing care Services in slimming clinics Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We reviewed all the information we have gathered about Southmead Hospital, carried out a visit on 15 January 2013, 16 January 2013, 17 January 2013 and 22 January 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

We spoke with 40 patients during our inspection. Some patients were on ward 1, ward 4 and U ward and others were people waiting to be seen by the nurses and doctors in the four outpatient departments.

We spoke with the nursing, clinical and administrative staff on the wards and those who were working in the outpatients department. We also spent time with allied healthcare professionals (physiotherapy, occupational therapy, speech and language therapy and dietetics) who provided both outpatient and inpatient services.

Patients told us they were treated well, received all the information they needed and were involved in making decisions about their care, treatment and support. The management of medicines was in line with good practice.

There was an overall positive view about the quality and quantity of food and drink provided by the hospital and patient's diverse dietary needs were well catered for.

Patients told us they felt safe in the hospital and there were good reporting protocols in place where concerns were raised about patient's treatment and safety. Staffing levels in the wards we visited were adequate although nursing staff reported that at times there had been reduced staffing levels.

We have asked the Trust to look at their patient care records because there is inconsistent practice. The records do not provide a clear and accurate account of the care and treatment given. There is the potential that people may not receive the appropriate care.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 13 March 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care. People's privacy, dignity and independence were respected.

Reasons for our judgement

Some of the patients we spoke with during our visit to wards 1 (stroke ward), 4 (general medical) and U (urology) were unable to tell us about how they were treated and whether they were involved in making decisions about their care. This was either due to frailty, being very poorly, confused or post operative. Others made the following comments: "The doctors and nurses always tell me what is happening and ask if I am happy with that", "the nurses are very kind and don't get cross if I am wet", "we are having a meeting with everybody tomorrow about what help I will need when I go home. I am going to the meeting" and "the nurses let me do what I can for myself but are around to help me when I need support".

We spoke with the visiting families of some of the patients. The relative of one person commented that there was good communication between the ward staff and themselves. Another family who were visiting their relative who was dying, said that they had been fully consulted about decisions made about end of life care and "the nurses and doctors were all compassionate and respectful of their views".

We saw that information leaflets were displayed on the wards. These may be about clinical conditions, operations and aftercare information, or a particular speciality related to the type of ward. The leaflets were produced in English but could be made available in other languages and formats. Information was displayed about interpreter and advocacy services that can be made available when needed.

Nursing staff on ward 1 told us that they ensured patients were involved in their care and treatment and provided them with a 'What to Expect' leaflet. They told us they would sit with patients and discuss treatment plans, how they would review the care and support provided and consult regarding changes to what had been agreed.

On ward 4 there was a display of 'Welcome to Ward 4' leaflets. These gave patients and their family's information such as the name of the ward sister, the direct telephone number

of the ward and the visiting times. The leaflet also provided information about infection control guidelines and things that should not be brought on to the ward (flowers, items of value and children under the age of 11). The leaflet informed people how they could make comments on how they had been treated or improvements that could be made on the ward.

We spoke with occupational therapy, speech and language therapy, physiotherapy and dietetics healthcare professionals. They told us how they consulted with patients about the care and support and treatment plans they were to provide. Patients in the stroke rehabilitation ward (ward 1) were given a written copy of their weekly rehabilitation programme. This meant that they were informed of when they would be collected to attend therapy sessions away from the ward. The written information was shared with the nursing staff, relatives and friends so that the delivery of care can be planned around appointments and visits.

Patients told us they were treated with dignity. We observed the nursing staff interacting with the patients they were looking after in a respectful manner and addressing them appropriately using preferred names. Behind each of the beds, the nursing staff had written up on the board the name that the person liked to be known by. One patient said "I like to be called Ted and the nurses asked me if it was alright for them to use my name". We saw that curtains were drawn around beds when personal care was being delivered and that there were signs on bathroom doors to indicate when the room was in use.

Men and women did not have to share accommodation or bathroom facilities. There were signs in place to promote awareness of male and female facilities.

We spent time in the four outpatient departments and were able to speak with nurses, one doctor, and people who were waiting to be seen. One person who was a regular visitor to the department said "everyone is always very polite and helpful but they tell us about expected waiting times". They also said "the waiting time has been very long today".

We were told about the new modesty gowns that were now provided. These enabled patients attending for a consultation with a doctor, to maintain their dignity and modesty. Nurses told us that patients were no longer expected to undress before seeing the doctor and were only asked to remove the minimal amount of clothing necessary for a physical examination to take place.

We looked at some of the comments that had been made on feedback forms from patients who had visited the outpatients department. The issues that were commented on were mainly around appointment letters being incorrect and waiting times not being notified in outpatients two. There were also comments about the environment, hospital transport and car parking fee's. The Trust may like to note that the information board in outpatients two where information about waiting times was displayed was sited behind the waiting area where patients sit with their backs to the board.

The Trust told us about the work of the Patient Experience group and the measures in place to capture information about patient's experience. Key Trust staff were also part of this group. The results of the groups October 2012 Board report showed that since July 2012 there had been an increase to 93% of patients who would recommend Southmead Hospital to a friend and that 85% of patients reported that their care choices were explained to them.

From April 2013 all acute hospitals will be expected to ask 100% of inpatients for their views on whether they would recommend the hospital. The Trust were working towards the implementation of the Department of Health 'Friends and Family Indicators' and were in the process of working towards identifying the resources needed to collect and collate the information.

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

The overwhelming response we received from patients and their visitors that we spoke with was that they were satisfied with the care treatment and support provided. "They are looking after me very well", "I have had such good care and I am now well on the road to recovery", " my life has been turned upside down by my stroke but all the nurses and doctors, OT and physio are helping me come to terms with things. They are all putting me through my paces, it is hard work" and "you read so many stories in the press but I can honestly say I have been very impressed with the care I have received".

Patients told us that the nurses and doctors kept them informed about what was going on, and that they were encouraged to help themselves as much as possible. Patients on the stroke ward and the medical ward told us that the staff were knowledgeable and experienced in looking after people with their particular needs. Many of the patients on U ward (urology) were patients with other medical conditions but a bed had not been available in the ward and speciality department, but they still stated they were satisfied with the care they received.

We received comments from all three wards that the nursing staff were always busy and at some times during the day (after lunch in particular) and overnight, that there could be a delay in call bells being answered or assistance being provided.

We asked the nursing staff how they knew what care and support each patient needed. They told us that they received a handover report at the start of their shift and were provided with a printed sheet. These sheets detailed the needs of each of the patients on the ward. The care they provided was based upon the information provided to them by the nurses from the previous shift. We were told that it was the responsibility of the nurse in charge of the shift to update these information sheets for the nurses coming on shift. These measures ensured that patients received the care and treatment that they needed. Nurses said that they were always kept informed of changes in care regimes and the health status of people. The handover report was followed up with a walk round where they would visit each patient and discuss any issues in terms of infections, nutrition, mood and mobility for example. All staff disciplines that we spoke with told us that on ward 1 there were daily 'board rounds' where patients individual care needs, deterioration or progress was discussed and their ongoing care planned.

We looked at the information that was kept at the bedside for patients on all three wards. We found that there was minimal information about patient's nursing care needs kept at the bedside and for patients on ward 1 some of the information was not relevant to them. For one person on U ward, who had returned from their operation earlier in the day, there were no observation charts, assessments or care plans at the bedside. Nursing staff said they had received information about the patients needs in the handover report at the start of their shift.

We looked at the clinical records and those nursing care records that were available, on each of the three wards we visited. All clinical notes provided a detailed account of doctor's consultations with patients and also included very detailed accounts of treatment plan progress by physiotherapists, occupational therapists and speech and language therapists. On admission to the hospital, patient's details were recorded on a nursing admission assessment form. We only saw these forms on wards 1 and 4 but only the front page of the booklet had been completed. We were told that all other information was recorded on electronic records on the Cerner computer system. There was difficulty on ward 1 (stroke unit) accessing a patients details to show us what information was recorded on Cerner. We were told that on occasions the Cerner patient record system could be slow to load and was only used on 60% of the wards. The Cerner contract expires in 2015, so the Trust will be going out to tender to renew or replace the system. We have referred in more detail about the concerns in respect of patient records in outcome 21.

Bedside information included intentional rounding charts. These were a checklist tool for fall prevention. The Trust may like to note that the intentional rounding charts required the nursing staff to identify whether the patient needed hourly or two hourly interventions but these had been left blank. The Trust were in the process of introducing an improved intentional rounding chart that incorporated a 24 hour fluid balance chart and a food record chart. The chart also enabled the nurse to record an assessment about falls risk, skin condition and prevention of pressure damage measures and the four 'P's' – pain, personal care needs, position and possessions.

Risk assessments were completed in respect of falls, nutrition and the likelihood of developing pressure ulcer damage. Patient handling risk assessments were undertaken and where people needed assistance to move, a handling plan was devised. We found that all the assessments had not consistently been reviewed and updated. However we evidenced at ward level that the nursing staff had a good awareness of the individual patients who were at risk and could tell us about the measures in place to reduce that risk.

Some people who were at risk of falls because of cognitive impairment and frailty, or their behaviour meant that they could not be left unsupervised, were being supported by a carer on an individual basis (1:1 care). These carers were generally provided by an agency and we spoke to one agency carer who told us that they were frequently booked to look after people on ward 1.

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

We spoke with patients on all three wards. Patients were generally very complimentary about the meals they were served and we received the following positive comments. "I find the food very good, you get a choice and the quantities are enough", "The food is alright and you can't expect it to cater for everyone's tastes", "we get to choose what we want to eat but the portions are too big" and "I have just had a very nice lunch but I am still hungry. My family bring me in food as well". One patient said "I wish we were served more cups of tea" and another said "I am a fussy eater anyway but I don't think the food is very good".

Nursing staff that we spoke with showed an awareness of the nutritional needs of their patients and the importance of monitoring food and fluid intake. They also referred to checking body weights as often as was deemed necessary. Nursing staff spoke about the importance of good nutrition in aiding a patient's recovery post-operatively. In U ward we saw information displayed in the staff office with guidelines and instructions about good nutrition.

Patients were able to choose what they would like to eat as a range of different meals were offered. Menu sheets were given out to each patient and they either filled them or were supported by the nursing staff of their family. Patients were making meal options for the following day and were able to specify the portion size of the meal they would like to be served. The menu sheets indicated the food choices for patients who were diabetic, those who needed a gluten free diet, vegetarian, or high energy diets. Soft food and pureed food options were catered for. When patients needed particular meal choices because of ethnic, cultural or religious reasons, the catering and dietetics departments would be contacted to arrange this.

We looked at feedback forms that had been posted outside of U ward. There was a mixed response from patients who had previously been on the ward. Whilst some patients said that the food was good others had negative comments to make. "I am not enjoying the food at all so my relatives have been bringing me in take-away food". The catering department provided 'snack boxes' at ward level available 24 hours a day, although none of the patients we spoke with were aware that this service was available.

The Trust had a protected meal time policy. Visitors were discouraged from being on the wards at this time, nurses were expected not to be making beds for example and doctors were not supposed to be doing ward rounds. This was so that people could enjoy an

uninterrupted meal and the nursing staff could monitor how much people had eaten. We found that on the three wards we visited the protected meal time policy was not consistently enforced. One nurse said it was difficult to turn away visitors when they had travelled from afar.

We saw that drinks were served with meals and patients had water jugs at their bedsides. People told us that hot drinks were served regularly throughout the day and additional drinks were supplied upon request. Some patients we spoke with did not feel they could ask for extra hot drinks. Those patients who needed support with eating their meal were either supported by nursing staff or volunteer meal time supporters. These volunteers had been specifically recruited to provide this type of support but did not go onto all wards in the hospital. We asked the nursing staff how those patients who needed support with their meals were identified. Red laminated red cards were placed above the beds – this measure was implemented in January 2012.

Prior to our visit to Southmead Hospital we looked at the feedback provided by patients on the NHS Choices website, the findings of the patient environment action team (PEAT) assessment and patient survey results. Results from the last in patient survey showed that the hospital had scored a good rating for menu, choice, availability, quality, quantity (portions), temperature of food, and the presentation of meals when they were served. The Trust had not scored well in the PEAT assessment in respect of nutritional needs screening, or adherence to the protected meal time policy.

The Trust used a nutritional screening tool on admission to assess whether patients were at risk from malnutrition or had a high body mass index (BMI) and needed dietary advice. We saw that these had been completed in the sample of nursing notes we saw, but greater details about the assessment were recorded on the Cerner electronic system. Fluid and food intake charts were completed where it had been identified that monitoring was required. The Trust had not scored well in the PEAT assessment in respect of nutritional needs screening, or adherence to the protected meal time policy.

We spent some time with the head of dietetics. They told us that each ward had a dietician assigned and a nutrition champion. Some wards had greater input than others from the dieticians due to the different types of patient who were looked after. The dietician assigned to ward 1 made daily visits to the ward because a significant number of patients required tube feeding. Other wards looked after patients who, due to the nature of their illness or disease process, required enteral (intravenous) feeding.

The dietetics departments analysed the nutritional values of all meals provided by the catering department and provided an over-arching lead to the various working groups that reported to the nutrition steering group.

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

Patients that we spoke with said "I feel safe in the ward and I am being very well looked after", "the nurses are very good and kind to me" and "I believe I am treated very well and could not ask for better care".

Visitors that we spoke with said they were satisfied with the way their relative was being looked after. "They can be a very difficult person, but the nurses and doctors are so patient" and "I have no concerns about the safety of my relative".

We observed the nurses and doctors interacting with patients in the hospital in a respectful manner. In general patients were referred to by their first name and those patients we asked about this, said they were alright with being called by their first name. Nursing staff spoke kindly about the patients they were looking after. One patient said "the nurses cheer me up and I enjoy the friendly banter. They make me feel better as well as helping me get better".

All Trust employees that we spoke with during our inspection visit said that they had received the mandatory safeguarding training. Staff demonstrated good awareness of safeguarding adult issues and abuse awareness and told us they would have no hesitation to report any concerns they had. Staff had access to the Trusts electronic safeguarding policy at ward level.

Nurses, doctors and allied healthcare professionals were able to report safeguarding concerns directly to the local authority and the Care Quality Commission however they tended to refer to the Trusts safeguarding team. The safeguarding team made the alerts to the local authority and had access to secure send facilities and were therefore complying with data protection. The Trust also had a responsibility to report to the strategic health authority and the Care Quality Commission and used the National Reporting and Learning System (NRLS) reporting process to do this.

We spent time with one senior manager who had the lead role for safeguarding vulnerable adults and the safeguarding children and vulnerable adult manager. They told us that all staff who worked for the Trust attended a level one basic safeguarding awareness training

session. This training included an overview of the Mental Capacity Act 2005 legislation and Deprivation of Liberty Safeguards (DoLS) procedures. It also covered domestic violence, learning disability, dementia and dignity issued. The Trust were 90% compliant with this training at the time of our inspection visit. For all clinicians with patient contact, it was mandatory that they also completed level two training and this 'passport training' had to be repeated every three years. Level three training was currently only provided in respect of child protection but was in the process of being developed for vulnerable adults. This training would be for senior manager, matrons and those staff that provide on call support to the wards. The Trust aimed to identify one lead person in each directorate to take responsibility for safeguarding patient matters.

Not all staff we spoke with were familiar with the term 'whistle blowing' and only one nurse referred to the Trusts whistle blowing policy. This staff member told us how they used the policy to report concerns about a work colleague's bad practice. The Trust whistle blowing policy includes the opportunity to raise concerns anonymously. Two anonymous concerns had been investigated via that route since September 2011.

The Trust analysed information received via feedback cards, the NHS Choices website, inpatient and outpatient surveys. If safeguarding concerns were identified these were passed to the safeguarding team to report to the local authority.

Prior to our inspection visit we met with senior managers and the DoLS manager from South Gloucestershire Council. The purpose of the meetings was to look at the Trusts compliance in respect of making applications for Deprivation of Liberty Safeguards (DoLS) restrictions. The Trust had further work to do to ensure that applications were made when appropriate. The Trust did not always make further applications when the period of authority had expired. Requests to have DoLS authorisations reviewed when they may no longer be appropriate were not always instigated.

There have been a number of occasions where the care and welfare of patients in the hospital had been affected by events that had happened. The Trust had reported appropriately and had worked with the local authority to resolve any issues. Measures were put in place to prevent similar events happening again. The Trust may like to note that the delays in concluding some of the more complex internal safeguarding investigations could potentially impact upon the care, treatment and support of other patients.

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

The pharmacist inspector met with the director of pharmacy and visited two wards at Southmead hospital. We spoke with five members of staff. We looked at 21 patient's medicine prescription and administration records.

Staff told us that the nurses gave most of the medicines used in the hospital, apart from some inhalers and creams which patients looked after themselves. We saw that some patients kept their inhalers next to their bed. Patients who looked after their own inhalers were happy with this arrangement. Staff told us that some patients did look after all their own medicines while they were in hospital but this did not happen often. The hospital had a self-administration policy, which included checks to make sure that this would be safe.

We spoke with 10 patients about their medicines. Patients told us they were happy with how the nurses looked after their medicines. They said that they were given their medicines at the correct times. One patient told us that they were not able to take their medicines exactly as they did at home but that it was okay. This patient told us that nurses gave them one medicine they usually took at night, in the morning. The patient said that this had continued despite them telling staff they took it at a different time at home. Staff told us that they tried to be flexible so that medicines were given at an appropriate time for the patient, whilst also fitting in with routines on the ward. Nurses recorded the time that they gave each medicine. This meant that they could make sure that medicines such as antibiotics were given at the correct time intervals.

Appropriate arrangements were in place for obtaining medicines on the ward. We saw that there were systems in place to ensure that patients were prescribed the correct medicines while in hospital. Systems were in place so that staff on wards would be able to obtain prescribed medicines even when the pharmacy was shut. Prescription records confirmed that medicines were available for people when they needed them.

We saw that appropriate arrangements were in place for the recording of medicines. The trust's medicine policy gave clear guidelines for prescribing medicines. Prescription charts were signed by the prescribing doctor. We saw that a pharmacist regularly checked the prescriptions. Comments from the pharmacist were recorded. A variety of codes were available for staff to explain the reason why, if a medicine had not been given. We saw

that pharmacy staff had been looking at updating the design of the prescription chart to make sure that it met Department of Health guidelines.

We were told that both pharmacists and nurses regularly checked patients' prescription and administration charts to ensure that they had been completed appropriately. The provider may like to note that we saw several examples where guidelines in the medicines policy had not been followed. For example the time that each drug must be administered was not indicated clearly utilising the 24 hour clock. When a prescription was cancelled the cancellation was not always signed and dated by the doctor. This could mean that people would not receive their medicines correctly.

Staff told us that the trust medicines policies were available on the hospital computer system. Other information relating to medicines was also available for staff on this system. Staff said that they were notified by email when medicines training needed to be updated. This meant that staff were able to be well informed about current medicines issues and keep their skills up to date.

We saw that medicines were kept safely in the hospital. Supplies of medicines prescribed for individual patients were kept in a locked cupboard by their bed. Ward stocks of medicines were kept in locked cupboards. Secure medicine trolleys were used to safely transport medicines around the ward. Pharmacy staff checked the arrangements for storing medicines in the hospital to make sure that they were kept safely.

Suitable arrangements were in place for the safe keeping, recording and checking of controlled drugs which need additional security.

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

Patients told us that the staff were always busy but they received the care and treatment that they needed. Some patients told us that they had to wait to see doctors or nurses. "They are very busy all the time", "they may be looking after someone who is very poorly so I don't like to complain" and "sometimes the nurses say they are short-staffed". Everyone we spoke with accepted the fact that "hospital staff were busy all the time".

Those wards and the out patients departments that we visited were staffed with nurses, health care assistants and trainee or qualified assistant practitioners. We also met student nurses on placement from the University of the West of England on ward 1 and ward 4. We spoke with clinical staff, matrons, bed managers, occupational therapists, physiotherapists and ancillary staff.

Nursing staff told us the skill mix of staff on the ward was determined by the matrons. On ward 1 the morning shift was covered by three trained nurses, 1 assistant practitioner, four health care assistants and three student nurses. This level of staff was allocated to look after 28 patients. The ward also had one patient who was being looked after by a dedicated agency worker because of the high risk of falls if left unsupervised. On ward 4, to look after 29 patients there were three registered nurses, five healthcare assistants, two students nurses and one agency nurse. The ward sisted on ward 4 told us that 17 patients out of the 29 were at risk from falls and the work load was high.

The Trust told us that there had recently been a significant increase in demand for inpatient beds - well above usual admission numbers, as well as having over 400 patients whose length of stay had exceeded 14 days. This reflected difficulties the Trust was experiencing in discharging and transferring care to community providers, resulting in a lack of capacity for new admissions.

Nursing staff we spoke with on the wards said that there had been many occasions recently when they had worked with 'one staff short' and that there had been a lot of staff movement between the different wards. The matrons monitored staffing levels in those wards for which they were responsible on a continual basis and re-allocated staff to work in busier areas or those where there was a staff shortage. They told us that there had been times when shifts had been run with less than the ideal numbers of staff, but that they had done the best with the resources available. Nursing staff were very accepting of

the situation with staffing levels and "just got on with the work they had to do and made sure that patients received the support they needed.

The outpatients departments were staffed with a team of registered nurses and health care assistants. In outpatients one and four there was also a qualified assistant practitioner in each. They told us they generally worked in the same department and therefore were familiar with the clinical staff, the speciality and the procedures they would support the doctors to undertake.

The Trust had a bank of registered nurses and healthcare assistants (NBT Xtra) that they employed to cover vacant shifts and also where extra staff were needed to look after an individual patient. When bank staff were not available agency staff were used if necessary. We were told that during the recent demands on staff because of demand for inpatient beds and high patient flow through the wards, that bank nurses had been deployed although there had been times where staffing levels were stretched.

We asked the Trust how they determined the staffing levels for each of the departments and wards. They used an acuity and dependency tool that had been developed to help NHS hospitals measure the acute needs and/or dependency of patients. This informed evidence-based decision making on staffing and workforce levels. The tool when associated with nurse sensitive indicators (quality indicators linked to nursing care) offered the trust a reliable method against which to deliver evidence-based workforce plans to support existing services or the development of new services. On individual wards patient flow information was collected by the matrons and passed to those responsible for nursing workforce reviews. Information was collected in respect of the number of patient admissions, discharges, transfers, other ward attendees, deaths and transfers away from the ward/department, levels of occupancy and staffing levels.

We were assured that all measures were being taken to provide safe levels of staff cover.

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

We asked patients and visitors if they would know what to do if they were unhappy about the way they were being looked after. Patients who were able to respond to our question told us that they would raise a complaint about their care and treatment with the ward sister and referred to the 'Concerns, compliments and complaints leaflet' they had been made aware of. They told us "I am being very well looked after", "the nurses are smashing, but I would say something if I wasn't satisfied" and "I have no reason to complain but would do so if something was wrong". We saw a supply of the complaints leaflets on all three of the wards we visited. We were also given a copy of the complaints pack that was provided to patients/family. This contained information about an independent complaints advocacy service available to patients who needed support with making a complaint.

Visitors to the wards said that they felt they would be able to voice their concerns if they had any and also referred to information that was kept at the ward entrance. They told us "I can not fault the way my relative is being looked after" and "I would ask to see the person in charge if I had reason to complain".

Feedback cards were given out to patients during their stay or when they were discharged home and results from these were then collated by the ward manager or the matron on a monthly basis. Both positive and negative comments were recorded and the results were fed into the nursing quality assurance audits.

Staff members that we spoke with said that they would deal with any complaints received but would escalate any concerns to line management if needed. One nurse said that they would provide the complainant with the complaints leaflet with directions on who to contact, if the complainant was still dissatisfied. Staff told us that they would try and resolve issues at ward level but would contact the Advice & Complaints Team for advice and support if this had not been possible. We were told that an account of the complaint would be recorded in the nursing or clinical notes.

We also spoke with allied health care professionals, such as a physiotherapist, who told us that they had similar procedures in place to deal with any complaints. If the staff were able to deal with complaints and concerns, this would be done at department level and only escalated if not resolved satisfactorily.

We met with the Trusts complaints manager. They told us that when a formal complaint had been received by the Trust, the matron of the relevant directorate would be informed. The Trust had introduced a more structured initial response letter to complainants in August 2012. The letter sets out the issues and informed them how the complaint was going to be handled and the timescales involved. This had led to a reduction in the number of people who "returned" or made a second complaint. We were shown the figures of 'Complaints, Concerns and Returns by Month' for 2012/13 and these showed a marked drop in the number of returns.

Where complaints had been rated as moderate or high risk, a remedial action plan was drawn up and would be tracked by the complaints team. Low risk remedial plans were tracked by the ward management team and the matron. Lessons learnt from complaints were followed up at directorate level with clinical directors responsible for implementing improvement plans. An example of these complaints may be in respect of clinical treatment or nursing care.

The complaints manager and team analysed all complaints received and were able to show how many complaints were attributable to each of the different directorates, and the numbers of complaints in different categories. Because of these measures the Trust was able to identify 'hot spots' and take remedial action. The information that was shared with us had been categorised into aspects of clinical care, attitude of staff, communication and delayed or cancelled inpatient and outpatient treatment.

We were shown examples of four 'Complaints – Learning Lessons' flyers that had previously been distributed to the wards and other departments by the Advise & Complaints Team. These detailed background information about the complaint, immediate action required and stated who needed to take this action

The complaints manager also referred to the NHS Choices website, where patients and relatives can post their views about the service provided by the Trust. The manager checked the website on a weekly basis and posted the Trust response to the information provided. We had looked at the website as part of our preparation for the inspection and saw evidence that the complaints manager had responded to each of the comments made. Where negative comments were made, the manager had referred the person to the Trusts formal complaints procedure.

The Trust had an improvement plan in place to provide clarity to those NHS patients who were funded for private treatment. This would ensure there was clarity of the complaints route for these patients. The Trust expected to have completed this by April 2013 with new information leaflets being available by June 2013.

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People may not be protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at the patient care records at the bedside on wards 1, 4 and U ward. We found that for the majority of patients bedside records we looked at there was little information recorded and in one case there were no records at all. This patient was post-operative and had been back on the ward for some hours. The patient handling risk assessment for one patient on ward 1 had been completed on 1st December 2012 but had not been reviewed in the six week period. We spoke to the nursing staff about this who said that the risk was reassessed each time they delivered care, but that a record of that review was not made. On ward 4, a patient handling risk assessment had been completed 4th January 2013 and had not been recorded as reviewed again when we looked at it on 15th January. Nursing staff said the risk was reassessed each time they delivered care and referred to the electronic risk assessments that were completed. We looked at wound care documentation. The forms had not been completed correctly. Nurses had not recorded a wound assessment after each wound dressing but had recorded when dressings had been changed. We looked at 'patient profile' sheets where nursing staff recorded the care given to patients. Not all of the forms we saw had been fully completed.

We were given examples of some of the different care plans that could be used to record patient's needs and the nursing interventions required. Examples included a care plan for a patient with a naso-gastric tube and a urinary catheter care plan. We did not see these plans in use for patients who had a urinary catheter or a naso-gastric tube, in their bedside records. Nursing staff told us that care plans were recorded electronically and they were given information about patients care needs on the handover sheets given at the start of a shift.

The Trust used their patient record system (Cerner) to record risk assessments and patient care plans. We found on ward 1 that the system was slow to load up and it was difficult from the information we were shown, to work out patients needs. Nursing staff told us that they were given a work sheet for each shift they worked that detailed the needs of the patients they were looking after.

At the bedside on ward 1 four care files we looked at each had a series of laminated 'Stroke Services Nursing Care Plan'. These plans were generic and not specific to the care needs of the patient and referred to nursing interventions that were not required. This system could cause confusion as to what the patient's support needs were leading to the potential of a patient receiving the wrong care, treatment and support.

We spoke with patients who were waiting to be seen in the out patients departments and they told us there were still problems with appointment letters being incorrect. One patient said "I have received three letters about the same appointment, it is such a waste of money", whilst another said "I received my appointment letter and a telephone call from someone here, just checking that the details were correct".

We spoke with one of the administrators in the outpatients departments and they said that the majority of problems that had been experienced when the Cerner electronic patient record system had been introduced at the beginning of 2012, were now resolved.

We spoke to senior managers and nurses for the Trust and they told us that 'Cerner recovery work' was still in place and weekly meetings were being held to monitor how things were going. They told us about the work-stream that was ongoing in respect of patient letters.

Following our inspection visit, the Trust told us that they were reviewing their position with regard to record keeping at the bedside. The director of nursing had visited three wards at Southmead Hospital and found that both had very clear records. The Trust did not state which wards these were. The first ward had core care plans at the bedside and these had been individually amended with information relevant to that patient. The director of nursing found that those records looked at, all had a manual handling record and noted manual handling requirements were recorded. These records had been reviewed on a daily basis. All members of the multi disciplinary team including nurses wrote contemporaneously in the medical notes. One of the wards was a temporary ward looking after patients who were medically fit to go home but who required social or therapy intervention before discharge from hospital. The patients each had a personalised discharge care plan.

The Trust had planned to be paperless by using the Cerner system but have said that in response to our findings, a paper bedside record for the plan of care will be re-implemented in the short term. The Trust still planned to continue to progress the need for better bedside access to IT and aimed to have this in place in time for the opening of the new hospital.

This section is primarily information for the provider

✕ Action we have told the provider to take

Compliance actions

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
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records
	How the regulation was not being met: Accurate and appropriate records were not maintained for some patients which meant that they may not be protected from the risks of unsafe or inappropriate care and treatment. Regulation 20(1) (a).

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 13 March 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ Met this standard This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

✗ Action needed This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

✗ Enforcement action taken If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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