Lewisham and Greenwich NHS Trust

Queen Elizabeth 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

We undertook an unannounced focussed inspection at the Queen Elizabeth Hospital in response to concerns from patients, relatives and staff about the equipment used in theatres, discharge arrangements for patients, staffing levels and poor care of patients. We inspected medicine (including older people's care) and surgery on 22 and 23 May 2018.

As this inspection is focused on specific areas of concern, we have not re-rated this service.

Queen Elizabeth Hospital (QEH) is part of Lewisham and Greenwich NHS Trust. The trust was formed in October 2013 by the merger of Lewisham Healthcare Trust and the Queen Elizabeth Hospital Greenwich (following the dissolution of the South London Healthcare Trust by the Trust Special Administrator). The trust provides acute and community services.

Prior to this inspection the hospital has had two planned comprehensive inspections in February 2014 and March 2017 and a focussed inspection in June 2016 of urgent and emergency care and medicine. Queen Elizabeth Hospital was rated requires improvement at all of these inspections.

Our key findings were as follows:

- A shortage of permanent nursing staff and medical staff was a significant challenge in medicine and while less obvious in surgery, there were still some problems.
- Learning from incidents and complaints was variable among staff.
- In medicine, some patient information was not always recorded in their notes.
- Some staff in medicine were not aware of their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- We found some problems with discharge arrangements for patients but, staff were working hard to improve the system.
- The environment in the day care unit did not promote privacy and dignity for patients.
- The concerns about equipment used in operation theatres were not substantiated. We found the hospital had effective and safe systems in place for the management of sterile instruments.
- The trust had improved its management of medical patients on the surgical wards with dedicated medical staff to ensure they received appropriate care and treatment.
- There was good multidisciplinary working in the services we inspected.
- The majority of patients in the areas we inspected were treated with dignity and respect.
- Many of the patients we spoke with were positive about the care they received, they told us the staff were kind to them.
- Staff were positive about the local leadership with the exception of the day care unit where we found staff felt they needed more support with managing the workload and making changes. They were aware managers were trying to recruit staff and were optimistic about the appointment of the new chief executive and chief nurse who they found supportive.

Areas of poor practice where the trust needs to make improvements.

Importantly, the trust must :

- Ensure medical and nursing staffing levels are in line with national standards to provide safe continuity of care for patients.

In addition, in medicine (including older people's care) the trust should:

- Ensure staff are aware of their responsibilities in relation to Deprivation of Liberty Safeguards and the Mental Capacity Act 2005 and that forms are filled in appropriately.
- Continue the work to improve discharge planning.

Summary of findings

- Ensure alcohol hand gels are filled at all times.
- Ensure processes are in place to prevent common themes of incidents and share learning from incidents and complaints with staff.
- Ensure staff are aware of the freedom to speak up guardians.
- Display latest infection control and safety thermometer information.
- Ensure all patient information is recorded in their notes.

In surgery

- Improve the monitoring of risks and the governance of the day care unit.
- Make sure patient's privacy and dignity are respected within the day care unit.
- Review and consider additional HCA cover on ward 15b for the night shift.

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 (including older people's care)		We have not re-rated this service as we have only focussed on specific areas of concern. We found vacancies in both nursing and medical staff was impacting on staff being able to consistently deliver quality and safe care. Staff were not always aware of learning from incidents and complaints. There were some problems with discharge planning but, work was in progress to improve the process. Staff were working very hard to meet the needs of patients and there was good multidisciplinary working. Staff spoke positively about their local managers and were optimistic about the recent appointments of the chief executive and chief nurse.
Surgery		We have not rated this service as we have only focussed on specific areas of concern. We found some concerns with the leadership and management of the day care unit with little improvement since the last inspection in 2017. The environment in the day care unit did not promote privacy and dignity for all patients. Staff in the day care unit expressed a need for more support with the workload and making improvements. We found safe and effective systems for the management of sterile instruments. The management and care of medical patients on surgical wards had improved since the last inspection. Staff spoke positively about their local managers and were optimistic about the recent appointments of the chief executive and chief nurse.

Queen Elizabeth Hospital

Detailed findings

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Detailed findings

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Background to Queen Elizabeth Hospital

The 2011 census found there were around 254,557 people living in the borough of Greenwich. QEH serves an area of high deprivation and the health of people in Greenwich is varied compared to the England average. Deprivation is higher than average and about 25% (13,600) children live in poverty. Life expectancy for both men and women is lower than the England average.

Queen Elizabeth Hospital (QEH) is a district general hospital providing a full range of services including emergency department, medical, surgery, critical care, maternity and gynaecology, services for children and young people, outpatients and diagnostic imaging and end of life care. The hospital has 495 beds. We inspected medical care (including older people's services) and surgery.

The main clinical commissioning groups (CCGs) for QEH are Greenwich CCG and Bexley CCG.

Our inspection team

Our inspection team was led by Margaret McGlynn Inspection Manager and overseen by Helen Rawlings Head of Hospital Inspection South London.

The team included CQC inspectors, assistant inspectors, inspection planners and nursing and medical specialist advisors.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held including inpatient and staff surveys, contacts from patients, relatives and staff, national audit and performance data.

During the inspection we spoke with 47 staff, which included senior and other staff who had responsibilities for the frontline service areas we inspected, as well as those who supported behind the scene services. We requested documentation in support of information provided.

We spoke with more than 20 patients and relatives and reviewed a range of documentation submitted before,

during and following the inspection. We made observations of staff interactions with each other and with patients and other people using the service. The environment and the provision and access to equipment were assessed.

Facts and data about Queen Elizabeth Hospital

QEH has 495 inpatient beds. Acute medical services has 271 inpatient beds across nine inpatient wards, a 78-bedded acute medical unit, a cardiac care unit and a discharge lounge escalation area. Two wards are dedicated to healthcare for older people and there is a respiratory ward and ward dedicated to patients medically fit for discharge.

The hospital has seven operating theatres based in the main building and three surgical wards identified as wards 12,15A and B and 17, with approximately 78 inpatient beds and a day care unit.

Results from the trust's 2017 inpatient survey showed an improvement compared to the 2016 inpatient survey, however, less responses were received in the 2017 inpatient survey. Areas that had improved included the length of time patients had to wait to get a bed on a ward and confidence and trust in medical staff. Some areas had deteriorated including nurses acknowledging patients and their answers to questions. Patients' confidence and trust in nurses, sufficient nurses on duty remained about the same.

In the NHS Staff Survey 2017 the top five questions for the trust included staff feeling their role made a difference, quality of appraisals and training. The bottom five questions included percentage of staff having an appraisal, staff satisfaction with resourcing and support, percentage of staff working extra hours and organisation's interest an action on health and wellbeing.

Medical care (including older people's care)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The acute and emergency medicine division and long-term conditions and cancer division provide medical care services at the Queen Elizabeth Hospital (QEH). Acute medical services comprise 271 inpatient beds across nine inpatient wards, a 78-bedded acute medical unit, a cardiac care unit and a discharge lounge escalation area. Two wards are dedicated to healthcare for older people and there is a respiratory ward and ward dedicated to patients medically fit for discharge. A surgical ward also has beds available for medical patients when there is a lack of capacity elsewhere.

We carried out an unannounced visit and focused on areas of concern identified through information sent to us from patients, relatives, staff and local authorities. At our last inspection in March 2017, medical care was rated as requires improvement overall. Safe, caring, responsive and well-led was rated as requires improvement and effective was rated as good. This was a focused inspection of medical care in response to concerns that had been raised with us. These related to problems with poor care, patients with pressure ulcers, neglect of patients, poor discharge processes, whistleblowing concerns about the lack of staff and training, and concerns around the complaints processes. We observed how people were being cared for and reviewed care records of people who were using the service at the time. As this inspection is focused on specific areas of concern, we have not re-rated this service.

During our inspection we visited wards one and two (acute medical admissions), 14 (medical ward), 15 (surgical ward with medical outliers),18 (elderly and medical planned discharge ward), 19 (elderly and medical ward), discharge lounge, discharge team and the PALS office. To help us understand the quality and safety of medical care services, we spoke with 11 nurses, 16 patients, two relatives, three matrons, three ward sisters, one practice development nurse, seven allied health professionals and reviewed 17 healthcare records.

Medical care (including older people's care)

Summary of findings

- Ward displays of planned versus actual staffing levels were not always up-to-date. Senior and junior nursing staff we spoke with felt there was a shortage of staff and on some occasions, nurse to patient ratios were 1:10 or 1:12. Shortages of nursing and medical staff had been recorded on the risk register since November 2016 and recruitment and role reviews were ongoing.
- Action plans had been put in place following incidents occurring, however, there were still common themes of incidents, particularly slips, trips and falls.
- Learning from incidents amongst staff was variable. Some staff members had no knowledge of learning from recent incidents that had occurred whilst others gave some information. Furthermore, staff were not able to provide examples of learning that had occurred from complaints and not all the complaints stated what actions had been taken as a result.
- There was a lack of clarity amongst some staff members about the systems in place for Deprivation of Liberty Safeguards (DoLS), including the management and documentation of DoLS.
- Staff were not aware of who their Freedom to Speak up Guardians were and they were not always aware of the best way to escalate their concerns.
- Concerns had been raised prior to the inspection around the discharge process. We found that the discharge teams were working hard to improve the discharge processes; however, these improvements were in their early stages. Communication between wards and the discharge teams needed to improve and this was an ongoing work in progress.

However:

- Improvements were made since the last inspection.
- Staff treated patients with dignity and respect.
- Staff cared for patients with compassion. The majority of feedback from patients from the inspection confirmed that staff treated them well and with kindness.
- Food record charts and malnutrition universal screening tools were generally well completed. We observed staff and volunteers supporting patients during mealtimes.
- Records were generally completed well such as the patient's national early warning scores (NEWS), waterlow scores, pressure ulcer care plans and glucose monitoring.
- Multi-disciplinary teams supported each other to provide good care.
- Staff were positive about the new chief executive and chief nurse that had recently started at the trust.

Medical care (including older people's care)

Are medical care services safe?

Incidents

- The common themes of incidents were slips, trips and falls, inadequate staffing levels and pressure ulcers.
- Actions that had been taken for patients with pressure ulcers included reviews at the pressure ulcer panel, commencement of pressure ulcer care plans, comfort rounds and completion of risk assessments. Staff told us that patients with pressure ulcers were not always highlighted at multidisciplinary team (MDT) meetings and that on occasions there was poor communication regarding ordering appropriate equipment for patients with pressure ulcers.
- Actions that had been taken for patient falls included post falls assessments, completion of inpatient falls proformas, care plans were updated and falls indicators were displayed by the patient's bed side. In some cases, the incident forms described what happened such as a 'patient fell from the bed' and a 'patient was found on the floor'. However, none of these incidents included a description to indicate what actions had been taken.
- A relative had told us that her mother had fallen twice whilst in hospital. When we visited the patient, we observed no signs to indicate that they were at high risk of falls.
- Since January 2018, there had been four serious incidents. Out of the four serious incidents, three were related to patient falls. Two of the three falls incidents were from A&E and one was from medicine. Gaps were identified such as not completing falls assessments and poor communication. Appropriate arrangements for shared learning were put in place such as sharing the outcome of the investigation with ward teams, however, incident reports on slips, trips and falls were still being reported since the serious incident occurred.
- On inspection, a matron told us about an incident that occurred where a staff member was assaulted by a patient on the ward. An incident form had been completed and the mental health team had reviewed the patient, however, there was no documentation of the assault in the notes for other staff members to read to be aware of this incident.
- Learning from incidents amongst staff was variable. Some staff members had no knowledge of learning from recent incidents that had occurred whilst others could give some information.
- Staff were aware of duty of candour and some were able to give examples of when they had displayed this with patients and relatives.

Never events, mortality and morbidity

- No never events had been reported in medicine by the trust in the last 12 months.

Safety thermometer

- The Safety Thermometer was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.
- Data from the Patient Safety Thermometer showed that the trust reported seven new pressure ulcers, five falls with harm and six new catheter urinary tract infections from February 2017 to February 2018 for medical services.
- On ward 14, harm free care was reported as 100% in February 2018, however no data was displayed on the ward for March or April 2018. Data from the trust showed harm free care was 100% in March and April 2018.

Cleanliness, infection control and hygiene

- Hand hygiene audits on ward 14 showed 95% in November 2017, 100% in December 2017 and was not done for January 2018. No other recent hand hygiene audits were displayed on the ward.
- Infection control audits from March 2018 showed that the wards were partially compliant with infection control standards. No information on MRSA, C.difficile or multiple drug resistant organisms rates were

provided in these audits. We observed no cases of MRSA and C.difficile on display on ward 14 during February 2018. No information was displayed for March and April 2018.

- We observed infection control notice boards displayed information on the infection control link practitioner, hand hygiene techniques, explanation of waste disposal bins, management of C.difficile and wound assessment tools.
- We observed staff following the correct procedures for hand washing techniques, however, alcohol hand gels were empty on some of the wards we visited.
- There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE during their activities when required.

Environment and equipment

- Prior to the inspection, pressure ulcer concerns were raised. On inspection, pressure ulcer equipment was checked and fit for purpose and pressure ulcer care plans had been completed. There was a central store for pressure relieving equipment. Once the needs of the patients were identified, nurses requested the porters to bring the equipment to the wards. The nurses told us they did not have problems ordering equipment from the company that supplied the pressure relieving equipment.

Records

- Records were generally completed well such as the patient's NEWs scores, waterlow scores, pressure ulcer care plans, glucose monitoring and MUST scores. However, some sections of 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms were not always filled in. We observed some forms that did not contain review dates and no documentation of family involvement.

Safeguarding

- Staff we spoke with understood their safeguarding policy. Staff had training on how to recognise and report abuse and they knew how to apply it.

Mandatory training

- Staff we spoke with told us that they were up to date with their mandatory training. From data provided by the trust, medical staffing rates from January, February and March 2018 were 58%, 57.6% and 62.2% respectively. Nursing rates from January, February and March 2018 were 82.9%, 84%, 84% respectively.
- We observed student nurse teaching sessions displayed, however, some staff told us they were unable to attend these sessions due to staff shortages.
- Appraisal rates for January 2018 was 83.8%, February was 87.32% and March was 88.73%.

Assessing and responding to patient risk

- We observed evidence of NEWS scores documented appropriately with evidence of escalation of deteriorating patients to doctors.
- The sepsis CQUIN) data collection aimed to monitor the assessment of the level of sepsis screening and rapid application of antibiotics. Results were provided by the trust with action plans provided when patients were not treated with intravenous antibiotics within one hour.

Nursing staffing

- Ward displays of planned versus actual staffing levels were not always up-to-date. Senior and junior nursing staff we spoke with felt there was a shortage of staff and on some occasions nurses to patient ratios were 1:10 or 1:12.
- A matron we spoke with told us that an acuity tool was used to assess staffing levels and that if there were staff shortages, incident reports were completed. The matron told us that when staffing levels were low, they escalated this to site managers who then tried to move staff around across the site and try and fill the gaps with bank or agency staff. A member of staff told us that having different bank or agency staff on different days impacted on continuity of care of patients.
- Shortages in staffing was also recorded on the risk register. From November 2016, there were 260 nurse and 13 consultant vacancies and significant vacancies for junior doctors. Recruitment and role reviews were ongoing since then.

Medical care (including older people's care)

Are medical care services effective?

Nutrition and hydration

- We observed water jugs left close by patients' beds which was a good way to ensure patients had access to hydration.
- Fluid balance charts were not always completed appropriately.
- Food record charts and MUST scores were generally well completed. We observed staff and volunteers supporting patients during mealtimes. We observed evidence of a speech and language therapy (SALT) assessment where a patient with dysphagia was given smaller meal sizes with the main calories and protein so that the meals were more manageable. We observed a dementia patient served food on a red tray to indicate they required support with eating.

Multidisciplinary working

- We observed two multidisciplinary team meetings. Doctors, nurses, physiotherapists, occupational therapists, social workers and a pharmacist supported each other to provide good care. Discharge plans, complex discharges, antibiotic reviews, psychiatric reviews and care packages were discussed at these meetings. We also observed MDT plans in patients' notes such as discharge planning, OT and physiotherapy input and input from the diabetes specialist nurse.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a lack of clarity amongst some staff members about the systems in place for Deprivation of Liberty Safeguards (DoLS), including the management and documentation of DoLS. The DoLS are part of the Mental Capacity Act 2005. The safeguards aimed to make sure that people in care homes and hospitals were looked after in a way that did not inappropriately restrict their freedom.
- We observed one set of notes where the DoLS application had expired and there was no indication of whether a new application had been made. The trust responded by informing us that the adult safeguarding team had a weekly DoLS sweep each Friday to ensure that all extensions were identified and addressed. A weekly list was circulated to all ward managers, matrons, heads of nursing and clinical site managers to ensure that staff were aware of patients with DoLS applications. The trust told us that at the time of the inspection, the QEH safeguarding team were uploading all the DoLS information directly into their new electronic system, which meant that there was no physical copy in the notes. The Safeguarding team were now ensuring that a physical copy is also put in the patient's medical notes.
- We observed good older people mental health services offered at the trust. Two sets of mental health patient's notes which were completed thoroughly and one set of notes had a DoLS assessment completed.

Are medical care services caring?

Compassionate care

- Staff cared for patients with compassion. The majority of feedback from patients confirmed that staff treated them well and with kindness. Patients had commented that "staff were very kind and they had received a lot of empathetic care", "staff were absolutely brilliant", "staff were superb", and "staff work very hard but there is not enough staff, especially at night". One patient commented about how "respectful and attentive" the staff were and how "marvellous the way staff treat patients with dementia". At times we did observe staff reluctant to engage with patients. Some patients we spoke with commented that "staff were overworked" and nurses were "underpaid and overworked".
- We observed patients being treated with dignity and respect. Staff were introducing themselves and drawing curtains around patients when necessary and a patient commented about how staff were "protective over their privacy and dignity".
- Staff introduced themselves to patients and explained their roles. They also asked if they required any assistance during mealtimes and patients were asked how they wanted to be addressed.
- We observed staff making the effort to celebrate a patient's birthday by making cake and having tea and

food served on a table for the patients. Patients also commented that staff made an effort to organise a royal wedding party on the weekend with tea and food for the patients.

- We heard the ward clerks speaking with visitors and telephone callers in a clear, calm and polite manner.

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care and treatment. Patients commented on how "questions were answered clearly" and that they were "very well informed".
- A patient with autism commented on how staff had been very understanding, spoke clearly and ensured they checked the patient's understanding of their care and treatment during their inpatient stay. The patient also commented on how they had "noticed a significant improvement" since they last visited QEH several years ago.
- We attended a multidisciplinary meeting and observed evidence of staff discussing psychiatric review, highlighting patients that required assistance with packages of care and occupational therapists discussing patient's choice when planning their discharge.
- One patient we spoke with had been seen by a diabetes specialist nurse and had been given lots of information about their condition and follow-up once discharged.
- Results from the 2017 inpatient survey showed an improvement compared to the 2016 inpatient survey, however, less responses were received in the 2017 inpatient survey. The 2017 survey looked at the experiences of 72,778 people who were discharged from an NHS acute hospital in July 2017. Between August 2017 and January 2018, a questionnaire was sent to 1,250 recent inpatients at each trust. Responses were received from 293 patients at Lewisham and Greenwich NHS Trust. Responses were received from 336 patients in the 2016 inpatient survey.
- Doctors answering questions, acknowledging patients, and confidence and trust had improved from 8.2/10 to 8.5/10. Nurses answers to questions and acknowledging patients had got worse. Confidence and trust in nurses, enough nurses on duty, and nurses in charge of care remained about the same. The overall care and treatment of patients had got better from 7.3/10 to 7.9/10, however, communication for not being told one thing by a member of staff and something quite different by another had got worse. Patients being told about any danger signals to watch for after going home had got worse and the overall leaving hospital experience remained about the same. Patient's views and information about complaints remained about the same with low scores of 2/10 and 2.5/10 respectively.

Emotional support

- We observed a multi-faith prayer room which was on the ground floor and was signposted well. We observed a chaplain visiting a patient on the ward to offer their support.
- We observed leaflets displayed on the wards entitled 'Working together' which encouraged carers and relatives to fill in the 'This is me' leaflets to support personalised care.

Are medical care services responsive?

Access and flow

- Concerns had been raised prior to the inspection around the discharge process. We visited the discharge lounge, spoke with the discharge team and attended a transfer of collaborative care team meeting.
- Patients we spoke with in the discharge lounge were happy with their discharge process and had been given everything they required for discharge and appropriate explanations. Staff we spoke with told us that common incidents in the discharge lounge were transport delays and delays in receiving medications. Staff told us sometimes patients did not have equipment or were discharged too soon due to the pressures in A&E.
- The hospital discharge team told us that they had discharge co-ordinators for the medical wards and that they would support with filling in discharge passports for patients that fit the criteria for the

'discharge to assess' model. Discharge to assess involved patients who were clinically optimised and did not require an acute hospital bed, but still required care services with short term, funded support to be discharged to their own home or another community setting. Assessment for longer-term care and support needs was then undertaken in the most appropriate setting and at the right time for the patient.

- The discharge co-ordinators attended multidisciplinary ward rounds and identified which patients had care package needs at an earlier stage. They gained consent from the patients or their relatives to complete the discharge passports. The discharge passports contained information on the discharge plan, transport booking, interim and other support required by the patients.
- One of the discharge co-ordinators told us that incidents had occurred where patients had been sent home and their care packages had not been confirmed and incident forms had been completed. Another team member told us that there was often poor communication and documentation from the wards. We observed a staff member from a ward highlight a patient that required a care package on discharge. The discharge team were not aware of this patient going home or requiring a care package. On investigation, the patient was not fit for discharge.
- The discharge team were working on ways to improve the discharge process. This included early stages of setting up transfer of collaborative care team meetings. We observed a meeting which was attended by the senior matron for discharge, interim director at Greenwich, service manager at Bexley, team manager at Greenwich from the hospital integrated discharge team and the team lead for discharge. The team were trying to plan ahead as much as possible including being mindful of the bank holiday and ensuring packages of care were in place as early as possible. Patients requiring physiotherapy, occupational therapy, mental health review, and social worker input were also highlighted at the meeting. Funding of patient's discharges were discussed and patients requiring escalation such as a patient needing rehabilitation who had been waiting a while for a bed at another hospital was to be actioned on the same day.
- During the inspection days there were four delayed discharges for patients under the discharge to assess pathway. This was due to transport and waiting for medication to be ready. The matron told us that the deputy chief operating officer and the chief pharmacist were arranging a meeting to look at ways to address these issues. The trust provided the delayed discharge data for the last month. There were 10 delayed discharges from the last month and action plans had been put in place to speed up the process, such as contacting relatives and booking financial assessments.
- The inpatient survey 2017 showed that patients waiting to get a bed on a ward had improved from 6.2/10 in 2016 to 7/10 in 2017. This meant that more patients felt that they did not have to wait a long time to get a bed on a ward.

Meeting people's individual needs

- We observed signs displayed for dementia support. A matron we spoke with told us that her role was going to change to a dementia specialist lead nurse. Plans were in place to create a safe wandering space for dementia patients, commission art work and refurbish the activity room. We observed activity cupboards for patients with dementia. These contained dolls and colouring in books and volunteers brought newspapers for patients to read.

Learning from complaints and concerns

- Prior to the inspection, there were concerns regarding the complaints processes. We observed PALS support signs displayed around the hospital and on the wards we visited. The PALS team were located next to the main reception and this was well signposted. There was a small waiting area next to the office with leaflets about local services such as the advocacy for NHS complaints and the citizens advice bureau contact number. We observed a noticeboard with contact numbers and emails for PALS and the complaints team.

- Staff we spoke with in the PALS team told us that they mainly received face to face or verbal concerns and that they saw approximately 100 people per week and that not all the complaints were regarding QEH. Staff told us that if complaints were unresolved, the complainant was asked to contact the complaints department. If emails or letters were sent to the trust, these were automatically sent to the complaints department. Staff told us that they had monthly meetings to discuss the numbers and the outcomes of complaints.

- Prior to the inspection, there had been concerns about neglect of patients, pressure ulcers, and patients being sent home without district nurse referral and appropriate equipment and medicines. The wards had received 22 complaints since December 2017. Most of the complaints were around poor communication and poor care received by patients. Action plans were put in place to address complaints; however, staff were not able to provide examples of learning that had occurred from complaints.

Are medical care services well-led?

Governance, risk management and quality measurement

- We observed evidence of monthly morbidity and mortality minutes. Where national guidance on learning from death was discussed, case record reviews and associated learning was discussed. Best practice from other trusts were discussed. For example, a video from a trust was chosen to be shared with committee members as the trust's learning from deaths processes were showcased as best practice by NHS Improvement (NHSI).

- We observed monthly governance meetings. The minutes from March and April 2018 showed that limited information was available about complaints, risks and serious incidents due to not having a Clinical Governance Manager. We observed pharmacy issues that were discussed, for example requesting doctors to complete prescriptions as early as possible. In April's minutes, it was highlighted that DNA CPR and Mental capacity assessment should have been documented correctly according to the Trust guideline and that a practice development nurse was due to organise training for health care assistants on fluid balance. These areas remained concerning on inspection.

- Risks were identified, recorded and managed on the risk register. However, staffing levels were still a concern at the trust since November 2016. This was reviewed in January and March 2018 and there was no change to vacancy numbers within nursing and medical staffing. There was ongoing recruitment and review of roles. Agency staff were used to mitigate the risks, however, this was expensive and presented its own risks. The trust had developed internal progression and training for hard to recruit posts and tried to improve retention through local training and development programmes.

Leadership of service

- Staff were aware of their whistleblowing policy and how to access it. Staff were not aware of who their freedom to speak up guardians were and did not use them.

- Staff felt their managers were supportive, however, the lack of staffing made it feel like a challenging environment to work in. Staff felt the managers were doing their best with the limited staffing resources they had.

- Staff were positive about the new chief executive and chief nurse that had recently started at the trust.

- A matron told us that the chief nurse had drop in sessions for staff to attend during their breaks and tea and coffee was provided. This gave staff an opportunity to discuss any concerns or issues at the workplace. At an engagement meeting with the CQC prior to the inspection, the new chief executive told us that the trust was planning a big brief about values over the next few months and will ask staff to come up with what they think the trust's values are to get people talking, set expectations, and engage more with staff.

Culture within the service

- Staff felt proud to work at the trust, however, the majority of staff felt it was stressful at times due to staff shortages and felt that this had an impact on the quality of care received by patients.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Queen Elizabeth Hospital is part of the Lewisham and Greenwich NHS Foundation Trust. The hospital has seven operating theatres based in the main building and three surgical wards identified as wards 12,15A and B and 17, with approximately 78 inpatient beds. A day care unit provided services for day surgery patients.

At our last inspection in June 2016, surgery was rated as requires improvement overall. This was a focused inspection of the surgery core service in response to concerns that had been raised with us. These related to problems with sterile instruments in the main theatres and the discharge arrangements in place for patients. As this inspection is focused on specific areas of concern, we have not re-rated this service.

During the inspection we visited main theatres, hospital and services decontamination unit (HSDU), recovery area, wards 12, 15A and B and 17, the day care unit and the discharge lounge. We spoke with approximately 25 members of staff including, senior leaders within the surgery division, nursing and medical staff, allied healthcare professionals which included occupational therapists and physiotherapists and healthcare assistants. We observed how people were being cared for and spoke with patients who were using the service and their relatives. In addition we reviewed a number of patient records and documents we requested during the inspection relating to performance and quality data.

Summary of findings

We found:

- There was a lack of leadership in the day care unit. Risks were not fully mitigated and the access and flow within the department was not effective. We found no improvements had been made since our last inspection.
- Patients were not always treated with dignity and respect within the day care unit.
- Due to the design layout of ward 15b, staff did not always have oversight of all patients during the night. The decision to reduce a member of staff meant some patients did not receive the care and attention staff wanted to provide.
- Patients medical notes were still loose within their file, which meant they could become lost. This had not improved since our last inspection

However:

- There were no concerns regarding the systems in place for discharging patients within the surgical division. We found staff were following the correct processes to ensure patients had the right packages of care for when they left the hospital. However, there were differences in the way the system ran between the two local boroughs which covered the area of the hospital.
- We found no concerns regarding sterile instruments within theatres. There were good systems in place within the hospital and services decontamination unit (HSDU) for the monitoring and auditing of their processes.

Surgery

- There was a significant improvement in the spinal trauma pathway, and the service's adherence to the pathway since our last inspection
- There was improved management of medical outliers within the surgical wards.The trust had employed a medical senior house officer (SHO) to manage medical outliers. This was an improvement since our last inspection in March 2017
- Rooms five and six in ward 12 were no longer used as escalation areas and additional patient beds were no longer placed in these rooms. This was an improvement since our last inspection.
- Overall surgical wards were clean and tidy. This was an improvement since our last inspection.
- Patient records were more securely stored in locked containers. This was an improvement since our last inspection.

Are surgery services safe?

Incidents

- There was a good incident reporting system in place for any concerns relating to sterile instruments. The hospital and services decontamination unit (HSDU) manager had oversight of all incidents and investigated each one. Feedback was discussed in monthly meetings between theatres and HSDU.
- All staff within HSDU that had an incident raised against them went through refresher training. Staff received theoretical training and were observed in practice. All staff were placed on local monitoring for a suitable period of time following an incident.
- We were able to view all incidents reported regarding HSDU concerns and found there had been a reduction in incidents for 2017 to 2018 regarding instrument and equipment issues. Seventy four incidents had been reported for 2017 to 2018 compared to 121 for 2016 to 2017. This meant there was a reduction from 0.12% to 0.08%. Incidents reported included, contaminated instruments, wet set, torn wrap, damaged and missing items. There were 13 reported incidents of contaminated equipment in 2017 to 2018 compared to 18 in 2016 to 2017.
- We viewed incidents reported for the surgical wards from January 2018 to May 2018. We saw there were two incidents reported regarding discharge arrangements which related to patient medication and a near miss of the patient being sent home too early. The report did not provide outcome information for all of the incidents reported.
- Nursing staff told us feedback from incidents was variable. Some told us they did receive feedback while others said they did not. However, most staff told us they rarely reported patient discharge incidents as there were very few to report.

Cleanliness, infection control and hygiene

- As part of our focused inspected we visited the HSDU and theatres to ascertain whether dirty instruments and equipment had been used. During our inspection we found no evidence to substantiate the concerns. Dirty instruments and equipment will put patients of risk of developing an infection and may delay procedures.

- We spoke with the trust decontamination manager who had been in post since August 2016 and found there was a robust quality system in place within the HSDU. We found the trust followed The Department of Health (DoH) Technical Memorandum of Decontamination. This is a set of guidance and protocols acute trusts should follow when sterilising medical instruments to minimise cross infection.
- Comprehensive electronic data was available to identify all non-conformances. The data showed non-conformance had fallen from 2016-2017 to 2017-2018 data. The hospital was below the national average for non-conformance when compared to other trusts at 0.08%.
- The decontamination manager had implemented in-house training and competency assessment to all HSDU staff and there had been a total review of the service. The service had recently undergone an external inspection for non-conformity by the British Standards Institution where it was found there had been no non-conformances which was regarded as a great achievement by the unit.
- There was an electronic tracking and tracing system within the HSDU and this provided the service with good quality data. There was no electronic tracking and tracing system within theatres but we were told this was due to be implemented within the next two to three months. The system will have an electronic traceability, which will allow for instrument trays to be be traced to the location and an electronic checklist of all contents available.
- We spoke with two members of staff from HSDU and both were able to confirm the process for re-processing instrument sets and we observed how staff checked instruments in both the dirty and clean zones of HSDU. Staff described the process they followed if an instrument was missing from a tray. They would contact theatres immediately and if out of hours would contact them at the next day. Staff told us that on occasions when there was a shortage of staff and they were under pressure, then the possibility of mistakes could happen.
- We spoke with theatre staff and they confirmed they had no major concerns with HSDU and they had noticed an improvement since the new HSDU manager had started. The matron confirmed instrument issues were not on the risk register as this was not regarded as a concern or risk.
- Theatre staff said they were times when the instrument sets may have something missing or the pack was ripped, but this happened only occasionally and they reported is as an incident via the electronic system. Staff confirmed they received feedback on the incidents they had.
- reported. Incidents were raised and discussed in the monthly meeting between HSDU and theatres.
- We looked at several sterile instrument trays within the preparation area in theatres and found packaging was intact with no visible damage.
- We viewed the monthly theatre and HSDU meeting minutes. There was a set agenda of non-conformances/ incidents, key performance indicators and innovations which were discussed on a monthly basis. We found the meetings enabled a healthy discussion between theatres and HSDU and enabled a good oversight of incidents and actions taken.
- In wards 15A and B, we saw clinical waste bins had been correctly used and were not overflowing. This was an improvement since our last inspection.
- Overall we found the each surgical ward was clean and tidy and this was an improvement since our last inspection.

Environment and equipment

- We were told the trust had spent approximately 1.7 million on new theatre equipment within the last year and that this was an ongoing rolling programme. During the inspection staff we spoke with did not raise any major concerns with the lack of suitable equipment within theatres. They did inform us that some equipment was old and in a state of repair.
- Staff told us that requesting or purchasing new equipment was a difficult task, although they understood the financial constraints the trust was under. Requesting, small equipment that would make the patients stay at hospital a better experience was virtually non-existent. For example, staff told us to have a television in one of the surgical wards rooms for patients to view would vastly improve their stay and could possibly have health benefits for certain patients.
- The replacement of the sentinel node probe (a probe used to detect radiation in patients and primarily used in surgery), was placed as a risk on the surgical risk register. Updates showed that funding had been secured in November 2017 for a replacement probe but

as of beginning of April 2018 the probe had not been procured and the risk was escalating. There were no further comments on the register to state what further action was being taken.

- During our inspection at the day care unit we encountered an inpatient with had suspected Methicillin-resistant Staphylococcus aureus (MRSA) had been placed in a cubicle with the door open. At our last inspection we raised concerns regarding the placement of infectious patients in this area. The cubicles had no hand wash basins and staff had to 'close a separate bathroom in order to minimise cross infection. However this then meant other patients had less toilet facilities to use. We therefore, found no improvement since our last inspection.
- Contracted decorators were also painting outside of this cubicle, and we saw they were talking to the patient with suspected MRSA. There was decorator's equipment, including unlidded paint pots on the floor of the day care unit just outside of the patient's room and opposite the area where female patients were awaiting treatment. The area where the decorators were painting had not been screened off and posed a potential health and safety issue as well as a privacy concern for those patients. We spoke with the head of nursing who stopped the decorating and removed the patient to a suitable side room on a different ward.
- The risk assessment document for the contracted decorating stated barriers would be placed around the decorators while they carried out their work. During the inspection we found there were no barriers in place when the contractors were decorating.
- At our last inspection we raised concerns regarding rooms five and six in ward 12 which were being used to 'board' extra patients. There was limited space in each room to allow for safe and dignified patient care. During this inspection senior nursing staff told us the rooms were no longer used as areas to place extra patient beds. This was an improvement since our last inspection.

Records

- From the records we reviewed we saw there was good input of multidisciplinary notes regarding the patient's pathway of care which included their discharge arrangements and discussions surrounding the patient's needs.
- Records were kept in a secure locked unit and this was an improvement since our last inspection. However, patient's medical notes were still loose within their file even though there were security tags to ensure documents were kept secure within the file. This meant the patient medical notes were not kept in an orderly fashion and posed a risk of becoming lost. This had not improved since our last inspection.

Nursing staffing

- Shortages of nursing staff were not considered a risk on the surgical risk register. We found in general there was sufficient cover on the surgical wards. Difficulties occurred when unfilled shifts were not covered, especially if there were high acuity inpatients. Staff told us this placed immense pressure on them and increased their workload.
- The nurse's station in ward 15B was not in a position where all the bays and side rooms could be viewed by staff and, therefore it was crucial that sufficient staff were available to provide care and treatment for patients.
- We were told last year a decision was made to reduce the amount of health care assistants (HCA) by one on ward 15B on the night shift. Staff described the impact this had. If there were one or two patients who required more attention, for example those at high risk of falls, then one HCA would have to stay in the bay with those patients. This meant staff were unable to attend other patients as quickly as they would like and were unable to visibly see other patients due to the layout of the ward.
- Ward 12 relied on one bank staff member every day to ensure they had suitable cover to support the additional Surgical assessment unit beds that have been opened to support flow. This unit has since been moved to the Ambulatory Care unit

Assessing and responding to patient risk

- At our last inspection concerns were raised regarding medical outlier patients placed within the surgical wards and the lack of oversight for these patients. During this inspection we found improvements had been made. The matron told us no medical outlier patients were placed within ward 12 anymore and very

few were placed in ward 17. Most medical outlier patients were placed within ward 15A and B and the trust had employed a medical senior house (SHO) officer to assist with these patients.

- However, high acuity medical outlier patients were sometimes placed within wards 15ab and we were told this was not meant to happen. Higher acuity medical patients required closer scrutiny and specialist medical support and this placed increased pressure on the SHO and surgical nursing staff.

Are surgery services effective?

Multidisciplinary working

- Overall we found there was good multidisciplinary (MDT) working for all aspects of patient discharge within the surgery division. We spoke with various members of staff who were able to describe the input they had with discharge processes and the other team members they worked with. Within patient records we viewed we saw relatively good MDT notes on discharge information for the patient.
- We attended a mid-morning bed site meeting. This was attended by members of staff from all departments within the hospital. During the meeting discussions took place on patient flow and patient discharge numbers within each department. We found there was no pressure on ward staff to discharge patients early and support was given to those departments where delayed discharge occurred. For example, if a patient was awaiting an x-ray, support was provided in co-ordinating the process more efficiently.
- Staff we spoke with told us since the introduction of these three times a day meetings, there was a better communication flow amongst different departments and they did not feel under pressure to discharge patients early.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff we spoke with were able to describe consent procedures and overall, records we viewed demonstrated patients consent was sought before treatment. Risks and possible outcomes had been discussed with the patient.
- However, the notes of a patient with dementia who was admitted to a medical ward at the beginning of May 2018 indicated they had not had the necessary capacity assessments completed while placed in that ward. When the patient was moved to the surgical ward we found staff had acted accordingly and started the process of the necessary mental capacity assessments involving the correct multidisciplinary team.

Are surgery services caring?

Compassionate care

- We saw compassionate care provided to patients in wards 12, 15ab and 17. Patients were treated with respect and their needs were attended to.
- Nursing staff within the day care unit were kind to patients and endeavoured to accommodate their wishes in difficult surroundings. Nursing staff recognised patients lacked privacy within the unit, but felt nobody listened or acted upon their concerns.
- Overall most patients we spoke with were happy with the care they had received. They were complimentary of all staff that had cared for them throughout their journey. Most patients commented on the immense pressure and how hard the nursing staff were working.
- The last inpatient survey was published on 13th June 2018. The results showed across the trust waiting lists and planned admissions, waiting to get to a bed on a ward; nurses, care and treatment, and leaving hospital was about the same. This meant that the trust was performing about the same for that particular question as most other trusts that took part in the survey.

Are surgery services responsive?

Access and flow

- Concerns had been raised prior to our inspection on the discharge arrangements at the hospital. We had received a number of concerns relating to the lack of sufficient equipment and support when patients were discharged home. During this inspection we found no major concerns to with the discharge procedures within the surgical division.

Surgery

- All staff we spoke with within the surgical division, from the matron, nursing staff, occupational therapists (OT), and the discharge team were able to describe the discharge system and the confirmed that there were no significant problems with the discharge arrangements in place. There were the occasional glitches, but staff confirmed there were no major concerns.
- Discharge co-ordinators were assigned to each ward and they organised the patient journey by ensuring equipment and essential care packages were in place before the patient arrived home. The coordinators worked in conjunction with nursing ward staff, OT, social services and consultants to arrange and assist with ensuring the correct package of care was in place.
- The hospital came under the area of two different local authorities and staff told us there were slightly different arrangements within each. Most staff said they experienced difficulties or delays with discharge arrangements from one particular authority and this either led to a slower process in making the necessary arrangements for patient's package of care. For example, one authority allocated social services at the hospital while the other did not and this led to inconsistency in the process.
- Other examples of the inconsistencies included the ordering of equipment. For example, to order a bed and mattress with one authority meant staff having to consult with two different manufacturers, while they did not have to do this for those patients who lived in the other local authority.
- Staff also fed back that they believed the discharge to assess system, which meant assessments were completed in hospital and social services followed up once the patient was discharged placed more pressure on staff within the hospital.
- Staff also felt patient's relatives sometimes did not completely understand the system and that their expectations exceeded the package of care that was agreed with the patient. Sometimes relatives expected the highest most comprehensive package of care, even if the patient did not fall into the category that determined the package. Staff also felt it was hard for patient's relatives to accept that sometimes patients returned to their home before they were placed into a care home.
- Weekly multidisciplinary meetings held within the surgical division, whereby each patient's package of care and discharge arrangements were discussed. The meetings were attended by consultants, OT, nursing staff, therapists and social services.
- We visited the discharge lounge and spoke to the lead nurse. They were able to tell us that delays to patients discharge were usually related to delays in transport and delays in obtaining medication. Patients were issued with a discharge passport, which was the agreement of care for discharge. Patient and patient's relatives gave consent for the passport and this was shared with social services at the follow up stage. On the day of our inspection there had been two lengthy delays of more than four hours and these were due to a transport delay and a delay in issuing medicines.
- Within the surgical wards there had been one delayed discharge and this was due to the patients relative not being at home.
- During our inspection we were told the discharge lounge sometimes closed early in the evening and patients were moved to the day care unit to await discharge. This placed pressure on the staff within the day care unit and meant patients were unnecessarily moved around.

Meeting people's individual requirements

- During this inspection, we found concerns with the hospital not meeting patient's individual requirements. The surroundings within the day care unit did not provide a dignified environment for patients and we did not always find patients were treated with sensitivity and respect.
- During this inspection, we found patients who were prepared for day surgery, waiting in theatre gowns sitting in an open area. The area was divided by a moveable screen for male and female patients (at the time of our inspection, this only covered half of the area) and an internal corridor was alongside where patients waited. Therefore, patients did not receive the privacy they were entitled to while receiving care and treatment. This was compounded by the fact that decorators were painting just outside the area and were not screened from the patients. Throughout the entire unit, there was a strong smell of paint.

Surgery

Learning from complaints and concerns

- Surgery services received two patient complaints from January to May 2018 in relation to discharge concerns. One related to incorrect medical information being listed on the patients discharge passport and the other related to a patient being discharged without their medication. The report did not say what actions had been taken as a result.

Are surgery services well-led?

Governance, risk management and quality measurement

- We viewed the surgical division and theatre risk register. We found the day care unit in terms of unsuitable space and environment to care for high numbers of day care patients was a new high risk, having been placed at the end of April 2018. The risk also described how the recovery area became blocked from 3pm and in addition patients from the emergency department were being admitted overnight. The risk recognised that staff morale was low and the patient experience was poor and there were delays in patient pathways.
- There were mitigating actions such as, immediate review of admission criteria for the area as well as an immediate review of booking and scheduling of patients in this area. Other mitigating actions included identifying plans for additional capacity within the hospital in order that the day care unit could function as a ring fenced care unit. At the time of our inspection such actions had not been fulfilled, however there was an expected date of completion for August 2018.
- At our previous inspection we found spinal trauma patients with a category rating of four were not transferred to another acute trust and were inappropriately being placed to inpatient beds. At this inspection we found the trust had acted on our concerns and had taken immediate action, by ensuring trauma and emergency department leads had reviewed and acted in accordance to the agreed policy. Having spoken to staff on ward 17, they were able to confirm that there had been fundamental changes for the better. We saw the closing statement on the risk register which stated the spinal pathway was now embedded and the risk was mitigated and therefore could be removed from the register. This was an improvement since our last inspection.

Leadership of service

- We found there was a lack of effective direct leadership within the day care unit. Patient's privacy and dignity were not respected and staff were not empowered to make changes or challenge decisions made. Risks were not managed well. Following our last inspection we asked the trust to take action to improve the governance in surgery. We found little improvement in the day care unit. Staff told us they felt overworked and under supported.
- The feedback from staff from the day care unit correlated with the bottom ranking results from the NHS staff survey 2017. The bottom ranking scores related to the percentage of staff working extra hours and staff satisfaction with resourcing and support and the organisation and management interest in and action on health and wellbeing.
- Although the trust recognised the day care unit was an area of concern and it was classified as a high risk on the surgical risk register, staff told us they did not feel there was effective leadership within the department. We were told the management style lacked support and direction. Staff felt they were firefighting problems and nobody was prepared to listen and act upon their concerns.
- We received good feedback from staff regarding the leadership style within the surgical wards 12, 15A and Band 17. Staff told us they felt supported by the matron and they had an open door policy where they were able to raise concerns.
- Staff described the new chief nurse as supportive. They were optimistic that changes would be made for the better.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure medical and nursing staffing levels are in line with national standards in services for medicine at Queen Elizabeth Hospital to provide safe continuity of care for patients.

Action the hospital SHOULD take to improve

- Ensure staff are aware of their responsibilities in relation to Deprivation of Liberty Safeguards and the Mental Capacity Act 2005 and that forms are filled in appropriately.
- Continue the work to improve discharge planning.
- Ensure alcohol hand gels are filled at all times.
- Ensure processes are in place to prevent common themes of incidents and share learning from incidents and complaints with staff.
- Ensure staff are aware of the freedom to speak up guardians.
- Display latest infection control and safety thermometer information.
- The hospital should make improvements with monitoring of risk and the governance of the day care unit.
- The trust should make sure patient's privacy and dignity are respected within the day care unit.
- The trust should consider additional HCA cover on ward 15b for the night shift.
- The trust should make sure patient medical notes are securely contained in their files

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
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 Health and Social Care Act (RA) Regulations 2014 Staffing 18 (1) • Staff shortages were reflected in the risk register and full time equivalent data. The risk register showed that from November 2016, there were 260 nurse vacancies, 13 consultant vacancies and significant vacancies for junior doctors. The planned versus actual staffing levels for nursing staff in April 2018 was 378.87 versus 269.77 respectively. These levels were consistently low in February and March 2018. • There were insufficient nursing staff within the service. Ward displays of planned versus actual staffing levels were not always up-to-date. • Staff felt that having different bank or agency staff on different days impacted on continuity of care of patients. This impacted on the ability for learning from incidents to be shared. This was reflected during the inspection and in a focus group that we attended. • Senior and junior nursing staff we spoke with felt there was a shortage of staff and on some occasions nurses to patient ratios were 1:10 or 1:12. The provider must take action to:

This section is primarily information for the provider

Requirement notices

- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. In particular at QEH this relates to nursing staff. (Regulation. 18 (1))