Inspection Report

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 Inspection: 31 July 2013

Date of Publication: August 2013

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Records ✓ Met this standard

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	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services 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

We carried out this inspection to check whether Southmead Hospital had taken action to meet the following essential standards:

- Records

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 31 July 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 staff.

What people told us and what we found

This was a follow up visit to look at patient records held at the bedside. This was because when we visited in January 2013, the records we saw were not fit for purpose. Although we spoke with some of the patients we met on wards 1 and 4, we did not ask them about their care records.

We looked at bedside and electronic records. We found that accurate records in respect of each patient were in place and that the Trust had implemented robust audit arrangements to ensure that the improvements were maintained.

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

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

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Patients were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

When we visited three of the wards in Southmead Hospital in January 2013 we had concerns about bedside documentation. We found that for the majority of patients, the bedside records we looked at were incomplete, irrelevant to the patient's specific needs, not up to date or had been completed incorrectly. Following that inspection we asked North Bristol NHS Trust to make improvements. They wrote to us and told us about the changes and improvements they intended to make and provided us with a copy of their action plan. On 23 May 2013 they wrote to us again and told us that their action plan had been completed. The purpose of this review was to check that these improvements were in place.

We revisited wards 1 and 4 on this inspection. We looked at bedside documentation. Daily Intentional Rounding (DIR) records had been introduced and were present at each bedside on both wards. These documents enabled staff to record information about the patient's wellbeing by the healthcare assistant or registered nurse responsible for the patient's care on each shift (early, late and overnight). Nursing staff told us that each patient was checked on a two hourly basis unless their needs warranted more frequent checks. Those patients who required one to one nursing care were reassessed on an hourly basis. The forms recorded assessments of each patient's pain, personal care needs, lying or sitting position and their possessions. The falls risk assessment was reviewed on each intentional round check and a patient's skin integrity was checked at each review. The DIR also included a 24 hour fluid intake and output chart and a food record chart. All the records we looked at had been fully completed and signed by the member of staff who had completed the entry. A registered nurse told us that at the end of their shift they were responsible for ensuring that all documentation had been completed.

In addition, patients had observation charts to record vital signs (temperature, pulse, respiratory rate and blood pressure). Patients were weighed on a weekly basis and records maintained both at the end of the bed and electronically. On ward 1 patients observations were checked on a daily basis unless the person's health status meant that

they should receive closer monitoring. Nurses used an early warning score (EWS) to alert them to those patients with deteriorating health. We saw care plans at the bedside in respect of specific clinical needs. Records were kept of blood glucose monitoring for patients with diabetes. Other examples included naso-gastric assessments, insertion records and care plans, intravenous cannula insertion records and rehydration prescriptions, and wound assessment and management care plans. For one patient who had learning disabilities they had a specific care plan in respect of communication and capacity issues.

Patient notes were also maintained electronically on the hospitals' computerised patient record system. Both wards had workstations on wheels and laptops that were taken into the bays. This meant that nurses could updates records at the patient's bedside. Nurses showed us what records were kept on this system, how they inputted new information and updated assessments and how alerts were made for overdue tasks.

Staff received bedside handover reports at afternoon and night time shift changes. A handover sheet was used to inform staff coming on duty about the needs of the patients in their care. These handover sheets were updated on a shift by shift basis and were the responsibility of the nurse in charge.

Ward managers completed audits several times a week of a sample of bedside documentation. We saw the records of actions taken where shortfalls had been found. The ward managers forwarded results of all audits to the matron and the heads of nursing.

A nursing quality assurance tool (NQAT), part of the Trust's audit process, was used to monitor ward performance and was repeated on a three to six monthly basis, dependent upon findings. Part of the audit involved looking at patient documentation. The March 2013 report for ward 4 showed that the ward had achieved 81% compliance with patient documentation. The ward manager told us that there was now more robust monitoring in place and the next NQAT would show a better picture. Their own audit results ensured that all patient records were completed correctly.

At this inspection we were assured that patient's personal care records were accurate and fit for purpose. We have based this judgment upon information we saw at the bedside on both of the wards we visited, our observations and information given to us by the head of nursing, ward manager and nursing staff on the wards.

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 other services less often. 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.

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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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.

Contact us

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