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

Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street Hospital, Great Ormond Street, London, WC1N 3JH

Tel: 02074059200

Date of Inspection: 25 September 2012

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

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## Details about this location

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<th>Great Ormond Street Hospital for Children NHS Foundation Trust</th>
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<td>Great Ormond Street Hospital for Children NHS Foundation Trust is a provider of children's healthcare services. The hospital is situated in central London and has 320 beds. There are more than 50 clinical specialities which largely provides highly specialist care. The trust achieved foundation trust status on 1 March 2012.</td>
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Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 25 September 2012, talked with people who use the service and talked with carers and / or family members. We talked with staff.

What people told us and what we found

As part of the inspection an unannounced visit was carried out by six compliance inspectors, one pharmacy specialist and one paediatric specialist on 25 September 2012. We visited various inpatient wards including private patient wards, outpatient areas, diagnostic and testing areas and administrative offices. Overall, we spoke with 24 children or their parents/families and to 35 members of various staff.

In general, the children and parents/families we spoke to were very positive about the experiences they had had at the hospital. Most of the children and parents we spoke with told us that they felt supported, respected and very happy with their involvement in the care provided. They spoke highly of the medical and nursing staff. The majority of children and parents we spoke with told us that they disliked the taste of the food and the choice of food was poor. All the parents we spoke with felt that their children were safe in the hospital, it was a clean environment and were happy with the way their medicines were managed. All of the parents we asked knew how to make a complaint if they needed to.

Some comments included:
"We are very happy with all the care and support we have received here".
"The staff are respectful".
"The nurses and the doctors are very, very good."
"Food is bland and plain, it's the same thing everyday."
"I feel safe".
"The ward has always been clean".
"Any issues I have raised have been sorted out immediately".

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

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**Our judgement**

The provider was meeting this standard.

People's privacy, dignity and independence were respected. 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**

Most of the children and parents we spoke with told us that they felt supported and respected and that their privacy and dignity was upheld:

"We are very happy with all the care and support we have received here".
"The staff are respectful".
"I am definitely treated politely".
"The nurses ask how you are feeling and are really understanding".
"Staff knock before they come in".

All the staff we spoke with described good practice in maintaining privacy and dignity. This included closing curtains in bay areas and doors in private rooms, the use of do not disturb signs and knocking on doors before entering a room. Older children were offered the choice of male or female staff for personal care, which was noted in their nursing records.

The trust had a privacy and dignity policy which staff told us they had received mandatory training in. An equality and diversity information pack was available which contained information about how people should expect to be treated at the hospital.

The majority of the inpatient wards that we visited had single rooms with en-suite facilities as well as bed bay areas. Some of the bay areas were mixed sex accommodation. We were told by staff that children and their families are always asked about gender preferences upon admission and they aim to meet each person's individual wishes. The minutes from the most recent trust board meeting in July 2012 showed that there have been no instances of complaints about mixed-sex accommodation for the previous quarter.

We inspected one ward that was struggling to provide sufficient privacy for the patients. This was Peter Pan Ward, which had 18 beds and cares for patients with Ear, Nose and Throat conditions. This ward is located in the Southwood Building which is the older part of the hospital and is due to be relocated to new accommodation in 2016. This ward has two bays with five beds or cots in a very small space. One of the side rooms is a nursery which contained two cots or beds in a small space. This meant that the beds and cots were very
close together and if a parent stayed with a child they had to sleep on a chair. It also meant that the patients were so close together than maintaining privacy was very difficult for the staff. We asked senior staff in the trust if there were any plans to address this lack of space prior to moving to the new ward and were told there were not. The provider might wish to note that the privacy and dignity of patients on this ward is hard for the staff to provide and steps to improve this for the next three years are not in place.

Staff told us that they ensure people are treated age appropriately and recognised the different needs that a young child would have from a teenager. We observed that where possible this had been considered in the décor of the wards. There were also wards that provided separate activity rooms for younger children and adolescents. People told us that illustrations and toys were used to explain procedures to younger children.

There are a range of accommodation facilities within the hospital as well as links with local hotels. People also told us:
"I stay overnight and I have a comfortable couch to sleep on".
"There is a couch in our own room and this is fine for sleeping".

The trust policy stipulates that one parent can stay at the hospital with their child overnight. In the Intensive Care Unit (ICU), both parents could stay overnight. In most cases a pull-out flat bed or couch was available for a parent to sleep on and bedding was provided. Each ward has a housekeeper, administrative staff or nurses who assisted families with accommodation arrangements. Parents told us that they were happy with the sleeping arrangements and hadn't had any problems being assigned suitable accommodation.

On the international and private patient wards (Bumblebee and Butterfly) children and parents had access to dedicated advocates who act as interpreters and translators for people when English isn't their first language. We were told that the majority of patients on the international wards are from the Middle East. We observed signage displayed on the ward in Arabic as well as written information in Arabic such as menus and feedback forms. The whole trust has access to NHS Language Line to request interpreters and written information in multiple languages.

There was a multi-faith chapel on the hospital site as well as a multi-faith chaplain who makes daily ward rounds. The trust has both a Family and Staff Equality and Diversity Group who meet quarterly to address equality and diversity issues. There was also a staff Black and Ethnic Minority network.

There were on site school facilities available to all children at the hospital. The school provides continuity of education within the framework of the National Curriculum and is regulated by OFSTED. As well as a school facility, we observed teachers coming to inpatient wards to give lessons to children in their rooms. One child told us that teachers came twice per week and she enjoyed her lessons. Another child said "If I am on dialysis and not able to go to school they will come and see me for a lesson on the ward". Administrative staff told us that the school calls each ward every morning to check the educational needs of children.

There were dedicated play specialists and volunteers on each ward who work during the week and at weekends. Timetabled group activities were available through the activity centre such as Scouts and Guides every Tuesday and Friday. Some children also had individualised activity plans kept with their nursing notes. A range of computer games were available and films were shown on the wards and in the hospital's lecture room. One
parent said "the play workers and volunteers come round – they are absolutely brilliant. This morning we did painting". One child said "the play therapist has arranged for me to have an IPad and games and so I have lots to do"
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

Children and parents told us that they felt very happy with their involvement in the care provided. The trust encouraged families to become actively involved in the children’s care. Comments from people included:
"We have been told what was happening".
"I have had lots of information".
"They explained the options and the risks".
"I have been able to ask questions about treatment and can understand".
"They have always listened to me".
"I have been given lots of written material about renal problems as well as lots of explanations". 
"I know all the staff and their names. They are just around all the time".

Each inpatient ward we visited had written information packs available for children and parents that explained about how the ward functions and who the staff were and their roles. A wide range of information is also available on the trust website. Nursing staff told us that once people are settled, they are taken around the ward and shown all the facilities. In addition parents are also asked to complete two forms; one with contact details and the second one about the child's normal routines and their likes and dislikes.

Treatment specific information was available in leaflets and guidance displayed in ward areas. Nursing staff described talking to patients and their families, explaining fully any treatment and procedures. Parents told us that they work very closely with staff, especially when they are trained to use equipment and give medication in order to care for their children themselves.

There was a standard risk assessment pack completed when each child was admitted. This included health and safety in the ward environment, manual handling, nutrition, pressure ulcers and risk of falls. The care planning package was a standard trust wide tool but there were individual care protocols prepared specific to each different clinical speciality. Risk assessments were also undertaken in outpatient areas and in pre-admission clinics, as well as on inpatient wards.

We observed medical and nursing notes on all the wards and found that risk assessments had been completed as appropriate and were generally up to date. Nursing staff told us that they had received training on how to complete risk assessments and care planning.
The trust had an improvement initiative in 2012/13 to reduce the number of pressure ulcers that are developed within the hospital, which are graded from two to four, by 20 per cent. Nursing staff were able to explain to us what they were doing to reduce incidences. They identified that there was a particular risk of pressure ulcers on the respiratory ward (Badger) due to oxygen masks causing irritation to the face. When a child was at risk of developing a pressure ulcer they would be assessed on a weekly basis at a minimum. ‘Body maps’ were also completed where there was any damage to the skin and repositioning charts were introduced. There was a team of tissue viability nurses (TVNs) within the hospital who were available both to assist and advise. The TVNs also offered training sessions and out-of-hours support and were able to access equipment for children such as pressure relieving mattresses. People told us that the TVNs were "very helpful and proactive". Nursing staff told us that pressure ulcers were discussed at handover and at staff meetings. Staff told us how they reported pressure sores through the incident reporting system and how the trust monitored the numbers of pressure sores.

Children and parents spoke highly of the medical and nursing staff and the support they received from them:
"The standard of care is 10 out of 10. The nurses and the doctors are very, very good."
"They are a really skilled team".

Ward rounds took place at least once a day. Multi disciplinary team meetings took place on a regular basis to discuss individual patient cases in more detail. 'Psycho-social meetings' were held on most wards to allow all those involved to discuss the child's and families holistic care needs. Staff and parents told us that these worked really well. Nurses told us that children had good access to and support from physiotherapists, occupational therapist and speech and language therapists.

Suggestion boxes were available on each ward which were reviewed by the ward manager. The Patient Liaison and Advice Service (PALS) also compiled patient feedback which is reviewed quarterly at trust board level and fed back to each specialty. Patient satisfaction surveys were conducted at trust level although the trust emphasises the importance of discussion about care at a ward level such as parents' tea meetings, which we observed taking place on our visit.

The trust has a target for 2012/13 to reduce cardiac and respiratory arrests for patients outside of intensive care units and theatres by 50 per cent. Staff told us that a number of measures had been put into place including the use of patient observation charts which included the Children's Early Warning System that assess risk and indicates the need to escalate if a child is deteriorating. This was in addition to additional nurse training in high dependency child care and working with the Intensive Care Outreach Service.

We visited the Cardiac MRI department as it had been identified that the MRI service is experiencing difficulties booking in all diagnostic MRIs within the target 6 week timeframe. The trust had introduced a demand and capacity analysis for the service to help reduce delays. We spoke with a consultant who explained that a new system had been introduced in the last few months whereby workload was shared with radiology which was helping to reduce delays.

The trust has an end of life care team who provide support to children who have life-threatening conditions and their parents. We observed input from the team in medical records which contained records of people's choices, and preferences to support the
child's quality of life.
Meeting nutritional needs

Food and drink should meet people’s individual dietary needs

Met this standard

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration and the trust was working to meet the preferences of the patients.

Reasons for our judgement

Meals were prepared in a central kitchen in the hospital and were sent up to each ward area in a hot trolley where they were distributed by the ward housekeeper or nursing staff.

There were also kitchen areas on each ward for parents to use for preparing drinks and snacks which were accessible 24 hours a day. Fridge temperatures were monitored by housekeepers using a daily checklist.

There were three-weekly menus available on each ward with a choice of different meals for breakfast, lunch and dinner. This included a lighter or heavier option for each meal. This was introduced as a result of feedback from the March 2012 patient and family survey of food. Children chose what they want from the menu the evening before. Meat, fish and vegetarian dishes were available each meal time.

Some children had specific dietary needs due to their condition and treatment. For some wards such as Butterfly and Elephant wards there were specific meals available to reflect their conditions. The staff on the renal ward (Eagle) felt the menus for children with renal conditions could be improved.

We observed that menus were displayed in the ward areas. Menus were available in Arabic on the international and private wards we visited (Butterfly and Bumblebee). If children changed their mind there were also alternatives available each day. The food provided met the religious and cultural needs of the patients.

The majority of children and parents we spoke with told us that they disliked the taste of the food and the choice of food was poor. Some responses from children and parents included:

"The food is terrible. Zero out of ten".
"Food is bland and plain, it's the same thing everyday. Its hard to eat."
"It is awful, but they do try and make it look good".
"They have the food I like – but not cooked in the way I like it".
"Food is not always hot".
"I bring in my own food and keep it in the kitchen as it is all he will eat".

The staff that we spoke with mostly agreed with the children and parents:

"The food is really bad. Shocking".
"I don’t think the food is very good. Has to be reheated and it can be really poor".
"The parents usually don't like the look of it. Can be a bit repetitive".
"Food often doesn't get eaten".

In 2011/12, the trust also failed to meet its own target to improve overall satisfaction with the quality and variety of hospital food in its annual inpatient telephone survey. Satisfaction levels fell from 60% to 54%.

The trust was aware of these issues and has put measures in place to try to rectify the issues by collecting feedback through an inspection of the food as part of an internal inspection in September 2012. Feedback was provided on the range of food served to patients and suggestions made for improvement. Simultaneously, housekeeping staff also conducted a Patient Meal Choice Survey. The results of the survey are currently being collated together with the feedback from the internal inspection, from which an action plan will be formulated. The Trust is also working in partnership with the Evelina Hospital on a "Food Vision" to ensure that food is procured, produced and served in the best possible way.

Children and parents felt that they had food alternatives:
"Can get extra snacks if I wanted".
"The sandwiches are okay and I like the jelly. Sometimes we go to a local cafés or McDonalds".
"In the parents kitchen there is always toast and biscuits and they bring round snacks"

There were snacks, toast, cereals, sandwiches and drinks always available on the wards if children wanted to eat or drink outside of mealtimes. These were also used for late and emergency admissions. Parents told us that access to meals at short notice was also good and that the housekeepers go out of their way to get children what they want to eat. The housekeeper told us that they will try and source alternatives if the children don't like the food. An online system of ward food ordering was in place which enabled last minute changes to an order. Snack boxes could also be ordered from the canteen and a snack trolley had been recently introduced.

Protected mealtimes were in place where appropriate and no medical interventions were given when the child was eating unless clinical need dictates. Parents were encouraged to be present at mealtimes to assist children to eat when required, however nursing staff and healthcare assistants were available to provide support to eat.

A nutritional screening tool used was completed on admission for all children. Children's likes, dislikes, cultural preferences, allergies, weight and dietary requirements were documented. Allergies were also noted on drug charts. Regular weight checking and nutritional screening was undertaken by nursing staff on each ward. Some children who have been identified as being at risk of malnutrition were weighed on a daily basis. Food and fluid intake was monitored for all children.

There was access to a dietician who provided specialist input for children with nutritional needs. The dietician visited most wards on a daily basis as many of the children need a special diet or had feeding tubes. There was also access to speech and language therapists to support children with swallowing difficulties.
Safeguarding people who use services from abuse

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

Parents we spoke with felt that their children were safe in the hospital. Some comments included:
"Thinks it is safe and they [staff] do know what to do".
"Yes, totally safe".

A child said to us:
"Yes, I feel safe".

All staff that we spoke with demonstrated a good understanding of safeguarding children from abuse. They were able to describe different types of abuse and explain the procedures for escalating any concerns appropriately. Staff told us that issues about how to keep the child safe were discussed at shift handovers. Some staff were able to cite specific examples of when they had previously had concerns about children and how they reported this.

Patient records reflected an escalation of safeguarding issues, however in one case it was unclear from a child’s records as to the outcome of a previous child protection issue due to the notes being incomplete. We informed the trust of this issue who explained that the child was no longer at risk and the case had been closed and they arranged for the notes to be updated.

The trust had dedicated child protection policies and procedures in place which were due for review in 2013. Staff told us they were sent email updates if amendments were made to the policies. There was also a dedicated safeguarding team within the hospital who provide support on safeguarding issues. Child protection link nurses were in place on most of the wards we visited and staff were aware of their roles. Staff told us that they have good links with social workers around safeguarding.

The trust had a clear training requirement in safeguarding for all staff. Figures provided by the trust showed that 89% of staff had received a minimum of level one safeguarding training in the last three years which is above the national requirement of 80%. Safeguarding training level one was covered at the mandatory trust induction and was also provided as an online e-training session. This training is refreshed every two years. Level two and three were available in an e-learning package. This is in addition to interactive
face to face opportunities for staff receiving level three training. All the nursing staff that we spoke with told us they were up to date with their level two safeguarding training and many had undertaken level three. Medical staff were trained to a minimum of level three, which incorporates training on the Mental Capacity Act. Staff told us that they found the training accessible and useful for protecting children.

We looked to see what information was available in the wards about safeguarding. The provider may wish to note that although staff were clear about safeguarding procedures there was a lack of written information available in ward areas about safeguarding procedures for visitors, families and children who may also wish to raise concerns.
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 the appropriate operation of systems to assess the risk of and to prevent, detect and control the spread of health care associated infections had been followed.

Reasons for our judgement

Children were cared for in a clean, hygienic environment. During our visit all the areas we saw were clean. We also observed that cleaning was taking place regularly. Staff told us that they thought they worked in a clean environment.

Children and parents we spoke with across most of the ward areas thought the hospital provided a clean environment. Comments included:
"The ward has always been clean".
"Staff are always washing or gelling their hands before they see you".
"I see them clean my son's room twice a day".
"Staff wear protective aprons and gloves".
"They do a proper scrub [of the bed area] between patients".
"The bedding is changed every day".

At the last inspection in July 2011 there was a minor concern about the process of labelling ward equipment that has been cleaned to ensure staff knew when this had taken place. We observed on this visit that a green stick-on label system had been introduced which identified when the item had been cleaned. The system was being used on all the wards we visited. Nursing staff told us that they cleaned equipment after use and the labelling system worked well.

There were clear roles and responsibilities identified for nursing staff, housekeepers and domestic staff with a daily cleaning checklist being used. We observed forms showing that rooms were being cleaned on a systematic basis displayed outside the room. Each ward we visited had at least one dedicated domestic staff on duty. We were told that there is good access to out of hours cleaning services and deep cleaning, although we were told that there were sometimes delays getting access to cleaning staff on weekends.

We observed that staff were all bare below the elbow and were wearing clean uniforms with appropriate personal protective equipment such as disposable aprons and gloves. Hand gel dispensers were being used and were replenished. We observed signage about hand-washing and being bare below the elbow displayed on the majority of the ward areas. Nursing staff told us that there was always sufficient disposable equipment and cleaning materials available.
We were told by staff that when a child was identified as being infectious that they would be put into a side room. The trust's infection control team would also be informed. Children with loose stools would also be automatically isolated. The trust had a screening programme in place for MRSA (Meticillin-Resistant Staphylococcus Aureus).

The trust has a dedicated infection control team and infection control link nurses assigned to each ward. Infection control meetings are held at board and ward level to discuss adherence with trust infection control targets. The infection control link nurses conduct infection control audits at ward level, such as ongoing hand hygiene audits. Results from these audits were displayed in some ward areas and showed good results, for example 90% adherence on the respiratory ward (Badger). Infection control link nurses also provided training at ward level on managing infection control. Staff told us that these nurses were very proactive and provided useful updates and ad-hoc training. There was also mandatory training in infection control delivered as part of the trust induction with annual refresher training available.

Infection rates for MSSA were within the trust's own targets between April 2012 and the date of the visit. An infection control action plan had been introduced at board level to ensure that the trust reduces rates of infection for 2012/13. Incidences of MRSA and Clostridium Difficile were on target for the trust for quarter one of 2012/13.

The trust had a target and action plan for 2012/13 to reduce central venous catheter (CVC) line infection days by 50 per cent. Infection control link nurses told us that they are undertaking audits of CVC lines. Nursing staff said they were using parafilm on all lines to reduce infection risk.
Management of medicines  

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

One family we spoke with said that they were happy with the way their medicines were managed. Medical and nursing staff were training them on how to administer daily injections to their child. They told us that medicines were always given on time and that they were given information on the medicines and the medical condition.

We observed medicines given to outpatients and saw that advice and information on the medicine was given to patients. Other general information was relayed on a monitor in the waiting area and there were leaflets on safe administration of medicines for people to take home with them.

Pharmacy services to the wards covered checking medicine prescriptions for accuracy, a supply function, and medicines advice and manufacturing services. There was a 24 hour on call service for an out of hours pharmacist who resides at the hospital.

All staff we spoke with said that they had a good service from pharmacy. Pharmacists were involved in programmes to reduce the risk of medicine errors from prescribing to administration and we saw the action taken when an error was identified. We were told about the 'Risk Action Group' which met monthly and the investments being made by the trust in new technology and software and new staff such as prescribing pharmacists and nurse educators. The trust was striving towards a zero tolerance to medicine errors as part of their quality account.

The hospital had done an audit on the security of medicines earlier in 2012 and was addressing concerns identified by developing smarter systems and informing staff about the importance of secure storage. They were due to audit the secure storage in a newly commissioned building before the end of the year and re-address some of the areas of concerns in other wards. We looked at storage in two wards and saw in one that all medicines were securely locked but in the other the medicines cupboard door was open in the locked clinical room.

We heard from ward staff and the pharmacy department how medicines were safely verified when people were admitted to the hospital. We also saw the way that medicines were prepared ready for discharge. We saw the discharge planning check list which included medicines and saw the new electronic tracking system in use so that nurses knew when they would be ready.
We were told that most people were not able to manage their own medicines but on two wards POD (patient own drugs) lockers were in use as these people were 'frequent fliers' and they and their carers and the staff were familiar with their medicines and their safe handling and administration.

Medicines were prescribed and given to people appropriately. We saw from the electronic records, prescription charts and medicine protocols that people's medicines were prescribed, checked and administered as intended by the prescriber.
Supporting workers

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

Met this standard

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

The majority of the staff we spoke with said they felt supported within their teams and by their manager. Some comments included:
"We work as a team and I feel well supported".
"I feel really lucky to be on such a nice ward and to have had such good support. It is brilliant and supportive and we work well as a team".
"I take pride in my work. It is a great place to work".

The results for the NHS Staff Survey dated December 2011 showed that staff at Great Ormond Street Hospital felt the support they received from their immediate manager was in line with the national average, however the number of staff who felt valued by their work colleagues exceeded the national average.

When we spoke to staff about morale it was mostly positive. Some staff told us that morale was "mixed" and other said it was much better that it had been previously due to management and staff changes. We asked staff in the Radiology department about morale and they felt that it had recently improved significantly. We observed that staff appeared very motivated. The results for the NHS Staff Survey dated December 2011 showed that overall staff engagement in their work was in line with the national average.

The results for the NHS Staff Survey dated December 2011 showed that the numbers of staff experiencing harassment, bullying or abuse from other staff in last 12 months was above the national average, especially those working in management roles. The trust put an action plan in place to address concerns from the survey. We spoke with staff about bullying and some said that this had been a historical problem and no members of staff told us they felt bullied at the time of our visit. Staff knew about counselling services available in the hospital through 'Care First' and were familiar with whistle blowing procedures if they wanted to raise any concerns.

At the time of our visit the trust staff turnover rate was 15.75% for all staff and 14.04% for nursing staff. When we spoke with ward managers about staff retention they said that although staff enjoyed their roles it was sometimes hard to keep nursing staff due to the specialisation that is required at the hospital which can sometimes restrict their general skill set. The trust had been actively trying to retain staff through a number of schemes including a nurse rotation programme to develop staff with a broader range of skills. The retention of nursing staff who had undertaken the programme was higher at 90%.
We noted that on a number of wards we visited that beds were deliberately being kept empty. When we asked the trust why this was happening we were informed that where patient dependency is particularly high or staffing is short (for example due to staff sickness), then beds are closed on a short term basis to maintain quality of care. We asked the trust about the steps they were taking to recruit nursing staff and they explained that there were a number of work programmes under way to recruit and retain nursing staff including holding two large recruitment fairs every June and December, reviewing the contracts for the agencies operating the nurse bank system, using external agencies to recruit, reviewing skill mix and recruiting from overseas with guaranteed accommodation for 12 months for every new starter.

An induction course was available for all staff joining the trust and all the staff we spoke to confirmed they had attended this training. After attending the induction there was a ward based preceptorship programme in place for nursing staff where staff are initially supernumerary for two weeks and shadow another qualified nurse. All new staff we spoke to had an individual preceptor to support them with their ongoing learning and personal competencies.

Ongoing supervision was taking place for nursing staff, mostly on an informal basis through team meetings, multi-disciplinary meetings and informal meetings with managers by request. Clinical supervision was available on an ongoing basis through ward based clinical support nurses and practice educator leads who looked at how staff can be developed in their role based upon their skills and interests.

The trust quality account showed that Personal Development Records (PDR) completeness was significantly below target and rated 'red' by the trust for quarter one 2012/13. The trust was not on course to meet its target by year end. The trust recognised this as an issue and put an action plan in place to achieve completion rates. At the time of our visit all the staff we spoke with said they were appraised yearly in line with their PDR and that there were many opportunities for staff development. Ward managers were able to explain the 'pyramid' appraisal system and nursing staff were able to show us their PDR documentation. Staff were able to obtain further relevant qualifications. One staff member said "They have made a point of maintaining staff education and are still growing their own staff".

We spoke with a consultant who explained that there was an induction programme in place for medical staff. This included a mentorship programme. Supervision took place through MDT meetings and there was an annual appraisal. Training was delivered in line with Continuing Professional Development (CPD).

Staff told us that there was training available and it was useful for them to carry out their roles. Some comments included:

"I have done lots of training – some online and others internal and external"
"I feel very well trained and they will look at specific training for you if you want"
"There are good staff training days".
Complaints

People should have their complaints listened to and acted on properly

Met this standard

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

People were made aware of the complaints system. This was provided in a format that met their needs. All of the parents we asked knew how to make a complaint if they needed to. Some comments included:

"Any issues I have raised have been sorted out immediately".
"I would find out how to complain if I needed to".
"We know who all the staff are and would know to go to the key worker if we had any problems. I know about PALS".
"They have been so good – I have not made a complaint".

We spoke with ward managers and senior nursing staff about the complaints procedure. They told us that initially they would try to resolve any issues at the time with children and parents but would direct them to the hospital based Patient Liaison and Advice Service (PALS) if needed. More serious complaints were investigated by the governance team.

We observed comments boxes in each area that we visited where people could anonymously submit their concerns. We were told these were regularly reviewed by managers.

Information about how to make a complaint was in each ward welcome pack. There is also information about making a complaint on the trust website. We observed PALS leaflets on some of the ward areas. All of the parents we spoke with knew about PALS and what it was for.

Some staff were able to tell us about specific example where changes had been made based on complaints. One example was a lack of support provided for staff and other parents after the death of a child on the ward. They are now developing a debrief system for staff and parents as a result.

We visited the PALS office and spoke with the team. They dealt with over 1000 cases per year. We were told that about half the people they see are referred by staff but they have an open door policy. They were involved in the trust induction programme to inform all staff who they were and provided them with training in conflict resolution.

The trust had a traffic light system for concerns which rated them by priority in order to manage them most effectively:
Red: These concerns are identified by the PALS team as high risk.
Amber: These cases take longer to resolve, are often complex and may involve differing expectations or perceptions of service
Green: These are routine PALS cases which are dealt with in liaison with other staff, within 24 hours or to a timetable agreed with the enquirer. These were around 70% of their workload.

PALS submitted a report to the Quality and Safety Committee discussing key themes.

We asked for and received a summary of complaints people had made and the providers' response. People’s complaints were fully investigated and resolved, where possible, to their satisfaction. The team told us that thought they were well resourced and told us that they were focussed on empowering children and their families.
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>Regulated activity</th>
<th>Description</th>
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<tbody>
<tr>
<td>Respecting and involving people who use services - Outcome 1 (Regulation 17)</td>
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<tr>
<td>Consent to care and treatment - Outcome 2 (Regulation 18)</td>
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<td>Care and welfare of people who use services - Outcome 4 (Regulation 9)</td>
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<td>Meeting Nutritional Needs - Outcome 5 (Regulation 14)</td>
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<td>Cooperating with other providers - Outcome 6 (Regulation 24)</td>
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<td>Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)</td>
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<td>Cleanliness and infection control - Outcome 8 (Regulation 12)</td>
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<td>Management of medicines - Outcome 9 (Regulation 13)</td>
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<tr>
<td>Safety and suitability of premises - Outcome 10 (Regulation 15)</td>
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<tr>
<td>Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)</td>
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<tr>
<td>Requirements relating to workers - Outcome 12 (Regulation 21)</td>
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<td>Staffing - Outcome 13 (Regulation 22)</td>
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<tr>
<td>Supporting Staff - Outcome 14 (Regulation 23)</td>
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<tr>
<td>Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)</td>
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<tr>
<td>Complaints - Outcome 17 (Regulation 19)</td>
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<tr>
<td>Records - Outcome 21 (Regulation 20)</td>
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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.
### Contact us

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<tr>
<th>Phone:</th>
<th>03000 616161</th>
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<tbody>
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<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
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