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<th>Region:</th>
<th>South East</th>
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<td>Location address:</td>
<td>Southwick Hill Road</td>
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<td>Type of service:</td>
<td>Acute services with overnight beds</td>
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<td>Rehabilitation services</td>
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<td>Date of Publication:</td>
<td>March 2012</td>
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<td>Overview of the service:</td>
<td>The trust was registered with the Care Quality Commission in April 2009 without any conditions. They are registered to provide the regulated activities of treatment of disease, disorder or injury; Surgical procedures; Diagnostic or screening procedures; Maternity and midwifery services.; Assessment or medical treatment of</td>
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<td>persons detained under the Mental Health Act 1983 and Termination of pregnancies. Portsmouth Hospitals NHS Trust is one of the largest acute hospital trusts in the country.</td>
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Our current overall judgement

Queen Alexandra Hospital was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review

We carried out this review to check whether Queen Alexandra Hospital had made improvements in relation to:

- Outcome 01 - Respecting and involving people who use services
- Outcome 04 - Care and welfare of people who use services
- Outcome 05 - Meeting nutritional needs
- Outcome 09 - Management of medicines
- Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 3 January 2012, carried out a visit on 4 January 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

The patients we spoke with were generally happy with the care provided at the hospital. They said that staff were kind and helpful and responded to calls for assistance, although they were very busy. They told us that staff maintained their dignity and privacy at all times by ensuring that the screens were always pulled around the bed when care and treatment was provided. Patients told us that staff provided them with sufficient information about their care.

The patients who were admitted for elective surgery told us that the system worked very well and they were provided with information prior to admission. One patient said that they also received the information in writing on admission which made it easier to remember what was happening.

Four relatives told us that information was very good on the current ward, but this had not been their experience in the medical assessment unit (MAU). Two patients told us that both they and their families had been involved in discussion about them going home.

Some people said that they were advised when their relative had moved to another part of
the ward into a side room. Three people said that they were not kept informed when their relative had moved to another ward following deterioration in their conditions. They only found out when they arrived on the ward and found that their relative had been moved during the night. One person said that they 'nearly pulled open the curtain' to another patient as they thought it was their relative.

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

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People have their dignity and privacy respected and are kept informed about their care and treatment.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People generally experience safe and appropriate care, treatment and support that meet their needs and protect their rights. People's needs are assessed and care implemented however the outcomes from risk assessments are not always used to inform care needs

Outcome 05: Food and drink should meet people's individual dietary needs

People are generally supported to receive adequate nutrition and hydration. There is a planned menu and the patients are able to make choices. However, dietary assessments are not consistently completed and used to inform plans of care to ensure that people's needs are met.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

On the basis of the evidence provided and the views of people using the services we found the Queen Alexandra Hospital to be compliant with this outcome; however the improvements currently being implemented must continue.

Outcome 21: People’s personal records, including medical records, should be accurate and kept safe and confidential

People's records are maintained securely and are available when required. Records do not always contain adequate information on assessments and care provided that may put people at risk of their identified needs not being fully met.

Actions we have asked the service to take

We have asked the provider to send us a report 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. When we propose to take enforcement action, our decision 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 reports for more information about previous reviews.
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 01: Respecting and involving people who use services

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

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement
The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
Patients told us that the staff maintained their dignity and privacy at all times when providing care. They said staff always ensured that the screens were always pulled around the beds when care and treatment were provided. They also told us that they had been asked how they wished to be addressed and that generally people introduced themselves.

On the day of surgery admission (DOSA) ward patients expressed satisfaction with the care and told us that they were kept informed about any delays in the operating theatre. One patient told us that the staff had told them they would be transferred to the ward and would go to theatre from there.

Other evidence
We visited the trust on 12 April 2011, as part of the Care Quality Commissions Dignity and Nutrition Inspection programme. At this time we identified minor concerns with this outcome.

On this latest inspection we saw that staff maintained the dignity and privacy of the patients by ensuring that the screens were always pulled around the bed when care and treatment were provided. Staff spoke to the patients in a sensitive manner and
explained the procedures to them. These included the nursing staff, medical staff, physiotherapists, occupational therapist and phlebotomists.

We observed the doctors' ward round on two different wards and found staff pulled the curtains round the patient's bed and where possible spoke quietly with the patients about their ongoing treatment. We saw an occupational therapist and physiotherapist gaining verbal consent and discussing with the patient what they were trying to achieve.

Staff treated people respectfully. This included a health care assistant accompanying someone to the bathroom and a staff nurse discussing pain relief with a patient. On both occasions the member of staff gave time to the patients and spoke to them on a one to one basis. We overheard staff explaining in a calm manner and gaining consent prior to assisting someone with their personal care. Staff spoken with had a good awareness of the standards of behaviour expected of them. They recognised individual patient needs and adapted their support accordingly. They said they had received training in the promotion of privacy and dignity, and keeping people safe from harm.

Patients told us they had been asked what they wanted to be called on their admission to hospital and that this was respected. Three people said that while they had not been asked they did not mind staff calling them by their first names.

Although the wards were mixed male and female, they all had single sex bays and the staff confirmed that these were adhered to. The toilets were clearly labelled as male and female facilities. In the newer area of the hospital each bay had an en suite facility.

The trust had a procedure on patients' privacy and dignity and staff spoken with told us that they had received training. On wards F2, F3 and E2 staff told us that they used pink pegs on curtains to indicate to others to ask before entering the area. We observed that staff did follow this to ensure people's privacy was maintained. We were told that the trust had a range of ways of monitoring whether people who used the service were involved and respected. This included spot checks, matrons' rounds and visits from directors.

On the day of surgery admission (DOSA) ward, patients were admitted for elective surgery on the day. The senior nurse in charge had devised a patient's information leaflet. This contained detailed information including admission time, assessment by anaesthetist, doctors and preparation for theatre. Patients were informed of the ward they would be returning to following surgery.

On ward C6 we spoke to a member of the medical staff about one patient's complex care needs. They were clearly aware of the complexity of the case and the patients and their family's expectation and the needs for these to be managed appropriately.

For three patients, one on ward F2, one on ward E2 and one patient on D2 we saw in their notes that assessments had been undertaken to assess their mental capacity and that a best interest meeting had either taken place or was planned. An independent advocate had also been requested for one of these people.

On ward D3 we spoke to five people, all except one patient were positive about the care they were receiving and raised no concerns about privacy. The one person told us
that they had inappropriately been wheeled out to the toilet on a commode and not a wheelchair.

We were told that the trust had developed bedside folders to ensure that patients had access to information. These bedside folders contained information about mealtimes, hygiene and infection control, preventing a fall, chaplaincy, visiting arrangements and discharge processes. Staff told us that the folder was available in a variety of languages on request.

On ward F3 and ward F4 the patients we spoke to had not seen this folder and it was not generally available to all patients. On ward E2, while they were available they were not all at the patients' bed side and patients had not seen them. We found that the availability of these folders was variable at the bedsides.

On ward F3 the record of a patient contained details of discussion with their family where they had expressed their views that treatment should continue. On ward F4 we found that patients' records did not always reflect their choices or preferences. Staff told us that patients and their families were involved in discussions about planning their care. We saw and heard that care and treatment was discussed with patients on the ward rounds but records did not always reflect these discussions. On ward F2 two patients told us that their families had been involved in discussions about their care and this was confirmed by entries in their notes.

We noted that the 'Patient Journey' board showed the patients full name. A member of staff reported that no consent was obtained to display patients' full name. We were later told by a senior staff member that this was supposed to be obtained but there was no current place on documentation for this to be documented.

Patients were positive about their experiences of care and treatment they were receiving at Queen Alexandra Hospital. They were kept informed about their care and their privacy and dignity was respected.

**Our judgement**

People have their dignity and privacy respected and are kept informed about their care and treatment.
Outcome 04:  
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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<td>There are minor concerns with Outcome 04: 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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| On Ward E2 people told us that they had been given detailed information about the procedure and what to expect before and after their operation. They also told us that their pain had been well controlled and monitored. We were told that the staff were very good and one patient commented on how good everyone was with an elderly gentleman who needed more attention then themselves.  
  
We spoke to four patients on ward C7 and they were happy with the care they received and said that their needs were met. Most said that explanations were good and that they understood what was happening. Patients said that they were offered regular pain relief and that staff attended if they used the call bell. One patient told us about how kind and compassionate nursing staff were when they arrived on the ward. They said that they did not feel ignored and that staff, both medical and nursing staff, kept them informed about their investigations and treatment. Another patient told us that they were 'very poorly' and had been transferred by 'air sea rescue' team. They said their family was kept informed and that 'you could not get any better treatment.'  
  
Patients and relatives that we spoke with on ward F3 felt that staff were "doing their best" and that "the quality of care was good". On ward F2 patients told us that they were well cared for. One patient was waiting to go home but knew that this could not happen until some work had been completed to make their home a safer environment.  
  
Patients were generally happy with the care they received and felt that staff responded to calls for assistance in a timely manner. |
Other evidence

We visited the trust previously in May 2011 and identified moderate concerns with this outcome. On our latest inspection we looked at 20 sets of records on eight wards. There was a variety of formats in use.

On ward D5 the staff were using the care pathways for total hips and total knee replacements. The ward was using the VitalPac system; this was the hospital's electronic care monitoring system. These clearly showed that the staff were following the care pathways and detailed records of post operative care and observations were recorded. The records for a patient showed that following a ward round the doctor had requested a special shoe. A record of the referral was seen on the VitalPac system and the occupational therapist had visited the ward. Referrals were made to the physiotherapists and occupational therapists prior to admissions. Staff told us that the discharge process began at the point that patients attended the pre assessment clinics. There was evidence that the multi disciplinary team worked well together.

We observed on ward D2 and ward E2 that patients had a venous thrombosis (VTE) risk assessment which assessed patients' risks to blood clots, this was completed and recorded on the VitalPac. Staff told us that patients were prescribed stockings or compression boots according to the surgeons' preferences. For two patients on ward E2 we saw that as a result of the assessment the patients had been fitted with anti embolism stockings prior to going to theatre. Staff on ward D2 told us that the VTE was also completed in the recovery room prior to the patients' returning to the wards. This information was then transferred to the VitalPac on the wards and helped ensure that these assessments were completed for all at risk patients.

On ward D2 we observed three patients for whom even though compression boots, to reduce the risk of blood clots were available at the bedsides, these were not in use. The member of staff responsible for the care of the patients told us that those patients on bed rest should be using the boots. This was confirmed by the senior nurse. We checked the patients' records which indicated that these patients should have been wearing the compression boots. The member of staff could not give a reason for them not being used. Therefore for these patients there was a potential risk, as care was not being provided as indicated.

One patient had become distressed and due to an underlying illness was unable to communicate to the staff what the problem was. We saw that the staff took the time to assess the patient and identify the cause of their distress. This was then dealt with in a timely manner.

We discussed the use of the care plan booklet with staff and found that in different areas the patient was involved at different levels. On ward E2 a staff nurse told us that they completed the care plan for the day during the morning drug round when they talked to patients. We looked at two sets of notes on this ward and though the patients care needs had been assessed and identified each day, there was no documented evidence of these discussions. A member of staff who usually worked on a different ward informed us that on this ward they recorded the discussion with the patient on the care plan.
On the ward we saw that people were well presented. One male member of staff was helping the gentlemen with their shaves. Support was given to enable patients to walk to the bathrooms. Assistance was given to those patients that required it. This included input from physiotherapist and occupational therapists.

On ward C6 at 16:30 we looked at the care plan for a patient with complex needs and the daily care plan for that day did not reflect their needs. Although the patient told us that they felt that their needs had been met. They were also very positive about the amount of time and the number of staff who had supported them the previous day to get out of bed. While this was positive it was clear from the risk assessment in the patient's notes that a hoist should have been used to move the patient. Therefore the staff had placed themselves and the patient at risk by not following their own assessment and plan of care.

On ward F2 we saw that staff responded to people's needs and assistance was given as required. However, on review of the care plans we saw that care was not clearly planned and risk assessments were not being used to inform care. This included the use of tools to assess the risk of poor nutritional intake, pressures sores, falls and moving and handling. These would have been an aid to assist the staff in reducing the level of risk to the patient and to themselves. For one patient who had been considered at risk of falling the risk assessment stated that a fall's alarm was in use though this had not been used since the patient transferred to the ward. A second patient, who would have been considered to be at risk of developing a pressure sore, did not have a completed risk assessment, although the patient told us that they were not concerned.

On ward F3 we found inconsistencies in the care plans and assessments. There was a lack of review particularly when patients had been transferred from other wards due to changes in their conditions. Fall risk assessments had not been reviewed or care plans written following falls. Some of the patients had suffered from a stoke but oral health assessments had not been completed. The senior nurse agreed that these should be done for all the stroke patients due to their risk factors.

On ward F3 patients at risk of developing pressure ulcers had been fully risk assessed on admission to the ward. Those people that had developed pressure ulcers had treatment plans in place. Pressure relieving equipment such as 'Nimbus and Pegasus mattresses' and pressure relieving cushions were in place. Staff confirmed that they could request equipment when needed from the mattress library.

On ward F4 staff were clear about the care needs of patients but it was only possible to establish this by talking to staff. This was because there was a lack of clear care plans to demonstrate how care should be delivered.

We also saw that the fluid balance charts were not fully completed to evidence how the patients' hydration needs were met. We observed one patient who was receiving fluids via an intravenous drip; it was unclear from the records what they had received. The volume of fluids was prescribed on the medicines chart, however the fluid records had not been completed and we could not ascertain if they had received the fluids as prescribed. The fluid balance charts had not been completed fully in relation to oral fluids taken by the patient that day.

On ward E3 we looked at three sets of nursing notes for patients on the ward. The
documentation identified individual needs and the post operative support that was required. We saw that other specialist healthcare professionals were consulted when necessary. For example one patient had been seen by the Tissue Viability Nurse Specialist (TVN) and had been prescribed some specialist wound treatment. On ward C7 we looked at two sets of records and found they contained details of the patients' identified needs and treatment.

Staff told us that they were informed of the patients' needs during the hand over at the start of the shift. They also used a printed information sheet that included some basic information about patients' needs.

The trust had developed an audit tool for the nursing assessment documentation, which focused on key aspects such as nutritional assessments, pressure area risks, pain, falls, blood clots risks and discharge planning.

On ward F2 and E2 we saw that discharge was being planned through the involvement of a multidisciplinary team. This was being coordinated by the discharge team. The patient's needs were being assessed including their home's environment.

Patients in the emergency department who had been brought in by ambulance were seen quickly when they arrived in the department, despite having to wait in the corridor. There were 12 patients in the corridor at one time but during the time we were in the department this reduced to one. Patients were seen by a triage nurse who assessed and prioritised each patient. They would then decide whether they should be seen by the doctor or whether they were safe to wait in the corridor, until a bay became available. We observed on our visit one patient who was assessed and deemed urgent and they were then moved to the next available bay.

The department was very busy; we were told the wards were full, leaving a number of patients waiting in the emergency department. At one point there were eight patients waiting to be admitted to either the medical admission and assessment unit or other wards within the hospital. Staff stated that surgical and orthopaedic patients could be moved on quicker.

In the emergency department we saw a large wipe board that kept track of patients' progress through the department. We saw that the system worked well and it was clear that the co-ordinating nurse and lead nurse had a clear overview of what was happening. We observed staff interacting with patients and making regular observations of their conditions. Nurses were seen to discuss changes in patients' conditions and other concerns with medical staff.

There was an assessment process in place and care plans were developed. The patients were mostly provided with information about their care and treatment. There was a lack of a consistent approach in reviewing plans of care and treatment.

**Our judgement**
People generally experience safe and appropriate care, treatment and support that meet their needs and protect their rights. People's needs are assessed and care implemented however the outcomes from risk assessments are not always used to inform care needs.
Outcome 05: Meeting nutritional needs

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

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement
There are minor concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
The patients told us that the staff came round and helped them choose from the menu. They told us that they were mainly satisfied with the food provided. The confirmed that choices were available. They said that food was mainly 'very nice'. Hot drinks were only available at set times and one patient said that 'you have to accept this.'

People were generally happy with the quality of the food and some said it was excellent and "couldn't complain". Patients thought they could ask for drinks between meals although they had not done so, as the tea lady comes round very often.

Other evidence
Previously we visited the trust on 12 April 2011, as part of the Care Quality Commission Dignity and Nutrition inspection programme. At that time we identified minor concerns with this outcome.

During our latest inspection we found the trust had systems in place with the aim to achieve and sustain nutritional nursing assessments in 100% admitted inpatients. This would be achieved through nursing documentation audits and actions to monitor and ensure assessments were completed. We were told that their internal audit showed improvement in assessment with a trust total of 85% which was a 10% increase since January 2011.

The hospital had a process in place to determine patients' medical, dietary and hydration requirements. The trust's procedure was for the Malnutrition Universal Screening Tool (MUST) to be completed within 24 hours of admission.
The MUST tool was available and the tool was seen to be present in most sets of patients' records reviewed. However, the use of the tool was not consistent. On ward F2 we saw that for one person who was obese and a diabetic with limited mobility no assessment had been completed and there was no nutritional care plan.

For a second person, also on ward F2 the MUST score indicated that a nutritional care plan would be required but nothing had been completed. Therefore it was not clear how staff were ensuring the individuals' dietary requirements were being met. For these two patients who were diabetic we saw that blood sugar levels were being monitored. Neither of these two patients had a nutritional care plan.

On ward F4 staff told us that MUST was carried out as part of the assessment on patients though the initial assessment was often performed in the Medical Assessment Unit (MAU) prior to the patients arriving on the ward. The process was for these to be reassessed every five days or more frequently if needed. On reviewing patients' case notes, we found that some of the nutritional assessments were either incomplete or blank. We saw in one patient's assessment that despite the MUST score being 4, there was no care plan to support what was done to ensure their nutrition needs were being met.

We observed the lunchtime meals on two days and found that the meals were nicely presented and looked appetising. Pureed diets were available and these were served in individual portions.

The trust had a red tray system that denoted patients who required assistance with their meals. We found that on most occasions these were adhered to and staff were available to support them with their meals in a sensitive manner. The ward environment was observed to be conducive to eating and the majority of patients were appropriately supported to eat. However, we saw that some patients who needed assistance during lunch did not receive help until all the lunches had been served.

Some staff told us that this system worked well and others said that it was not a flexible system. We observed that the meals were served according to the list, and not according to the patients' needs. For example all the meals were served including those patients on red trays at the same time. We were told that this did not take into account whether the staff were available to help the patients. This in turn meant that people on red trays sometimes did not receive the support they needed in a timely manner.

On wards F2, F3 and E2 we saw that all those that needed assistance received one to one help. Staff were seen to take time to ensure that people could reach their meals and this included repositioning were necessary. People were either provided with a hand cleansing wipe on their tray or these were readily available on their bedside table. At other times we saw that tables were positioned so that people could reach their drinks.

We observed that the white board at the patient's bedside showed that they needed a red tray. This patient was given a green tray at lunchtime and did not receive any assistance with their meal until 30 minutes later. A staff member came to help this patient and we observed they interacted well with them, whilst assisting them. We discussed this with the staff member who told us that it was a mistake and they should have had a red tray. This patient was on a pureed diet and this was available to them.
On wards D2 and D3 we observed that in two bays all the patients did not receive their mid morning drinks. In the bay on ward D3 the staff member offered drinks to only one patient and not the others. All the patients in that bay were able to have a drink. On ward D2 none of the patients in the bay we were monitoring were offered or received a drink.

On wards D3, D2, F3 and F4 we found inconsistency in the recording of food and fluid intakes, with records for a whole day that had one to two entries or were blank. It was not clear how staff ensured that people's needs were met.

On ward F3 for patients who had been identified as at risk, the trust had designated staff who were trained to carry out swallowing assessments and referrals were made to the appropriate assessment team. This was to ensure that the patients received their diets and fluids in a safe manner. We saw that these were completed and detailed information was available in three sets of records. These included the consistency of fluids to be administered.

The record for one patient showed that a speech and language therapist assessment was required as they were having difficulty with their fluids. We asked staff whether this had been done. We were told that there was no record as they would have made a phone referral. We were told that this should have been recorded. On the wards where the VitalPac system was used we found that records of referrals were recorded on this system.

On ward D2 we found one patient's record showed they were prescribed thickened fluids. A tin of the thickening agent was on their side table. The patient had a cup of tea with no thickening agent added. We were told that they no longer required this to be added. Their record showed that they received thickened fluids three days ago and there was no evidence that a new assessment had been carried or how the decision to stop the thickener had been reached. Staff told us that this patient did not require thickener in their drinks.

Patients were provided with a balanced diet and choices were available to them. Most people were satisfied with the meals provided. Assessments of the patients' nutritional needs were completed; however these were not consistent and were not always followed by a care plan. The records of food and fluids were not always adequately completed to enable assessment of people's dietary intake.

**Our judgement**

People are generally supported to receive adequate nutrition and hydration. There is a planned menu and the patients are able to make choices. However, dietary assessments are not consistently completed and used to inform plans of care to ensure that people's needs are met.
Outcome 09: 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
The provider is compliant with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
People told us that they were happy with the way their medicines had been given to them. One person told us the nurses were 'spot on' with medicines. We saw that some people had had to wait a while for medicines to be ready for them to go home and one person told us they had had to wait 'some time'. People told us that they had been informed about their new medicines whilst in hospital and we saw medical staff and nurses explaining medicines to people.

Other evidence
We visited the trust previously in May 2011 and identified moderate concerns with this outcome.

Before our current visit we looked at information that the trust had supplied to the National Patient Safety Agency (NPSA) about medication errors. The report showed that the trust has a higher proportion of incidents relating to 'medicine' than other large acute trusts with 14.1% as compared to 9.8%. We also saw information from the trust about how these errors had been followed up and the subsequent action taken.

During our visit we talked to staff who described how the learning from these incidents was passed on. We were also told about changes in the provision of pharmacy services that was supporting the safer management of medicines in the hospital. This included clinical pharmacy teams and near patient dispensing. The pharmacy regularly audited the use and handling of medicines in the hospital and we saw evidence of these audits.
and any action taken as a result.

The trust had told us that a new pain assessment tool for patients with Learning Disabilities was being reviewed, for use in the acute setting. Nursing staff specialising in pain management and the care of people with communication difficulties had worked together to develop the use of appropriate pain assessment tools. We did not see anyone needing this support during this visit.

People we spoke to had been given information about their medicines by doctors, nurses or pharmacists. We saw nurses giving medicines to people in an individual and safe manner. Nurses told us of the training and assessments that they had received in medicines handling, and we saw that only nurses trained and competent to administer intravenous medicines undertook this task.

We found one medicine had not been administered and was recorded as 'out of stock' over a bank holiday weekend, on ward F3. We discussed this with nurses and the pharmacist. This medicine could have been obtained from the pharmacy during this time. Other medicine charts we looked at showed that medicines were available when they were needed.

The prescription charts we saw on most wards were written clearly and the administrations were signed for or coded when omitted. Staff were able to tell us why medicines had been omitted and could refer to the patient's notes to confirm this. However on ward D2 and D3 we saw that there were some gaps on the medicines charts and a senior staff member told us that staff should be using the codes to explain why the medicines had been missed. Staff could not explain why the medicines had not been administered.

On wards D2 and D3 we saw that nutritional supplement drinks had been signed as given on the medicines' charts. These supplements were left unopened on the patients' tables and remained so when we checked at lunchtime. Although the medicines records would indicate that they had received these supplements.

The medicines we saw were all stored securely. Appropriate emergency medicines were available. These were checked daily and we saw that they had been replaced promptly after use during our visit.

A new electronic discharge process was being used on some wards, including those for older people and people with musculoskeletal conditions; we were shown plans to extend this service. This meant that people were given a printed copy of their information, including medicines, when leaving the hospital. Nursing staff described to us how this could also be used to answer concerns from patients or other care settings after discharge.

When we last visited, people were concerned about the length of time they had to wait for discharge medicines. After this an action plan to reduce the time taken for people to get their medicines was drawn up. We saw that many of the proposed actions had been implemented, including near patient dispensing and staff organisation. Nursing staff told us how the system of near patient dispensing had reduced the waiting times for people discharged from the hospital and we saw an audit that demonstrated this. However, we also saw that there were still some delays.
The trust had told us that the Pharmacy will monitor the turnaround of medicines to take home requests. They said that they were aiming for a 90 minute turnaround and to achieve 80% by January 2012. People who had left the wards to wait in the discharge lounge were still, on occasion, waiting for a long time. We saw that some people on the day of our visit had waited for more than three hours. The nurse who looked after these people described how incidents of prolonged waiting were escalated and followed up by senior managers.

The trust has made improvements in this outcome area and has plans in place to continue this process and audit the results.

**Our judgement**

On the basis of the evidence provided and the views of people using the services we found the Queen Alexandra Hospital to be compliant with this outcome; however the improvements currently being implemented must continue.
Outcome 21:
Records

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

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement
There are moderate concerns with Outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not speak to the patients about this outcome.

Other evidence
On each ward we visited we saw that the current patient's records were stored in trolleys close to the nurse's station. These could be closed, but during the day when staff were at the desk the trolleys were kept open.

We looked at 20 sets of records on eight wards. There was no one set format for care plans. In some areas they were using care pathways, which detailed the expected journey and outcome for patients undergoing elective surgery. There was a pre printed care plan in two parts. The first part was an admission assessment and the second part daily care needs. This booklet included a number of risk assessments. There were also loose leaf records where the nursing staff were responsible for writing in detail the patients' needs and expected outcomes.

We were told that a standard audit tool for record keeping had been introduced across the trust. The same tool was being used regardless of the type of documentation used. The audit tool had been developed focusing on nutrition; skin integrity; pain assessment; VTE assessment, name bands and call bells. We were told the benchmark had been set at 95%. Each ward had been instructed to select 10 sets of patients' notes fortnightly and to use this to complete the audit.
We were told that the emerging picture showed that some areas were improving while others were not. Results were recorded using an online system so the results would be immediately available and these could be seen by others. The results were reviewed and discussed at matron's meetings with the ward sisters.

On those wards using care pathways we saw that patients care needs were clearly documented and informed through the use of risk assessments. For those areas using the pre printed care plan the information was not outcome focused, but was generally used well, with a record of care recorded and risk assessments used to inform practice.

On ward F4 we found that risk assessments had been completed but we were unable to follow the care being delivered to that patient without talking to the staff looking after the patients. This was due to a lack of clear care plans to demonstrate how care would be delivered. We did not see records of care that had been provided such as assistance with personal care. The fluid balance charts were not fully completed to evidence how the patients' hydration needs were met.

On ward F3 we looked at five sets of records and found inconsistencies in the care plans and assessments. These included a lack of reviews particularly when patients had been transferred from other wards due to changes in their conditions. Fall risk assessments had not been reviewed or care plans written following falls. There were inconsistencies in oral health assessments as these had not been completed. The senior nurse agreed that these should be done for all the stroke patients due to their risk factors.

On ward C6 at 16:30 we looked at the care plan for a patient with complex needs and the daily care plan for that day did not reflect their needs.

On ward F2 where issues with record keeping had been identified through audit, information had been displayed to remind staff of all the information that should be included in patients' records. We looked at three sets of records and found that the documentation was inconsistently used. In one set there were no risk assessments, in the second set risk assessments had not been reviewed, or care plans as indicated by the assessment had not been written. In all three sets the sheets for the recording of the plan of care had not been completed. There was no information on expected outcomes or how these were to be achieved.

On wards E2, F2, F3 and D5 we saw that the occupational therapist, speech and language therapist and physiotherapists kept good records which included evidence of consent from the patient for any interventions and on going review.

Following a documentation workshop with representatives from different aspects of service we were told that an agreement had been reached that the nursing model Roper Logan and Tierney would be used. This is a model of nursing care based upon activities of living. This would be included in the development of any future documentation and anything developed will go through a verification process.

We were told that the trust had also reviewed the pain assessment tool for people who had learning disabilities. It was the trust's intention to use the Abbey pain scale. A system for assessing pain for people who are unable to communicate. While this was being implemented it could not currently be recorded on the Vital PAC system as we
were told it did not have the correct software. To ensure constant recording the trust had worked to match the results from the Abbey scoring tool to that used by the VitalPac system while they worked with the suppliers to find a solution.

There were inconsistencies in the assessments, reviews and recording of care. The records did not always clearly demonstrate personalised care, treatment and support. Patients could not be assured that contemporaneous records were being maintained.

**Our judgement**

People's records are maintained securely and are available when required. Records do not always contain adequate information on assessments and care provided that may put people at risk of their identified needs not being fully met.
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>
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<th>Outcome</th>
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<tbody>
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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 to us within 14 days of the date that the final review of compliance report is sent to them.
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.

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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 the date that the final review of compliance report is sent to them.

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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<tbody>
<tr>
<td>Author</td>
<td>Care Quality Commission</td>
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<td>Audience</td>
<td>The general public</td>
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<th><a href="http://www.cqc.org.uk">www.cqc.org.uk</a></th>
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<tr>
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| Postal address   | Care Quality Commission  
                   Citygate  
                   Gallowgate  
                   Newcastle upon Tyne  
                   NE1 4PA |