Inspection Report

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

Barnet Hospital

Wellhouse Lane, Barnet, EN5 3DJ

Tel: 08451114000

Date of Inspections: 30 January 2014
28 January 2014
27 January 2014

Date of Publication: February 2014

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
Meeting nutritional needs	✓ Met this standard
Management of medicines	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Complaints	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Barnet and Chase Farm Hospitals NHS Trust
Overview of the service	Barnet Hospital provides acute health services and specialist treatments and therapies to more than 500,000 people living in Barnet, Enfield, Haringey, East Harrow, South Hertfordshire, South Essex and Waltham Forest. It is a modern acute hospital with more than 450 beds.
Type of services	Acute services with overnight beds Community healthcare service Domiciliary care service Dental service Diagnostic and/or screening service Long term conditions services Rehabilitation services Urgent care services
Regulated activities	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'.

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 27 January 2014, 28 January 2014 and 30 January 2014, 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 given to us by the provider. We were accompanied by a pharmacist, talked with local groups of people in the community or voluntary sector, were accompanied by a specialist advisor and used information from local Healthwatch to inform our inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

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

We carried out inspections of the hospital over a three day period and were accompanied by three specialist advisors, a pharmacist inspector and a team of ten inspectors. We visited the accident and emergency department (A&E), the Acute Assessment Unit, four in-patient wards (Beech, Larch, Walnut and Olive) and the operating theatre suite. We inspected an additional four wards, Clinical Decisions Unit (CDU), Galaxy, Rowan, and Palm, and outpatients in respect of the arrangements in place for medicines management. We spoke separately with the Head of Patient Engagement and staff from the Patient Advice and Liaison Service (PALS) about complaints management in the trust.

At our last inspection of the hospital in May 2013 we had found that the very long delays experienced by a significant number of patients in A&E meant that the planning and delivery of care and treatment did not always meet their needs and ensure their welfare and safety. During the current inspection on 27 January 2014 we found that significant improvement had been made. Although a few patients had spent long periods in the department action was being taken to mitigate the risks to their health and well-being and ensure their stay was as comfortable as possible.

During the inspection we spoke with more than 60 patients and relatives about their

experiences of care and treatment in the hospital. The majority of patients and relatives were pleased with the standards of care provided. For example, a patient on Beech ward told us that from the moment they had come arrived at A&E they had been "entirely satisfied and impressed" by the care and treatment they had received. Staff on the wards were said to have "gone out of their way to be helpful and considerate." Physiotherapists were described as "very good, they know how to speak to people" and "really excellent." A patient who had just undergone a surgical procedure told us, "I left very reassured as they (staff) made sure I knew what was happening and who was who." Parents of children we spoke with in paediatric A&E were very positive about their experience describing staff as "fabulous" and having the "patience of saints."

Patients had mixed views about the quality of meals provided on the in-patient wards but the majority were positive. For example, one patient told us "the food is really very good; there is a good menu choice." Another patient said, "the menu is fantastic, I'm amazed at the amount of choice, including healthy options." A few patients considered the meals were "just OK" or not to their liking.

The trust was well-led and responsive to people's needs. Systems were in place to assess and monitor the quality of service that patients received and ensure care was provided safely and effectively. Systems in place for managing complaints about care and treatment were improving. Action plans were in place to address a backlog of complaints and the quality of responses to complaints had improved. Medicines were managed appropriately. They were stored securely and patients received the medicines they needed at the right time.

However, we identified some shortfalls in record keeping in different areas of the hospital. Some of these related to incomplete records of checks of key equipment used in the care and treatment of patients. In addition, some patient records were not accurately maintained in respect of checks carried out during and after surgery to ensure surgical procedures were conducted safely.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 13 March 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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.

Care and treatment was planned and delivered in a way that was intended to ensure patient's safety and welfare.

Reasons for our judgement

At our last inspection of the hospital in May 2013 we had found that the very long delays experienced by a significant number of patients in A&E meant that the planning and delivery of care and treatment did not always meet their needs and ensure their welfare and safety. During the current inspection on 27 January 2014 we found that significant improvement had been made.

We spoke with patients and relatives in all areas of the hospital we visited. This included A&E, several in-patient wards and the operating theatre suite. Most patients were happy with the care and treatment they had received. For example, a patient on Beech ward told us that from the moment they had come arrived at A&E they had been "entirely satisfied and impressed" by the care and treatment they had received. Another patient said their experience in the hospital had been "generally positive", particularly in A&E, where they were seen "very promptly and professionally."

We spoke with more than 30 patients and relatives in A&E. Everyone told us they had received an initial assessment from a nurse or doctor soon after arriving in the department. The A&E was very busy during our visit and several people said they had waited a long time to be seen. However, they were all complimentary about the treatment they had received and the way they had been cared for and treated by staff. For example, one patient said, "the doctor was very good and helpful." A relative told us "the triage nurse was very good and understood what was going on." Another patient said staff had been "helpful and communicative," and that "sufficient information" had been provided. Several patients told us they had been given pain relief in A&E which they told us had helped considerably. Parents of children we spoke with in the children's waiting room in A&E were very positive about their experience describing staff as "fabulous" and having the "patience of saints."

Most patients on the wards told us that staff responded to call bells "within a few minutes" and "fairly quickly" and had observed other patients being attended to "promptly." A few

patients were less positive. For example, one patient said they had had to wait a long time for their water jug to be refilled and for IV medication to be administered.

Staff on the wards were said to have "gone out of their way to be helpful and considerate." Physiotherapists were described as "very good, they know how to speak to people," "very friendly" and "really excellent." Nurses were described as "all very gentle and endlessly patient" when caring for a patient with dementia. A patient on Olive ward described staff as "very attentive."

A patient told us their treatment in the theatre suite "could not have been any better", and described staff as "knowledgeable and helpful." Day surgery patients said that post-operative instructions, for example, administering eye drops, were explained clearly before they left the department. Patients knew who to contact if they had any concerns after their discharge.

Patients told us they had received clear explanations of their care and treatment from staff. For example, a patient said their treatment had been "fully explained to me every step of the way." Another patient told us their treatment had been explained "perfectly" and they had been given a leaflet to take away that explained the procedure they had undergone. A patient in A&E said, "the doctors have answered my questions really well." Several patients said that medicines prescribed for them had been explained well and included discussion of possible side-effects. However, one patient told us they had not been happy with standards of communication on the Clinical Decisions Unit (CDU) and said, "sometimes patients are left in the dark and don't understand what is happening. From a patient's point of view, this increases anxiety – explanations can make a great deal of difference to wellbeing."

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual care plan. On the wards patients' needs were assessed on admission. We saw from the patient healthcare records we reviewed that risk assessments were carried out in a number of key areas including falls, skin integrity and malnutrition. Risk assessments were reviewed weekly or sooner if a change occurred in the patient's condition. On Beech we found that some needs had not been identified through the assessment process and consequently there were no care plans in place to address all their needs. For example, we found that for one patient whose foot was heavily bandaged and who used a walking aid, there was no record of a moving and handling assessment and no up to date falls risk assessment in place.

Patients' nutritional needs were assessed on admission. We saw from records we reviewed that some patients had nutritional and fluid balance charts in place to monitor what they were eating and drinking and ensure their needs were met. However, although the majority of these were completed we did note a significant number of gaps in recording and the total volume of individual fluid intake and output in a 24 hour period was not always recorded. We saw staff encouraging patients to drink sufficient fluids.

We saw many positive, caring and compassionate interactions between staff and patients in all clinical areas. We saw that patients were given time to do things for themselves and were not rushed. Staff were proactive in approaching patients to check whether they needed anything and responded promptly to requests for assistance. Staff were gentle in their approach and sensitive to the needs of patients with dementia. We saw staff attend to patients' needs for pain relief promptly and explain how long it would take to provide relief.

Larch ward had introduced evidence-based approaches to meeting the needs of patients with dementia. For example, we saw there was a brightly coloured table and chairs near the nurses station which had a number of everyday items for patients to use when they wished, including playing cards, magazines, books, purse and handbag. Staff explained that the bright colour of the table attracted patients to it and it had been successful in providing a point of interest and activity to patients who had previously appeared lost and distressed on the ward. The ward was being further developed with each bay being painted a different colour to help orientate patients with memory impairment. Ward staff were enthusiastic about the changes.

On the day of our inspection we noted that a few patients had been in A&E since the night before and were waiting for beds to become available so that they could be admitted to a ward. Staff told us that for older patients who had to spend long periods in A&E the trust had purchased new trolleys with mattresses that provided support equivalent to that of a bed. The new trolleys and mattresses helped mitigate the risks of damage to patients' skin integrity and made them more comfortable. Assessments of skin integrity were carried out regularly in A&E and patients encouraged or assisted to change their position. Staff in A&E conducted regular checks on patients ('comfort rounds') to ensure their needs were being met.

Despite a large volume of patients attending A&E on the day of our inspection, the service was able to respond promptly to most patients arriving by ambulance. We spoke to two paramedics who had brought patients to the A&E. Both of them complimented the system in place for the transfer of patients to the healthcare staff in the department. One paramedic told us that the provider had a "better system" in comparison with other hospitals. The paramedics were generally satisfied with the handover process and one said there was "good rapport" between staff.

We observed a theatre team brief before the start of a surgical list in theatres. The running order of the list and any concerns were discussed. We saw the list order was changed due to one patient being diabetic and the anaesthetist considered it was in the patient's best interest to undergo surgery earlier in the day. Theatre staff told us there were five copies of the theatre list available around the hospital. If the list order changed we saw that staff contacted the ward to inform them of changes. This ensured all staff knew the patient and procedure to be carried out and reduced the risk of wrong patient/wrong site surgery.

Appropriate checks took place when the patient was collected from the ward by the porter and taken to the theatre suite. The handover of the patient from ward staff to theatre staff was safe. Checks included the patient's identity, date of birth and any allergies. Nurses reassured patients about the procedure they were about to undergo. One patient told us after the procedure, "I left very reassured as they made sure I knew what was happening and who was who."

Care was provided in line with patients and families religious and cultural beliefs. We saw that a range of culturally and religiously specific meals were available to patients. Where palliative care was being provided a junior doctor told us they discussed patients' wishes in respect of their care after death with them and their relatives so that arrangements would be in keeping with their cultural and religious beliefs. In A&E a relative of a patient who spoke little English told us that staff had made great efforts to communicate with them. The relative said, "it has been a good experience (for the patient), he told me the staff were very good and explained everything very easily in English he could understand."

There were arrangements in place to deal with foreseeable emergencies. All resuscitation trolleys that we checked were well stocked with functioning equipment for use in an emergency. The emergency drugs which we checked were all within the expiry date. Records of checks of resuscitation equipment in most clinical areas showed they were being completed on a daily basis, although we noted that in Walnut ward there were some gaps in the recording of checks of the resuscitation trolley in December 2013 and January 2014. All staff told us they received annual update training in adult life support and paediatric life support depending upon their area of work. Staff we spoke with confirmed that they knew how to respond to emergencies.

In the children's waiting room in paediatric A&E there were a large number of children waiting to be seen by a doctor. We saw that at one point the waiting room had run out of chairs and mothers holding children were forced to stand. In the main A&E waiting area we noted that the main entry doors opened frequently due to a high number of people entering the department. Patients and relatives told us that this made the room very cold one told us "it's absolutely freezing in here." We fed this back to trust senior managers who confirmed they would look into the matter.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

Patients were protected from the risks of inadequate nutrition and hydration.

Reasons for our judgement

Patients were protected from the risks of inadequate nutrition and dehydration. On admission to the wards all patients underwent a nutritional assessment to determine whether they were at risk of malnutrition and to identify their individual needs. The patient healthcare records we reviewed confirmed that nutritional risk assessments took place when the patient was admitted and re-assessed weekly or sooner if a patients' nutritional status changed.

We spoke with patients on four wards, Beech, Larch, Walnut and Olive, and asked them what they thought about the meals provided to them. There were mixed views on the quality of food but everyone told us they were provided with a choice of suitable meals. For example, one patient told us "the food is really very good; there is a good menu choice." Another patient said, "the menu is fantastic, I'm amazed at the amount of choice, including healthy options". The meal menus identified which meals were suitable for certain diets and which were 'healthy' meals. Several patients told us this helped them choose their meals. Other patients considered the meals were "just OK" or not to their liking. Several patients remarked that the meal they ordered was not always the meal provided. Meals were generally hot enough on arrival having been heated in the wards prior to serving. One patient told us the food was "piping hot."

Several patients told us they were disappointed that a tea trolley did not come round the wards between meals although staff told us that patients could ask for a drink or snack at any time. We fed this back to senior mangers in the trust who said they would check the arrangements in place.

Patients' food and drink met their religious and/or cultural needs. Staff understood the individual needs and requirements of patients. We saw that the food preferences of some patients were displayed at their bedside. We saw that patients' dietary requirements in terms of their religious needs were met. This included the provision of Kosher and Halal meals where requested. However, a relative of a patient receiving Kosher meals was disappointed that a sandwich option was not on the menu and said the meal chosen was "never the meal that actually comes."

Patients were supported to be able to eat and drink sufficient amounts to meet their needs. Staff told us that patients were assisted to eat their meals in line with their individual

needs. Records showed that patients were referred to a dietician when required and dietary supplements were provided.

We observed staff helping patients at the lunch time meal on Beech and Walnut wards. For example, staff helped patients to sit comfortably and asked whether patients preferred to sit out of bed, on a chair, to eat. Patients who required particular help with eating and drinking were provided with meals on red trays. We saw that patients with red trays received individual support. Staff were proactive in opening cartons and placing meals and drinks within easy reach, which ensured patients were able to take adequate nutrition and were hydrated. We saw that staff provided patients with alternative meals, such as a sandwich, if they changed their mind about what they wanted to eat.

Although the wards operated a 'protected meal time,' which meant that patient meals should not be interrupted by clinical activity, we saw this was not always followed. All meals were heated on the wards so that their delivery to patients could be timed to ensure the food was hot. However, we observed that the timing of the delivery coincided with a clinical examination or procedure on two occasions on Beech ward. On one occasion a clinician commenced an examination of a patient just as their meal arrived and on another a nurse took five minutes to adjust a patient's intravenous infusion whilst their meal was left on the patient's table.

Hot meals and drinks were available to patients in A&E during the day and snacks and drinks were available out of hours. This helped meet the needs of patients who spent longer periods of time in the department and make their wait more comfortable.

Management of medicines ✓ Met this standard

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.

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

Reasons for our judgement

During the inspection we looked at the arrangements in place for the management of medicines, medicines storage and the records relating to patients' medicines. We talked to pharmacy staff and nurses working on four wards, CDU, Galaxy, Rowan, and Palm as well as out-patients. In addition we checked the medicines storage arrangements and recording in A&E and on Walnut, Beech and Olive wards. We spoke with patients and visitors on these wards about medicines.

Appropriate arrangements were in place in relation to the recording of medicines. The prescriptions and records of administration that we looked at were clear and complete. Pharmacy staff visited the wards regularly and we saw evidence of medicines' reconciliation on admission and clinical interventions to ensure the records were accurate and safe.

Appropriate arrangements were in place in relation to obtaining medicines and medicines were available when patients needed them. We saw that medicines that were not held as stock were ordered for patients promptly, and arrangements were in place for the wards to obtain medicines outside of the opening hours of the pharmacy. On some wards medicines for discharge were arranged by pharmacy staff working on those wards, which meant that people could be discharged promptly. Other wards obtained discharge medicines through the main pharmacy and we were told on one ward that this could sometimes cause delays. The pharmacy checked waiting times regularly and had set targets to improve delays.

Medicines were prescribed and given to patients appropriately. We observed nurses administering medicines carefully, following a safe procedure. They took time to explain to patients what their medicines were. Patients told us that they received their medicines when they needed them and that they were given adequate pain relief. We saw that patients with inhalers kept them close by so that they could use them when needed. This was in line with the trust policy and patients we spoke with appreciated being able to access them easily.

Medicines were mostly kept safely, including controlled drugs. Regular stock checks and

audits were undertaken of the controlled drugs and the procedures surrounding their use by ward and pharmacy staff. The temperatures of refrigerated storage were regularly monitored on the all wards we visited and shown to be suitable, however the provider may find it useful to note that on Olive ward and CDU the records were incomplete. Emergency medicines were kept in each ward and department and we saw evidence that they were checked regularly and correctly maintained, so that they were suitable for use when needed.

We found that drugs were stored securely and not being left unattended on any of the wards we visited. However, in A&E we found a box of Proprofol, a powerful anaesthetic, on a work surface in the resuscitation area. While the patients receiving treatment were very unwell and unable to reach the box there were also relatives in the area. When we alerted staff to this they acted quickly to ensure this drug was locked away.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that patients received. Risks to the health, safety and welfare of patients and others were identified, assessed and managed effectively.

Reasons for our judgement

Most patients were positive about their care and treatment in all areas of the hospital we visited. For example, a patient described their experience as an in-patient as "care beyond what you would expect". Another patient told us, "the care was better than I expected" and said they had been "pleasantly surprised" by standards of care and treatment. A relative of a patient on Larch ward said, "staff have treated my relative as an individual, not as just another patient number."

Some other patients however, were less positive. For example, a patient told us "it's not a perfect service, more communication is the key, sometimes you feel you are just left" and another said "things have been generally ok but some fine tuning wouldn't hurt."

Patients, their representatives and staff were asked for their views about their care and treatment and they were acted upon. We reviewed reports of feedback from patients obtained via electronic trackers in some of the areas we visited. We asked to see patient feedback about the four wards we visited over the last three months. We were told that the results for Olive ward were not available as the patient experience tracker was not working properly. The results for Walnut, Beech and Larch wards showed that most patients were happy with their care and treatment and were 'likely' or 'extremely likely' to recommend the ward to family and friends. Responses from patients on Larch ward were consistently positive throughout the three month period. Beech ward showed the most improvement between October and December. We saw the results of patient feedback questionnaires were displayed on the wards and other clinical areas so that staff could see what was working well and where there were any shortfalls or suggestions for improvements. Actions were taken in response to feedback, aimed at bringing about improvements in care and treatment.

The hospital carried out a programme of audits as a way of monitoring the quality of care and treatment provided and the implementation of trust policies. For example, a nursing action plan had been put in place to address shortfalls in cleanliness in ITU following an environmental audit in January 2014. There was a named lead for implementation of the

plan and a re-audit was planned for February 2014 to assess whether the actions had brought about the necessary improvement. This showed that audits were being used effectively as a way of improving the quality of care and treatment provided to patients.

There were systems in place to assess and monitor the quality of cleaning and infection control in theatres. However, we noted these were not always being implemented as planned. For example, although we saw cleaning taking place in the operating theatre suite not all records of cleaning were up-to-date and some equipment that should have been labelled with the last date and time of cleaning were not labelled. We found six items of equipment which either had no labels or records showed they had not been cleaned for over a week. We discussed this with the theatre manager who said cleaning records needed to be reviewed and this would be added to the regular audit carried out in the department.

In addition, despite there being a large sign on the door leading into the theatre suite informing staff they needed to be 'bare below the elbow' we saw some medical staff ignoring this. When challenged by theatre staff, they were sometimes reluctant to comply with the policy and procedures. We fed back this back to the Director of Nursing who said they would address the issue with medical staff immediately.

Staff we spoke with told us they knew how to report incidents and the types of events, near misses and incidents they needed to report. Staff could describe how to report incidents and told us of examples of the dissemination of learning that occurred. We also saw evidence of safety alerts and recalls of medical equipment and devices managed safely. This meant that staff had the information they needed to manage risks associated with patient care.

Staff told us that incidents and learning from incidents were discussed in team meetings and other forums to ensure learning from these took place. Staff provided examples of changes made in response to learning from incidents, for example, staff in theatres explained changes that had been made following an investigation of a serious incident where an unsterile screw had been mistaken for a sterile screw. Measures had been implemented to prevent a reoccurrence including training for staff and clearer separation of sterile and unsterile items.

The Head of Patient Experience explained that complaints were analysed to identify themes. The themes identified were then shared with clinical directorates and the trust Board. Training was being provided to frontline staff in complaints handling and writing statements in an effort to improve complaints management in the trust.

An analysis of concerns raised with the Patient Advice and Liaison Service (PALS) had identified that many patients were confused by the content of letters relating to admissions. The standard letters advised people to contact the department within a certain timescale to confirm their admission. They were then unable to get through on the telephone which caused frustration and anxiety. The Director of Nursing told us that this matter was being addressed and the content of standard letters was in the process of being changed.

The conclusions of local and national reviews carried out by expert bodies were taken into account and changes made to the care and treatment provided to patients where appropriate. For example, the trust had reviewed how it managed complaints in line with the recommendations of a recent national report of the NHS complaints system published in October 2013. An action plan to address areas where improvements could be made had

been put in place.

The hospital was well-led, as were some individual departments and wards, such as A&E and Walnut ward. Senior managers were regularly reviewing the quality of service delivery and making improvements where this was required. There was a clearly defined committee structure in place to support the delivery of services and ensure lines of communication between senior managers and frontline staff were effective. Trust board members visited the wards and clinical areas and spoke with patients and staff about their experiences. This helped maintain their effective oversight of services and enabled the trust to be responsive to changes in patients' needs.

Significant changes in the configuration of local health services involving A&E, maternity, paediatrics and changes in surgical services had been effectively managed. Actions to improve the flow of patients through A&E, including a reduction in the number of delayed transfers of care, had been largely successful. There had been an improvement in waiting times in A&E and only two patients had spent more than 12 hours in A&E from the decision to admit to actual admission. This was a significant improvement on what we had found during our inspection of A&E in May 2013.

Complaints ✓ Met this standard

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. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

There was a system in place for identifying, receiving, handling and responding to complaints and comments. We saw that the provider had a complaints and Patient Advice and Liaison Service (PALS) policy in place which outlined the complaints process.

Detailed information on how to make a complaint was available on the provider's website. However, apart from an A4 sized sheet of paper on the wall of Larch ward, we found little evidence that this information was available on the in-patient wards. Most patients we spoke with said that they had not seen a complaints leaflet or poster. Most patients had not heard of PALS and we saw no information on wards we visited that explained how PALS could be contacted. Most patients, however, said they felt they would be able to make a complaint if they needed to and would raise their concerns with staff caring for them initially. We raised the lack of written information on the complaints process and PALS with the senior manager responsible for complaints management and a member of the PALS team. They both told us they thought there were complaints leaflets available on the wards but would check to make sure that stocks had been replenished.

Patients were given support to make a comment or complaints when they needed assistance. Those patients who needed help to complain were referred to an independent complaints advocacy service for support. Records showed that advocates had supported people in complaints meetings held with hospital staff. Interpreters were available to people who had made complaints via the trust's interpreting service, although complaints and PALS staff told us they could not remember an occasion when an interpreter had been used.

Patients had their comments and complaints listened to and acted upon. Ward staff told us that they tried to address any concerns patients or relatives had as soon as they arose. If they were unable to resolve the complaint locally, staff told us they referred complainants to PALS who had an office at the entrance to the hospital. The Head of Patient Experience told us that about 10% of people who contacted PALS went on to make a formal complaint. We had received feedback from several patients before the inspection who said that they had felt frustrated after contacting PALS as they were not sure what action had been taken to address their complaint. They had had to contact PALS again after several weeks to say they had not received a response either from PALS or from the department

about which they had a complaint. PALS staff told us they dealt with a high volume of contacts from people and once they had passed the complaint to the relevant department in the hospital they received no further information about the progress of the complaint.

People's complaints were fully investigated and resolved, where possible, to their satisfaction. We spoke at length with the Head of Patient Experience who was responsible for complaints management in the trust. They acknowledged the trust had a serious backlog of complaints and many complaints had not been responded to within timescales set by the trust. A report of complaints received by the trust between April and October 2013 identified the average time taken to process and close a complaint was about 123 days with a range of 20 – 218 days noted. A few complaints had been open for more than 200 days. We were told that dealing with the backlog of complaints was a priority for the trust and an improvement plan was in place. Complaints that had been open for the longest duration were reviewed on a weekly basis to ensure progress was being made towards a final response.

The trust aimed to acknowledge receipt of all complaints within three working days. The Head of Patient Experience told us that about 60% of acknowledgement letters were sent out within the timescale.

Where different services were involved in delivering care and treatment the provider took appropriate action to co-ordinate a response to the person raising the complaint. The Head of Patient Experience told us this could lead to a delay in the response but where more than one department or directorate was included in the complaint all relevant staff were interviewed and a response was co-ordinated. We saw examples of complaints that spanned more than one department which were detailed and addressed all parts of the complaint. People who made complaints were offered the opportunity to meet with staff involved in the complaint in order to try to resolve the concerns. People were given an audio-recording of the meeting to take away with them if they wished. A senior manager told us more than 100 meetings had been held in the last year.

The Head of Patient Experience told us that the quality of responses to complaints had improved. Fewer complainants had escalated their complaints to the Ombudsman than in previous years and there had been a decrease in the number of complaints that were 're-opened'. This suggested more complainants were satisfied with the outcome of their complaint.

We reviewed ten examples of recently concluded complaints. These showed that complaints had been investigated and detailed responses had been provided. All response letters were reviewed by the Director of Nursing to ensure they fully addressed the complaint and were signed by interim Chief Executive Officer of the trust who had oversight of all complaints.

A recent national report of the NHS complaints system (Clwyd-Hart report) published in October 2013 had been presented to the trust Board. Compliance with the recommendations made in the Clwyd-Hart report had been assessed and an action plan put in place to address areas where improvements were needed. In addition the trust Board had asked to review individual complaints to ensure they had effective oversight of the complaints management process. We saw evidence to show that the annual complaints report had been discussed at the Quality and Safety Committee in December 2013 and commitment to speed of the process of responding to complaints was re-iterated.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

The registered person had not always ensured that patients were protected against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them. Some patient records and some records related to the management of the regulated activity, such as checks on equipment functioning, were not accurately maintained. Regulation 20(1)(a)(b)(ii)

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Patients' healthcare records were kept securely and could be located promptly when needed. All patient records were kept in lockable trolleys. We saw no records that had been left unattended. Senior managers located documents and records promptly when we asked to see them.

We found, in some clinical areas, that most patient records were completed accurately. For example, in paediatric A&E we found 100% compliance with documentation concerning child safeguarding and amongst adults attending A&E all patients had had an assessment completed within fifteen minutes of arrival in the sample of records we reviewed. In Larch ward most fluid balance charts had been completed and daily totals calculated and the majority of patient care plans had been personalised.

However, in several clinical areas the standard and accuracy of record-keeping was inconsistent and not all records were accurate. For example, in A&E we reviewed 20 randomly selected patient records for 10 adults who had attended the department in the 24 hours preceding our visit. We found that, whilst patients told us that staff had completed comfort rounds and assessed pressure areas, this was only documented in 20% of the notes we checked. Patients told us that they were given pain relief quickly and that is was effective but we found pain scores were only recorded in 30% of cases.

In the majority of wards, other than Larch ward, most standard care plans had not been modified to address the particular needs of the individual patient. On Beech and Olive wards we found that most patients had a fluid balance chart in place to record their input and output of fluids and ensure they were adequately hydrated. However, these were not always completed consistently. Some records were left blank for no apparent reason and some contained very few entries suggesting that patients had received very little fluid in 24 hours. Few of the charts contained totals for input or output of fluids during the 24 hour

period. In Olive ward we found a number of gaps in records of patients' two-hourly repositioning charts. This meant an accurate record of the care and treatment provided was not always being kept.

Accurate records of checks on the functioning of medical equipment were not always maintained. For example, in an operating theatre we found that daily checks on an anaesthetic machine had not always been recorded. We reviewed the records of checks carried out since 11 November 2013 and saw that checks had not been recorded on at least two days (excluding weekends) for most weeks up until the day of our inspection. We were told that the operating theatre was in use every day from Monday to Friday and sometimes at weekends. When we asked theatre staff about the gaps in the records they were unable to explain why the records were not completed. They confirmed that anaesthetic machines were checked daily to ensure they were functioning but said they were always very busy and the recording may have been overlooked.

We found other examples where records of checks on equipment were not always accurately maintained. For example, on Olive ward records of daily checks on the temperature of the fridge used for medicines requiring cold storage were missing on ten occasions between 1 January and 28 January 2014. Similarly in Walnut ward there were 21 gaps in drug fridge temperature recording in November 2013 and 19 gaps in December 2013. On Walnut ward we also found that records of checks of the resuscitation trolley was inconsistent. There were six occasions between 1January 2014 and 28 January 2014 when checks on the emergency equipment were not recorded and six further gaps in the recording of checks in December 2013.

We checked 11 World Health Organisation (WHO) safer surgery checklists, which were part of records of surgical procedures, of patients who had recently undergone surgery and were patients on Beech ward (the WHO checklist is a tool for minimising the risks of wrong patient/wrong site surgery and to ensure surgical procedures are carried out safely). We noted a number of gaps in the records of checks undertaken. We spoke with senior managers in the trust who told us that some WHO safer surgery checks were recorded electronically. Specifically, the sign-in phase of the checklist was being completed electronically. The time out and sign-out phases were still being recorded on paper until discrepancies between the electronic and paper versions of the checklist had been corrected. The trust provided records of the electronic sign-in process to show they were being completed.

Taking this into account we reviewed the paper records of the 11 patients again and noted that five records did not contain records of both the time out and sign-out checks. Four records had not been completed in respect of the time out checks and five had not been completed in respect of the sign-out phase. A further two records, although completed for the time out and sign-out phases, were not signed by the staff member carrying out both sets of checks. A trust audit of WHO checklists carried out in the main theatres in the hospital in November 2013 showed that 100% of sign-in and time out checks were being recorded in theatres and 92% of sign-out checks. However, this did not correspond with what we found in patients' records where 64% of the time out checks had been recorded and 55% of the sign-out checks. Almost half of the WHO safer surgery checks we reviewed on Beech ward were not completed in respect of both the time out and sign–out phases. This meant that records of patients' surgery were not always accurately maintained. As a result patients were not being protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.

We reviewed a further four records of patients who had undergone day surgery on the day of our inspection. We found that all sign-out phases of the WHO checklist had been completed as well as three of the four time out checks. However, three of the four checklists had not been signed by the staff member performing the checks. This meant an accurate record was not in being kept as it was not possible to determine who had conducted the WHO safer surgery checks.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Surgical procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The registered person had not always ensured that patients were protected against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them. Some patient records and some records related to the management of the regulated activity, such as checks on equipment functioning, were not accurately maintained. Regulation 20(1)(a)(b)(ii)

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

The provider's report should be sent to us by 13 March 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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 other services less often. 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.

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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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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