

# Review of compliance

## Brighton and Sussex Universities Hospitals NHS Trust

### The Royal Sussex County Hospital

<b>Region:</b>	South East
<b>Location address:</b>	The Royal Sussex County Hospital Eastern Road Brighton East Sussex BN2 5BE
<b>Type of service:</b>	Acute Services
<b>Date the review was completed:</b>	05 July 2011
<b>Overview of the service:</b>	Brighton and Sussex Universities Hospitals NHS Trust is the regional teaching hospital working across two sites: the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath. The Brighton campus includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital, and the Haywards Heath campus includes the Hurstwood Park Regional Centre for Neurosciences.

The organisation provides District General Hospital services to the local populations in and around the City of Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients across Sussex and the south east of England.

Both hospitals provide many of the same acute services for their local populations. In addition, the Princess Royal is the centre for elective surgery and the Royal Sussex County Hospital is the centre for emergency and tertiary care. Specialised and tertiary services include neurosciences, paediatrics, cardiac, cancer, renal, infectious diseases and HIV medicine. The trust are developing their capability as the designated major trauma centre for the region with a 'go live' of March 2012.

Treating over three quarters of a million patients each year the trust works as one hospital across two sites, and plays to the strengths of both. This gives them the flexibility to develop services which meet the needs of patients at different stages of their treatment and care.

Central to their ambition is their role as a developing academic centre, a provider of high quality teaching, and a host hospital for cutting edge research and innovation; and on this they work with partners, Brighton and Sussex Medical School (BSMS) and the Kent, Surrey and Sussex Postgraduate Deanery, and local universities.

# Summary of our findings for the essential standards of quality and safety

## What we found overall

**We found that The Royal Sussex County Hospital was meeting all the essential standards of quality and safety we reviewed but, to maintain this, we have suggested that some improvements are made.**

The summary below describes why we carried out the review, what we found and any action required.

## Why we carried out this review

We carried out this review because concerns were identified in relation to:

- Respecting and involving people who use services
- Consent to care and treatment
- Care and welfare of people who use services
- Meeting nutritional needs
- Cleanliness and infection control
- Management of medicines
- Safety and suitability of premises

## How we carried out this review

We reviewed all the information we hold about this provider, surveyed people who use services, carried out a visit on 5 July 2011, observed how people were being cared for, talked with people who use services, talked with staff, checked the provider's records, and looked at records of people who use services.

## What people told us

People who use this hospital said that they felt supported by the staff to receive the care they need. They told us that every effort is made by the staff to help them maintain their mobility, independence and regain confidence to help them live independently when they are discharged, wherever possible. We spoke to many patients and were told that people felt able to express their preferences and that as

far as practicable and in accordance with their wishes and individual care plans, people were enabled and encouraged to make choices about their daily lives.

As part of our compliance review of The Royal Sussex County Hospital we visited Accident and Emergency departments, Chichester, Donald Hall, Bristol, Fleming and Lister, Albion, Solomon, Vallance, Jowers and Lewes wards. All units and wards were found to be well managed and the staff we spoke with were confident and competent in their roles. The environment was found to be clean and generally well maintained.

Patients in all areas of the hospital appeared to be safe, generally comfortable and well cared for. This was supported by positive comments from patients and their relatives and also evident from direct observation of individuals being supported in a professional, sensitive and respectful manner. We were told by one patient that “the staff are all so kind and friendly and the care they provide is second to none”. Another told us that “we feel very involved with the hospital and we are kept informed about what is happening”.

As far as practicable and in accordance with their wishes and individual care plans, people were telling us that they were enabled and encouraged to make choices about their daily lives and the care they were to receive.

## **What we found about the standards we reviewed and how well The Royal Sussex County Hospital was meeting them**

### **Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run**

- Overall, we found that The Royal Sussex County Hospital was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

### **Outcome 2: Before people are given any examination, care, treatment or support, they should be asked if they agree to it**

- Overall, we found that The Royal Sussex County Hospital was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

### **Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights**

- Overall, we found that The Royal Sussex County Hospital was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

### **Outcome 5: Food and drink should meet people's individual dietary needs**

- Overall, we found that The Royal Sussex County Hospital was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

### **Outcome 8: People should be cared for in a clean environment and protected from the risk of infection**

- Overall, we found that The Royal Sussex County Hospital was meeting this essential standard.

### **Outcome 9: People should be given the medicines they need when they need them, and in a safe way**

- Overall, we found that The Royal Sussex County Hospital was meeting this essential standard.

### **Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare**

- Overall, we found that The Royal Sussex County Hospital was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

### **Action we have asked the service to take**

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

### **Other information**

Please see previous review reports for more information.

**What we found**  
for each essential standard of quality  
and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

# Outcome 1: Respecting and involving people who use services

## What the outcome says

This is what people who use services should expect.

People who use services:

- Understand the care, treatment and support choices available to them.
- Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
- Have their privacy, dignity and independence respected.
- Have their views and experiences taken into account in the way the service is provided and delivered.

## What we found

### Our judgement

**There are minor concerns**  
with outcome 1: Respecting and involving people who use services

### Our findings

**What people who use the service experienced and told us**

People who use this hospital said that they felt supported by the staff to receive the care they need. They told us that wherever possible, every effort is made by the staff to help them maintain their mobility, independence and regain confidence to help them live independently when they are discharged. We spoke to many patients and were told that people felt able to express their preferences and that as far as practicable and in accordance with their wishes and individual care plans, people were enabled and encouraged to make choices about their daily lives.

During our visit we spoke with people attending the Accident and Emergency (A&E) and on a variety of wards who had been in the hospital between 2 days and 3 weeks and they told us they were generally very happy with the care provided. They said that they were called by their preferred names with some having a preference for a less formal first name to be used. We saw that staff were wearing name badges identifying their job titles. Patients told us that this was extremely

helpful as they could not remember staff names and it was friendlier being able to address people personally.

General observations made by the inspectors throughout the day found that overall staff talked politely, respectfully and treated patients with dignity. Patients told us that they felt involved in their care and goal setting with staff working hard to make sure they were fully informed about their treatment and medication. We asked patients about their care and many of the people we spoke to told us that although they were confident that the doctors and nurses made the right decisions about their care and treatment, they were not always sure that they fully understood all the details. They said that when they asked or needed things explained in more detail the ward staff took time to explain things more clearly and were good at making sure people understood about their illness, their treatments and care. They also said that they were offered choices about many aspects of their daily living wherever practical. They said that staff were happy to do this even when they were busy.

Amongst the comments we received from patients were the following:

*“Yes, I do feel that I am involved. Although they are obviously very busy, the doctors and nurses take the time to explain what is happening and I have been kept informed about how my treatment is going. They have told me I’ll be here for another 3 or 4 days’.*

*“The staff are always busy but very efficient. I am amazed at how well they all do their individual jobs. It is understandable, with the time it takes between one thing and the next that people sometimes have to wait. But the staff here are all friendly and very kind’.*

*“They have treated me as an individual as far as possible in this set up, in the circumstances”.*

We also received positive comments from patients’ relatives, spoken with during our visit:

*“I can’t fault the nurses – they are wonderful. They are always very helpful and explain what is happening. It can get very busy in here, as you can see, but the care is always there. They have time for everyone - I don’t know how they do it!*

During our visit, we watched staff checking that people were okay, listening to patients’ needs and responding to any concerns. We saw that in the main call bells were placed on beds in easy reach of patients, although on Jowers ward several call bells were found not to be working leaving elderly patients having to attract the attention of staff for assistance.

Patients we spoke to in A&E told us that once they had registered at the reception area they had been asked to wait to be assessed by the relevant health care professional. They told us they had already been assessed as needing further

treatment and or diagnosis and been asked to wait in a second waiting room. Patients told us that they had been informed what was going to happen next for example one person knew they were going to have an X-ray, another person had been advised they would need to have blood tests completed and be examined by a doctor. They said they felt "*included and informed*".

We spoke with one patient who had already had an X ray and was waiting for the results but they said they had not been told how long this would be. When we saw them later in the morning they had received their results and had been told they would be able to go home but would need to come back for further treatment. They said they had been told someone would come and talk to them about this but had not been told when this would be. Other patients we spoke to told us they had similar experiences and that not knowing timescales made it difficult for them to make arrangements for childcare, parking, being collected and informing their place of work or relatives, all of which considerably raised their anxieties and stress levels. They said this could be addressed very simply by better communication with patients. When we discussed this with senior nursing staff they told us that the trust is looking into providing more information to patients attending A&E regarding anticipated waiting times. Although there were many publications available regarding identifying staff by uniforms, common injuries, procedures and treatment plans there was no information available for patients to inform them of their journey through A and E or of an overview of the A&E department and its workings.

Some patients told us that the A&E department waiting room did not appear busy and yet they had been waiting for over two hours and no one had explained why that was or how much longer they would have to wait. Patients told us that whilst they were aware that they needed to wait and did not mind waiting they found it frustrating that they were not kept informed of how long their wait would be. Most of the patients we spoke with were not aware that emergency admissions via ambulance went straight into the treatment bays at A&E and that the same team of doctors and nurses treated the emergency admissions and the patients in the waiting rooms.

Patients told us they felt they had been well informed about their condition, the treatment they needed and what needed to happen but were not kept informed about when it would happen. They said that on previous visits to A&E they had been given information to take away with them about medication they had been prescribed, exercises they needed to complete and when to seek further medical advice.

Inspectors spent time on a range of wards and in particular when we visited Jowers ward we noted that patients' beds were very close together. The nurses' station was in a side ward which also accommodated eight nursing beds. Whilst curtains were always drawn when treatment or personal care was being delivered the proximity of beds and the nursing station made it difficult to fully protect a patient's privacy and dignity and conversations at a bedside or at the nurses station could easily be overheard.

We spoke to one person on Vallance ward who said that their privacy and dignity had been respected and that they had received all the information they needed. They said they understood why they were in hospital and what the treatment was. The patient said "*the doctors have been really good*". We asked the patient about making choices, and they said that they had been in the chair all day but sometimes they would have preferred to be in bed. The only option available to patients on the elderly wards is to remain in bed or sit next to their bed in a busy and noisy environment. We observed that many people were left sitting in chairs wearing pyjamas or surgical gowns all day long. We discussed this with the ward manager and she told us that the issue of people being in pyjamas had been considered and that relatives had been asked to bring in clothes. However, this presented problems with difficulties for elderly relatives to manage. The lack of laundry facilities on the ward presented problems if relatives couldn't take soiled or dirty laundry home with them.

The ward manager told us that improvements introduced had included identifying how people wished to be addressed, not talking in front of them, treating them kindly, and replacing continence pads with continence pants. On this ward we sampled the care plans for the two people whose beds were situated a yard or two on either side of the busy nursing station. Their care notes indicated that although they could be assisted to the toilet and to the bath or shower room they were receiving their personal care within their bed area. For one of them it was frequently recorded that they were using a bottle to urinate and there was no indication that assistance to the toilet (the person was recorded as confused) was being offered. We were concerned that this indicated a lack of practical awareness of the privacy and dignity issues for these two people who were receiving washes or using the toilet only a yard or two from a busy nursing station.

We spoke to a patient on Lewes ward who said they had been involved in planning their care, and that everything had been discussed with them. The patient said "*people have been very patient and have given up their time to explain things to me*". This person said they had been treated with dignity and respect, and that staff used the curtains every time. The patient gave the example of when they wandered out of bed at night and staff were very kind when they were guided back to bed. They said that staff regularly walked around to see if anyone needed anything.

### **Other evidence**

It is clear from discussions that we had with staff throughout the hospital that there is an emphasis and commitment to not only listening to patients but actively involving them in their ongoing care and treatment.

Staff appeared enthusiastic when they told us about procedures in place on the wards, including drawing curtains around patients' beds, role modelling and acting as patients' advocates, and said there was a high awareness of privacy and dignity on the wards for examinations. They said this was sometimes difficult given the restraints of the environment. Staff talked about a culture of respecting patients, and during our visit we observed that staff talked to patients respectfully, patiently and in a quiet friendly way. We saw that curtains were closed around patients' beds when they were receiving treatment and care. Staff talked gently to patients,

checking and asking permission before administering care. We observed that staff asked patients regularly if they were okay and if they needed anything. When asked they met patient needs quickly. We observed staff re-positioning patients with care when requested or prior to eating or drinking.

We spoke with a senior Matron who told us that amongst the new initiatives recently introduced on her ward was the 'patient bedside handover'. This is carried out at the commencement of each shift and directly involves the individual patient regarding their assessed level of care and support. We were told that the handover will establish updated details of the patient's condition, treatment and provision of personal care. It will also incorporate any outstanding actions and plan for the day ahead, including any scheduled operation, doctor's review or discharge. It was explained to us that this is in addition to the conventional, office based, team handover, where confidential issues can be discussed. We were able to observe this nursing handover in practice during our visit to other wards.

While we were on Vallance ward we saw a computer on wheels on the ward, which staff told us was used on ward rounds to facilitate doctors accessing patients' results and being able to input information at the bedside. The ward manager explained to us how patients were involved in consultant rounds, and that multi-disciplinary team feedback was always discussed with patients.

Other welcome developments that we were informed about included the appointments of a Dementia Care Link Nurse and an Older People's Champion. This demonstrates good practice and should heighten awareness of dementia and related issues. It also enables staff, patients and relatives on the ward to have access to an identified nurse with specialist skills and knowledge, able to provide relevant support, guidance and training, as required.

Written information is made available for patients, relatives and staff both in main areas of the hospital and on the wards, including various notice boards. We saw examples of this including the Older People's Champion Board and a notice board with contact details and useful information regarding dementia awareness and care. Information regarding chaperones, translating services and advocates was clearly displayed in the A&E departments.

However, through our discussions with staff it was evident that some of these positive initiatives are in danger of 'losing momentum'. With the acknowledged increase in the number of elderly people requiring care services, including hospital treatment, it is important that the developments that have been introduced are closely monitored and associated improvements that have been implemented can be sustained. Staff we spoke with on various wards were often not aware of these specialists or told us they were only available on weekdays which provided a limited resource to patients, relatives and staff.

During our visit we spoke to a variety of staff who told us that they had received training in patient involvement, privacy and dignity and were fully aware of the trust procedures and expectations and their individual responsibility regarding

maintaining people's privacy and dignity. They gave examples of how this had informed their practice, including talking to patients privately, use of private rooms and involving patients in their day to day care. Staff commented that issues such as promoting patients' independence and privacy were also discussed as general practice at handovers, team meetings and ward meetings.

Staff told us that complaints information was available on request, and that they would explain to patients how to make a complaint, either informally or formally. One member of staff said she would ask a member of staff from the Patient Advice and Liaison Service (PALS) to come over and talk to a patient if necessary. Concerns may be dealt with at the time, or could be escalated to a matron. Information was displayed in many areas of the hospital about who to make a complaint to and how to contact the PALS team. Information on the services including complaints was also detailed in the booklets designed for patients such as "Welcome to Brighton and Sussex Universities Hospitals NHS Trust". When we asked people if they knew how to make a complaint, some said that although they were not fully aware of the formal system in place they knew who to speak to on the ward if they were unhappy about anything. Generally people told us that they had nothing to complain about and were very happy with all aspects of their care.

### **Our judgement**

We had concerns relating to the environment which is not conducive to providing privacy and dignity to patients particularly on those wards providing care for elderly people like Jowers and Vallance in the Barry Building. These ward environments are particularly challenging for staff to be able to provide care to patients with the required levels of privacy and dignity.

There was no evidence of information being provided for patients regarding their pathway through A&E and what they could expect from the service provider.

Overall we found The Royal Sussex County hospital to be compliant with this outcome but to maintain this, improvements are needed.

# Outcome 2: Consent to care and treatment

## What the outcome says

This is what people who use services should expect.

People who use services:

- Where they are able, give valid consent to the examination, care, treatment and support they receive.
- Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
- Can be confident that their human rights are respected and taken into account.

## What we found

### Our judgement

**There are minor concerns**  
with outcome 2: Consent to care and treatment

### Our findings

**What people who use the service experienced and told us**

We spoke to staff who were keen to tell us they were constantly aware how important it was to ask patients what they would prefer and if it was ok to do things. One nurse told us that *“people deserve to be treated kindly and you need to ask if it’s ok”*.

Patients told us that they were consulted about their care and treatment on a regular basis and that they receive personal care, from staff, in the way in which they wished it to be provided.

Amongst the comments that we received from patients were the following:

*“Obviously the nurses are here all the time and, although they are very busy, they will always discuss and explain what they are going to do beforehand – like taking blood”*.

*'I see the consultant or one of the other doctors every day. They are usually very good at explaining things like how my treatment is going or any changes to my medication'.*

However, a couple of patients said that they didn't always feel able to disagree with the treatment being proposed and felt they were not always listened to when they raised objections. This was largely due to feeling unsure about the treatment or believing that their opinions were not important or valued by some staff.

### **Other evidence**

During our visit we observed patients being asked for consent prior to staff administering care. We saw and heard staff talking gently to patients telling them what they were going to do and asking if they were happy about it. It was apparent that throughout the hospital there was a culture of recognising the importance of the principles of gaining consent both verbal and at a more formal level when planning clinical interventions.

Throughout the hospital ward managers confirmed that up to date and accurate information regarding their care and treatment is provided to patients. We were told that in cases where a patient lacks capacity and is unable to give consent to treatment, there are various options available including a referral to an Independent Mental Capacity Assessor (IMCA). It was explained that this would often involve holding a multi-agency best interest meeting with the multi-disciplinary team. If it was then felt that a person did not have the capacity to make a decision, they might have a family meeting, and the multi-disciplinary team and family would make the decision. Ultimately, the consultant would be responsible for the decision.

In the majority of individual plans and records that we looked at during our visit, assessments were found to be full and comprehensive and incorporated physical, psychological, social and emotional needs. We also found evidence that MCA, psychological and Deprivation of Liberty (DOLs) assessments are undertaken and Best Interest meetings are held, as necessary.

We spoke to a consultant on Vallance ward who said that a significant proportion of patients on the ward are lacking in mental capacity, but this is not regularly documented. He said that if a patient has family then they would be involved in making decisions about their care, and that increasingly they are involving independent advocates. The multi-disciplinary team is also involved in making decisions, and social workers may be involved with this. He felt that awareness of mental capacity issues in the elderly care department is quite good, partly as a result of learning from incidents in the past.

We looked at patient records throughout the hospital but on Jower Ward we noted that important issues relating to patients treatment and conditions and options had not always been discussed fully with the patient and or their relative when it should have been. Some of the records we saw completed during June 2011 stated that discussions regarding consent issues would take place with the family at the

weekend but no further entries had been recorded. It was therefore, not possible to establish if these discussions had taken place and not been recorded or if they had not taken place at all. Other records were not completed fully with counter signatures or in line with policy requirements. These concerns were raised immediately with the ward sister, matron and consultants responsible for the patients on this ward. An immediate review of all patient records on this ward was undertaken and the consultants instigated an instant strategy in place to address the shortfalls. Further measures were put in place to review procedures within other wards and throughout the trust to ensure that all consent documentation is appropriate, current and correctly documented.

The ward manager of Vallance ward told us that a patient is always assumed to have capacity unless there is a reason to think they may not. She said that everyone has the right to refuse treatment. We saw documented examples in a patient's notes where the patient had declined pain relief, and also where the patient had refused to get out of bed to be weighed.

When we spoke with staff they were knowledgeable about the Mental Capacity Act and their responsibilities for gaining consent both verbal and written. We spoke to a nurse on Lewes ward who confirmed that she had received training in the Mental Capacity Act and consent. She told us that every patient has the right to refuse treatment, and explained how she would get consent from a patient or their family before using bed rails. A Healthcare Assistant told us that she had had training in the Mental Capacity Act in February of this year, and this was confirmed by the training matrix on the wall of the office. She said that she would ask the ward manager if she had any questions.

When we spoke with staff we were told that the use of bed rails is not routine but if they are used then a risk assessment for use of bed rails is completed that they would ask the patient's permission and involve their relatives in the discussion. We looked at patients' records on Vallance and Jowers wards which verified that the risk assessments had been done, and that consent to the use of bed rails from the patient and/or family had been recorded.

### **Our judgement**

Throughout this hospital people are usually asked for verbal consent prior to an intervention by hospital staff. Explanations are given and most staff take time to ensure people really understand what they are consenting to.

Records do not always clearly document where people may lack capacity to give informed consent and record when decisions need to be made on their behalf.

Consent documentation is not always completed in accordance to policy.

Overall, we judge this hospital to be compliant with this outcome but to maintain this, improvements are needed.

# Outcome 4: Care and welfare of people who use services

## What the outcome says

This is what people who use services should expect.

People who use services:

- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

## What we found

### Our judgement

**There are minor concerns**  
with outcome 4: Care and welfare of people who use services

### Our findings

**What people who use the service experienced and told us**  
During our visit we received positive comments from patients and relatives that we spoke to across all areas of the hospital. We were told by one patient that *“the staff are all so kind and friendly and the care they provide is second to none”*. Another told us that *“we feel very involved with the hospital and we are kept informed about what is happening”*.

Patients we spoke with in A&E were happy with the treatment and support they were receiving. One patient and their relative told us that they visited the hospital on a regular basis for treatment as an outpatient and that the care and treatment they had received was second to none. They said that they had no complaints what so ever about the treatment and care received. Other patients had similar experiences and said they felt the treatment they had received was good.

We spoke with patients on Jower Ward and on Vallance ward who said they were happy with the treatment they had received and had been given really good care. One patient told us that when they used the call bell, a nurse came straight away, and that when they needed pain relief staff got the medication quickly. This was the same during the night. The patient also said that staff came round regularly and asked if everything was okay and had been given water for washing and had had a

shower that day. We asked this person if anything could have been improved, and they told us that it was cold on the ward at night as the window was open, although they had been given extra blankets.

A patient on Lewes ward told us that all their needs were met and that nurses came quickly when they were needed. They said "*the nurses always have a smile*". We asked if anything could be improved and they couldn't think of anything.

A relative whose wife had passed away in the Acute Medical Unit wrote directly to the unit and thanked staff for the "*tender loving care they had given his wife, treating her gently and despite the fact that she was unconscious, talking to her and explaining everything they were going to do for her before they did it*". He said that staff in this unit had "*made the unbearable bearable*" and he would never forget their kindness.

### **Other evidence**

During our visit we asked to have a tour of the Accident and Emergency department (A&E) and were able to track the patient journey through the two entrances which accommodate self presenting patients and those brought in by ambulance.

The initial reception area for patients who present themselves at A&E records the patients' arrival and then directs them to the waiting room for assessment by a Nurse Practitioner in one of eight consulting rooms. These consulting rooms were clean tidy and fully equipped with locked drugs cabinets, computer terminals and basic treatment equipment. Patients have their immediate needs assessed by the Nurse Practitioner and a basic plan of care is initiated. Their details are entered onto the 'Symphony' tracking system which facilitates all further information regarding their patient journey and any care/treatment received by all relevant departments. We were able to see how patients are tracked and their progress documented at all stages of their care. From here patients are then moved to the second waiting area to await further attention, treatment or investigation. The A&E unit is equipped with its own imaging facility which reduces the waiting time for patients who require x-rays.

In both waiting areas we observed notices offering the services of chaperones, advocates, dementia link nurses and translating services. Wall dispensers were full of leaflets giving information about a range of common injuries and conditions such as burns, whiplash, sprains etc. These were freely available for patients to take away with them. Staff told us that patients are always given the appropriate information about their injury or condition when leaving the hospital. The Assistant Chief Nurse explained to us how these leaflets were designed and reviewed by the nursing team to ensure they were up to date and reflecting current best practice. We were told that the trust also has a Carer and Patient Information Group which consistently reviews patient information to ensure that it is an appropriate format. Leaflets are translated into other languages if required.

A separate paediatric waiting area is provided with a large fish tank which we were told promotes a calm atmosphere in the area for the children. Appropriate leaflets

specifically written for children were displayed. 24 hour immediate access to paediatric consultants is available from the assessment unit in the Royal Alexandra Children's Hospital which is also located on site. The matron for paediatrics undertook an audit of parents and children's experiences in A&E in February 2011 which supported the trusts view that this paediatric facility falls short of current best practice and a dedicated children's A&E dept is due to open in the children's hospital later in 2011.

At the time of our visit the resuscitation area was not being used and we were able to review fully the range of equipment in place. The area was clean, very well organised and although the bays were challenging in size best use of space had been organised by the staff. One bay which was set aside for the treatment of paediatrics was well equipped and of particular note was the colour coded system of emergency grab bags coded according to age and approximate weight of child. These were prominently displayed and easily accessible to staff.

Patients arriving into A&E via ambulance and needing emergency treatment are delivered and handed over at the main desk located within the treatment area. It was explained to us how the unit is now trialling a system called Patient Assessment Team (PAT) which receive the patient immediately they enter the unit from the ambulance crew whilst receiving valuable handover information concerning the patient's condition. Patients are then assessed and treated in order of priority rather than strictly in the order they arrive at the department either by ambulance or self referral.

In the main treatment area of the A&E department the Matron took time to explain how each shift has an appointed team leader who is assisted by a clinical operation assistant. These people were introduced to us and further explained how in this role they manage and control how patients are assessed together with responsibility for storing their treatment information and displaying their status of care. This role of team leader is rotational within the A&E team. We were able to see this system in operation and were particularly impressed at how all staff including clinicians, consultants and specialists were directed appropriately by this team leader to deliver treatment and care within the department. We observed that this system worked particularly well and was an excellent example of good team work in a potentially stressful and busy environment.

We were told that a specialist rapid response team is available for patients who arrive at A&E following a suspected stroke. This team is provided with all the relevant information available prior to the patient's arrival and they make their way to A&E to wait for them to arrive. We were told that following a stroke people need to be treated quickly with a procedure known as thrombolysis by specially trained nurses from the stroke unit, providing they meet essential criteria. During our visit we observed this team which included porters, consultants and stroke nurses assembling in response to an alert.

Staff told us about the team of staff who are now in place to support patients with dementia who work not only with the staff in A&E but throughout the hospital. They

told us how there was a marked increase in patients presenting with these specialist needs. End of life specialist link nurses are also available within the department and staff told us that end of life training is incorporated within their initial departmental induction programme. Learning disability liaison nurses provide support in the community to patients who need to come into the trust, working with both the patients and their carers to identify any reasonable adjustments the trust may need to take when these patients are admitted.

Within the A&E department there were specialist teams for supporting patients with mental health, drug or alcohol problems and at the time of our visit there were 4 such specialists on the unit. The enthusiastic and inspiring consultant in charge of the Clinical Decision Unit (CDU) spent time with us explaining in detail some of the initiatives that were in place to support people who were treated and admitted with drug and alcohol related problems. He explained how patients presenting with an alcohol problem are automatically recorded, followed up by the community teams and encouraged to access ongoing support. Follow up sessions are now held within the hospital rather than in external drug and alcohol units in an effort to protect patients privacy and dignity. Patients are legitimately then able to say they are attending follow up hospital appointments rather than it being obvious that they are going to drug and alcohol units. We were told how well this has been received by patients and directly influenced the number of people who take up the additional support.

With the consent of the patient we accompanied this consultant during his ward round and observed first hand an examination and consultation with an elderly gentleman who had a badly sprained shoulder and suspected hip fracture. Throughout the examination this consultant was respectful, kind, caring and took a great deal of time to explain everything to the patient in language that he could relate to. The consultant asked the patient to demonstrate how well he could actually walk and spent time exploring what supportive measures needed to be put in place prior to his going home. Following the consultation the patient told us that he *"couldn't have been treated better"*. He said that the staff were *"wonderful, caring and he would not have wanted to be treated anywhere else"*.

At ward level, we saw nursing assessment and care plans were in place for people although the quality of the detail in personal care plans differed between wards. We also saw risk assessments in relation to skin, moving and handling, mobility, continence, nutrition and hydration. Care plans were in place for catheter care, wound care and pain and infection control. We saw people had pressure relieving equipment when required although not all staff appeared to be aware of the correct settings required for pressure mattresses and on Vallance ward the staff resorted to contacting the manufacturers for advice.

Whilst we were visiting Jowers ward a nurse told us that two of the patients whose beds were accommodated in the balcony area of the main ward were able to walk independently. We noted that one of the patient's records stated that they needed staff support to walk and the patient confirmed this. The patient in the next bed told us they also needed staff support to walk. At our visit both of these patients asked us to call a nurse for them to support them to access the bathroom. One of these

patients told us they had tried to call a nurse using the bell but it didn't work. This led us to believe that although assessments had been completed they did not reflect the needs of the patient and nursing staff were not always aware of these needs.

We saw from other records that assessments had been completed on Jower Ward to establish the level of confusion that some patients presented with. One patient's records in relation to these assessments had only been partially completed. We raised this with the consultant on duty who examined the records. They told us the assessment should have been fully completed and they could not understand why it had not been. They assured us the assessment would be completed immediately.

There were photographs on the wall on Jower Ward of two nurses who were Dementia Care Champions. One of the nurses we spoke with was aware that the Dementia Care Champions existed but was unable to tell us about what their role is or what they do other than they had had additional training in dementia care. The ward sister, one nurse and one care assistant on Jower Ward have also had training in dementia care. There was no other evidence to support that other staff on the ward had received training in dementia care.

We asked the ward manager on Vallance ward about how staff cared for people with dementia on the ward, and she told us that she would request an additional Healthcare Assistant (HCA) who would give that person one to one care. One member of staff told us that it was not always possible to get an additional HCA, but another member of staff gave an example of a patient who was discharged on the day of our visit who had had one to one support for the majority of their stay due to their high risk of falls and wandering. The consultant on the ward told us that a recent audit had demonstrated that the number of falls had decreased significantly as a result of the ability to provide one to one care in high risk cases.

When we spoke to staff on this ward about caring for people with dementia, they told us about how they managed aggression but not about other aspects of care. Some staff on the ward have had dementia training but not others. The ward manager told us that they were able to get support from the Registered Mental Health Nurse on Chichester ward. If necessary a patient might be transferred to a mental health bed. We asked staff whether there was a dementia link nurse, and they said they thought there was one in the hospital but they didn't know how to contact them. We looked at the notes of a patient who had been identified to us by a nurse as being confused. This was not documented clearly in the notes, although the daily nursing notes did mention that the patient was confused. There was no evidence of an assessment of this person's capacity, and the activities of daily living risk assessment had not been completed. There was no information in a care plan about managing the patient's confusion.

The ward manager on Vallance ward told us that patients were risk assessed on admission to the ward and placed in a suitable bed for the duration of their stay. We noted that there was a six-bedded bay at the end of the ward which was not within sight of the nurse's station. The ward manager told us that patients in this bay would be low risk, with a low dependency level, and would have a low risk of

falls and no confusion. However when we spoke to one person in this bay he was very confused, which one of the nurses confirmed to us. This patient had been admitted after recurrent falls, and was identified as at high risk of falls which was documented throughout their notes.

We spoke to the Safety Ombudsman about care for people with dementia, and she told us that this was still a difficult area for the hospital although there had been a drive to raise awareness of dementia. She told us that she spends a lot of time on the elderly care wards as the patients there are so vulnerable, and she will sometimes call the safeguarding lead if she has a concern.

Staff told us that risk assessments are completed for all patients on admission, and that these are used as the basis for care plans. Risk assessments would be checked daily and reviewed every week. We reviewed the records of two people on Vallance ward and saw that there was a folder of risk assessments to be undertaken on admission, some of which were marked as mandatory. In one of the patients' records, not all of the risk assessments had been completed, including the nutritional assessment, oral assessment, continence assessment and activities of daily living assessment. These assessments were all considered to be mandatory.

Nursing and medical staff on Vallance ward told us that there were not always enough staff. The ward manager told us that they had recruited a lot of newly qualified nurses last year who it had been time-consuming to train. She said they had all now left as they didn't want to work in elderly medicine long term. The consultant responsible for the ward told us that the staffing levels on the ward have been increased for both nursing and untrained staff, and there will soon be more staff working on the ward in the afternoon and evening. He also said that a number of additional consultants are being recruited who will work partly in the community and partly on the inpatient wards. The ward manager told us that two new nurses have been recruited. We could see during our visit that staff on Vallance ward were very busy, and they told us that it was hard work, although individual staff we spoke to enjoyed working on this ward. The ward manager told us that she used bank staff to fill gaps where possible, and that most of these staff worked regularly on Vallance ward.

We spoke to a member of staff who told us that they try to give each person a shower twice a week. She said they used to give everyone a bath on Sundays but the only bath that was suitable to use was broken. There was another bath on the ward, but she said that it was too difficult for elderly people to use as it was very hard for staff to get people in, so it was only used when there were younger people on the ward who could bathe independently.

The Ward Manager on Donald Hall and Solomon told us that the unit provides a high quality service for people who have suffered a stroke, which is not available anywhere else in East or West Sussex and therefore attracts patients from a large geographical area. When the clinical needs and on-going care for patients, from outlying districts, are stabilised then negotiations begin to return them to a more local hospital nearer to their home.

On these stroke wards we found that personalised care plans were in place and developed, in consultation with the individual or their representative, to ensure that any necessary care, support and treatment was provided in a structured and consistent manner. The Matron confirmed that any such treatment is routinely discussed with the patient. This was supported through direct observation, during our visit, when a Consultant Physician, came onto the ward to do his round. Having obtained consent from both the patient and the consultant, we sat in on a brief examination and consultation. The process was relaxed and the Consultant was very reassuring as he gave the patient an update on his condition and explained what further treatment would be necessary to maintain the improvement. There was also a brief discussion on how long the patient would be likely to remain in hospital.

Speaking alone to the patient afterwards, he was clearly satisfied with his treatment and confirmed that he had felt involved and '*listened to*' and certainly happy and reassured by what the Consultant had said to him.

Staff on these wards were enthusiastic and knowledgeable and understood the basic principles of stroke care in order to achieve successful results. Whilst the majority of people admitted to the stroke units are elderly or middle aged, staff told us that they are 'fully able' to care effectively for younger people should the need arise. As well as a professional and dedicated staff team, including a stroke coordinator, occupational therapists and physiotherapists, patients on the unit also benefit from a small yet well equipped rehabilitation gym.

### **Our judgement**

We observed a great deal of very good care being provided across most wards and departments at the hospital. Patients and relatives talked about staff being kind, attentive and helpful. We saw staff who treated people well, who worked hard to ensure that patients needs were met and who were committed to high standards.

We saw in the main that patient records reflected that clinical care was well documented, however, there were examples in some wards, particularly those caring for elderly patients where personal care plans and risk assessments fell short of the required standard. This meant that peoples' needs were either not being fully met or recorded appropriately.

Overall, whilst recognising that most people receive good care we judge this hospital to be compliant with this outcome but to maintain this, improvements are needed.

# Outcome 5: Meeting nutritional needs

## What the outcome says

This is what people who use services should expect.

People who use services:

- Are supported to have adequate nutrition and hydration.

## What we found

<b>Our judgement</b>
<b>There are minor concerns</b> with outcome 5: Meeting nutritional needs

<b>Our findings</b>
<p><b>What people who use the service experienced and told us</b></p> <p>In A&amp;E we observed that some people who were receiving care in the treatment bays were being offered food and drink by staff. We saw a patient being transferred to a ward in a wheelchair and heard her being asked by the healthcare assistant if she had received any lunch or a hot drink. When the patient replied she had not the staff member responded by saying “well that’s what we must do first then”.</p> <p>Patients on Jower Ward told us that they were able to choose their meals and that they were provided with sufficient food and drink. They said the food was good and that generally they had no complaints. One person told us “<i>the food is always plentiful and very tasty – they must use lots of herbs and spices and it is always sufficient</i>”.</p> <p>Two patients told us that they had eaten cereal for breakfast but they had not been offered anything else to eat, although when they asked for toast it had been provided.</p> <p>A patient who said that the food was not great further commented that you could always get a cup of tea and that staff had brought a salad for someone on the ward</p>

who had missed lunch.

The members of staff we spoke to told us that they thought the food served is of good quality. They said there was a good choice and that special diets are provided for by the kitchen, sometimes an individual menu will be developed with the dietitian and the catering team. One member of staff on Jowers ward told us that older patients were sometimes put off eating by portions which were too large and some of the food was not traditional enough for elderly people's tastes. This was reinforced by a patient on this ward who also said "*It's not the food I'm used to but I try it anyway*".

### **Other evidence**

The hospital was able to demonstrate that it has a robust process in place to determine patients' medical, dietary and hydration requirements. All patients are assessed for nutritional support within the trust as a matter of course and the organisation has a protected mealtime's policy in place. Systems are embedded with regular audits being undertaken and records kept of any actions taken to address shortfalls. The Patient Environment Action Teams (PEAT) inspections found that the hospital food scored excellent for choice, availability and presentation. PEAT is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient including environment, food, privacy and dignity. We were told during our visit that catering staff regularly and actively seek the views of patients and staff on the content and quality of the food.

Patients visiting A&E were able to access refreshments from a vending machine with water dispensers in both waiting rooms. A shop run by WRVS where patients and visitors could purchase snacks and refreshments was located near the A&E department.

We were told about a project to improve nutrition called Mission for Nutrition which has recently been introduced on Vallance ward and we saw a poster on the wall in the corridor inviting suggestions from patients, relatives and staff about how nutrition on the ward could be improved. Suggestions included having more staff available to feed patients, fully protected mealtimes and better choice of food. The ward manager described to us how she had recently met with the catering team to discuss menus. The head of the Patient Experience Team at the hospital has been involved in the nutrition project and we were told that potentially the trust has set aside a budget for implementing some of the ideas.

Specialist staff such as dietitians, speech and language therapists (SALT) and physiotherapy teams are available for advice, planning and support for patients and staff. The dietitian provides nutritional support for a variety of conditions such as diabetes. Patients with specialist feeding regimes such as Percutaneous Endoscopic Gastrostomy (PEG) or Nasogastric (NG) feeding are discussed at the multidisciplinary team meeting which includes allied healthcare professionals. The SALT team recommendations are adhered to and staff felt it provided good support for the ward staff and patients.

We spoke to senior members of ward staff who told us that the Malnutrition Universal Screening Tool (MUST) is used on admission of all patients to identify the patient's level of risk of malnutrition. All inpatients are then screened weekly or more frequently if needed. Action taken depends on the MUST score, and could include monitoring of weight, completing food and fluid intake charts, or referral to the hospital dietitian and we did see evidence of this in patient notes. Staff told us that they had very good access to the specialist staff they need, and that specialist staff are involved and included in the multi-disciplinary team.

During our visit we checked patient records on various wards and found that in the majority of cases the MUST tool had been completed appropriately but we found one record that did not have a current assessment and throughout the hospital isolated incidents were noted where the MUST tool had not been reviewed or patient's records updated in line with policy and procedure.

On the wards that we visited which accommodated elderly and more frail patients, staff were able to confidently talk to us and identify systems that were in place to support those people that had been assessed and identified as needing additional fluids or at risk of dehydration. The system of giving these particular patients water jugs with red lids was demonstrated and staff we spoke to on Jowers Ward immediately recognised that this indicated a person who was required to be encouraged and assisted to take fluids at every opportunity. However, when we reviewed the records of patients on these wards we found that staff were not always accurately recording fluid intakes or summarising daily consumption rates. We noted that one particular patient had been identified as needing support to ensure they received sufficient fluids. Although the red water jug was in place and staff were aware of the need to support this individual, records showed that the fluid intake for this person the day before our visit was low and that the amount of fluids taken had not been totalled. Unfortunately it was not possible to identify from the records for this patient if any action had been taken to increase the patients intake or to demonstrate if fluids had actually been given and not recorded or not given at all.

Staff told us that they had received training on nutrition, including various study days such as dysphagia (difficulty in swallowing), and on tube feeding. Staff told us that the dietitian is involved in training and refresher courses on nutrition are available. They were able to tell us they were mindful of the need to ensure patients were kept hydrated and appropriate drinking cups given to assist those with manual dexterity limitations, but we did observe on two occasions drinks being placed in areas which were inaccessible for patients.

The wards we visited were quiet and peaceful during the lunch period and patients did not appear to be interrupted during this time with wards operating protective mealtimes for a 30 minute time period to enable patients to eat their food in a calm environment. Mealtimes throughout the hospital are a protected time of the day and doctors, other professionals and visitors are all asked to respect this and to avoid visiting patients during this period. We were told that there were still some doctors who did not abide by this practice and nursing and healthcare staff have to repeatedly remind them.

Ward areas especially Vallance and Jowers wards were challenging and with the lack of any day room facilities especially on the older people's wards patients were forced to eat in bed or in a chair by the side of their bed. This made it difficult for staff to assist them with such limited space available between beds and prevented any social interaction or stimulation, particularly important in the care of elderly people.

There is no formal system in place to identify people who are at risk of malnutrition during mealtimes. We asked the ward manager on Vallance Ward how people who are at risk of malnutrition are cared for and she told us that they would be referred to the dietician. Staff said that the dietician would visit the patient that day. Staff were able to identify which patients required help at mealtimes from the ward handover sheet and the ward manager said that the staff knew the patients and would help whoever needs assistance. On the day of our visit there appeared to be adequate numbers of staff available to assist patients with specialised eating equipment provided for those patients who needed additional support. We observed patients receiving sensitive and discreet support with eating where necessary. People serving and helping with distribution of meals were seen wearing protective aprons. It was noted that hand wipes were either placed on the meal trays by staff or available at the bedside for patients to use for hand cleansing, although we did not observe patients being encouraged to use them.

Information on meals is provided for patients on a daily basis with the next menu choice selection form circulated in the ward after each meal. Staff said there is generally support available to assist patients in choosing their meals and during our visit to Jowers ward we saw a healthcare assistant spending time with a patient discussing their choices from the dinner menu and assisting with filling out the form. As no picture prompts were being used it is unclear how people with confusion or dementia on Vallance Ward were being supported to make a meaningful choice.

Sandwiches and snack boxes are available throughout the hospital so that people can access food whenever they need it. Staff told us that if people request something which is not on the menu they will do their best to try to get it for them.

### **Our judgement**

Overall we found that the hospital was compliant with this outcome although we had minor concerns that there was a lack of evidence to support that robust arrangements are in place to demonstrate that people who need their fluid and food intake are monitored.

Not all staff particularly consultants respect the provision of protected mealtimes.

# Outcome 8: Cleanliness and infection control

## What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*.

## What we found

### Our judgement

**The provider is compliant**  
with outcome 8: Cleanliness and infection control

### Our findings

**What people who use the service experienced and told us**  
We were told by a patient on Albion ward *“the whole place is spotless”* and that staff wash their hands and change gloves and aprons between patients.

Whilst visiting Jowers ward a patient told us that she normally went private but *“cannot believe how much better it is now, the whole place is so clean so will always ask to come back here now”*.

**Other evidence**  
During the visit we were aware that this hospital is accommodated in a range of buildings over a large site and battles continually to maintain a high standard of hygiene throughout all areas of the estate. Furthermore the hospital is undergoing a programme of re-development with continual redecoration and refurbishment to address the challenges and complexities of the increased population it treats.

The hospital has robust infection control procedures in place with a designated person who has responsibility for co-ordinating infection prevention and control. A process of review is embedded into the culture that ensures regular cleaning and infection control audits are undertaken. The organisation has policies and procedures and risk assessment processes in place for the control of infection which are supported by appropriate governance structures headed at trust level by the Director of Infection, Prevention and Control (DIPC). Link nurses work in ward areas to ensure that infection control procedures are monitored.

We saw notices displayed in the lifts reminding staff of the importance of not wearing scrubs outside of the appropriate clinical areas but still observed several members of staff arriving at the hospital wearing them prior to starting work. Discussion with the Chief Nurse confirmed that this was not acceptable and action would be taken immediately to remind staff to adhere to policy.

We observed that communal areas, wards and treatment areas were clean and free from any odours. Information notices were clearly displayed at the entrance of the hospital and throughout corridor and ward areas regarding hygiene and actions to be taken if people visiting the hospital were suffering from diarrhoea or sickness. Hand cleansing gel dispensers with information on hand cleaning were also available throughout the hospital. There was good access in all areas for staff to obtain disposable gloves. On wards that we visited cleaning schedules were displayed on notice boards.

We visited the toilet areas in A&E on several occasions throughout the day of our visit and each time found that toilet rolls required replacing and patient rubbish needed removing. When we informed the reception area these issues were addressed immediately by cleaning staff.

Whilst we were visiting the resuscitation room in the A&E department we saw that a member of staff was checking that cleaning reminders made by the night shift and recorded on the notice whiteboard had been addressed. We were told that the night team had found dust on the storage shelves and rails of the beds and the floor needed cleaning. The person told us that everyone is encouraged to take responsibility for making sure that the hospital is clean and ensuring that items requiring attention are noted and actioned.

Staff were able to tell us that they had undertaken training in infection control and we were able to confirm this by checking training records and data.

Whilst visiting Jowers ward we observed that staff were wearing protective aprons and gloves when assisting patients with toileting or personal care. We observed one member of staff touching a patients drinking cup whilst wearing the gloves that she had been using to administer care to another patient. We asked the staff member if she was aware of her actions and requested that she change the patients drinking cup and jug.

### **Our judgement**

We found that The Royal Sussex County Hospital was compliant with this outcome.

We found evidence that the hospital was taking measures to protect patients against identifiable risks of acquiring infection and to prevent and control the spread of infection. Despite the challenging constraints of the building we found that the hospital was currently maintaining the appropriate standards of cleanliness and hygiene with robust processes in place to prevent infection and control the spread of infection in the hospital.

# Outcome 9: Management of medicines

## What the outcome says

This is what people who use services should expect.

People who use services:

- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

## What we found

### Our judgement

**The provider is compliant**  
with outcome 9: Management of medicines

### Our findings

**What people who use the service experienced and told us**  
People told us they were felt their medicines were well managed and were able to ask nurses if they had any concerns with pain being well managed and that analgesia was given whenever they needed it.

One person told us that they liked the nurses putting their eye drops in for them as that made it easier. We spoke with a person who was waiting to go home who told us that their new medicines had been explained to them, including the blood tests that they would need whilst taking them and they had been given a booklet about it to read. Another person told us how the hospital had arranged for their medicines to be in a special pack which would help them remember to take them when they got home.

In the A&E assessment area we observed the consultant discussing medication with a patient and assessing possible side effects and how the patient might manage these, whilst constantly checking the patient’s understanding. The patient told us how wonderful and patient he found the consultant and staff.

### Other evidence

The trust has written policies and procedures regarding the handling, storage and administration of medication. Nurses all receive training in medication procedures and the safe handling of medicines before administering any medicines in the hospital. This includes a workbook, test, competency assessment and further training days. We saw that the records of these are kept on the wards and competency is re-assessed at intervals. Further training in specialised techniques was given regularly.

We saw medicines being given to people on one ward. Three nurses used the same trolley to give medicines to the people in their section of the ward. This meant that the trolley could not easily be moved close to the patient and medicines had to be carried across the ward. The trolley was locked between each use, but with only one set of keys this was not easy for the nurses to manage. On some other wards we went to we saw that most of the patients' medicines were kept in individual lockers by their beds. Pharmacy staff told us that that this system was to be extended to other areas of the hospital. The prescription charts we viewed were all completed correctly, if someone refused their medicines or they were not given, the reason was recorded.

When patients were admitted to hospital the medicines that they were taking were checked so that they received their correct medicines during their stay. We saw that the pharmacy staff often did this check, using information from patients and their GP. New medicines are recorded on the prescription chart and on a printed discharge summary which the patient and their respective GP receive. We saw that patients also receive a card advertising a telephone medicines helpline that they can access when they leave hospital.

We heard from some ward staff and patients that there was sometimes a delay in receiving medicines for discharge. The pharmacy told us of the changes they were making to improve this process, which included some near patient dispensing, a tracker system for wards to know when the medicines would be ready and extra delivery rounds. Some nurses had seen that progress had been made, and on one ward a meeting was set up to improve the timely prescribing of discharge medicines.

The hospital has a discharge lounge where people can wait for their medicines and transport. We heard that some people could wait here for up to four hours. The staff in this unit said that medicine delays were still an issue for their patients. A recently opened 'Step Down' unit supported people with more complex discharge needs and in this unit the medicines are prepared in advance as part of their discharge plan.

We saw evidence of regular audits of missed doses and controlled drugs on the wards. Pharmacists are involved in a multidisciplinary forum to investigate and provide learning from any medication incidents and the trust has a robust governance structure in place to review policy and practice and address areas of risk.

### **Our judgement**

We found that the hospital had appropriate arrangements in place to ensure that medicines were safely handled and administered.

On the basis of the evidence provided and the views of people using the services we found the hospital compliant with this outcome.

## Outcome 10: Safety and suitability of premises

### What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are in safe, accessible surroundings that promote their wellbeing.

### What we found

#### Our judgement

#### There are minor concerns

with outcome 10: Safety and suitability of premises

#### Our findings

#### What people who use the service experienced and told us

People we spoke with during our visit including patients and relatives told us that they were generally satisfied with the environment which they described as “*reasonably comfortable*” and “*safe*”.

However, the temperature on some of the wards that we visited and the lack of space were recurring issues with many people (including staff). We received various comments about how it was always “*far too warm*” and the heat was sometimes “*overbearing*” and there was “*no air*”.

Many people also spoke of how cramped certain areas of the wards were, particularly when in bays the beds were so close together that it had an impact on people's privacy and their personal space. We were told by one patient *"There's just no room between the beds. You can hardly get a chair in the gap and when it's busy you can hardly move or hear your self speak"*.

One person accommodated on Vallance ward said he found it *"a bit crowded"* and a lady on Jowers said *"the staff are wonderful and work so hard in such cramped conditions"*.

### **Other evidence**

During the visit we were aware that this hospital is accommodated in a range of buildings over a large site and staff battle continually to deliver care in an environment that in areas is not conducive to modern day delivery of clinical care. In particular the Barry Building which is the oldest building on the site and requires a high level of maintenance poses a constant challenge for the organisation. The trust is maintaining the building to a reasonable standard and it was found to be clean throughout. However, the numbers of people being accommodated means that every area is utilised for the delivery of clinical and nursing care and there is insufficient communal space. The wards are cramped and the environment gives the impression of being over crowded.

It is recognised that the hospital is undergoing a programme of re-development with continual redecoration and refurbishment to address the challenges of the increased population it treats.

We visited several wards in the Barry Building including Vallance ward, which is an elderly medicine ward with 19 beds. Staff told us that one bed on the ward had been removed as there was not enough space in the bay. Nursing and medical staff told us that the ward was not fit for purpose. The ward was overcrowded, with only space for one chair in between beds. In some cases the chair was behind a pillar so there was no space for a visitor's chair and it would have been very difficult to get any equipment, such as a wheelchair, next to the bed.

The nurse's station was very busy, with a lot of people coming and going, which meant that the environment was very noisy and lacking in privacy for the people whose beds were in the bay overlooked by the nurse's station. Two beds were right next to the nurse's station and effectively in a corridor, providing very limited privacy unless the curtains were drawn around the bed. Another bed was in a small recess behind the nurse's station, directly outside the isolation room. The ward sister told us that the isolation room was not fit for purpose because of this, but that patients would be immediately transferred to the hospital's isolation ward if a diagnosis requiring isolation was confirmed.

The ward had no day room, which denied people the opportunity for people to socialise or for their independence to be promoted through eating together at a table. When we sampled two care plans we saw that the people had been resident

on this ward for longer than 10 days. The lack of any communal areas for sitting or having meals meant that these elderly people could only sit in the very confined space next to their bed day after day with little or no social interaction or stimulation.

The ward had insufficient storage facilities, although the ward manager told us that a toilet had recently been removed so the room could be used for storage. We saw several cases where equipment was causing an obstruction; for example there were three commodes in the store cupboard preventing access to the shelves of supplies which would be in regular use; and there was a clinical waste bin in the middle of the floor in the clinical room. The bathroom had a notice on the door saying that equipment must not be left in the bathroom, but there was a weighing chair in the room which had to be removed before we were able to enter.

Whilst we were on this ward we observed an incident where due to the lack of space between beds on the ward staff assisting one person accidentally knocked over a jug of water on a bedside table at the next bed along.

We found similar problems when we visited another elderly care ward called Jowers. We found some of the bathing facilities were out of use. One walk in shower was not being used and nursing staff told us this was because it was not suitable to use with elderly patients as they needed to step down into the shower and the room itself was too small to accommodate any moving and handling equipment or for staff to safely assist patients whilst showering. There was also a bathroom that was out of use and being used as a store room. Nursing staff explained that the bathroom had been out of operation for some time because the bath chair was broken. We noted that it had not been serviced since January 2010. The ward sister on Jower Ward told us that they would use the bathroom should it be repaired.

The beds on Jower Ward are sited very close together and whilst there is a quite room that can be used by relatives there is no day room for patients to use. This means that again patients either have to stay in bed all day or sit at the chair at the side of their bed. There is no air conditioning on this ward with 2 patients being located on a balcony area. Staff advised us that this presented real problems in trying to regulate a comfortable temperature particularly on a hot day.

The ward office for Jowers ward was situated in the centre of a six bedded bay and on occasions throughout the afternoon this area was full of consultants, nursing staff, visitors, cleaning staff and was extremely chaotic and noisy. However, when we asked two patients accommodated in this area they said it was *“great to see everything that was going on” and did not disturb them even at night.*

We spoke with a consultant on this ward regarding the cramped and often unsuitable environment. She informed us that the trust was fully aware of the problems and plans were in hand to move the wards to a more suitable location within the hospital. She praised the dedication of staffing in their constant battle to provide the highest levels of care working within the constraints of the environment.

**Our judgement**

Overall we found that the provider is compliant with this outcome but improvements are needed.

We have minor concerns that many of the wards providing care for older people are not environments conducive to modern day delivery of clinical care. We are mindful that the trust fully acknowledges these concerns and is working towards providing both short term solutions together with long term redevelopment of the site.

Some facilities provided within these wards were not found to be maintained in good working order. Bathrooms and shower rooms which are currently out of commission need to be available for patients.

## Action

we have asked the provider to take

### Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures	<b>Regulation 17</b>	<b>Outcome 1</b> Respecting and involving people who use services
	<p><b>Why we have concerns:</b> We had concerns relating to the environment which is not conducive to providing privacy and dignity to patients particularly on those wards providing care for elderly people like Jowers and Vallance. These ward environments are particularly challenging for staff to be able to provide care to patients with the required levels of privacy and dignity.</p> <p>There was no evidence of information being provided for patients regarding their pathway through A&amp;E and what they could expect from the service provider.</p>	
Accommodation for persons who require nursing or personal Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures	<b>Regulation 18</b>	<b>Outcome 2</b> Consent to care and treatment
	<p><b>Why we have concerns:</b> Records do not always clearly document where people may lack capacity to give informed consent and record when decisions need to be made on their behalf.</p> <p>Consent documentation is not always completed in accordance to policy.</p>	

<p>Accommodation for persons who require nursing or personal</p> <p>Treatment of disease, disorder or injury</p> <p>Surgical procedures</p> <p>Diagnostic and screening procedures</p>	<p><b>Regulation 9</b></p>	<p><b>Outcome 4</b></p> <p>Care and Welfare of people who use services</p>
<p>Accommodation for persons who require nursing or personal</p> <p>Treatment of disease, disorder or injury</p> <p>Surgical procedures</p> <p>Diagnostic and screening procedures</p>	<p><b>Regulation 14</b></p>	<p><b>Outcome 5</b></p> <p>Meeting nutritional needs</p>
<p>Accommodation for persons who require nursing or personal</p> <p>Treatment of disease, disorder or injury</p> <p>Surgical procedures</p> <p>Diagnostic and screening procedures</p>	<p><b>Regulation 15</b></p>	<p><b>Outcome 10</b></p> <p>Safety and suitability of premises</p>
<p><b>Why we have concerns:</b></p> <p>In the main patient records reflected that clinical care was well documented, however, there were examples in some wards, particularly those caring for elderly patients where personal care plans and risk assessments fell short of the required standard. This meant that peoples' needs were either not being fully met or recorded appropriately.</p>		
<p><b>Why we have concerns:</b></p> <p>Overall we found that the hospital was compliant with this outcome although we had minor concerns that there was a lack of evidence to support that robust arrangements are in place to demonstrate that people who need their fluid and food intake are monitored.</p> <p>Not all staff particularly consultants respect the provision of protected mealtimes.</p>		
<p><b>Why we have concerns:</b></p> <p>We have minor concerns that many of the wards providing care for older people are not environments conducive to modern day delivery of clinical care. We are mindful that the trust fully acknowledges these concerns and is working towards providing both short term solutions together with long term redevelopment of the site.</p> <p>Some facilities provided within these wards were not found to be maintained in good working order. Bathrooms and shower rooms which are currently out of commission need to be available for patients.</p>		

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

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 within <XX> days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

# What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions:** These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action:** These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations.

These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

## Information for the reader

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