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

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**Manor Hospital**

Manor Hospital, Moat Road, Walsall,  WS2 9PS  
Tel: 01922721172  
Date of Inspection:  12 March 2014  
Date of Publication: April 2014

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

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<tr>
<th>Standard</th>
<th>Status</th>
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<tbody>
<tr>
<td>Staffing</td>
<td>✓ Met this standard</td>
</tr>
<tr>
<td>Records</td>
<td>✓ Met this standard</td>
</tr>
<tr>
<td>Registered Provider</td>
<td>Walsall Healthcare NHS Trust</td>
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<tr>
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<tr>
<td>Overview of the service</td>
<td>Walsall Manor hospital is a 600 bedded acute hospital providing a range of medical and surgical services for adults and children. Maternity services are also provided at this service.</td>
</tr>
<tr>
<td>Type of services</td>
<td>Acute services with overnight beds</td>
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<tr>
<td></td>
<td>Community healthcare service</td>
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<tr>
<td>Regulated activities</td>
<td>Diagnostic and screening procedures</td>
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<td>Maternity and midwifery services</td>
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<td></td>
<td>Treatment of disease, disorder or injury</td>
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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 12 March 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. We were accompanied by a specialist advisor.

What people told us and what we found

We inspected Manor Hospital, Walsall on an unannounced, scheduled visit to review previously identified non-compliance in Outcome 21 (records). We also reviewed concerns received by CQC from a whistle blower regarding paediatric staffing levels.

Three compliance inspectors, a paediatric specialist advisor and the CCG lead nurse inspected Manor Hospital. We visited five wards and the accident and emergency department (A&E). We spoke with 31 staff including doctors and nurses, eight patients and five relatives.

At the previous inspection it was identified that improved record keeping was required to provide assurance that people would receive the care they needed. During this inspection we saw that many new, improved records were in place. We found that all areas we visited were adequately staffed, both in terms of nursing, care staff and medical personnel.

We reviewed the staffing levels at all grades for paediatric care in the hospital. We found that medical and nursing staff levels were appropriate for the delivery of care at the current time and these were continually under review. The staff we spoke with were all keen to demonstrate innovation and were enthusiastic about working for the trust.

One relative we spoke with told us: "I am very impressed with the care my mother has received".

Whilst in A&E we identified that the consideration of safeguarding was not always documented. We brought this concern to the attention of the matron

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

<table>
<thead>
<tr>
<th>Staffing</th>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>There should be enough members of staff to keep people safe and meet their health and welfare needs</td>
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</tbody>
</table>

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

The essential standards of quality and safety state that the registered person should ensure that people who use the service are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

We received information from a whistle-blower who had concerns relating to the amount of skilled paediatric staff working at the trust.

Whilst in A&E we met and spoke with the Matron, senior sister and a consultant. We reviewed paediatric medical cover in the department and it was confirmed that there was 24 hour cover, seven days a week. There were currently six consultants based in the department. All senior nursing staff working in the department were paediatric trained to support the acutely ill child. In more serious cases, when it was deemed medically necessary to transfer a child to a neighbouring hospital staff were supported by the 'retrieval teams' prior to transfer.

The matron told us they had clear escalation procedures to follow should a child need more specialist care. All senior staff had received training in advanced paediatric life support and safeguarding. The consultant we spoke with was confident that the department was a safe place to be cared for. There was a standard operating procedure in place.

We met and spoke with a senior sister who was due to be commencing a supernumerary role as the practice development nurse in the A&E department. Their role was to support medical and nursing staff with their individual competencies, skills updates and to promote good practice. The role being supernumerary meant that they were not included in the staffing numbers and would be available to assist staff where necessary to increase their skills and confidence in decision making.

We visited the paediatric assessment unit and we met and spoke with the lead nurse, the matron and a consultant. We were told that all trained staff were registered sick children or...
paediatric trained. A few staff were dual trained. We identified that there was an integrated process in place with involvement of the GP, midwife and health visitor in the community which ensured that safeguarding issues were identified and monitored.

We were told that paediatric consultant cover for the wards and assessment unit was 24 hours a day, seven days a week. Six full time hospital consultants plus two locums were covering a 1:8 in rota in the hospital. There were also two hospital based consultants who are not currently on the acute rota. To ensure that the cover was sufficient and effective there were also the three middle grade medics covering out-of-hours support. We were told that the winter pressure staffing which increased staff numbers due to increased numbers was being reviewed. A business case was currently being drafted to increase the workforce to match the predicted increase in patient numbers.

Throughout the inspection we were told about the innovative work of the paediatric team. The 'well child' charity had invested in a three year acute/community discharge nurse post. Their support in some cases avoided an admission to the ward and also safe discharge in to the community from the ward. The ward staff had recently won a Kings Fund Patient Experience Network Award for their asthma care pathway. Two nurse specialists had been employed one for paediatric asthma and one for paediatric epilepsy.

Relatives we spoke with on the paediatric ward told us they were very happy with the care their child had received in the hospital. One person told us: "I have the details of who to contact if we have a problem when we get home. The staff have all been excellent". Another person told us: "Very pleased with the care and attention".
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

The essential standards of quality and safety require that people’s records including medical records are accurate, fit for purpose, held securely and remain confidential. Records required to be kept to protect people’s safety and wellbeing are to be maintained and held securely.

Previously, we had identified non-compliance in this area. Notes were incomplete which may have made care unsafe. It was identified that improved care records were required to provide assurance that people would receive the care they needed. On this inspection we saw that new, improved records were in place. On the wards, improvements were seen in the completion and availability of care records since the last inspection in December 2012. Through pathway tracking at this inspection we identified that some recording methods still required further embedding to be fully in use for example the bookmark checklist introduced by the trust for good record keeping purposes.

We found that some medical staff did not know what the phrase ‘bookmark’ meant. However, as soon as we described the plan and the record keeping all grades of medical staff knew what was required of them, told us about emails they had received from senior colleagues, best practice guidelines and what the trust required of them. One F1 (junior doctor) told us: “Reading properly written, clear notes really helps when you are on call. It encourages me to write better notes and maintain the standard”. Another F1 told us: “We are encouraged by the middle grades and our consultants to maintain good record standards”. A consultant we spoke with told us how important it was to change the culture in the organisation and that communication was the most important part of this process. The consultant explained the induction process for F1’s on the medical rotation and that good record keeping was a very important part of this. This was confirmed by the F1’s we spoke with throughout the day. This meant medical staff looking after adult patients were aware of the need for the trust to improve record keeping and that they were working to meet required standards.

We found that best practice dementia assessments were in place in A&E. This meant that people’s individual dementia needs were being assessed and considered at the earliest of opportunities.

Nursing staff within A&E did not know what we meant by the ‘bookmark’ within patient
records. When we discussed this with them in more detail they explained that they did not use existing medical records for people, but generated new records. The provider may wish to consider that adhering to the best practice standard for record keeping at hospital entry points, for example the emergency medicine team could help embed the record keeping practice.

On the medical and surgical wards we saw new comprehensive nursing assessment records in place with risk assessments. There was evidence in the notes of 360 degrees care through community multi-agency working. This meant that people received care from people who were knowledgeable about the care they required. The records we saw were up to date.

One person we spoke with told us: “It’s like a first class hotel here; I don’t want to go home”. Another person we spoke with told us: “They (staff) have arranged carers for when I get home, I can’t look after myself now”.

Through a process called ‘pathway tracking’ we followed the care of four children who were being treated at the hospital. Pathway tracking helped us to understand the outcomes and experience of the person. The information we gathered helped us to make a judgement about whether the service was meeting the essential standards of quality and safety. Through pathway tracking we identified that some recording methods still required embedding to be fully in use. On the wards, we saw improvements in the completion and availability of care records since the last inspection in December 2012.

The four sets of notes we looked at on the paediatric assessment unit reflected the care delivered to the children. This meant that people were protected against the risk of unsafe or inappropriate care because accurate and appropriate information was available. We found that people’s medical records were kept in trolleys at the nurse’s station. We saw that nursing care records were kept at the bottom of the person’s bed. These records included an assessment of the care they needed and the care provided.

Whilst looking at patient notes on the paediatric assessment unit it was identified that in one child’s notes it did not identify if a safeguard situation had been considered on their casualty card. We were told that this issue would be picked up by the paediatric safeguarding liaison nurse, as they had a responsibility to check the cards and refer the information to the community health visitor. We met and spoke with the paediatric safeguarding liaison nurse. We reviewed 12 casualty cards from the previous day and only one had the safeguard section completed correctly. We then visited A&E and looked at 14 casualty cards from that day. Of those we looked at one had been completed correctly and only 5 stated who had presented with the child. We were told that consideration of safeguarding was taking place but it was evident that this was not being documented on the casualty cards. We brought this concern to the attention of the matron who told us they would ensure that this was addressed immediately.

Nursing staff on the surgical ward knew what we meant by the record ‘bookmark’. They were able to tell us how helpful this was in identifying the exactly where the records for the patients’ current admission were kept. Nursing staff on the medical ward knew about the ‘bookmark’ but we did not consistently find that these were placed in the current record section. We observed that some patients’ notes had not been moved from one very large folder into two or more folders as expected. This meant that some of the records relating to a person’s current admission were at risk of falling out of the folder, which could make it harder to follow the care they had been prescribed.
On the surgical ward we found that the medical record for pre-assessment had a space for a label with the patients’ details on it at the top of every page. However, we found that the label was applied to the facing sheet only.

Nursing records within all adult areas had improved since our last visit. We found consistent clear documentation had replaced the range of confusing forms and documents we had been concerned about at our last inspection. We found that the changes in the documents made it easier for staff to follow what care was required for each person in their care. This meant that the risk of people receiving unsafe or inappropriate care had been reduced.

We found that the ward managers on both medical and surgical wards carried out a wide range of safety and satisfaction audits which formed a ward dashboard. Although there was inconsistency in the way these boards were kept up to date and maintained, the staff on the wards understood the importance of the audits and could tell us about the results and what these meant. For example on the surgical ward staff knew that they had received one complaint in February and that this had been resolved at ward level.

Auditing throughout the hospital took place weekly on a Thursday morning and the senior staff on each ward supported each other in peer review of this process. The peer review process meant that staff from one ward would review the audit for another ward and so on. Staff told us that this process encouraged friendly competition, but also improved the sharing and learning from the quality initiatives the trust were putting in place.

We asked about the audit process for the World Health Organisation (WHO) surgical safety checklist. We were told that this was audited monthly. We had concerns that the trusts record keeping procedure for the WHO checklist was not followed. We also discussed the timing of the checklist and if there was a process for staff to halt a process whilst a further safety check was made. (The purpose of the WHO safety checklist is to enable staff to make clear checks at dedicated and time recorded points within the theatre pathway; until the safety check is completed for each step the next step may not be taken). We discussed these concerns with the Director of Nursing and they said they would review this audit.

During the inspection we checked on the completion of the mortality records when a patient had died. The trust had taken steps to improve the review of these records and told us about the improvements they had made. This meant that the trust had a system in place to apply lessons learned from the review of mortality records. The trust linked this learning to current research guidance and best practice.
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.