Inspection Report

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

Royal Surrey County Hospital

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Date of Inspections: 24 May 2013
17 April 2013
16 April 2013
15 April 2013

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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
Safeguarding people who use services from abuse	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Royal Surrey County Hospital NHS Foundation Trust
Overview of the service	The Royal Surrey County Hospital, situated in Guildford, is a general hospital and serves a population of 320,000 people for emergency and general hospital services. It is the specialist centre for cancer patients in Surrey, West Sussex, and Hampshire, serving a population of over a million people. The hospital became an NHS Foundation Trust on 1 December 2009.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies 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'.

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 15 April 2013, 16 April 2013, 17 April 2013 and 24 May 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We sent a questionnaire to people who use the service, talked with people who use the service, talked with carers and / or family members and talked with staff. We reviewed information given to us by the provider, reviewed information sent to us by other authorities, reviewed information sent to us by local groups of people in the community or voluntary sector and talked with other regulators or the Department of Health. We were accompanied by a specialist advisor.

What people told us and what we found

During our four day visit we carried out interviews with 21 in-patients and some of their relatives across nine wards, and handed out questionnaires in outpatients. Specialisms on the wards included elderly and dementia care, children's medicine and surgery, orthopaedics, urology, respiratory conditions, cancer care, and gastro-intestinal disorders. On the final day of our visit we visited operating theatres, the elective surgical unit and day surgery ward.

The majority of both in-patients and outpatients who responded to our question on consent told us their consent had been sought, and positive comments included "Staff always ask and explain." Most patients also confirmed that staff had involved them in decisions about their care and treatment.

In relation to the care and treatment they had received, the vast majority said they had been treated with dignity and respect, and felt safe in the hands of staff at this trust.

We asked patients if there were enough staff to meet their needs and we received some mixed responses. Most people said they got the care they needed but staff seemed very busy; one person summed this up: "More staff would make the service smoother."

Most patients were satisfied with the record keeping arrangements, and positive comments included "Yes, and records are frequently verified and checked." They also commented positively on the overall quality of the service.

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 patients were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

The majority of both in-patients and outpatients who responded to the question about whether they were asked to consent to their care and treatment, told us their consent had been sought. Positive comments included "Staff always ask and explain" and "I often say 'no' (to treatments) and they always listen." Patients gave examples where they had been asked for their consent, for example when staff had taken blood, and when they had a scan. This told us patients were satisfied with the arrangements for gaining their consent to care and treatment.

We saw and were told by staff that people could ask for or would be offered a chaperone where they requested or where examination or treatment involved intimate practices. In areas such as outpatients the use of chaperones was part of the consent process and offered an additional degree of respect for dignity.

Patients attending for planned elective surgery told us that they had consented to their treatment and we saw that consent forms were completed in their records. These forms were checked by staff on numerous occasions as part of the safety procedures prior to going to theatre.

Patients who had gone to theatre for their surgery directly from the specialist wards, such as the vascular ward and paediatrics (children's) had completed consent forms prior to surgery and these were present in their medical records. Patients that we spoke to told us that they had been given a range of information prior to consenting to their operation.

During this inspection we reviewed 29 patient's nursing records in detail, including the relevant sections where the patient had been to the operating theatre. We noted that people had given their consent to care and treatment, though this was recorded in different

places.

We saw that nursing records contained information about consent in the evaluation and variance reporting in care plans. We saw that consent had been given for individual procedures, for example inserting a naso-gastric tube to support a patient with artificial feeding.

We interviewed 35 staff of varying grades and positions. We also circulated 100 pre inspection questionnaires to staff and a total of 21 were returned. Overall staff were knowledgeable on issues that related to consent, and told us what actions they needed to take when a patient was unable to give their consent. Staff told us that they had received training on consent and could give examples of how they gained both verbal and written consent from patients.

We were told by nursing and care staff that annual updates to their training included lectures on mental capacity, equality and diversity, and consent to care and treatment. We noted the provider had a variety of forms in place for gaining consent from patients, including one for adults who lacked capacity to consent to investigation or treatment.

The specialist advisor who assisted CQC during this visit spoke with the medical director and with individual doctors on the wards, and noted no concerns in relation to consent. Doctors spoken with were very confident about their ability to take informed consent and had received training on this. The trust had a Consent Committee to review and share good practice. This told us the provider had systems in place to gain and review consent from people who used the service.

In relation to consent, there should be clear procedures in place in relation to people who are being detained under the Mental Health Act. There had been a separate unannounced visit by a Mental Health Act Commissioner. This had identified that Royal Surrey had satisfactory arrangements in place for managing detained patients. In addition they had multi-agency protocols in place to ensure as far as possible, the smooth transition of detained patients between services. This showed us that where people did not have the capacity to consent, the provider acted in accordance with legal requirements. It was recommended at that visit that there was a need for more information for detained patients and staff on consent issues, which differentiated between whether it was treatment for a physical illness or a mental illness.

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.

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

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. The majority of patients told us they had been involved in discussions about their care, and their preferences and wishes had been taken into account. One patient told us they would be involved in their own discharge planning meeting later that day.

Positive comments from patients about their care and welfare included, "Several times my treatment time was changed to suit me", and, "Everyone seems keen to take good care of patients." One person told us they had eye surgery booked but had to be admitted early with another unrelated condition. They told us "The consultants worked together" to ensure the best outcome.

Care and treatment was planned and delivered in a way that ensured people's safety and welfare. Procedures were in place to identify and manage risks from the point of admission to discharge. This included admission criteria for the elective surgical unit, day ward or general wards. This ensured people with additional health needs, such as insulin therapy were not admitted to the elective surgical unit. Staff used the NICE clinical guidelines for carrying out pre-operative tests for patients who were having elective surgery. This meant that staff took into account best practice guidance.

We saw that there were arrangements in place to prevent patients from going to the operating department before having all the required assessments completed. For instance, patients were required to have a venous thromboembolism (this related to the risk of having a blood clot) assessment and preventative treatment commenced. Staff told us that if this was not completed then the patient did not go to theatre.

With patient agreement, we saw the process of them having their pre-operative checks carried out on the ward through to the theatre environment. At each stage of the process we saw staff were fully responsible for ensuring safety checks had been completed. This included checking the side of the body to be operated upon and patients that had consented to the procedures.

Our specialist theatre advisor made observations of practices and documentation that

confirmed the correct checks were made in accordance with the World Health Organisation recommended practices. This included observed 'sign in', 'time out' and 'sign out' from the operating room.

We saw in the records, and staff confirmed in discussion with us, that patient's had regular assessments of their vital signs, such as blood pressure and heart rate checks following their operation. The provider may like to note that in relation to paediatrics, the guidelines for frequency of checks were not clearly defined, which could lead to a potential for error.

Our specialist advisor saw that staff used a Paediatric Early Warning Score (PEWS) system for ensuring the safety and wellbeing of children. These were present within documentation and staff we questioned knew how to use them effectively. The junior staff we spoke with were clear how to escalate concerns.

We saw other safety measures were in place. All staff on the children's ward had completed paediatric basic and intermediate life support. In addition to this, the nursing rota allowed for one European Paediatric Life Support (EPLS) provider to be on duty.

Staff were seen undertaking and discussed with us the preparation processes for patients going home after their day surgery. These measures ensured that where required medication was provided and that information was provided to the patient's general practitioner about the procedure that had been performed.

Patient's records reviewed contained an initial assessment, and a care plan was then drawn up to meet those needs. This included assistance patients required in relation to activities of daily living, as well as more specialist care such as wound and drain management, and pain control. In relation to children we saw that the 'Wong Baker faces' pain scoring chart was used. A 14 year old patient told us the care had been good and he had been asked to score his pain on a regular basis. He said analgesia was provided quickly when he felt pain. The care plans we sampled had been regularly reviewed and evaluated. This showed us the trust planned care in a way that would meet individual patient's needs.

Risk assessment booklets were used for each patient, and these were seen to cover a variety of risks, such as manual handling, nutrition, and skin integrity. We noted that where specialist equipment had been recommended for use in the operating theatre, this was available. This told us arrangements were in place, ensuring the safety of patients.

Staff told us they referred to care plans and risk assessments to ensure the correct care was provided. We were also told by staff that they referred to the 'handover sheet' which was given to all staff at the 'handover' from the previous shift. These contained basic details of each patient, and instruction of the assistance required, such as mobilising, and nutritional support. This told us the trust had made arrangements to ensure staff had up to date information about the needs of all the patients in their care.

There were arrangements in place to deal with emergencies. We saw that there was emergency equipment available in all areas, and access to oxygen and suction equipment. A team of staff carried emergency bleeps that would alert them to such events.

Emergency equipment was available in theatres and staff were trained in the usage of this, as part of resuscitation training or within the scope of their role, such as Operating Department Practitioners. The provider may like to note that staff did not always take portable suction equipment with them when collecting children, which could have

compromised the child's safety.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

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

We asked patients if they felt safe in the hands of staff at this hospital and they told us they did feel safe. A few people added additional comments which indicated they had some reservations, for example one person said they 'mostly' felt safe. Another said they felt safe but a member of staff had been rude when supporting them with personal care. However, the majority of patients made positive comments and these included "Yes, all staff day and night are very good" and "Yes, staff are very professional."

One patient gave an example of how they had concerns on a previous visit about another patient who 'wandered.' This patient told us that staff had stayed with them to observe and ensure everyone was safe. Other comments included "Definitely feel safe with staff."

We held a meeting and had discussions with key people who oversaw the safeguarding arrangements at the trust. We were told that the trust worked closely with the local authority in relation to safeguarding adults and children, and used the local authority procedures, as well as in-house procedures. The trust had different arrangements for safeguarding adults and children, and these were explained to us during this meeting. We were told that a number of safeguarding alerts went directly to the local authority, for example if they came through CQC, whilst others were reported through the trust's internal reporting mechanisms.

In relation to safeguarding adults, the trust had an Adult Safeguarding Committee, and this met on a weekly basis and included local authority representatives. The trust's head of nursing and the lead person for mental health attended. There was also a quarterly Safeguarding Committee chaired by the director of nursing, and attended by the local authority representatives. These meetings discussed any new safeguarding matters, and reviewed progress with previous reports. There was also a review of any learning that had resulted.

In relation to safeguarding children, a form was completed by the hospital if there were any issues of concern about a child. These are scanned onto a database and despatched securely within 24 hours to the relevant community professionals. We were told this was an improvement on the previous arrangement whereby a health visitor would collect the forms several times a week. Anything urgent was immediately referred to the local authority. We were told there was a weekly meeting with named doctors, nurses, midwives, health visitors and the local authority.

We were told improvements in relation to safeguarding since the last visit to the trust in 2012 included better information sharing with adults' services. We asked for some examples of this. One example we were given was that if an adult was admitted following an overdose, a form would be completed in respect of any children in that family. This told us that the Trust had a systematic approach to safeguarding both adults and children

We reviewed the referral forms used for safeguarding adults, and asked for examples of learning from safeguarding incidents and investigations. We were given examples of recent learning, one for example related to hospital transport. The trust had changed its policy in relation to discharging people to nursing homes in the evenings. We were told this would now only take place where both the home and the patient (and their relatives) were in agreement.

We were shown the flow chart used to advise staff on the action to take if any patients wanted to leave a ward, but it was in their best interests to stay. These potential deprivations of liberty safeguarding situations were covered in staff training, and we saw that there were clear contact details where staff could get advice if such a situation occurred. We saw information for staff on both the Mental Health Act, and the Mental Capacity Act. This information set out the main principles and included notes on good practice. Staff we spoke with were clear on their role should such a situation arise. This told us the trust had taken steps to ensure staff were informed about the correct actions to take if they had to detain patients in the hospital.

We spoke to staff and asked them about their understanding of safeguarding issues, and what action they would take if such a situation arose. Staff were knowledgeable on the types of abuse to look out for, and the majority confirmed they had received training on this subject. A few staff could not remember if they had received this training and we passed this on to the hospital's management for their information.

We noted that since our last visit to the trust in August 2012 there was evidence of closer working with other community professionals such as the police. We saw that new protocols had been set up with organisations such as a local prison, to improve the patient's experience, and this included during and following discharge from the hospital.

We contacted the local authority and were told there was a very good working relationship between the trust and the local authority in addressing safeguarding concerns. They confirmed that weekly and quarterly meetings took place. The local authority said they tracked progress on existing alerts, either regarding strategy meetings related to concerns in the community, or with regard to concerns raised about practice within the hospital. We were told the local authority's safeguarding advisor participated in the safeguarding induction and training programme for the hospital's staff. We were told that overall the trust and social care had worked well together to develop a robust safeguarding response to alerts. This told us the trust worked collaboratively with the local authority, the lead agency for safeguarding adults and children.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by suitably qualified, skilled and experienced staff.

Reasons for our judgement

Appropriate checks were undertaken before staff began work.

The trust provided us with policies and procedures which related to the recruitment of staff. These included 'Pre-Employment and Employment Checks Policy', 'Professional Registration Checks Policy' and 'Recruitment and Selection Policy.'

We were informed, by the Head of Resourcing, that the trust carried out detailed checks which related to new members of staff. We looked at 10 staff files and found that checks had been undertaken before staff commenced employment.

Each file had a check list of what was required before someone started with the trust. This included the completion of an application form, interviews and interview notes, obtaining criminal records checks and obtaining written references prior to employment commencing. We saw that a full employment history had also been obtained.

We saw that risk assessments had been undertaken to ascertain whether the person was suitable to start work before the criminal records checks had been returned. We were told that there had not been any instances where a member of staff's employment had been terminated due to them being in receipt of an unsatisfactory criminal records check.

All of the staff that we spoke with told us that they had been subject to pre-employment checks before they started work. These checks ensured that only staff that were suitable to work with vulnerable people had been employed by the trust.

We were told by the Head of Resourcing that where appropriate, staff who were registered with a professional body were required to confirm that this was up to date. This included but was not restricted to nurses, doctors and physiotherapists. We were shown a monthly report that was produced by the trust to highlight where staff needed to provide their up to date registration. This meant that only suitably qualified staff were employed by the trust.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

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

We asked patients if there were sufficient staff available to meet their needs, and we had some mixed responses. The respondents from St. Luke's Cancer Centre provided the most positive replies, with 28 out of 31 patients stating there were enough staff. The provider may wish to note that in the eye clinic and the main outpatients clinics, on 10 of the 24 returned surveys, patients felt there were not always enough staff. People added comments about waiting times and cancelled appointments, though the trust made us aware that their statistics showed under 2% of appointments in the eye clinic had been cancelled by the hospital. The trust also made us aware of plans that were being rolled out to make improvements, particularly in the eye clinic.

The provider may wish to note that some in-patients also gave us mixed comments about the staffing levels. These included "I get seen to fairly quickly but alarms on drip stands and bells seem to go on for ages unchecked." and "I think they are short staffed at the weekends, but treatment was good." When we asked the trust about weekend staffing levels, they told us there are fewer staff at weekends as there is no scheduled surgery or specialist tests. Positive comments from patients included "Yes I do think there are enough staff, and bells are answered quickly" and "No concerns, there are two very experienced people on most of the time."

We reviewed the wards we visited to see whether there appeared to be sufficient staff to meet people's needs. On one ward we were advised that they were "Two members of staff down" that day. When we asked the trust about this they told us two staff had gone off sick at short notice that day. We were told that there had been a few problems recently with staffing levels on that ward. On this ward we noticed that one patient waited fifteen minutes before their call bell was answered and we alerted the visiting matron who assisted this patient. On another ward a patient's dignity was compromised whilst they waited five minutes for a bell to be answered.

We asked the trust to send us information about the staff rosters and staffing levels on the two wards where we had concerns. In both cases the trust had already identified the shortfalls and had taken steps to address these. For example they had shortlisted 19

candidates for the five vacancies that existed. Interim arrangements included the use of bank and agency staff, and additional funding to enable the senior ward sister to be supernumerary (on duty but in addition to the other staff) to the working number of staff. This told us that staffing levels had been identified as an area of concern by the trust, and they had taken steps, and had a plan in place, to address these concerns.

Our observations on four other wards showed patients received the help they needed in a timely way. We noted that there was assistance for people who needed help to eat for example. The sister in charge of one of these wards said they had no issues with staffing levels, and said they had the lowest usage of bank and agency staff throughout the hospital. This told us that on these wards the staffing levels were appropriate for the needs of patients. Our observations of staffing levels in the elective surgical unit, day surgery and theatres indicated that there were good levels of staff with appropriate skills and experiences to meet the needs of patients.

A specialist advisor to CQC spoke with medical staff. We were told some doctors were 'over-running' their hours, with junior doctors sometimes unable to get to clinics due to the workload on the ward. We were told that a new shift system would be implemented across the trust in August with the new junior doctor intake. We were also told "There is a robust plan for expanding junior doctors' numbers from August 2013." This told us that the trust was taking steps to address shortfalls that had already been highlighted to them in relation to doctor's hours.

We spoke with representatives of the trust's management team about their arrangements for ensuring the correct staffing levels. The trust used an acuity tool, which is a tool to measure the optimum staffing levels on each ward. The trust told us that since 2009 the nursing and midwifery establishment figures had increased by 25%, whilst administrative and clerical staff numbers had increased by 10%.

A rostering tool was used to create the ward rota schedules. The ward sister could over-ride the system to make changes if, for example, there was a change in staff. A different process was used for agency staff. The heads of nursing, the matrons, and the director of nursing all had an overview of the rotas. We noted there was a high use of agency staff for specialist units, for example the intensive care unit. Overall this showed us that the trust had systems in place to manage staffing levels, and had increased staffing numbers over time to meet the additional demands of the service.

The trust had proposed a number of redundancies, though we were told that frontline nurses and doctor numbers would not be reduced as a result of these changes. We asked staff if they felt there were sufficient numbers of suitably qualified and experienced staff. Around a third thought that on some occasions there were not enough staff. When asked about the impact of this we were told that "There is less time to interact with patients." About a third of staff said staffing levels were fine if all those rostered were present. We also asked staff how well they felt their own skills and qualifications matched what they were asked to do in relation to patients in their care and most staff thought their skills were well matched, and said the trust was good on training and development.

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 effective systems to regularly assess and monitor the quality of service that people received.

Reasons for our judgement

We found the trust had extensive arrangements in place to monitor the quality of the services provided. This included reporting on aspects of the service to various governance committees. For example, the clinical quality risk management group, clinical quality governance committee and 'Paediatric SBU meeting'. We interviewed, via telephone, a non-executive (NED) director of the Trust Board in order to confirm the arrangements that were in place.

The NED said they sat on three committees, including finance, drugs and therapeutics, and governance. Information from sub-committees fed into monthly clinical governance quality committee (CGQC). Meetings were attended by responsible leads, and a reporting framework was used for identifying the top three risks. These were discussed at sub-committee level, before submission to the overarching CGQC meeting.

Incidents, adverse events and complaints were said to be discussed and explored at the governance meeting and information fed up to the Trust Board. We saw minutes from these meetings and saw trust Board minutes on the hospital website. We also reviewed minutes from the respective governance meetings. Information described within these indicated an open and active process for identifying issues, taking action to resolve these and associated time frames.

Decisions about care and treatment were made by appropriate staff at an appropriate level. There were clinical leads for specialities at consultant level. Role profiles for a number of positions indicated specific requirements and responsibilities. This included patient safety and service performance at Clinical Director level. Responsibilities related to children's services included patient care and support, as well as governance.

Formal arrangements were in place in the form of agreed policy between the trust's pathology service and two other local hospital pathology departments for managing the assessment and reporting of some complex samples or samples requiring a second diagnostic opinion. Measures indicated the trust was proactive in managing any potential risks where a diagnosis was required to enable on-going care and treatment of a patient.

The Resuscitation Service Manager told us the resuscitation committee met regularly to review resuscitation practices. We saw that the committee had looked at training attendance compliance and patient information. The latter had led to the completion of an information booklet for patients, relatives and carers on 'Do Not Attempt Resuscitation' that had been distributed around the hospital.

Staff told us they would report concerns or question practice where they identified non-compliance with hospital policies. Most of the staff we spoke with felt able to challenge colleagues and senior staff if they were not happy about their practice. There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. We saw risk assessments in place which covered a range of matters from risks related to poor attendance at resuscitation training to environmental risks in the operating theatre environment. There were contingency arrangements in place, such as business continuity plans for all areas.

We saw systems in place to review incidents through root cause analysis (RCA). The RCA process demonstrated a pathway from identification of the matter through to lessons learnt and action plans. The trust had other investigative panel meetings in place as a means of establishing the root cause, identifying learning points, good practice and making realistic recommendations. These panels included for example, 'Serious Incident Learning Panel Root Cause Analysis Investigation Meeting.' Staff said that information, such as where they needed to change practice as a result of an adverse event, was received from their line managers, at team meetings, or through notices.

The provider took account of complaints and comments to improve the service. The trust had a Patient Advice and Liaison Service (PALS) department, which had responsibility for collecting and reviewing issues received from patients. Information formed part of a wider quality system that encompassed complaints, litigation, incidents and PALS, known as the CLIP report. We reviewed the report for quarter two and three of 2012/13 and saw that the information demonstrated detailed analysis of each event and actions where relevant.

In our discussion with the head of human resources we were told about the arrangements for managing complaints that pertained to doctors. Such matters were said to be arranged through the same processes as other employees, such as through capability or disciplinary actions, but with the additional link to maintaining high standards. We saw examples of anonymous letters that had been sent out to doctors as part of the process for ensuring such complaints made had been investigated and responded to.

The Medical Director said he had oversight of all performance reviews for the medical staff and explained his responsiveness to any concerns raised. This demonstrated a robust system for dealing with issues that indicated unprofessional or unsafe practices.

We explored how the quality of service was maintained in the area of children's services. The Clinical Director for this area explained how the focus was trying to minimise disruption to the service as a result of vacancies at the middle grade tier of doctors. Measures taken were described and included prioritising available working hours across wards and outpatients, consultants acting down in their normal role to cover hours and identifying gaps early on so that agencies were given suitable notice. This demonstrated that the trust took seriously its responsibilities to manage short falls in clinical staff and to identify other means of supporting the service to ensure patient safety.

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 records were kept securely and could be located promptly when needed.

Reasons for our judgement

Records were kept securely and could be located promptly when needed.

We asked both in-patients and outpatients if, in their experience, their records had been accurate and up to date. The overwhelming majority who answered this question had no concerns on this, and comments included "I'm not aware of how records are kept but staff seem to know who I am and what is required" and "Staff are good at record keeping." However a few patients had experienced problems. For example, one person told us their notes often could not be found, and that scan results had referred to another patient.

We spoke to the hospital's management representative about records, and we went to the medical records area to see the arrangements that were in place. A tracking system called 'Oasis' was used by staff to locate records wherever they were in the hospital. The trust told us there had been an increase of 33% in the number of medical records in circulation over the last three years, with a total of 240,000 medical records now being managed by the Trust. As a result of this increase, and some difficulties locating records, we were advised that a new system had started just weeks before this inspection which enabled quicker and more efficient sorting of the medical records that were returned to the central records library. Initial feedback suggested this had brought about improvements. This showed us the trust had identified that there had been shortfalls in the speed and efficiency of retrieving medical records, and had taken steps to address this.

We reviewed patient records whilst visiting the wards, theatres and the outpatient area. We also looked at staff records when we reviewed the recruitment arrangements at the trust. We were told by staff that they were aware of their responsibilities in relation to record keeping, and that ward records were checked and audited. We found that records were generally well kept, for example, the nursing records we saw were up to date and had been regularly reviewed.

We saw and were told about the arrangements for records that related to do not resuscitate. Staff confirmed that where such a formal request had been completed by a patient a marker was placed on the front of the medical notes and the form was placed at the front of the patient record. This enabled staff to follow the requested directive with assurance that the appropriate record was in place.

Within the theatre environment we saw that records were completed for the operative procedure and all associated checking processes. This included separate records for recording such items as samples going to the pathology lab for analysis. Records for these were seen to be centrally stored and 'logged in' with a signature within the department, and collected by pathology personnel four times a day when they are 'signed out'. This told us the trust had satisfactory arrangements in place for keeping accurate and up to date records in respect of patients and staff.

We spoke to staff on the wards, and to some medical secretaries, about the arrangements for managing the security of records. Staff were aware of their responsibilities in relation to maintaining confidentiality, and we noted that access to records was restricted. We saw this when we visited the medical records library where both the outer and inner doors were protected and access was only allowed to those given specific clearance. We also noted on the wards that trolleys that contained medical notes were kept at the nurse's station or in the multi-disciplinary rooms which were locked with a keypad.

One staff member mentioned there had been an issue with a trolley being left unattended following a ward round, and told us reminders had been given to doctors to return the trolleys. Other staff interviewed told us records were kept securely and they felt that that the risk of information not being protected was very low. We were told that staff logged out when they had finished using the computer screen to ensure that information was protected, and we saw instances when this happened.

We also noted that computer screens were placed in a way that would make it difficult for visitors or none clinical staff to see the screens. However, in one area in outpatients we noted that the positioning of the computer screen, and the proximity of waiting patients, meant confidentiality could not be guaranteed, and we passed this on to the hospital's management for their attention.

When we interviewed senior staff about safeguarding adults they told us about a new initiative that had been developed following learning from a previous safeguarding matter. We were told that passwords had been agreed between families if the main relative could not come in to the hospital. This ensured patients could be confident that their information would be shared only with the family and friends they had previously nominated, either in person or by telephone.

We were also told that printed records, related to confidential matters such as safeguarding, were minimised. This was because a secure e-mail, with restricted access, was now the preferred method for transmitting such information between the relevant professionals.

When we asked staff about the availability of medical records, most said medical records were usually available when required, although some staff mentioned occasional delays. Ward staff were aware of the records tracking system and how to request medical records they needed. This told us the Trust had satisfactory systems in place to locate patients' records in a timely way.

We noted there were some potential health and safety issues in the medical records area due to the limited space available. The trust shared with us their plans to expand the space available for medical records sorting and storage, which they anticipated would address this shortfall.

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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