# Review of compliance

## Portsmouth Hospitals NHS Trust

### Queen Alexandra Hospital

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<tr>
<th>Region:</th>
<th>South East</th>
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| Location address:  | Southwick Hill Road  
                    Trust Headquarters, F Level  
                    Portsmouth  
                    PO6 3LY |
| Type of service:   | Acute Services |
| Publication date:  | October 2011 |

### Overview of the service:

Portsmouth Hospitals NHS Trust is one of the largest acute hospital trusts in the country providing a full range of emergency and other care services to more than half a million people across Portsmouth and surrounding areas but also across the whole of South East Hampshire. The Queen Alexandra Hospital site was completed in 2009. The hospital can accommodate 1400 patients.
What we found overall

We found that Queen Alexandra Hospital was not meeting one or more essential standards. Improvements were needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out a responsive review as we had received some concerns in relation to:

- Care and welfare of service users
- Cooperating with other providers
- Safeguarding service users from abuse
- Management of medicines
- Staffing

However we also looked at cleanliness and infection control and assessing and monitoring the quality of service provision as part of our visits. This was to assess the processes that the trust had in place in relation to infection control management.

How we carried out this review

We reviewed all the information we hold about this provider, sought the views of commissioners, carried out visits on 23 and 26 May 2011, observed how people were being cared for, and talked with people who use services and staff. We checked the provider’s records, and looked at records of people who use services. As part of this review we also used a pharmacy inspector to look at how the patients’ medicines were managed.
What people told us
Patients said “staff always had a kind word”. Some of them said that the staff did not have “a lot of time for chit chat.” They said that they were happy with the care given.

People told us that staff understood their needs and were generally very caring. People also said that the wards were clean, and that staff washed their hands or used antibacterial gel before and after providing care.

Some people we spoke to said they were “moved around a lot” and not told what was happening until staff came to move them to another ward. People said that they were not always told that they would be moving and sometimes they were moved “in the middle of the night.”

Patients on some wards told us that the staff “did their best” but there was not always enough staff and that this was particularly in the mornings and evenings, when they often had to wait for assistance.

Some people told us that they had to wait for hours for their medicines on discharge and that the transport was “very bad” where it was provided for them on leaving hospital. Comments from some of the patients were that “they want to clear the beds as quickly as possible.”

What we found about the standards we reviewed and how well Queen Alexandra Hospital was meeting them

This review assessed whether Queen Alexandra Hospital provides care to patients that meets essential standards of quality and safety, respects their dignity and ensures their rights. This review focused on seven of the regulations and associated outcomes that most directly relate to the quality and safety of care. We found that the trust was compliant in five areas. In three areas we have made improvement actions to ensure the provider maintains compliance with these essential standards. We have identified two moderate concerns and we have set compliance actions. These concerns include patients’ assessments and care plans and management of medicines.

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights
Although some care plans and assessments are available, these do not always include all of the identified risks and these are not always fully implemented. There are some areas of concern and further work is needed to ensure that the patients’ needs are effectively met.

Overall, therefore, we found that there were areas of non-compliance with this outcome.

Outcome 6: People should get safe and coordinated care when they move between different services
There is a process in place that shows that the trust works well with partners involved in the care, treatment and support of people who use services. However, there are concerns about the long wait and delays in the discharge of patients, particularly in the discharge lounge. Patients are left for hours waiting for their medicines and transport.

Overall, we found that Queen Alexandra Hospital was meeting this essential standard but improvements are needed to ensure the provider maintains compliance with this essential standard.

**Outcome 7: People should be protected from abuse and staff should respect their human rights**
There are guidance and processes in place to safeguard patients against the risk of poor care and abuse. However, staff practices do not always reflect these and people may not be protected from risks to their health and welfare as staff knowledge and awareness around safeguarding is lacking.

Overall, we found that Queen Alexandra Hospital was meeting this essential standard but improvements are needed to ensure the provider maintains compliance with this essential standard.

**Outcome 8: People should be cared for in a clean environment and protected from the risk of infection**
There are adequate systems and processes in place for infection control. The premises are clean and maintained in good physical repair and condition.

Overall we found that Queen Alexandra Hospital was meeting this essential standard.

**Outcome 9: People should be given the medicines they need when they need them, and in a safe way**
Although some processes are in place, further developments are needed to ensure that the patients receive their medicines in a planned, timely and safe manner to meet their needs at all times.

Overall, therefore, we found that there were areas of non-compliance with this outcome.

**Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs**
The trust has a system in place to identify and manage staffing requirements. However, at times there are shortages of staff and there is a concern that the staffing ratio does not always meet the needs of the patients.

Overall, we found that Queen Alexandra Hospital was meeting this essential standard but improvements are needed to ensure the provider maintains compliance with this essential standard.

**Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care**
There is a system in place to monitor the service provision that includes regular auditing, and continuously identifying, analysing and reviewing risks, adverse events, incidents, errors and near misses.

Overall we found that Queen Alexandra Hospital was meeting this essential standard.

**Action we have asked the service to take**

We have asked the provider to respond to us within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns, we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

**Other information**

Please see previous review reports for more information.
What we found
for each essential standard of quality
and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety.*
Outcome 4:
Care and welfare of people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
• Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

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<th>Our judgement</th>
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<tr>
<td><strong>There are moderate concerns</strong> with outcome 4: Care and welfare of people who use services</td>
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<th>Our findings</th>
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<td><strong>What people who use the service experienced and told us</strong></td>
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<td>We spoke to a number of the patients, relatives, staff and visitors in all the wards that we visited. Patients said “staff always have a kind word.” Some of them said that the staff did not have “a lot of time for chit chat.” They said that they were happy with the care given.</td>
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<td>People we spoke to also said they were “moved around a lot”, and they were not told what was happening until the staff came to move them to another ward.</td>
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<td>Some of the patients said they were well looked after and received a good standard of care. People told us that staff understood their needs and were generally very caring.</td>
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<td><strong>Other evidence</strong></td>
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<td>During our visits, we looked at some of the care plans and assessments that the trust had in place to meet the assessed needs of people admitted. We found that there were some consultations or family involvement for those who were not able to participate in their care and decision making processes.</td>
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<td>The trust reported in November 2010 that 87% of all adult inpatients received the</td>
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appropriate venous thromboembolism (VTE) risk assessment. The aim was that all patients admitted were assessed for this risk and appropriate actions taken. The trust was aiming to improve on this performance by the end of March 2011 and meet the 90% expected performance limit but results were not available at the time of our review. Following our visit, the trust told us that they had met the 90% target in the fourth quarter to March 2011. The trust told us that the target was not met in the first quarter of that year. This dip in performance was anticipated and was due to the introduction of a new system of recording this information.

During our visits, we observed that the staff treated the patients in a courteous way. We observed the staff telling a patient who was distressed how they were going to move them saying “what we are going to do is to slide you over there”. Another patient told us that they had received support from social services to plan for their discharge home. They knew what equipment they would need when they were discharged.

The trust had a process in place to assess pressure area risks and prevention of skin breakdown. There was also an internal process to look at hospital acquired pressure ulcers. The records that we looked at showed that these assessments were carried out and some people had the appropriate pressure relieving equipment in place. Other information included moving and handling details such as the type of hoists and number of staff required to carry out this task safely. We found people identified as at high risk and an instruction in their care plans indicated that pressure relieving mattresses should be in place, but this had not been implemented. We spoke to a nurse about this, who agreed that this was needed as per their assessment, and told us this may not have happened as the staff had to put in a request for equipment and this had not been done.

We also looked at people who were diabetics and were having their blood sugar monitored. Some records were available and staff stated that one of the patients was having their blood sugar monitored four times a day. We found that there was no blood sugar recording on two days for this patient and it was recorded only once on one day.

We also observed that one patient was on thickening fluids. The healthcare assistant was aware of this and said this had been shared at ‘hand over’ in the morning. However, we found that there was no care plan or any information about this in the patient’s records that we looked at. The nurse spoken with agreed that, following assessment, the care plans should have been developed to include the consistency and thickness of fluids to be administered but this had not been done.

We also noted that one patient had been prescribed to have stockings put on as part of the prevention of blood clots to their legs. This had been prescribed for two days, however this had not been followed as no stockings were put on to their legs. The patient was aware of this and told us that the staff had said they would need to be measured for the stockings, but he said that this had not happened. A staff member spoken with at the time confirmed to us that this had been missed.
Patient records were generally well filed and entries were legible. However, not all entries were consistently timed and dated, and patient identifying details were not included on every page of their record. Where patients had moved between different wards, it was sometimes hard to track people’s history of care, as different teams had used different record-keeping formats.

Senior nurses we spoke to said that the trust was aware that the care plans and records needed to be looked into and they told us that they were working on these. However, information from the trust from their self-assessment had indicated that risk assessments and treatment plans were amended accordingly and documented such as for falls and pressure ulcers.

The trust had reported this outcome area as a minor concern in their self-assessment and told us the current nursing assessments and care-planning documentations were being amended and had acknowledged that this had yet to be rolled out.

Following concerns about the quality of ‘end of life’ care raised by a Department of Health survey in 2010, staff told us that the end -of life care patients were now accommodated in the single side rooms and they relied on the ‘mobile’ end of life care team to support them with the patients’ care. Staff reported that the new system of end of life care arrangements were still at an early stage; however the team “tried their best” to support them and staff were available at night also.

Following the Dr Foster report in November 2010, the trust was identified with the highest number of cancellations of operations due to missing notes. We sought information from the trust and feedback received showed that this had been resolved. The trust had introduced an electronic document management system on one site. As a result of the move, all notes were now housed at a single site using a common filing system and this allowed access to files on a 24 hour basis.

**Our judgement**

Although care plans and assessments are available for all patients, these do not always include all of the identified risks and these are not always fully implemented or maintained. While the active care provided is generally of a high standard, the documentation of care is not always adequate.

Overall, therefore, we found there were areas of non-compliance with this outcome.
Outcome 6: Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:
- Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

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<tr>
<td>The provider is compliant with outcome 6: Cooperating with other providers</td>
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<th>Our findings</th>
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<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
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<td>The patients we spoke to said that they were not sure what process was in place for transfer between wards, but thought that the staff “will ring the other ward to let them know” about their transfer. People said that they were not always told that they would be moving and two people said that they were moved “in the middle of the night.”</td>
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Other people told us that they had to wait for hours for their medicines on leaving hospital and transport, where provided, was “very bad”. Comments from some of the patients were that “they want to clear the beds as quickly as possible.”

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<th>Other evidence</th>
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<td>Information that we had received from the primary care trust (PCT) during our review showed that there was an integrated plan such that all the organisations within the local health economy had joined together under the local sustainability programme to ensure demands placed on the system were spread across the local health economy. For example, in view of Southampton University Hospitals Trust's recognition as a centre of excellence for paediatric cardiac surgery, these services were commissioned from that trust. This decision was made in conjunction with scrutiny review undertaken by Portsmouth Health Overview and Scrutiny Committee.</td>
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As part of the Quality, Innovation, Productivity and Performance (QIPP) programme, people suffering with cystic fibrosis were assessed to be better served by Southampton University Hospitals Trust than in Portsmouth because of the small numbers of patients in this part of the health economy. There were some facilities at the hospital, such as transitional clinics and the service for some groups of children, however there was a lack of a facility such as a young person’s unit.

The Local Involvement Network (LINks) carried out a survey in March 2011 through a series of visits at the discharge lounge and they identified a number of issues that had delayed or disrupted discharge such as, timely dispensing of medication, access to transport home, and availability of support after leaving hospital. They also found that there may have been difficulties in some cases about sharing of records so that treatment and care could be continued with another service agency or provider. Through their observations at different times in the discharge lounge, LINks detected a lack of consistency in the way that services were provided. This seemed largely to be dependent on shift management arrangements at the time and a lack of consistency in how well the care provision was managed. The patients would arrive in the discharge lounge at 09:30 and some patients waited an average of 6 hours or more before they were taken home.

We had also received concerns about the lack of processes and the long delays that some people were experiencing in the discharge lounge prior to our visits. People said that some of the ward staff were failing to give proper instructions to the patients regarding their discharge.

People in the discharge lounge told us that they had been waiting for a long time and some had arranged their own transport home due to the delays.

Information from the trust indicated that an integrated discharge bureau operating protocol had been developed to look at concerns about discharge delays. A virtual team of health (hospital and community) and social care teams met regularly and reviewed all patients with complex discharge needs. According to the trust, this had effectively reduced the delays.

The staff commented that the trust needed to look at developing a single point of referral, for referring patients to the multidisciplinary team. They said that currently it took three separate referrals for occupational therapy, district nurses and care management or social work inputs.

Our judgement
There is a process in place that shows that the trust works well with partners involved in the care, treatment and support of people who use services. However, there are concerns about the long wait and delays in the discharge of patients, particularly in the discharge lounge.

Overall, we found that Queen Alexandra Hospital was meeting this essential standard but improvements are needed to ensure the provider maintains compliance with this essential standard.
Outcome 7: Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

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<tr>
<td>The provider is compliant with outcome 7: Safeguarding people who use services from abuse</td>
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<th>Our findings</th>
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<tr>
<td>What people who use the service experienced and told us</td>
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<tr>
<td>We did not speak to patients and visitors about this outcome area.</td>
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<td>The trust told us it was taking action to ensure that staff and people who used the services understood the aspects of the safeguarding processes that were relevant to them. A trust wide strategy and implementation plan was introduced in August 2010 and this had identified 5 key areas for development and improvement.</td>
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The trust told us that the clinical restraint guidance was being rewritten in response to the staff feeding back that it was too complex. Interim practice guidance had been issued regarding de-escalating techniques. The trust said that the Royal College of Nursing (RCN) guidance on restraint was available to nursing staff. The trust confirmed that the trust’s security staff were also trained in the use of restraint as were other staff groups who predominantly used this technique.

Information from the trust showed that Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLs) training were included in the trust’s induction for all staff. The trust gave an example of a successful (DoLs) application to safeguard the welfare of a patient.
During our visits, we spoke to staff who said that they had received training in safeguarding. Training was delivered through the wider e-learning programme, and information from the trust showed that there was guidance that was updated in October 2010, and was available on the intranet. The trust had also appointed a safeguarding lead and was developing links with the local authority adult services team to ensure that there was a joint approach to safeguarding processes.

We spoke to senior managers who explained their processes for investigating concerns relating to safeguarding, and the work they had done to improve joint working with adult social services. For instance, incidents of serious concern were discussed at a joint critical incidence panel. Safeguarding referrals were made as appropriate as a result of these panels.

Staff told us that the safeguarding arrangements had improved since the appointment of a lead. Adult services also had the names of operational leads for each department which they said was an improvement.

We asked staff what they would do if there was an allegation that a vulnerable adult had been abused by hospital staff. This could include neglect or a severe pressure ulcer which was developed in hospital. Staff were clear that they would report to the person in charge.

Staff told us that once a concern had been raised and the hospital was investigating, there was sometimes a delay in getting a response on the outcome of this. For example, we were told that when the local authority adult services team had raised a concern relating to a pressure ulcer, they received a response from the hospital that all grade 3 and 4 pressure sores were investigated under the serious incident reporting policy (within 48 hours). No further information was received until a month later when the report was received. The adult services team said that the report was detailed, however, the lack of information sometimes made it difficult for them to work with families who wanted to know what was happening.

Other staff told us that, sometimes, care managers noticed pressure ulcer issues and raised a safeguarding alert but this was not always done, for example if the hospital staff noticed them, these were treated but not reported. Some staff told us that when patients had been discharged, they sometimes noticed that incidents had been recorded in the notes which could have been safeguarding incidents. These staff were of the view that these had not been referred and investigated appropriately. Management staff said that the trust was working towards raising staff awareness.

During our visit, a patient made a disclosure to us about bruising to their arm. This was recorded in the patient’s record, but no action had been taken to raise a safeguarding referral or to investigate and report the event. We brought this to the attention of the senior person at the trust at the time of our visit. The trust carried out an investigation but no referral was made to the safeguarding team. The trust judged this as not a safeguarding issue but we did not agree and followed this up by
A referral to the local authority adult services team.

Staff on one ward told us they had been subject to physical and verbal abuse by patients who had complex care needs. They told us they had completed incident forms but they were not aware of any action being taken to reduce further incidents. The senior nurse explained the procedure for reporting incidents of actual or suspected abuse. We saw confirmation that a recent referral had been made to adult services.

A senior nurse told us that each patient’s skin was checked on admission to ensure it was intact. Any damaged or marked skin was recorded, and a skin care plan put into action. We saw records for one patient recently admitted and the care plan was in place. We saw that a risk event form had been completed where patients had been admitted with, or had developed, pressure sores. We were told of an incident where the trust was carrying out an investigation following a patient who had been admitted with pressure ulcer and no action was taken by the staff for a couple of days. The trust was undertaking an internal investigation; however it was unclear why this had not been reported as a safeguarding alert.

We spoke to the hospital safeguarding lead who recognised that processes differed from hospital and social services departments both within and outside the hospital, which had led to confusion. They told us that a recent audit showed 78.6% staff had completed the 3 yearly safeguarding training. Staff told us that the policies and procedures were available on the intranet, but they said it would be easier for them if there was information available to them on the wards.

Some of the staff we spoke with were not able to explain their understanding of the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLs). The safeguarding lead for the hospital told us that training in the MCA and DoLs would be provided to the staff as it is part of induction training. Since the visit, the trust told us that a multidisciplinary staff training event had been held in March 2011 in the MCA and DoLs, facilitated by the Department of Health South East lead.

Staff told us they did not use any form of restraint and were aware of the policy regarding restraint and this was available on the hospital intranet, that they could access when on duty.

We had been informed prior to our visits of concerns regarding the care and treatment of people with learning difficulties. Information from the trust indicated that a multi-agency document had been developed in response to the lack of clarity about care needs of people with a learning disability and the trust had received positive feedback from the learning disability team and had shared this with the staff.

Senior management at the trust reported that work was ongoing in this area, for example a serious case review was undertaken about the care of a patient with autism. It was recognised that staff knowledge and awareness was lacking. We were told that a project had been agreed, and funding secured to deliver training to
clinical and non-clinical staff from 1 April 2011.

Our judgement
There are guidance, processes and training in place to safeguard patients against the risk of poor care and abuse. However, staff practices do not always reflect these and people may not be protected from risks to their health and welfare as staff knowledge and awareness around safeguarding is lacking.

Overall, we found that Queen Alexandra Hospital was meeting this essential standard but improvements are needed to ensure the provider maintains compliance with this essential standard.
Outcome 8: 
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*.

What we found

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<td>The provider is compliant with outcome 8: Cleanliness and infection control</td>
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Our findings

What people who use the service experienced and told us

We spoke to six patients on the wards we visited and all told us the ward was clean. People told us that they saw staff washed their hands before and after contact with them. They also saw them wearing gloves and aprons whilst providing personal hygiene care. People told us they were happy with the arrangements for cleaning the ward and that they found the hospital clean and tidy. Comments from patients included that there was 'very thorough cleaning' and staff 'pull out bed and cupboard to clean behind them. Also scrubs window sills and lights.'

Other evidence

As part of our review of the trust, we visited some wards that included the medical, surgical and the accident and emergency units. During our visit we spoke to three porters, two physiotherapists, three healthcare support workers, two nurses, one head of nurse for the department, an NHS professional, a pharmacist, one consultant, a doctor and three cleaners. They told us that they had received infection control training in the last year. Some of the staff were aware of the audits being undertaken on hand hygiene.

During our visits, we observed two staff visiting a patient and found that they observed hand hygiene procedures before coming into contact with the patient. However, we visited another medical ward treatment room and we found mounds of dust at the bottom of the medical dressing cupboard. We examined 3 cupboards
and all had dust. The linen room was dusty at the bottom and it appeared that it had not been cleaned for some time. We brought this to the attention of the senior person on the ward at the time. It was unclear from a discussion with staff who had been identified to clean the cupboards and to ensure the environment was clean.

We also visited surgical wards and the accident and emergency department. We found that all these environments were clean. The treatment rooms and the cupboards in these areas were clean. We spoke to three consultants, two nurses and three healthcare support workers and all told us that they had received training and supervision on infection control. For example, to encourage hand washing, the accident and emergency department had put a “light box,” a machine that checked how clean their hands were, in the staff dining area. It encouraged staff to check how clean their hands were before they ate and staff reported that it had encouraged compliance with hand washing procedures.

In all the wards we visited, we saw posters and leaflets on the wards asking patients and visitors to wash their hands or to use hand-wash gels. We observed a staff member requesting two visitors on a ward to use the hand-wash gel as they entered the ward area.

We spoke to trust staff and contracted staff in the ward areas and found that they were all aware of how to clean equipment that was used at the point of care, for example, hoists, beds and commodes. The cleanliness of these items was regularly checked and audited by the ward manager. The results of the audits were seen on the wards visited. Information from the trust indicated that they carried out monthly audits on hand hygiene. The trust indicated that the variable compliance result was reviewed at Board level, and an action plan was developed to address this.

We found that staff were aware of policies that helped prevent and control infections. We spoke to four staff and all were aware of when they would isolate a patient with a suspected infection. They were also aware of when they would use isolation facilities and the action that would be taken as a result of an outbreak of infection. On one of the wards, we found detailed instructions called “you are what you clean” for staff displayed.

We were told that the uniform and dress code policy was currently under review and we found all staff dressed according to the present dress code policy. Information that we had received from the trust indicated that they had Infection Control Committees and designated staff leading on and responsible for infection control.

The trust had point of care hand hygiene facilities to compliment hand hygiene stations. They also provided information and leaflets on topics such as ‘stop the bugs’, hand hygiene, MRSA, Clostridium difficile, Norovirus and influenza care. The Individual Trust Health and Safety policies included the following for employees: hepatitis B; hepatitis C; HIV; tuberculosis; MMR and Varicella. The details were included in the relevant e-induction sections by the Occupational Health and Health & Safety departments and hand hygiene was covered for infection control on induction.
Our judgement
There are adequate systems and processes in place for infection control. The premises are clean and maintained in good physical repair and condition.

Overall we found that Queen Alexandra Hospital was meeting this essential standard.
Outcome 9: Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are moderate concerns with outcome 9: Management of medicines

Our findings

What people who use the service experienced and told us
People told us that they were given information about their medicines and conditions, and they could ask nurses for pain relief when they needed it. Some people told us that they had had a long wait for their discharge medicines.

Other evidence
Information from the trust’s self-assessment indicated that there was an annual medicines management programme. They reported that the robustness of the audit programme had been significantly improved with the introduction of more rigorous unannounced visits. The audit programme had, to date, reviewed 23 wards or departments out of a total of 75 across the trust, but we cannot report on the findings, as we did not look at this.

As part of our visits, we looked at the process that the trust had in place to deal with the management of the patients’ medicines. We had received concerns last year about some practices in relation to controlled medicines. Following an investigation, the trust produced an action plan about how the recommendations would be implemented. During this visit, we targeted part of our review at the maternity unit where these concerns had arisen. The hospital had told us about their plans to
increase the use of pharmacists on the wards and the changes they had made to the arrangements for medicines in the maternity unit. We saw that these improvements had been made and nurses and midwives told us that this had made a difference to how people received their medicines, particularly on discharge in the maternity unit. We saw pharmacists and technicians on the wards and noticed how they worked with other healthcare professionals to improve the safety of medicines in the hospital. Medicines were checked on admission and extra information was obtained from the person’s GP to ensure that they received all the medicines they needed.

We saw some people being asked about their need for pain relief, others were told that these were tablets that they needed to take and no explanation was given. One patient asked us if we knew what the tablets were. We asked the staff who then confirmed to the patient that these were for pain.

We saw new processes for obtaining discharge medicines, which meant that the patient’s chart did not leave the ward so that medicines could still be given if they were needed. However, we were told that there were still some delays in getting the discharge medicines from the pharmacy. Concerns had been raised that some patients were waiting between 3-5 hours for their medicines. In the discharge lounge, someone told us that they had had to wait for three hours. The Local Involvement Network (LINks) survey found that 51% of patients were waiting for their discharge medicines. We spoke to three people on the wards who were ready for discharge and they also told us that they had been told that they would have to wait for three hours for their medicines and they understood that this was normal. Nurses confirmed that this could often happen, but they had regular meetings with the pharmacy department to enable them to work together to achieve a better outcome for the patients.

Information from the LINks annual report in June 2010 said that the pharmacy was short of 22 staff; this was due to due to maternity leave and vacancies. Since then, the trust had employed 3 new staff. However, these staff were at low grades which meant that they would need several months training, although they had lost the 5 agency staff that they were using. The trust had since confirmed that a workforce restructuring process was initiated in April 2011 to reflect current service demands. The trust had told us that they had held some posts open as part of restructuring and to ensure safety, agency staff were employed to cover critical vacancies.

We saw that one person was supported to look after their own inhaler, which meant that they could use it when they needed to and could maintain their independence.

We looked at prescription charts on three wards and found that changes to medicines, omitted medicines and variable doses had been recorded appropriately. Medicines were kept securely on all the wards we visited.

People who had had surgery were prescribed different types of pain relief that could be used depending on how severe their pain was. Nurses could tell us how they would look for signs of pain in someone who could not communicate or who had a
cognitive impairment. However, we found that there were no assessments or care plans for people we looked at with cognitive impairment to show how this would be managed in a consistent manner in practice, such as individual pain assessments and plans to meet the individual needs.

There was a risk that a patient with cognitive impairment or communication difficulty may not receive adequate pain relief to meet their needs. This was particularly evident on the elderly care wards and for patients with a degree of dementia and some of those who had suffered a stroke and were unable to communicate their needs effectively. We spoke to the nurses on the stroke wards who stated that they did administer regular painkillers to people and agreed that clear assessments were needed to manage the patients' pain effectively.

The trust had declared this outcome as overall moderate concern and had produced an action plan to be compliant by August 2011. The trust action plan included making Drug Therapy Guidelines more accessible. It also identified that the training for junior doctors joining the trust needed to be via e-learning on high risk drugs. The trust was to develop a system to monitor and ensure training was completed. Other actions included making a business case for the use of insulin pre-filled syringes and new drug charts were to be finalised and implemented. The orthopaedic wards audit was planned to be rolled out with the other wards.

We observed that not all drug charts had full patients details, the trust had identified that this needed developing to ensure that full patients’ details were recorded on charts to enable full identity checking and pharmacy checking of dose, weight and critical medicines.

Information from the trust Forward Audit Plan (2010/11) showed that the trust had been planning an audit on the use of ‘medicines to take home’ as part of their service development, however this had been abandoned. It was not clear whether this would be carried out at a later date.

Other concerns raised with us prior to our visits, by the local authority adult services team related to pain management for people with learning difficulties. During our visits, the senior staff confirmed that this was being looked into to include development of a pain assessment pathway. Patients were experiencing waits of hours whilst waiting for their medicines.

During our visit, we also observed that a patient was asked to go to the discharge lounge because that they were told “this is where you will receive your medicines to take home.” We found that this was incorrect, as the patient showed the staff their medicines they had already received.

Our judgement

Although some processes are in place, further developments are needed to ensure that the patients receive their medicines in a planned, timely and safe manner to meet their needs at all times.
Overall, therefore, we found there are areas of non-compliance with this outcome.
Outcome 13: Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with outcome 13: Staffing

Our findings

What people who use the service experienced and told us
The patients we spoke to said that the staff “did their best” and they were aware that the staff were “very busy” and “you just have to wait, but they are nice and they do help you.”

Other patients said the staff worked very hard to provide the right level of care and support. All said that they felt that additional staff were needed at busy times of the day, such as mornings.

People said that “you often have to wait to speak to someone” when they needed information about their relatives. A patient commented that “sometimes (the) bell goes for a long time. Good care but not enough staff.”

Some patients said that the staff responded as quickly as could be expected when they used their call buttons. They said that delays were sometimes worse in the mornings, but they told us that they understood that this was the busiest time.

Other evidence
As part of our visits, we looked at the process that the trust had in place to manage the staffing on the wards. In the most recent NHS staff survey, 65% of staff in the
trust agreed with at least two of the following three statements: that they were satisfied with the quality of care they gave to patients; that they were able to deliver the patient care they aspired to; and that they were able to do their job to a standard they are personally pleased with. The trust's score of 65% was in the lowest (worst) 20% when compared with trusts of a similar type. This result had not changed significantly since the 2009 survey when the trust scored 60%. 87% of staff in the trust agreed that their role made a difference to patients or service users. The trust's score of 87% was in the lowest (worst) 20% when compared with trusts of a similar type.

The ‘releasing time for care’ system that the trust employed had identified a high number of the shifts that needed to be covered. During our visits, the nurses we spoke to reported that the lack of staffing “was a constant battle” and this increased their level of stress. Staff said “you can only do your best.” On one of the wards, the staff told us that the shortage had been recognised by management. Some staff said morale was low but this was picking up a bit due to reorganisation. Others said that “things had improved a bit since one of the bays on the ward had been closed.” Staff told us that they reported all the shifts that were not covered to the matron who was responsible for the wards. Comments were that “you just have to get on.” The multidisciplinary staff team on the wards also reported that, due to staff shortages, they were asked to help the nurses and this meant that they could not get on with their planned work in supporting the patients.

During our visits, we observed that, at times, call bells were not answered promptly and staff told us that they were aware that patients waited a while to get attention. The majority of the staff commented that the lack of staff was a “problem.” We observed that two patients were receiving personal care at lunchtime in one bay and staff stated that this was normal and they tried to get to the patients as soon as they could. Another patient was observed to have their neck support covering part of their face for most of the morning until they were assisted with their personal care nearer lunchtime.

The trust had confirmed that efforts to recruit were ongoing. There was also recognition that staffing remained an ongoing issue. The trust told us that recruitment of nursing staff had not been restricted but the agencies that were used had been unable to fill the vacancies.

**Our judgement**

The trust has a system in place to identify and manage staffing requirements. However, at times there are shortages of staff and there is a concern that the staffing ratio does not always meet the needs of the patients.

Overall, we found that Queen Alexandra Hospital was meeting this essential standard but improvements are needed to ensure the provider maintains compliance with this essential standard.
Outcome 16: Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
- Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People were not able to tell us about the trust’s process for assessing and monitoring of the quality of the service so we cannot report what they said.

Some people we spoke to said that they thought there were some surveys done as all ‘big companies did them.’ Two people said that they had seen some questionnaires on the ward.

Other evidence
We sought the views of commissioners of the trust’s service as part of our review. Information we had received showed that the trust used feedback mechanisms such as surveys and ‘satisfaction with service’ questionnaires. For example, there was an on-line questionnaire for all visitors to the hospital which provided readily available information on patient experience of its services.

The trust did not specifically list evidence in their self-assessment about having a clinical audit strategy and with the overall aim of improving patient outcomes. However, the Trust did have a clinical audit department and conducted local and
national audits and produced action plans.

The visit to the clinical audit department as part of the review, confirmed that many of the audits were focused on improving patient outcomes although this was not explicitly stated. The clinical audit department used a bespoke tool created in house and adopted in 2004. The tool allowed the tracking of audits from request to completion. A list of completed or in progress audits were available on the trust’s intranet site. One of the main benefits of the tool was the monitoring of requests to avoid duplication; recipients could be directed to an already completed audit if the same speciality was requested. We were told that a new process would be rolled out at the beginning of next year, where all specialities would be required to produce clinical audit reports on outcomes and implementation of outcomes in line with National Priorities. A Forward Audit Plan was produced for regular monitoring of audits. On our visit, we saw that the trust had effective processes in place with regard to the monitoring of clinical audits.

We found that the Serious Incident reporting team produced a central log of all serious incidents which were, in turn, sent to the primary care trust (PCT). These were tracked and logged and any that were overdue or not resolved were discussed individually at monthly serious incident review board meetings attended by the Executive Management Team. Following recommendation from the Pressure Ulcer User Group, the risk assessment process and changes had a positive impact. This had increased the staff’s awareness and increased incident reporting. We also saw that the trust had a system to continuously identify, analyse and review risks, adverse events, incidents, errors and near misses.

The Forward Audit plan indicated that an audit of adverse incidents was proposed in August 2010 and was in progress. The trust had a monthly rolling audit of the implementation of a risk assessment tool for the risk of blood clots (VTE) for patients admitted to the Emergency Department observation ward. The trust had also completed an audit of hospital acquired pressure sores twice yearly, however a review of the outcomes of these audits was required to determine if the trust had improved outcomes for patients.

We found that the majority of incidents were reported to the national patient safety agency (NPSA) within 30 days of the date of the incident (57%). Whilst the figure was positive; the time taken to report incidents could be improved substantially.

Our judgement
There is a system in place to monitor the service provision that includes regular auditing, and continuously identifying, analysing and reviewing risks, adverse events, incidents, errors and near misses. However, incidents are not always reported without delay to the NPSA.

Overall we found that Queen Alexandra Hospital was meeting this essential standard.
Improvement actions

The table below shows where improvements should be made so that the service provider maintains compliance with the essential standards of quality and safety.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Treatment of disease, disorder or injury.</td>
<td>24</td>
<td>6</td>
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<tr>
<td>Surgical procedures.</td>
<td></td>
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<tr>
<td>Diagnostic or screening procedures.</td>
<td></td>
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<tr>
<td>Maternity and midwifery services.</td>
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<tr>
<td>Assessment or medical treatment of persons detained under the Mental Health Act 1983.</td>
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<tr>
<td><strong>Why we have concerns:</strong></td>
<td></td>
<td></td>
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<tr>
<td>There is a process in place that shows that the trust works well with partners involved in the care, treatment and support of people who use services. However there are concerns about the long wait and delays in the discharge of patients, particularly in the discharge lounge.</td>
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</table>

| Treatment of disease, disorder or injury.                                          | 11         | 7       |
| Surgical procedures.                                                               |            |         |
| Diagnostic or screening procedures.                                                |            |         |
| Maternity and midwifery services.                                                  |            |         |
| Assessment or medical treatment of persons detained under the Mental Health Act 1983. |            |         |
| **Why we have concerns:**                                                          |            |         |
| There are guidance and processes in place to safeguard patients against the risk of poor care and abuse. However, staff practices do not always reflect these and people may not be protected from risks to their health and welfare as staff knowledge and awareness around safeguarding is lacking |            |         |

| Treatment of disease, disorder or injury.                                          | 22         | 13      |
| Surgical procedures.                                                               |            |         |
| Diagnostic or screening procedures.                                                |            |         |
| Maternity and midwifery services.                                                  |            |         |
| **Why we have concerns:**                                                          |            |         |
| The trust has a system in place to identify and manage staffing requirements. However, at times there are shortages of staff and there is a concern that the staffing ratio does not always meet the needs of the patients. |            |         |
The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent within 14 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.
Compliance actions

The table below shows the essential standards of quality and safety that are not being met. Action must be taken to achieve compliance.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
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<tbody>
<tr>
<td>Treatment of disease, disorder or injury.</td>
<td>9</td>
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<tr>
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**How the regulation is not being met:**
Although some care plans and assessments are available, these do not always include all of the identified risks and these are not always fully implemented. There are some areas of concern and further work is needed to ensure that the patients' needs are effectively met.

**Why we have concerns:**
Although some processes are in place, further developments are needed to ensure that the patients receive their medicines in a planned, timely and safe manner to meet their needs at all times.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider’s report should be sent to us within 14 days of this report being received.
Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called Guidance about compliance: Essential standards of quality and safety.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions**: These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions**: These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action**: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.
Information for the reader

<table>
<thead>
<tr>
<th>Document purpose</th>
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<tr>
<td>Author</td>
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| Postal address | Care Quality Commission  
Citygate  
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NE1 4PA |