Inspection Report

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

Nottingham Woodthorpe Hospital

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Date of Inspection: 13 February 2014

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Ramsay UK Properties Limited
Registered Manager	Mr. Simon Milner
Overview of the service	Nottingham Woodthorpe Hospital is an independent hospital providing care for adults.
Type of service	Acute services with overnight beds
Regulated activities	Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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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 looked at the personal care or treatment records of people who use the service, carried out a visit on 13 February 2014, 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, talked with staff and reviewed information given to us by the provider.

What people told us and what we found

We spoke with five patients who used the service, three relatives and 11 members of staff. We also reviewed four medical records.

All the records we reviewed demonstrated clearly that the care had been discussed with the patient using the service. We saw patients signed to consent to their treatment.

We saw that patients were seen as outpatients prior to admission. During these clinic appointments multi-disciplinary pre admission assessments were undertaken. We saw documentation for patients which showed us that consultants, nurses and allied health professionals were involved in patient's care.

We saw there was a process for identifying staff who were approaching the date for their training or were out of date with their training. This demonstrated that the provider monitored staff development and training attendance and was able to follow up non-attendance.

We saw a selection of comment cards completed by patients. All rated their care as good or excellent. We were also told that an external patient satisfaction survey had been conducted.

We found the medical records and daily records we reviewed were up to date, accurate and fit for purpose. Documentation was complete, detailed and easy to follow. We saw that records were secure and either locked in a filing cabinets, trolleys or within a locked office.

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

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

We reviewed four medical records and the corresponding daily monitoring records. All the records were complete and up to date. Every record demonstrated clearly that the care had been discussed with the patient using the service. We saw patients signed to consent to their treatment.

We spoke with the staff and asked them to explain their approach to ensuring patients understood and agreed to their treatment. Their responses showed us that they understood the need to explain and gain consent before carrying out care and treatment. We saw detailed consent forms completed prior to procedures taking place and saw the information was reiterated on the day of admission. This demonstrated to us the provider ensured patients were given detailed information and time to process the information before making an informed decision.

We also spoke with a number of patients who used the service and asked them if they had discussed and agreed to their treatment. Their responses indicated to us that before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. One patient told us: "The consultant was very clear I knew exactly what to expect and understood what the risks and benefits were. I knew what I was signing up for."

We asked staff what action they took if they felt patients did not have the capacity to understand or retain information. Their responses indicated to us they understood the need to ensure the patient was represented and best interest decisions made. We were also given examples of where representatives were asked to support the consent process. However staff did not have a standardised pathway to guide them through the process.

From what we saw and heard, where patients did not have the capacity to consent, the provider acted in accordance with legal requirements. However the provider may wish to consider developing a standardised pathway for staff to follow.

Staff had access to guidance on consent. We saw policies on gaining consent, assessing mental capacity and national guidance for gaining consent for children. We asked for and received a training schedule for all staff. We saw that clinical staff attended training in consent and all staff attended training in customer service. This demonstrated that staff had access to information to ensure the consent process was followed for all patients.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We saw a variety of information in the reception and ward areas. All the leaflets and signage throughout the building were in English. We asked what arrangements were in place to ensure patients who could not read or understand English were given information in a way they could understand. The manager explained there had been two patients in the last twelve months who were unable to communicate in English. The manager told us interpreters had been used. The manager also explained that head office supplied leaflets in other languages as required.

We looked at four medical records and the corresponding daily monitoring records and saw patients' needs were assessed and care and treatment was planned and delivered in line with their individual treatment plan. The medical records contained risk assessments relating to people's individual care and health needs.

We saw that patients were seen as outpatients prior to admission. During these clinic appointments multi-disciplinary pre admission assessments were undertaken. We saw documentation for patients which showed us that consultants, nurses and allied health professionals were involved in patient's care. Following admission pre-operative, peri-operative and post-operative assessments of needs were undertaken. All the records we reviewed were detailed and comprehensive.

We also spoke with patients and asked them their views in relation to the care and treatment they received. All patients spoke with high regard for the quality of care, kindness and professionalism displayed by the staff. One patient told us: "I rate the care here pretty high. I am absolutely satisfied." Another patient said: "I am treated with respect and all the staff are polite. They have gone through my notes with me and I feel involved in my care." Patients' responses to our questions indicated that care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

We spoke with a number of staff and asked them to explain their approach to meeting the needs of the people they cared for. Their responses demonstrated they understood the concept of ensuring care and treatment records were current and health needs accurately recorded. One member of staff explained to us: "The care is person centred here." Another member of staff told us: "I would rate the care here as very good, even

exceptional."

There were arrangements in place to deal with foreseeable emergencies. We saw a business continuity plan. The document detailed the plans in place for dealing with emergencies which may affect the running of the service. There was emergency equipment and drugs on each ward. We saw that the emergency trolleys were checked on a weekly basis. The last check had been carried out on 9 February 2014. The emergency drugs were in date and due for renewal on 28 February 2014. All the rooms contained points for the administration of oxygen and suction. A call bell was available for all patients should they require assistance.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Staff had access to a selection of guidance for accessing training, supervision and performance development. We saw policies for performance development review, clinical supervision and mandatory training.

We asked to see the training schedule for all staff. We noted that staff had access to a variety of training, such as safeguarding the vulnerable adult, health and safety, basic life support and moving and handling. Staff also told us they were able, from time to time, to obtain further relevant qualifications. All the staff we spoke with told us they had attended mandatory training and had received an appraisal in the last year

A member of staff demonstrated a database which was used to monitor attendance at training, completed appraisals and personal development plans. We saw there was a process for identifying staff who were approaching the date for their training or were out of date with their training. This demonstrated that the provider monitored staff development and training attendance and was able to follow up non-attendance.

There was a process for checking and recording professional registration. We saw that all care and treatment was provided by qualified doctors, nurses and allied health professionals. This demonstrated to us that patients were cared for by professionally qualified staff who were current with their registration and suitably qualified to carry out their duties.

We saw and heard evidence that staff received regular supervisions. We asked the staff we spoke with to describe to us how supported they felt. Their responses indicated they were very well supported. One member of staff who had recently joined the service explained their induction programme had been structured, supportive and very useful. Another member of staff told us: "Managerial support is good. We have access to internal and external training sessions. We are also required to complete competency assessments on line when we have completed our mandatory training."

We spoke with a number of patients and asked them if they felt they were care for by competent staff. All the people we spoke to with told us they were well looked after and the staff were attentive to their needs. One patient told us: "I feel safe. All the staff are

competent and attend to my needs in a timely manner."

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

Patients, their representatives and staff were asked for their views about their care and treatment and they were acted on. We saw a selection of comment cards completed by patients. All rated their care as good or excellent. We were also told that an external patient satisfaction survey had been conducted. We reviewed the results and noted that the summary of results had been discussed at the head of department meetings.

Staff were also encouraged to share their views. We saw the results from the 2013 staff survey and an external survey had been conducted in January 2014 but as yet the results had not been collated. Changes to practice had been implemented following suggestions made in the staff forum. We noted that administration support had been improved following concerns made by staff.

The provider took account of complaints and comments to improve the service. We saw a complaints policy and asked for and received evidence of complaints people had made and the provider's response. The provider demonstrated complaints were dealt with appropriately and were fully investigated and actions taken. None of the people we spoke with had made a complaint and told us they were very happy with the care they received.

There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. We saw that incidents were reported by staff and the provider investigated and developed actions to resolve any concerns.

There was an extensive audit and risk assessment programme. We saw audits were carried out on such areas as documentation and record keeping, consent, medication prescribing and administration. We also noted that a range of health and safety, environmental and equipment risk assessments were carried out. Local risks were entered onto the risk register. The provider demonstrated that quality assurance and risk management was an integral part of the provision of the service.

There was a robust governance framework and reporting structure. Incidents, serious untoward incidents, complaints, risks and audits were analysed and reported through the committee structure to the Board and learning and actions were cascaded to staff. We saw a variety of management and staff meetings took place on a monthly basis and quality issues were discussed.

We spoke with staff and asked them to detail how their practices were monitored. They all explained that they had regular supervision and clinical supervision sessions. They were also required to complete competency assessments, accessed through the intranet.

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.

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

Reasons for our judgement

We found the medical records and daily records we reviewed were up to date, accurate and fit for purpose. Documentation was complete, detailed and easy to follow. We saw that records were secure and either locked in a filing cabinets, trolleys or within a locked office. The provider's policy and procedure documents were available for all staff to reference and use as guidance for their working practices. This demonstrated to us that records relevant to the management of the services were accurate and fit for purpose.

The provider explained they had suitable arrangements in place to ensure that records were secure. The medical records manager told us that records were kept for approximately 18 months and then all records were managed by an external company. We asked for and received confirmation of a service level agreement between the provider and the external company. This demonstrated that records were stored, archived and disposed of in accordance with the Department of Health's national standards.

We also saw data protection and confidentiality issues were discussed in the staff meetings. We spoke with staff and asked them to explain what they understood about data confidentiality. Their responses indicated to us they understood the importance of keeping accurate personalised care records secure and confidential. The manager also explained to us they were in the process of arranging training for the staff on the importance of accurate record keeping.

Medical records were kept securely and could be located promptly when needed. The medical records manager explained that a record tracking system had been introduced and practical training sessions given to staff on how to use the system. We also saw staff guidance on safe tracking of records in the departments we visited. The system had only been introduced three months previously. The manager explained there were plans to audit the process but early thoughts were that the system had improved the traceability of records.

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.

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