Inspection Report

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

John Radcliffe Hospital

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Tel: 01865741166

Date of Inspections: 27 February 2013
26 February 2013

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

Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Staffing	✓ Met this standard
Supporting workers	✓ Met this standard

Details about this location

Registered Provider	Oxford University Hospitals NHS Trust
Overview of the service	The John Radcliffe Hospital is the largest hospital in the Oxford University Hospitals NHS Trust. It provides acute medical and surgical services, trauma and intensive care. The John Radcliffe Hospital site includes the Children's Hospital, the Oxford Eye Hospital, the Oxford Heart Centre and the Women's Centre. It is Oxfordshire's main accident and emergency site.
Type of services	Acute services with overnight beds Community healthcare service
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Nursing care Personal care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

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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 26 February 2013 and 27 February 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.

What people told us and what we found

At this inspection we reviewed the care and treatment provided from one surgical and one medical ward in the main hospital block and inspected the Women's Centre. We spoke with 29 inpatients, five relatives and 38 staff, including doctors, nurses, midwives and managers. We also observed the care provided to other patients throughout the two days of our inspection.

Patients were complimentary about the care they received. Patients said "The nurses here are brilliant and the cleaners are all very friendly "; "The doctors are very good here" and "Absolutely wonderful midwives and anaesthetists". We were also told "There is a culture of politeness and making sure everyone is looked after here".

In all areas inspected, patients told us the environment was very clean. One patient said "The cleanliness is excellent" and another person said "It's all neat and hygienic. I see all the staff wash their hands and use hand gel before they examine me".

The majority of patients thought there were enough staff to meet their needs. We were told "Yes, there are enough staff on duty but occasionally they're extremely busy" and "I would say there are enough staff, I've never had to wait for the bell to be answered".

We found staff received relevant training and professional development to enable them to provide safe care to an appropriate standard. The trust selected new staff using value based interview criteria, such as testing for compassion.

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

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

Patients were complimentary about the staff and felt they were caring and attentive. Patients said "The nurses here are brilliant and the cleaners are all very friendly "; "The doctors are very good here" and "Absolutely wonderful midwives and anaesthetists". We were also told "There is a culture of politeness and making sure everyone is looked after here" and "The staff are there for you, even if you just need a chat".

Patients told us staff kept them fully informed about their care and treatment. They said "The care is excellent. They explain everything" and "The staff always introduce themselves. They explain what the instruments and equipment do and explain what they are doing". Our observations of the care provided by staff supported what patients had told us.

The wards had introduced an 'intentional rounding' system. This meant a member of staff visited every patient on the ward at set intervals to check on patients' welfare. The aim was to do this on an hourly basis although this was not always possible. We saw records by each bed confirming when 'rounding' checks had been carried out. The records were updated and signed by the member of staff carrying out the round. One ward sister said "Since the introduction of rounding, the frequency of patient call buzzers has reduced and patients say they feel more secure". Patients also told us that staff generally attended quickly if they pressed their call bell. A typical comment was "Staff come quickly, I very seldom hang on".

Most patients were happy with the quality and choice of hospital food. One patient said "The food is very good, there's a good selection and plenty of it. My only comment would be that it could be hotter". Another person said "It's not bad considering I'm a vegetarian. There is always a vegetarian option available".

We observed serving of the lunchtime meals on the wards. There were signs saying it was protected mealtime, this meant visiting was discouraged and no ward rounds took place during this time. All ward staff assisted with serving the meals. We observed staff taking

time to assist those patients who needed help with eating their meals. The meal time was calm and unhurried and assistance was provided in a caring and patient way. We saw that food was always placed within easy reach of the patients and they were able to eat at their own pace. The ward housekeeper told us they checked that people had eaten their meal and followed this up if meals were returned uneaten.

Women and their partners told us they were generally very happy with the care and treatment provided in the Women's Centre. They felt they were thoroughly supported by the midwives on a one to one basis throughout their labour. But some people told us they experienced communication problems. One new mother said "My baby had to go to the high dependency unit. Nobody came to talk to me to tell me what was happening. I think communication between the ward staff and the baby unit could be better".

We looked at a sample of patient records on each ward visited. Records contained detailed clinical assessments, medication sheets, observation charts and various risk assessments, such as risk of falls and pressure sores. We saw the daily care notes were completed by a range of healthcare professionals including medical, nursing and therapy staff. All entries recorded the time and date and were signed by the person providing the care or treatment. Staff told us they rarely experienced problems with missing notes.

On one of the main hospital wards we looked specifically at discharge planning records. All of the records contained a two page discharge planning assessment form which was meant to be started on admission. However, the first three forms we looked at were either not completed or contained minimal detail. We were then shown a fourth record which contained a fully completed discharge planning form. We discussed this with senior nursing staff who said planning for discharge on admission was fairly new to the hospital. They said they were disappointed with our findings as they would have expected at least 75% of records to contain an estimated time of discharge. They said they knew this was an area for improvement and they were working on this.

Patients spoken with had varying degrees of information about their discharge arrangements. Some patients said they had been fully informed. Others told us they were not clear about their discharge plan and said they were waiting for further tests or for the doctors to do their rounds. We asked senior nursing staff about discharges during unsociable hours. We were told that patient safety was paramount and patients were only discharged when they were medically fit. They also said they did their best to avoid moving patients within the hospital after 8pm.

The hospital held two bed management meetings each day, one in the morning and one in the afternoon. Meetings were attended by senior nursing and management staff. We saw the systems used to ensure optimum utilisation of available beds and staff. We were informed that the hospital had experienced extremely high emergency admissions for several months and had opened all of its escalation beds.

We looked at the trust's overall mortality rates for all services. These were within the expected range compared with similar trusts. However, 2011-2012 data showed mortality rates at weekends were higher than expected. We discussed this with the trust's medical director. He said there were questions about the data such as the way certain conditions, like palliative care with co-morbidities, had been recorded and coded. However, mortality reduction was one of the trust's strategic goals including plans to reduce avoidable mortality. We looked at the monthly Dr Foster reports which showed a reducing trend in the overall mortality rates for 2012-2013, with no significant difference between weekday

and weekend rates.

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

In all of the areas inspected, patients told us the environment was very clean and they said they saw staff regularly performing cleaning tasks. One patient said "The cleanliness is excellent. First thing in the morning it's all so sparkly" another patient said "When I'm not sat in my chair they move things out of the way so they can clean underneath".

People told us they saw all grades of staff washing their hands, using hand cleaning gel, protective gloves and aprons. One woman said "It's all neat and hygienic. I see all the staff wash their hands and use hand gel before they examine me" and another woman said "I saw how they carefully opened the sterile packs they used. I saw them clean the area, prepare things and clean them away".

We observed the environment throughout the hospital looked clean and free from clutter. We saw infection control posters and other information alerting staff and visitors to good hand cleaning practices. There were illustrations of correct hand washing techniques next to all soap dispensers. We saw staff frequently used hand cleaning gel, washed their hands and used disposable protective aprons and gloves.

We found the hospital had effective systems in place to reduce the risk and spread of infection. Staff in all areas inspected told us they received good infection control training when they first started and then had annual refresher training. Staff told us, and we observed there were sufficient supplies of hand gel, soap dispensers and disposable personal protective clothing for staff use. Hand gel dispensers were available at each bedside and staff also had their own individual gel dispensers clipped to their uniforms. We were told that hand hygiene audits were carried out in all patient care areas on a weekly basis and the results were monitored at monthly clinical governance meetings.

Staff told us that inpatients were screened before being admitted to the hospital and any history of infection was investigated. While in hospital, if an infection was suspected the patient was moved to an individual side room to isolate the risk and provide appropriate treatment.

We were told that all ward staff were responsible for ensuring it was clean and tidy. The

cleaner was considered an integral part of the ward team although they were employed by an outside contractor. In addition to individual ward cleaners there were rapid response teams for cleaning vacated areas once patients were discharged. During our inspection we observed beds and surrounding areas being stripped back and cleaned after patients had been discharged.

We spoke with the trust's infection control manager. They were responsible for overseeing the trust's infection control activities and for implementing the annual infection control programme. They liaised closely with the trust's medical director who was also the nominated director for infection prevention and control. We looked at the trust's overarching Infection Control Policy which made it clear that all clinical and non-clinical staff were required to adhere to infection prevention and control policies and procedures.

We looked at some of the detailed guidelines for staff on the appropriate management of specific infections, such as clostridium difficile. We were told that the infection control team carried out routine sampling of patient specimens to detect and treat suspected cases. These processes had enabled the hospital to reduce the incidence of healthcare associated infections.

The infection control manager described the trust's comprehensive programme for continuous weekly and monthly cleaning and hygiene audits. They delivered annual mandatory training in infection control to all staff. Training was split into both clinical and non-clinical staff programmes. Staff completed a workbook, e-learning modules and attended annual presentations by the infection control team. This included practical demonstrations and a competency assessment at the end of the training.

Staff told us the infection control manager visited all clinical areas to carry out monthly cleanliness and hygiene audits. If a problem was identified a re-audit took place within a week. We looked at the most recent monthly audit for one of the wards. The provider may find it useful to note that although staff were able to explain the action taken to address a low antimicrobial audit score, they could not show us a written record to confirm this had been completed. This meant there was a gap in the audit trail.

Staff told us that the nurses and midwives were responsible for cleaning bodily fluids and clinical equipment and cleaning staff were responsible for all general cleaning. One midwife said "We have mandatory training on infection control when we start and then annual refresher training. The cleaners do a good job and it's been clearly defined what the midwives should clean and what the cleaning staff do".

A cleaner said "I feel part of the team. The housekeeper supports me and I can always ask if I do not know how to do something. I got a lot of training when I started here. I've had refresher training in infection control, how to clean the toilets properly and the right cleaning equipment to use". A doctor said "I'm astounded at how many cleaners there are. The cleaning has been outsourced but it seems to work well, they clean to a good standard".

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

The majority of patients told us they thought there were enough staff to meet their needs. We were told "Yes, there are enough staff on duty but occasionally they're extremely busy"; "I think there's enough staff. I hear their voices and I see lots of staff" and "I would say there are enough staff, I've never had to wait for the bell to be answered". But we also received some adverse comments such as "Sometimes they are run off their feet, especially when there are lots of bed changes or new admissions". In the Women's Centre one person said "Sometimes the staff seem stressed so they come across as rude. They say I need to wait but they haven't got time to explain why".

The majority of staff spoken with said there were usually sufficient staff to carry out their duties. A matron said they always planned to have the optimum number of staff on duty but would then lend staff to other wards if the need arose and they had capacity. Staff on one ward said they would be given an extra staff member if they admitted a patient with very complex needs. Staff on another ward said staffing was not increased to meet changing needs. Midwives told us they were able to provide women with good one to one support when in established labour. We were told there was an emergency bleep holder who could always be contacted if there were staffing problems.

However, some midwives felt stretched. One midwife said "The workload is only manageable because we don't take our breaks. We have nearly no vacancies but the birth rate is continuing to rise so the workload is still increasing". Another midwife said "There are probably a couple of shifts a month when it feels unsafe because there aren't enough staff". A consultant said "There are adequate numbers of doctors. There does seem to be a high turnover of midwives, though". A specialist registrar told us "Staffing levels are stretched. I've not seen anything that compromises care but that's because it's people's good will that gets us by. The consultants always come in from home at short notice if you need help".

We spoke with midwives and two registrars from the maternity theatres. We were told they now had one dedicated theatre team which was staffed 24/7. A second maternity theatre was used on average once a week for emergencies with the theatre team assembled from elsewhere in the hospital when needed. There was now a dedicated anaesthetic nurse but approximately half of all sessions lacked a dedicated scrub nurse. In these cases the midwives had to cover as scrub nurses but some felt they were not sufficiently trained or

experienced for this role. We discussed this with senior management who said recruitment had improved but there was a national shortage of experienced scrub nurses.

We received mixed messages about weekend cover from staff. Some said staffing levels were the same and others said it was lower at weekends. However, the majority of staff did not feel this was a problem as they said the flow of patients slowed at weekends. A divisional nurse told us "The nursing rotas are exactly the same as during the week although there may be a different duty sister. We are moving toward seven day working". The medical director said overall medical staffing was about the same at weekends. Four additional emergency department (ED) consultants were being appointed which would then ensure that an ED consultant was on duty for the majority of the time.

From our observations on the day of inspection there were sufficient staff to look after patients needs and patients did not have to wait long for assistance. Staff were observed talking to and reassuring people as well as providing clinical care and treatment. We saw the systems used by the hospital for reviewing staffing levels took into consideration dependency of patients as well as overall numbers. The staffing on each ward was reviewed twice daily at the hospital bed management meetings. Where staffing shortages were identified staff were transferred from other wards and/or bank or agency staff were brought in.

Overall we found there were enough qualified, skilled and experienced staff to meet people's needs. We were told that, at times, staff were very stretched but still managed to complete their essential duties. We observed and were told there was good multi-disciplinary team working and staff in the hospital displayed a lot of good will. When we inspected, it was a pressured time for the hospital in general. We found the management and staff were working hard to respond to the rise in admissions and to meet the health and welfare needs of patients.

Supporting workers ✓ Met this standard

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

All staff had to complete trust wide mandatory training modules in subjects such as health and safety, infection prevention and control, and fire prevention. In addition, there were specific training programmes tailored to the needs of different staff groups. Much of the training was through e-learning modules incorporating questions to test staff learning and understanding. Staff also attended group training workshops and received practical demonstrations and assessment of their competencies in subjects such as manual handling, resuscitation and life support.

We were told the trust selected new staff using value based interview criteria, such as testing for compassion. This approach was based on the premise that as long as staff had the right value base their technical skills and competencies could be further enhanced through training and development.

Staff told us they received regular mandatory training and were encouraged to take additional training to further their personal development. Staff said they were able, from time to time, to obtain further relevant qualifications and they received appropriate professional development. All staff spoken with said they received corporate and local induction programmes and annual performance and development appraisals. We looked at training and development records and these substantiated what we had been told.

Staff said they were well supported by colleagues and other more experienced staff. However, when asked if they received formal supervision we received a range of responses. Some staff told us they had ongoing one to one supervision sessions but others said they did not receive regular supervision. It was a statutory requirement for midwives to have formal one to one supervision on an annual basis and midwives confirmed this was happening.

All staff spoken with said they received informal on the job supervision from senior staff. This often took place during shift hand-over or at group supervision sessions to discuss particular cases. Staff said they felt they could always look to their more senior or experienced colleagues for support and advice.

Nursing staff told us the trust had recently introduced a system of formal supervision for

new nurses. New nurses had an initial induction programme and then attended formal appraisal meetings after three, six and 12 months in post. These meetings were minuted and the focus was on the individual's development. More experienced nursing staff told us there used to be formal supervision meetings for all nurses but these had slipped due to the pressure on staffing the wards. They said they were aware that a new trust wide policy for professional supervision was being looked at.

We discussed clinical supervision with the trust's executive directors. They said they knew there were different local arrangements in place and that more uniformity was needed. The chief nurse said the executive team was currently reviewing a new trust wide clinical supervision policy. Once the draft was signed off at executive level it would be circulated for formal consultation to the various professional groups and the education committees.

The chief nurse said clinical competency assessments had already been updated for all grades of nurses and work had started on the therapies and scientific staff. The new competencies included value based staff behaviours. She informed us of other corporate initiatives such as mentoring, nurse preceptorship training for newly qualified staff and ward leadership programmes for more experienced nurses.

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:

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

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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