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

Southport & Formby District General Hospital

Town Lane Kew, Southport, PR8 6PN
Tel: 01704704781

Date of Inspection: 17 October 2012
Date of Publication: November 2012

We inspected the following standards to check that action had been taken to meet them. This is what we found:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and welfare of people who use services</td>
<td></td>
</tr>
<tr>
<td>Management of medicines</td>
<td></td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td></td>
</tr>
</tbody>
</table>

✓ Met this standard
## Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>Southport and Ormskirk Hospital NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of the service</td>
<td>Southport and Ormskirk Hospital NHS Trust is registered as an NHS provider. Services are provided across two hospital locations Southport &amp; Formby District General Hospital and Ormskirk &amp; District General Hospital, and a number of community clinics. These services provide health care to a population of 260,000 primarily within the West Lancashire and Southport and Formby areas. This compliance inspection was carried out at Southport and Formby District General Hospital.</td>
</tr>
<tr>
<td>Type of service</td>
<td>Acute services with overnight beds</td>
</tr>
</tbody>
</table>
| Regulated activities | Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Family planning  
Management of supply of blood and blood derived products  
Maternity and midwifery services  
Surgical procedures  
Termination of pregnancies  
Treatment of disease, disorder or injury |
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'.

### Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of this inspection:</td>
<td></td>
</tr>
<tr>
<td>Why we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>How we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>What people told us and what we found</td>
<td>4</td>
</tr>
<tr>
<td>More information about the provider</td>
<td>5</td>
</tr>
<tr>
<td>Our judgements for each standard inspected:</td>
<td></td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>6</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>8</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>10</td>
</tr>
<tr>
<td>About CQC Inspections</td>
<td>12</td>
</tr>
<tr>
<td>How we define our judgements</td>
<td>13</td>
</tr>
<tr>
<td>Glossary of terms we use in this report</td>
<td>15</td>
</tr>
<tr>
<td>Contact us</td>
<td>17</td>
</tr>
</tbody>
</table>
Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Southport & Formby District General Hospital had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Management of medicines
- Assessing and monitoring the quality of service provision

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 17 October 2012, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff and talked with stakeholders.

What people told us and what we found

Patients told us staff were responsive and attentive to their requests, with nurse call bells responded to in a timely way. We heard one patient say "They [the staff] always close your curtains to try and keep things as private as they can." A relative told us the staff had been "kind and considerate."

Patients said they were provided with enough information about their medicines and treatment. One patient said "Medicines are given to me correctly." Another patient told us "I get pain relief medicines when I need them."

Overall, patients were aware of their plan of care and felt they had received adequate information to understand their condition and treatment. The health care records we looked at showed that care and treatment was planned and delivered in a way that ensured patient safety and welfare. Some patients told us the discharge process had not been efficient. Senior managers were aware of this concern and explained that plans were in place to improve the discharge process.

The trust had reviewed and revised its quality and risk management systems. For example, the trust had invested in new storage facilities, including the provision of lockable doors to all medicine storage areas, new lockable fridges, new medicine trolleys and secure medicine disposal bins. These developments had assisted in ensuring medicines were safely stored to help prevent misuse and mishandling.

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

<table>
<thead>
<tr>
<th>Care and welfare of people who use services</th>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>People should get safe and appropriate care that meets their needs and supports their rights</td>
<td></td>
</tr>
</tbody>
</table>

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

During our inspection we visited two wards and the discharge lounge. We spent time with eight patients and two relatives and invited them to share with us their experience and views of care and treatment at the hospital. Patients told us staff were responsive and attentive to their requests with nurse call bells responded to in a timely way. We heard one patient say "They [the staff] always close your curtains to try and keep things as private as they can." A relative told us the staff had been "kind and considerate."

Overall, patients were aware of their plan of care and felt they had received adequate information to understand their condition and treatment. Most of the patients we spoke with were aware of who their named nurse was. One patient said "I have been kept well informed by the registrar and they were very good at telling me what was going to happen." We spoke with another patient who said "I've been in the hospital many times and have never had any complaints."

During our visit we looked at a selection of health care records on two wards. Clear information was recorded about each consultation, assessment and treatment plan. All the records we looked at included risk assessments relevant to areas such as nutrition, moving and handling and bed rails. The trust used standardised care plans but we observed that staff could document any additional information to support staff in meeting patients' specific individual needs.

Care and treatment was planned and delivered in a way that ensured people's safety and welfare. All of the health care records we looked at showed risk assessments had taken place around key areas such as falls and skin integrity. We saw evidence that these assessments were completed in a timely manner following admission to the ward. When people were identified as 'at risk' in these areas, care plans were put in place to support staff to minimise these risks. We also saw evidence that documentation was reviewed regularly throughout the patient's stay by nursing staff.

The patients we spoke with told us they regularly had contact with their consultant and were also seen by a variety of other health professionals, including dieticians, speech and
language therapists, physiotherapists and specialist nurses. The health care records we
looked at also demonstrated the involvement of other health professionals. Staff described
communication about patient care, such as the handover between shifts and
multidisciplinary team meetings, as "thorough".

Whilst on the wards we observed staff regularly monitoring patients, asking how they were
and whether they needed anything. Staff informed us patients who were assessed as at
risk of developing pressure ulcers were checked throughout the day and we saw evidence
of these checks documented in the patient's records.

Staff informed us any adverse events and incidents were reported in accordance with the
trust incident reporting procedure. A trust-wide web-based patient safety software system
for incident reporting was established. Senior ward staff showed us the past six months of
incidents reported through the system, and outlined the learning that had taken place
following incidents.

For example, a recent learning session related to the management of grade 2 pressure
ulcers had taken place which demonstrated that ward staff were offered opportunities to
learn from adverse events and incidents so the risk of these being repeated was
minimised. We also looked at a specific incident involving the use of bed rails. We could
see from the records that this had been reported appropriately. A bed rail assessment and
associated care plans were in place and these were reviewed and revised following the
incident. In addition, we noted an assessment of the patient's capacity was established
and this had been regularly reviewed prior to the incident. It clearly highlighted that
bedrails were used as a measure to prevent falls rather than as a restraint.

We spoke with four patients in the discharge lounge. They were all positive about their
experience of care and treatment at the hospital. However, three of the patients
commented that they did not feel the discharge process had been efficient. One patient
told us "This is where they fall down, it was the same last time I was in" and another
patient said "It's been a bit of a wait to go home." We discussed this with senior managers
at the trust who told us they had identified patient discharge as an area for improvement.
They had case tracked patients to establish where improvements were needed and were
due to pilot an additional pharmacy resource shortly after our inspection. This pilot had
recently taken place at another of the trust locations and the outcomes regarding the
discharge process was positive.
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 trust had appropriate arrangements in place to manage them.

Reasons for our judgement

Following our inspection in May 2012 we identified serious concerns about the safe storage of medicines and we required the trust to make urgent improvements. We visited two wards and the discharge lounge and we spoke with patients about the arrangements for receiving their medication.

Patients told us they were provided with enough information about their medicines and treatment. They also told us they had no concerns about the way their medicines were handled. One patient said "Medicines are given to me correctly." Another patient told us "I get pain relief medicines when I need them."

Since the previous inspection, the trust had invested in new storage facilities, including the provision of lockable doors to all medicine storage areas, new lockable fridges, new medicine trolleys and secure medicine disposal bins. These developments assisted in ensuring that all medicines were safely stored to help prevent misuse and mishandling.

We looked at a sample of patient's medicines records and found some good improvements. Previous issues with medicines being unavailable on the wards had now been resolved because medical, nursing and pharmacy staff were being more proactive in obtaining medicines promptly. The prescription charts we checked were signed by nursing staff after medicines were administered. Previous issues with gaps on charts had been resolved.

Nursing staff told us, and we saw evidence, that managers were carrying out regular checks of the medicines charts to make sure they were being completed correctly. Ward pharmacists checked the medicine records to help make sure records and information were correct. We were told that this service was being reviewed with a view to extending it further during the weekends as there was a greater risk that prescribing errors would occur outside normal pharmacy working hours.

We looked at how patients were supported to look after their own medicines and found some improvements since our last visit. We saw paperwork was now completed correctly and general risk assessments had been carried out regarding the safe storage and handling of medicines. Significant investment had been made in new bedside lockers that could now store patient medicines safely. However, we found these were not fully in use
because the full process for self medication was still being developed. One patient told us
"I'm not able to self medicate they [the staff] just take your tablets off you." Trust managers
told us they would take urgent action to make sure the bedside lockers could be used for
patients who were assessed as being able to manage their own medication.
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 in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

We included this outcome as we had identified concerns with the trust's quality and risk systems in an inspection we carried out in May 2012. We looked at the trust's approach to quality and risk at both ward, departmental and corporate level. We reviewed the information we hold about the trust, interviewed staff on the wards, senior medical and managerial staff and looked at a number of policies, procedures and reports, which supported the assessment and management of quality and risk in the trust.

The Risk Management Strategy had been revised and rolled out across the trust in September 2012. This strategy explained the structure used for managing risk across all levels of the organisation. Senior managers provided an overview of how they managed risks to patients, staff and to the trust itself. Risks with a score of 15 or above were defined as 'extreme' and were included in the corporate risk register. Risks rated as 'high' were managed at clinical business unit (CBU) level. 'Moderate' risks were addressed at CBU governance meetings. Risks rated as 'low' were managed at ward level. We observed a schedule, which demonstrated risk registers were reviewed via a rolling programme.

Prior to the inspection, we selected, from our data base, a range of patient safety incidents rated as 'moderate' or above so we could track through the actions within the trust's risk management framework. Through review of documentation and discussion with staff, all the incidents and the one complaint we tracked had been appropriately reported, escalated, investigated and action taken identified. We could see from meeting minutes that risk ratings were discussed and reviewed and, if appropriate, the risk register updated. Senior managers informed us all staff had received training in incident reporting. Levels of reporting by different staff groups was being monitored and no concerns with under reporting by staff groups had been identified.

We tracked an incident in the community service, which was raised in May 2012. We could see from the meeting minutes that the incident was escalated to the risk management committee and then to the trust quality committee. The minutes demonstrated the risk rating was discussed alongside ways that risk could be minimised. We could see the CBU risk register was updated on October 2012 to take account of this risk.

We spent time on two wards and spoke with senior ward staff about how they manage
incidents at ward level. We heard the approach to risk management had been strengthened in recent months. Staff reported a positive and effective relationship with risk managers. They told us risk managers came to the ward when a serious incident occurred. We had access to the risk management health and safety audit completed for one ward in September 2012. It was a detailed audit which took into account issues such as incident reporting, environmental safety and staff training.

Staff showed us how incidents were managed via the web-based patient safety software system. This was still being embedded and some staff had requested additional training in its use. Senior managers informed us all wards and departments were using this system with the exception of the walk-in centre. Paper incident forms from this service were entered onto the system by the risk team. Some problems had been identified and plans were in place to modify the system so it was more user-friendly. The staff we spoke with had a good understanding of the risk management reporting structure.

We looked at incidents on the incident reporting system on both wards. Some incidents had not been reviewed within the agreed time frame. We were informed it would be challenging to review all incidents at ward level so senior ward staff prioritised the ones of higher significance. An in-depth investigation was undertaken if required. Although senior ward staff provided us with a good verbal account of the action taken and the learning from specific incidents, the provider may find it useful to note that there were some gaps around the recording of this information in relation to low risk incidents. We were told matrons monitored the incidents to observe for trends. We found trend reports were produced each month.

Arrangements were in place to support trust-wide learning. Wards and departments received electronic notices on a regular basis which provided feedback and lessons learnt. We looked at a selection of notices and saw that the outcome of five complaints was provided. In addition, some of the feedback related to use of equipment, quality of care documentation, attitude of staff, medicines management and feedback on the inpatient survey.

The trust's Quality Strategy (2012-2015) had been finalised in September 2012. We looked at how quality was managed at ward level. We saw that information on performance at ward level is collected and monitored using a 'dashboard'. This is a system that pulls together all relevant information about performance from a number of sources. Senior ward staff told us information related to incidents was added to the dashboards. It was clear from our discussions that wards had ownership of their dashboard. We looked at the dashboards for five wards and observed performance was monitored each month against a range of indicators. Performance issues were discussed formally between senior ward staff and a senior manager each month.

Wards were audited each month through a process referred to as the 'Matron's Checklist', the outcome of which was uploaded to the ward dashboard. The previous inspection identified limitations and sensitivity issues with the checklist. Staff highlighted, and we saw, that the format had been strengthened and including more rigorous checks related to the management of medicines. We had access to a report which showed a trust-wide summary outcome, based on the checklists, for September 2012.
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.
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.
### (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.
<table>
<thead>
<tr>
<th>Contact us</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phone:</strong></td>
</tr>
<tr>
<td><strong>Email:</strong></td>
</tr>
</tbody>
</table>
| **Write to us at:** | Care Quality Commission  
Citygate  
Gallowgate  
Newcastle upon Tyne  
NE1 4PA |
| **Website:** | www.cqc.org.uk |

Copyright © (2011) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.