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

Queen Alexandra Hospital

Queen Alexandra Hospital, Southwick Hill Road, Cosham, Portsmouth, PO6 3LY  
Tel: 02392286000

Date of Inspections: 06 March 2013  
05 March 2013  
Date of Publication: April 2013

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>✅ Met this standard</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>✅ Met this standard</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>✅ Met this standard</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>✅ Met this standard</td>
</tr>
<tr>
<td>Supporting workers</td>
<td>✅ Met this standard</td>
</tr>
<tr>
<td>Complaints</td>
<td>✅ Met this standard</td>
</tr>
</tbody>
</table>
## Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>Portsmouth Hospitals NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of the service</td>
<td>Queen Alexandra Hospital is the main hospital site for Portsmouth Hospitals NHS Trust. It provides a range of services including: Accident and Emergency, Medical Assessment, Surgical Assessment and a wide range of inpatient and outpatient services.</td>
</tr>
</tbody>
</table>
| Type of services | Acute services with overnight beds  
Rehabilitation services |
| Regulated activities | Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Maternity and midwifery services  
Surgical procedures  
Termination of pregnancies  
Treatment of disease, disorder or injury |
### Contents

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

<table>
<thead>
<tr>
<th>Summary of this inspection:</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>How we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>What people told us and what we found</td>
<td>4</td>
</tr>
<tr>
<td>More information about the provider</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our judgements for each standard inspected:</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>6</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>8</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>10</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>12</td>
</tr>
<tr>
<td>Supporting workers</td>
<td>14</td>
</tr>
<tr>
<td>Complaints</td>
<td>16</td>
</tr>
</tbody>
</table>

| About CQC Inspections | 18 |
| How we define our judgements | 19 |
| Glossary of terms we use in this report | 21 |
| Contact us | 23 |
Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 5 March 2013 and 6 March 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information we asked the provider to send to us. We reviewed information sent to us by local groups of people in the community or voluntary sector and were accompanied by a specialist advisor.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

During our two day inspection we spoke to 51 patients and nine relatives or representatives. We also spoke to 57 staff including consultants, senior nurses, ward managers, support workers and domestic staff. The majority of patients we spoke to were positive about their care and treatment including those that had been treated in the Accident and Emergency Department (ED). A minority of people commented on waiting a long time in the ED, although those people had been offered food and drink and where necessary were being treated.

During this inspection we spent a day and half in the ED, we observed care and treatment, spoke to patients, spoke to staff, observed shift handovers and looked at patient records and other documentation, such as the hospital's "Queue management system policy" and staff rotas. We also spent time on the Medical Assessment Unit (MAU) and its various wards. Also, G2, G3, E1, the oncology day ward and the oncology inpatient wards F5, F6 and F7 were visited. We also visited other wards to track the care of specific patients, for example, people who had been admitted through the ED and patients with a learning disability.

Overall people were satisfied with their care and treatment saying things like "They are very respectful", "They are brilliant" and "I feel safe in here". Our observations confirmed that in the main people were well looked after, treated with respect and involved in the decisions about their care and treatment.
You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

Respecting and involving people who use services  ✔ Met this standard

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

Our judgement

The provider was meeting this standard.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

Care records we looked at showed that people had been involved in their care and treatment plans where possible and this was confirmed by the patients we spoke to. Where patients were unable to get involved due to illness, mental impairment or a language barrier we saw evidence that staff had spoken with the patient's family/representatives. Another example of how patients were enabled to get involved and have their wishes respected even when they could not easily express themselves was the service provided to patients with a learning disability. We met three patients with a learning disability and saw that they either came with a "hospital passport", (this is a document containing information needed to inform nursing staff about their health and care needs/preferences) or this would be completed with the help of a learning disability liaison nurse. We were told by one of the two learning disability liaison nurses based at the hospital, that some patients with a learning disability needed a carer who knew them to stay with them, for example a care worker from their residential home. When this could not be funded by the home the hospital paid for this. This was a vital resource that ensured their needs and wishes were respected. The learning disability liaison nurse service was also integral to ensuring patients with a learning disability had their views and needs taken into account. The learning disability liaison nurse had met all the current inpatients and could describe their needs and the arrangements that had been put in place to ensure they were met. This service was also available to outpatients.

On the oncology ward patients were very aware of what their treatment plan was and felt able to speak with staff if they had any concerns. They were aware of the choices available to them.

Patients were asked for and addressed by their preferred name. This was confirmed through observation, care records and by conversations we had with patients across the hospital. Only one patient commented that they didn't like to be called "love". Most of the patients we spoke to told us their privacy and dignity was respected. They gave examples of the curtains being pulled around when doctors came to speak to them or they just wanted to be left alone. We saw that signs were pinned to the curtains stating "Please
respect my privacy and dignity whilst the curtains are closed”. We observed that nurses and doctors were respectful in their dealings with patients for the majority of our two day inspection. The provider may find it useful to note that we witnessed one member of staff who spoke in a disrespectful manner about patients with dementia. They were clearly stressed; we reported this to the ward manager. Also, one patient commented that it was difficult to maintain their privacy because of their hearing impairment.

We observed doctors including patients in the decision making about their treatment. We also saw that the decision making process and the patient’s agreement or satisfaction was recorded in their care records. Nurses asked patients politely before taking blood or doing blood pressure and explained what they were doing throughout the process. Staff we saw showed warmth and an understanding of their patients. They spoke at a relaxed pace giving patients time to understand explanations and choices they were being offered. Patients were given time to respond.

We saw leaflets about the types of treatments being offered on the wards we inspected, what to expect and guidance for after care which families and visitors could look at.

A ward manager told us that they were developing leaflets aimed at 16/17 year old patients, explaining treatments such as scans, using language they were used to. The ward had made a request to the hospital League of Friends for folding beds so that if they would like company their parents/guardians could stay with them while they were in hospital. These changes were as a result of feedback from patients.

Staff promoted patients’ independence. For example, the hospital had a same sex policy so none of the bays were mixed sex. On one ward there was a husband and wife who were patients. Although, they were in separate bays we saw that the husband was able to visit his wife and continue some of the care tasks which he normally carried out for her when they were at home.

In the Accident and Emergency Department (ED) we saw that all patients were treated with privacy and dignity once placed into a designated area. Curtains were able to be pulled around each trolley space and a ‘Privacy and Dignity’ notice was displayed in the trolley bays. However, the provider may find it useful to note that it was not always possible for patients to have their privacy and dignity maintained as at times we saw, up to 10 patients waiting in the corridor for a designated trolley space. We were informed by the matron that on most days the department did not have the capacity to accommodate the volume of patients attending due to a lack of available beds within the main body of the hospital. Patients that were waiting in the corridor did have a designated nurse or ambulance personnel responsible for their care, any interventions required were carried out in a side room whilst waiting.

The provider may also find it useful to note that in one area of the MAU we saw the toilet and bathroom could only be accessed via a corridor, where other patients sometimes waited to be assessed in the ED. Although no patients commented on this and some patients in this area used commodes we felt that others may not have their privacy and dignity respected due to this arrangement. This was discussed with the Chief Executive and the Director of Nursing who have provided us with their plan to build bathroom facilities within the area. In the meantime, they have a plan in place for patients on that ward to access alternative bathrooms until the building work is complete.
Care and welfare of people who use services  
Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with individual care plans. All the wards and departments we inspected had undertaken detailed assessment of patients' needs that included their physical, personal and mental health needs. Daily records were completed for each patient. This showed us that the care and treatment plans were followed by nursing and care staff. The records we saw had a suitable amount of detail and were kept up to date.

Staff told us that they sought support from other professionals as needed, such as, falls advisors, learning disability nurses and mental health specialists. Our sampling of the service provided to people with a learning disability supported this.

In the Accident and Emergency department (ED) we found that patients were kept informed about their plan of treatment and care, supported by written evidence in their medical and nursing notes. There was evidence that regular checks were being undertaken, termed as “intentional rounding”. We saw that patients were checked hourly to ensure all their care needs were being fully met. This gave patients an opportunity to ask any questions and make sure they understood their plan of care and treatment. Any risks which had been identified through an assessment were clearly recorded and there was action for staff to take to reduce risks. For example, a person who had a history of falls had a bed pressure mat put in place by their bed.

When we spoke with patients on G3 and G2 they told us staff gave them the help and support they needed. They said staff would support them in the way they preferred and also encouraged and supported them to do as much for themselves as possible; especially when they needed to be able to complete certain tasks in order to be discharged. Patients told us that not only did the nurses and support workers assist and motivate them but they also received support from other health care professionals such as physiotherapists, nutritionists and occupational therapists.

On the oncology ward patients told us staff were “very kind and friendly” and were “always checking that you are okay”. Patients spoke very positively about the explanations given to them about their treatment and said they felt involved in their care and treatment planning.
On the wards for older patients we saw a magnetic board above the beds. These had symbols on them which could be changed depending on the patient and their needs. For example a flower/forget me knot which indicated that the patient had dementia or other mental impairment. A picture of foot prints, which showed that the patient had mobility needs/was prone to falls and a picture of a puppy that came in three colours, and indicated if the patient had a pressure sore and the type. Staff told us that they found them a useful tool for giving a snap shot of the needs of the patient.

Patients and relatives we spoke to were satisfied with the care and treatment. When we asked people if staff were knowledgeable about their care and treatment they said "Yes" and "Oh yeah" without hesitation. When we asked "If they cannot answer your questions do they find some one who can?", people said things like "I have never been in that situation but from what I have seen if one nurse does not know they will consult with another nurse". We were also told that nurses always responded promptly to call bells. A relative told us they accidentally sat on a call bell and a nurse responded quickly, giving them confidence. Some people we spoke to had experienced adverse reactions to their treatment that had necessitated urgent action by staff. They said that after this, they were confident that they were in safe hands, that staff would react promptly.

People's care and treatment was planned and delivered in a way that protected them from unlawful discrimination. Patients we spoke to said they had been asked about any religious and cultural needs on admission. Notes in their treatment plans confirmed this. Staff we spoke to were aware of respecting people's diverse needs and were aware of what to do should people have any. For example, there is a translation service known as "The Big Word" that can be used and information is available in a range of accessible formats. Staff were aware of the Mental Capacity Act and the Deprivation of Liberty Safeguards.

The provider may find it useful to note that the ED was very busy and at times people were waiting on trolleys in the corridor. Whilst this was not ideal we observed that everyone was being attended to and the "Queue management system" was put into operation and the ED staff worked as a team to reduce the queue as quickly as possible. Also, not every patient was seen, treated and discharged from the ED within the four hour standard. Many patients were waiting long lengths of time for a hospital bed if they needed to be admitted to a ward. The nursing staff endeavoured to ensure any patients deemed at risk of pressure damage were placed onto a hospital bed. Patients waiting longer than four hours were also prioritised. The majority of the patients we observed in the ED were receiving care and treatment and had been offered food and drink. However, one patient we saw who was deemed to be at risk of pressure damage was placed on an appropriate mattress after being in the department for seven hours. Their treatment plan stated "would benefit from an application of Sudocrem, none in department". Another older patient was complaining of feeling very uncomfortable. However, when this was reported to the Matron they were quickly placed onto a hospital bed and made comfortable.
Safeguarding people who use services from abuse  

Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

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

The provider has worked closely with Hampshire County Council and Portsmouth City Council in devising a single system for the reporting and handling of safeguarding issues. Our experience is that this has worked well so far and referrals were followed through and investigated where necessary.

All staff we spoke with had a good understanding of the hospital's safeguarding policy and procedure. They had a good understanding of what constituted abuse and the signs to look for.

Staff at every level understood how to report any safeguarding concerns and who to report them to. One health care support worker we spoke to gave us two examples of safeguarding concerns they had reported. Nurses also gave us examples. There was a designated 'Safeguarding Link Nurse' in each department. The Safeguarding Link Nurse kept records of all referrals made to the local safeguarding team. All the staff we asked had a good overall awareness and knowledge of the Mental Capacity Act and the Deprivation of Liberty Safeguards and the support required if patients lacked full mental capacity. Regular teaching sessions were held on safeguarding and all staff were expected to undertake mandatory safeguarding training. Staff on all the wards we visited told us they had received training in safeguarding. Training records we saw confirmed the frequency, content and assessment of the training which also included whistle blowing. All the staff we spoke to said they would "blow the whistle" if they felt patients' safety was compromised. One person gave us an example of having done this.

The majority of training was computer based, however, staff said they did have training days with face to face training and they were able to discuss issues at staff meetings.

All patients with either grade three or grade four pressure sores were reported by completing an incident form and a safeguarding alert form, prompting an investigation to
be undertaken by the local safeguarding team.

Patients told us they felt safe in the hospital, saying things like "There is always someone around if you need them" and "I feel safe in here".
Cleanliness and infection control

Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed. People were cared for in a clean, hygienic environment.

Reasons for our judgement

There were effective systems in place to reduce the risk and spread of infection. Our observations on the wards we visited confirmed a good level of cleanliness, with no issues relating to infection control. We found members of staff knew how to respond to infection control issues. We observed them washing their hands regularly and there was appropriate use of personal protective equipment such as gloves and aprons. For example, we observed members of staff wearing aprons when offering food to people. We also saw that patients were given wipes with their meals to clean their hands. Patients confirmed to us that wipes were regularly supplied if needed and that staff wore gloves and aprons.

All of the patients that we spoke to told us they thought the hospital was clean. They said they were "very happy with the cleaning on the ward." Some people told us they had seen two different cleaners before 10am. Relatives we spoke with told us the place was "spotless."

We found the leadership of the deputy director for infection prevention and control to be effective and focused. The monitoring systems that were in place ensured the risks of infection were minimised at the hospital. The systems were clear. For example, as soon as a patient was admitted to the hospital and if they were previously recorded to have had an MRSA or Clostridium difficile (C. diff.) infection, the infection control department would be alerted of this. We found the pre-emptive systems for cleanliness that were initiated allowed the infection control department to pro-actively take steps to ensure the individual's risk to have an MRSA or C. diff. infections were minimised. This included ensuring the individual was always transferred to a single room and then a six hourly deep clean of that room was undertaken. On the day of our inspection, we saw the system work in practice and followed through a patient who had previously had an MRSA infection and found that the cleaning regime for their room followed the set protocol. We found that the cleaner was aware of what needed to be cleaned and how often.

The hospital also had a proactive approach in the management of intravenous lines into veins. This is a piece of equipment for the administration of medicines and other therapies directly into a person's veins. Recognising that these were the entry point of any infections, the hospital had devised a system of alert whereby the infection control department were
made aware when the lines were inserted and any observations recorded of those lines. This ensured that infections surrounding those lines were minimised. For example, if there had been no recorded observations of a line inserted into a patient, the infection control department would proactively enquire about this and ensure the necessary actions were taken. The hospital also ensured that all high risk intravenous lines (central line) placed into patients were done by specialists. Members of staff we spoke with told us this further reduced the risk of infections.

All of the staff we spoke to told us they received the necessary support for infection control including the resources for deep clean. All of them had received training on infection control. Training records available on the wards confirmed this. The staff we spoke with that had a specific role in relation to infection control were very enthusiastic about their work and clearly took pride in it.

We inspected 10 mattresses across different wards and found them all clean. The member of staff responsible for the management of mattresses within the hospital, explained the detailed process in place to decontaminate the mattresses. We were also shown the mattress audit that was undertaken every year. This member of staff was very confident that all mattresses in the hospital were clean. We also inspected 10 commodes across different wards and they were all clean. There were systems in place to ensure members of staff knew how to clean commodes. We observed the cleaning of one commode and found suitable procedures were followed.

Members of staff we spoke with were aware of infection control audits being undertaken on the wards. The results of these audits were prominently displayed on the wards we visited. We spoke with members of staff who knew how to decontaminate equipment after use. We checked the cleanliness of various equipments such as hoists and beds and found them all to be clean.

The reporting of infection control to the executive board was clear. For example, the board received monthly updates on infection control. The "infection control dashboard" that contained all the quality monitoring information was regularly presented to the board. We spoke with the director for infection prevention and control (DIPC) who told us the board regularly asked questions on infection control.

The only negative thing we saw in relation to hygiene was a member of staff knocked some of a patient's belongings to the floor from their bed table. The member of staff picked them up and put items that were rubbish in the bin and a packet of tissues back on the bed table.
Supporting workers

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Staff received appropriate professional development. All the staff we spoke with confirmed that they were supported to undertake their roles. We were informed that staff received support through yearly appraisals and staff meetings. Newly qualified nurses had two appraisals in their first year at six and twelve months. Each nurse was responsible for keeping their training up to date and the training was monitored by the Learning and Development team. Staff confirmed that they were responsible for arranging their training to ensure that they were up to date, however, training was also monitored by the ward managers we spoke with. One ward manager told us that they ensured staff had study days so that they could read around the subject to help them pass their assessments. Staff told us about the training they had received so that they could perform their duties effectively. Examples of training undertaken included understanding dementia, moving and handling, fire training, food hygiene and hygiene and infection control procedures. Staff were encouraged to undertake additional training, specific to the ward or department where they worked. For example, Accident and Emergency nurses were expected to undertake an Advanced Trauma Life Support course for adults and children.

New staff were supported by mentors and preceptors. We looked at the induction and ongoing training for staff. Staff files contained a job description, record of learning including induction, essential training and ongoing development. We saw on the files that each member of staff had a knowledge and skills framework, record of competencies and a personal development plan. The record included an introduction to the wards, understanding of medicines and how to safely carry out intra venous medicines. We saw that staff were signed off by their mentor when competent; some comments included; "Good technique, needs to remember equipment, more practice for primary IV line". Another stated "Very good technique, gentle and thoughtful", however, this one had not been signed.

Each ward and department had a system in place to ensure good communication between all staff. For example, regular handovers at the "white board" were observed in the Accident and Emergency department (ED). These were attended by senior nursing and medical staff. This gave the senior staff working in the ED an overview and an update to ensure every patient was receiving appropriate care and attention.
The ED had a suitable allocation of medical and nursing staff. The scheduled numbers of both medical and nursing staff were on duty most of the time and any vacant shifts were covered by agency nurses. If the department required additional staffing at busy times then nurses were moved from other areas within the hospital to meet the demands of the department. Shift patterns were planned in accordance with the expected volume of patients attending the ED.

The majority of the staff that we met were happy in their work and a sense of team working was observed. Staff were motivated, enthusiastic and proud of the standard of care and treatment they provided. Over the two days we observed one member of staff who showed signs of stress and spoke about patients in a disrespectful manner and another who showed a lack of awareness about how to support people with a learning disability and other aspects of their role. In the case of the second member of staff the ward manager informed us they were aware of the person’s development needs and plans were in place to address this. Otherwise, staff worked competently and confidently and confirmed that they were supported to do this by their seniors.

Staff said that they had staff meetings, annual appraisals and were supported in their learning and development. Records we looked at confirmed this. They said there were forums available to them and they felt there was an "open culture" for them to be able to share ideas and issues. Several staff commented that their senior was "open to ideas" and gave us examples of how their ideas and skills had been used to improve patient care. The open culture was demonstrated to us by staff not only giving us examples of things they were proud of about the hospital but also telling us about the things that could be improved or they had concerns about. For example, staff commented to us about the waiting times in the Accident and Emergency department (ED). A member of staff told us it could get "scary" on Blue Ward at the weekends and it was this that let us to look at this area of the MAU and notice the improvements needed to the bathroom arrangements which we outline under Outcome 1 of this report.

Patients spoke highly of the staff and the care and treatment they received. Comments such as "Excellent, can't fault them" and "Feel confident with the skills and treatment" were made to us.

We had been made aware by the trust that there was a shortage of staff qualified to give chemotherapy, this included monitoring and observing for side effects. The ward manager told us of active recruitment from Portugal and more locally at job fairs. We were told that the aim is that the ward would have 90% of their nurses trained in chemotherapy by the end of 2013. The ward manager believed that they would reach that target. Seven staff had completed their training and nine staff will commence their training in April 2013. One member of staff had sought a placement on the oncology ward for six months and had recently been successful.
Complaints

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available.

Reasons for our judgement

People’s complaints were fully investigated and resolved where possible to their satisfaction. The hospital had a very detailed and thorough complaints procedure. This was available in a variety of formats, including pictorial and “easy read”. We saw that patient leaflets were available throughout the hospital and other information about how to complain was posted in the wards and departments. Ward managers told us that complaints could come directly from patients or from the hospital’s Patient Advice and Liaison Service team (PALS). Depending on the issue they might be investigated by the ward manager or the matron. Statements and information were then returned to the customer services team, who responded to the complainant. If an issue was raised verbally on the ward then the ward team would look into it. A record was kept of complaints and this along with other information is sent to the governance board. We saw that the governance team acted on individual complaints and implement changes where there is a common thread or recurrence. We also looked at a sample of complaints made to the hospital and saw they were clearly documented and the actions, outcomes and level of satisfaction of the complainant were recorded.

Staff told us that complaints were discussed at staff meetings so they were aware of issues and what action if any was needed. Staff said they felt this open discussion meant that they saw the issue from the patients/relatives perspective and responsibility was accepted by the staff team to resolve it. Staff also told us about the comment cards which could be left on each ward in a box. The ward manager told us they empty it every month and collate any comments. One recent comment simply said “Thank you for looking after my daddy”. We saw these boxes on each of the wards we inspected with an explanation of what to do with the comment cards.

We were also told that surveys were also taken round each month by a volunteer on the oncology wards. They select five people from each ward every month and if needed will support the patient by going through the survey with them.

When we asked patients if they had any complaints their main criticism was of the waiting time in the Accident and Emergency department (ED). Although none of the people we spoke to wanted to make a formal complaint about this. The hospital was aware of the problem and was endeavouring to rectify the situation in collaboration with other external agencies that had a vital part to play in helping to address the problem, such as GP services.
The "intentional rounding" process provided written evidence of the care provided to address any complaints relating to the lack of care needs being met.

The provider may find it useful to note that our evidence supports that good information on how to complain was available on the wards and throughout the hospital. However, most of the patients we spoke to said they had not seen any leaflets or information on how to make a complaint. All said they would feel able to complain and would talk to a doctor or nurse if they needed to.
About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✅ Met this standard

This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

❌ Action needed

This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

❌ Enforcement action taken

If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

**Minor impact** – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
### Glossary of terms we use in this report

#### Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

<table>
<thead>
<tr>
<th>Outcome 1 (Regulation 17)</th>
<th>Respecting and involving people who use services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 2 (Regulation 18)</td>
<td>Consent to care and treatment</td>
</tr>
<tr>
<td>Outcome 4 (Regulation 9)</td>
<td>Care and welfare of people who use services</td>
</tr>
<tr>
<td>Outcome 5 (Regulation 14)</td>
<td>Meeting Nutritional Needs</td>
</tr>
<tr>
<td>Outcome 6 (Regulation 24)</td>
<td>Cooperating with other providers</td>
</tr>
<tr>
<td>Outcome 7 (Regulation 11)</td>
<td>Safeguarding people who use services from abuse</td>
</tr>
<tr>
<td>Outcome 8 (Regulation 12)</td>
<td>Cleanliness and infection control</td>
</tr>
<tr>
<td>Outcome 9 (Regulation 13)</td>
<td>Management of medicines</td>
</tr>
<tr>
<td>Outcome 10 (Regulation 15)</td>
<td>Safety and suitability of premises</td>
</tr>
<tr>
<td>Outcome 11 (Regulation 16)</td>
<td>Safety, availability and suitability of equipment</td>
</tr>
<tr>
<td>Outcome 12 (Regulation 21)</td>
<td>Requirements relating to workers</td>
</tr>
<tr>
<td>Outcome 13 (Regulation 22)</td>
<td>Staffing</td>
</tr>
<tr>
<td>Outcome 14 (Regulation 23)</td>
<td>Supporting Staff</td>
</tr>
<tr>
<td>Outcome 16 (Regulation 10)</td>
<td>Assessing and monitoring the quality of service provision</td>
</tr>
<tr>
<td>Outcome 17 (Regulation 19)</td>
<td>Complaints</td>
</tr>
<tr>
<td>Outcome 21 (Regulation 20)</td>
<td>Records</td>
</tr>
</tbody>
</table>

#### Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.