CareQuality Commission

St George's Healthcare NHS Trust

Queen Mary's Hospital

Quality Report

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Date of publication: 24 April 2014
Date of inspection visit: 10–13, 22 February 2014

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Accident and emergency	Good
Surgery	Good
Outpatients	Good
Community inpatient services	

Summary of findings

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Summary of findings

Overall summary

Queen Mary's Hospital was originally a 200-bed hospital founded by Mary Eleanor Gywnne Holford in 1925 to provide rehabilitation services to injured military personnel. With a new purpose-built hospital opened in 2006, Queen Mary's Hospital provides specialist seating and limb replacement services to a wide community. . This hospital has a number of organisations working together to provide services for the people of Roehampton and surrounding areas, as well as further afield for specialised services such as limb replacement and a special seating service which casts and makes wheelchairs for people who cannot use a standard wheelchair.

St George's Healthcare NHS Trust is one of the largest hospital and community health service providers in the UK. With nearly 8,000 staff and around 1,000 beds, the trust serves a population of 1.3 million across South West London. The trust provides healthcare services, including specialist and community services, at two hospitals – St George's Hospital in Tooting and Queen Mary's Hospital in Roehampton – therapy services at St John's Therapy Centre, healthcare at Wandsworth Prison and various health centres.

The services provided by St George's Healthcare NHS Trust at Queen Mary's Hospital include outpatient services, 60 inpatient community beds, a minor injuries unit and a day case surgery unit. While the hospital does not have a full accident and emergency (A&E) service, the minor injuries unit provides first-line care which is described in the A&E section of this report.

We found that the services at the Queen Mary's Hospital site met the needs of most of the patients attending. The minor injuries unit was described as a valued service to the local population. The outpatient services offered a variety of routine clinics as well as a number of specialised clinics. The hospital is famous for its specialised seating service which casts and makes wheelchairs for people who cannot use a standard wheelchair and its prosthetic limb-fitting service; the inspection team were impressed with the dedication and skills of the people working in these areas. The atmosphere was warm and friendly and staff appeared to enjoy working in this hospital.

Services were safe, effective, responsive and caring and locally well-led. The staff on some units reported feeling distant from the main trust site. When we discussed this with the trust senior team, we were informed that the trust had wanted the hospital to have its own identity.

Staffing

While we noted some staffing vacancies at the hospital, there were systems in place to manage the risks associated with these. A bank of regular staff was maintained and used to cover any gaps in the staffing rotas. Agency nurses were also used as necessary. During our inspections we did not note any shortages of nursing which impacted on the care provided to patients.

Cleanliness and infection control

We found the hospital to be clean and well organised. While storage of equipment in some departments was a challenge, we noted that it been stored safely. We also noted that there were regular cleaning schedules in place including deep cleaning. These were followed and audited to ensure compliance with the schedule.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We found that the service provided by Queen Mary's Hospital was generally safe. However, we found that there was a poor general understanding and implementation of the principles of the Mental Capacity Act 2005 across some services at the hospital. We found that staff had access to training and support and that the service had systems to learn from incidents, accidents and complaints at a local level.

The data we obtained prior to our inspection showed that the number of serious incidents was low and that the clinical indicators, such as the number of infections, falls and pressure sores, were within acceptable limits. In most areas we inspected, patients were treated as outpatients or day cases which reduced the likelihood of adverse effects of hospitalisation such as pressure sores and infection. However, there were some significant gaps in recording the intentional rounding carried out which could affect the safety of patients on Mary Seacole Ward, specifically regarding pressure ulcer management.

Are services effective?

Good

We saw that the service at Queen Mary's Hospital was effective as there were systems in place such as incident reporting and complaints monitoring. Staff were able to describe how lessons were learnt from the investigation, and how the causes of the incident were fed back to them. Staff were able to give examples where systems had changed as a result of an incident.

The hospital monitored the effectiveness of initiatives to enhance the patients' recovery and experience through tools which were in line with best practice, an example of this is the monitoring of protected mealtimes. We saw examples of good practice in making sure that the care provided was effective. An example of this was the library of best practice and clinical guidance, available for staff to access in the minor injuries unit. These were discussed with the team and guidance implemented across the service.

Are services caring?

Good

Patients told us that they felt respected and well cared for. We observed care which ensured that patients were treated with dignity and most family members we spoke with told us that they were happy with the care that was provided at Queen Mary's Hospital.

We observed that staff interacted positively with their own patients but also with relatives and with patients in corridors and other public areas. We saw that patients were attended to in a timely manner and patients informed us that staff "could not do more for them". Despite a number of issues raised at focus groups prior to our inspection (regarding the lack of care, dignity and respect) we observed, and patients reported, that staff were respectful and provided appropriate care.

Summary of findings

Are services responsive to people's needs?

Good

Services in Queen Mary's Hospital were responsive to the needs of the population it served. We saw evidence of clinics being identified and run to meet local needs, including being offered on a Saturday. The minor injuries unit was particularly aware of meeting the needs of the patients who used this service, discussing pertinent issues such as fostering and female genital mutilation so that staff had a greater awareness of the need of their patients. These were issues raised by people attending the service.

While waiting times were variable, we found that, on the whole, patients were able to access the service. Services which had a high number of children accessing them did not have the facilities to engage with children. Cancellation of appointments on the day in the surgery unit was low, as was the number of complaints about the hospital.

Are services well-led?

Good

Services at Queen Mary's Hospital were well-led. Staff reported feeling well supported by their line manager. We found that multidisciplinary teams worked effectively together and that they were able to ensure that people received care and treatment which was appropriate to meet their needs. We found that a specific acute admissions avoidance care pathway which allowed GPs to refer directly to Mary Seacole Ward was a useful community resource which improved the wellbeing of people who used the service.

Staff received appraisals, training and ad hoc support and felt that their local managers were very supportive. However, there was some concern that, while the chief executive was known throughout the hospital, other senior managers were less visible. This led to the staff at Queen Mary's Hospital feeling that the trust's managers did not always recognise their achievements.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

Good

We found that the minor injuries unit (MIU) at Queen Mary's Hospital provided an efficient and effective walk-in service to patients who attended with minor injuries. The service had robust internal auditing procedures which ensured that the environment was clean and hygienic. Medication was stored appropriately and the service was run efficiently. However staff were unclear as to the

Patients attending the minor injury clinic were provided with information about their treatments and given comprehensive information verbally and in written form to take away with them. Patients who attended the unit told us they felt it was a good service and that they were treated with respect. The service was working to current National Institute for Health and Care Excellence (NICE) guidelines and had procedures in place to ensure that clinical information was current.

We found that services were well led and that the unit interacted well with the other services at Queen Mary's Hospital. However we were told that here was less interaction of this service with the main A&E service at St George's Hospital due to the location of the unit and the type of service which was provided. However this did not impact on the good service this unit provided to its patients.

Surgery

Good

There were arrangements to enable safe practice in day surgery services and for infection control.

The service was effective and their work based on evidence-based practice. The unit has achieved accreditation with the Joint Advisory Group on Gastrointestinal Endoscopy which assesses quality of practice in patient care, quality and safety and staff training.

Staff in the unit were caring and patients felt they had been well looked after. Management practices within the unit are good and staff felt supported. At a wider organisational level there is fewer acknowledgements of their achievements.

Outpatients

Good

There were arrangements to enable safe practice across the outpatient services. There were clear arrangements in place for infection control.

Care and treatment was evidence-based and achieved good outcomes for people, enabling them to have a good quality of life. People were treated with kindness and respect and were supported to be make choices with regard to their care.

Summary of findings

Overall the service was responsive to people's needs but facilities for children should be improved in the orthotics clinic. The outpatients department was well-led with high levels of patient and staff satisfaction.

Community inpatient services

We found that the service provided by the inpatient community wards was generally safe. However, we found that there was a poor general understanding and implementation of the principles of the Mental Capacity Act 2005. We found that staff had access to some training and support. Services had systems to learn from incidents, accidents and complaints at a local level. However, there were some significant gaps in recording the intentional rounding activity which could affect the safety of patients on Mary Seacole Ward, specifically regarding pressure ulcer management.

We saw that the service was effective as there were systems in place such as incident reporting and complaints monitoring which ensured that lessons were learnt. We saw that tools to monitor the services provided and the impact of these for patients. There were designed in line with best practice guidance.

Patients told us that they felt respected and well cared for. We observed care which ensured that patients were treated with dignity. Most family members we spoke with told us that they were happy with the care provided at Queen Mary's Hospital.

We found that multidisciplinary teams worked effectively together and were able to ensure that people received care and treatment which was appropriate to facilitate their rehabilitation. We found that a specific acute admissions avoidance care pathway, which allowed GPs to refer directly to Mary Seacole Ward, was a useful community resource which improved the wellbeing of people who used the service.

The local leadership at Queen Mary's Hospital was responsive to the needs of staff and patients on the inpatient wards. We found that the leadership had an understanding of the challenges faced at the hospital and there was a plan and vision to move the services forward. However, some staff felt there was a detachment from the acute trust services based at St George's Hospital.

This area is not currently being rated as it is part of a pilot phase within CQC.

Summary of findings

What people who use the hospital say

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment. The results have been used to formulate NHS Friends and Family Tests for Accident & Emergency and Inpatient admissions. In Queen Mary's Hospital, the Mary Seacole Ward was included in this test. Every respondent felt that they were likely or extremely likely to recommend the ward to their friends and family.

The minor injuries unit (MIU) is not part of the NHS Friends and Family Test for A&E, so no data exists in this area.

Areas for improvement

Action the hospital MUST take to improve

- There was a poor general understanding and implementation of the principles of the Mental Capacity Act 2005.

Action the hospital SHOULD take to improve

- Outpatient services were not always child-friendly, in that rooms were bare and there were no toys to distract children.
- Gaps in recording meant we could not be assured that the care delivered was safe. This included information regarding pressure sore management.
- Staff who used hoists to move patients should have formal training in moving and handling.
- The waiting space in the orthotics department was inadequately signposted.
- Confidentiality could be further protected by the use of a number system rather than receptionists calling names in the sexual health clinic.

The hospital should ensure that all staff are aware of the location of emergency equipment.

Good practice

Our inspection team highlighted the following areas of good practice:

- One person told us they had come to the ward before their surgery and had met with the doctor on the ward. This meant that, when they were discharged after their surgery, they were familiar with the setting and some of the people responsible for their care.
- An up-to-date library of best practice and national guidelines in the minor injuries unit (MIU).
- Staff were knowledgeable about the use of the Butterfly Scheme that provides training and templates to hospitals working with patients with dementia. Information was indicated on a board which was centrally located and not on individual's beds.
- The day surgery unit has achieved accreditation with the Joint Advisory Group on Gastrointestinal Endoscopy which assesses quality of practice in patient care, quality and safety and staff training.
- We saw that people were given advice about health education during their consultations in the MIU and that people were asked about smoking cessation, alcohol use and childhood immunisations so that they could be signposted to other services if necessary.

Queen Mary's Hospital

Detailed findings

Services we looked at:
Accident and emergency; Surgery; Outpatients; Community in patients

Our inspection team

Our inspection team was led by:

Chair: Gillian Hooper, Director of Quality & Commissioning (Medical & Dental), Health Education England

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission (CQC)

The team was made up of eight people, including CQC inspectors and a variety of specialists, including experts by experience, nurses and doctors.

Background to Queen Mary's Hospital

Queen Mary's Hospital was originally a 200-bed hospital founded by Mary Eleanor Gywnne Holford in 1925 to provide rehabilitation services to military personnel. A new purpose-built hospital was opened in 2006. This hospital has a number of organisations working together to provide services for the people of Roehampton and surrounding areas, as well as further afield for specialised services such as limb replacement and special wheelchair facilities. The services provided by St George's Healthcare NHS Trust include outpatient services, inpatient community beds, a minor injuries unit (MIU) and a day case surgery unit. While the hospital does not have a full accident and emergency (A&E) service, the MIU provides first-line care which is described in the A&E section of this report.

Why we carried out this inspection

We inspected St George's Hospital, Tooting, as part of our in-depth hospital inspection programme. We chose this hospital because it was considered to be a low risk service.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection:

- Accident and emergency (A&E)
- Surgery
- Outpatients
- Community inpatient services.

Detailed findings

Before visiting, we reviewed a range of information we hold about the hospital and asked other organisations to share what they knew about the hospital. We carried out an announced visit on 10 to 13 February 2014. During the visit we held focus groups with a range of staff in the hospital including nurses, doctors, physiotherapists, occupational therapists and pharmacists. We talked with patients and staff from all areas of both hospitals, including the wards, theatre, outpatient departments and the MIU departments. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the location. An unannounced visit was carried out on 22 February 2014 to review the ward areas.

Good

Accident and emergency

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

Queen Mary's Hospital does not provide an accident and emergency (A&E) department, it provides a minor injuries unit (MIU) on site. This is a nurse-led clinic. The minor injury unit is open from 8am to 8pm on weekdays, (with the last person being seen at 7pm) including weekends. It operates 364 days a year, only closing on Christmas day.

The MIU saw 16,456 patients in 2013 and 1,264 patients in January 2014, which was the last complete month prior to our inspection. The unit is a nurse led unit with access to medical staff at the main A&E at the St George's Hospital site. It was staffed by two nurse practitioners with administrative support and there were two nurses based at the MIU during our inspection. The service provides treatment for minor injuries and has access on site to x-rays and a plastering service. Some medication was dispensed from the MIU.

The unit treated all people (over the age of 2 years) on a walk-in basis. It also received patients brought in by ambulance staff when it is judged to be the most appropriate destination. We spoke with four patients who attended during our inspection and collated information from feedback forms which were in the reception area and had been completed recently. We also looked at information which patients had left about the service on the NHS Choices website. We also reviewed information which had been provided to us by the trust.

Summary of findings

We found that the minor injuries unit (MIU) at Queen Mary's Hospital provided an efficient and effective walk-in service to patients who attended with minor injuries. The service had robust internal auditing procedures which ensured that the environment was clean and hygienic. Medication was stored appropriately and the service was run efficiently.

Patients attending the minor injury clinic were provided with information about their treatments and given comprehensive information verbally and in written form to take away with them. Patients who attended the unit told us they felt it was a good service and that they were treated with respect. The service was working to current National Institute for Health and Care Excellence (NICE) guidelines and had procedures in place to ensure that clinical information was current.

We found that services were well led and that the unit interacted well with the other services at Queen Mary's Hospital. However we were told that here was less interaction of this service with the main A&E service at St George's Hospital due to the location of the unit and the type of service which was provided. This did not impact on the service that this unit delivered.

Good

Accident and emergency

Are accident and emergency services safe?

Requires improvement

Safety and performance

We found that the MIU provided a safe service. There was information available in the clinic area which ensured that patients who attended were aware of the parameters of the service. The staff used the trust's systems to report incidents when they occurred. Information relating to incidents was fed back through management systems to ensure that learning took place. We spoke with the manager about processes to report safeguarding concerns. The information and key contacts were clearly indicated in one of the offices so that staff would be able to seek advice if necessary. There were two identified nurse leads for safeguarding within the MIU. However, all staff had a basic awareness of the actions to be taken. We saw that safeguarding was a standing agenda item in the monthly team meetings.

Learning and improvement

We saw that the MIU had systems in place to ensure that learning from incidents was implemented and had an influence on the effectiveness of practice. We saw that there were audits undertaken of clinical work, for example, there was an auditing system which ensured that when patients had x-rays taken, the results were followed up within seven days by a radiologist. Staff at the MIU ensured that any further actions needed, for example, recalling a patient to a review clinic or liaising with a fracture clinic, were undertaken in a timely fashion.

We looked at recent minutes from the regular monthly team meeting which was held with staff at the MIU and saw that it clearly identified practice and clinical learning issues. These issues were discussed as a team, ensuring that the unit learnt from feedback and incidents when they occurred.

The manager of the MIU explained to us that they had adapted an audit tool on site specifically relating to hand hygiene audits as the tools which had been developed for them did not meet the specific needs of a service where there autonomous working. This audit tool had been shared with the community teams in the trust and had been adopted by other teams. This showed that learning within the unit had been transferred to other areas in the trust.

Systems, processes and practices

We checked the environment, including the clinical areas and areas that patients had access to, and found they were clean and hygienic. We saw that there were frequent audits which ensured that the clinical environments were maintained to a high standard of cleanliness. We checked the medication which was kept in the MIU and saw that it was appropriately stored and audited. We saw that there was a fridge which contained vaccines and the temperatures were checked regularly. The MIU kept emergency medications and this was ready to be used if necessary.

We saw that there were sharps bins and clinical waste bins in the clinical areas which were used in accordance with Regulations.

These practices meant that there were systems in place to ensure that staff delivered safe care.

Monitoring safety and responding to risk

The internal auditing systems which we saw, such as the audits for x-rays and the hand hygiene audits, had been developed locally at the MIU by the manager on site. We saw that there were initial local initiatives to build stronger links with the urgent care centre at St George's Hospital but these were at the embryonic stage of development and were reliant on the relationship between the managers of the unit rather than something that had been instigated by the trust leadership.

Patients we spoke with told us that they felt they were provided with a good service. We saw that there were emergency medications in place and the nurses who worked in the MIU were trained in emergency care. The unit had access to the trust's emergency call system if a situation were to arise where additional support was needed.

We asked how patients who may lack the capacity to make a decision about their treatment might be supported. The manager of the MIU told us that this was not something that was often evident. However, they had an awareness of when to ask for additional support, such as contacting a patients' GP, if they did have concerns about someone who may not have the capacity to consent to treatment. The

lack of specific guidance relating to the Mental Capacity Act 2005 may give rise to a risk that people who lack the capacity to consent to treatment or understand their treatment may not have the best access to the service on weekends or when their GP is unavailable.

Anticipation and planning

We saw that the MIU had real-time information available about the patients who were waiting for treatment and the length of time that they had been waiting. We saw that audit systems which were in place ensured safe practice, for example, the system by which x-ray audits were checked to ensure that patients were followed up effectively.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Using evidence-based guidance

We saw that the unit had a library which they had developed where staff could get information about specific injuries, illnesses and medical conditions which they might come across. This was organised into two files, with one having information about current NICE guidelines and research evidence, and the second file which included summary information about the guidelines and the evidence base to ensure that best practice was followed. This meant that staff could look at a summary of the best practice guidelines but had access to more in-depth information about particular conditions to refer to as necessary. We found that NICE guidance was therefore in place and that staff worked to this within their daily practice.

The manager of the unit told us that the summary information sheets were updated at least every two years to ensure that necessary additional information was added and that the guidelines used on the MIU were current.

We saw that information about best practice and recent research evidence was discussed regularly in team meetings to ensure that this practice was shared with the team. The manager told us that this information was sent to staff by email so they could read it if they were not able to make a team meeting or if they wanted to access the information away from the MIU.

Performance, monitoring and improvement of outcomes

We saw that information about the unit's performance over the past five years was displayed for staff to see. We saw that this was also broken down on a month-by-month basis for the past year so that trends and performance could be monitored with clarity by the service.

Patients were asked for feedback when they were discharged from the service. Patients we met told us that they were asked to give feedback after their consultations and they were happy to do so. We observed consultations where we saw records generated with background notes and information about patients' previous attendances at the MIU. Patients also allowed information about their attendance at MIU to be shared electronically with other professionals, particularly with GPs and follow-up services which were signposted during attendance at the MIU.

Staff, equipment and facilities

During its opening hours, the MIU was staffed by at least two band 7 nurses who had training and background in emergency nursing. There was also administrative support during the opening hours. We saw that the staffing complement was 7.37 whole time equivalent (WTE) members of the team; the current staffing level was 7.17 WTE, with the remaining 0.2 WTE gap due to changes resulting from recruitment of staff. The manager told us that they have access to bank (overtime) and agency staff when necessary. The staff team was stable, with some new members of staff having been taken on recently. Medical advice should it be necessary is obtained from the main A&E at St George's Hospital and patients sent to St George's or the own General practitioner should they need medical attention.

Multidisciplinary working and support

While the MIU operates as a discrete service within Queen Mary's Hospital, there was a review clinic held by a consultant A&E doctor for emergency medicine on Tuesdays and Thursdays between 9.30am and 11am through a service level agreement with Kingston Hospital. This meant that some patients who had been seen at the MIU could be called back to the MIU if they needed a follow-up treatment. There was also a GP clinic based in the MIU and, while this was not a service provided by St

Good

Accident and emergency

George's Healthcare NHS Trust directly, informal links had been built with the team in the MIU so that informal advice could be sought if necessary. This means that patients can access medical advice locally.

As the MIU had access to x-ray facilities, they had support from radiologists based at Queen Mary's Hospital, particularly when x-rays needed to be reviewed within the seven-day timeframe. We were told that the MIU was also able to refer directly to fracture clinics. We saw that there were systems in place to ensure that information was passed on to patients' GPs, wherever they were located in the country.

Are accident and emergency services caring?

Good

Compassion, dignity and empathy

We spoke with six patients who were attending the MIU. One patient told us, "It's excellent" and another patient told us, "it's a good local resource and I'm happy that it's here". All the people we spoke with had attended previously, either for themselves or with family members, and all the direct feedback we received was positive.

We looked at some recent feedback which had been left in the reception area. Some of the comments included: "Excellent and efficient service"; "two-and-a-half-hour wait, however, staff helpful and polite and nurse knew immediately what was wrong and how to deal with it"; and "I had excellent treatment". We also looked at the most recent feedback which had been left on the NHS Choices website and it was very positive. Since January 2014, it included comments such as, "Only had to wait five minutes for treatment. Staff were very friendly, helpful and efficient," and "I couldn't have asked for more thoughtful, friendly and expert treatment".

We observed staff interactions with patients, including some consultations, with the permission of patients. We saw that the staff treated patients with respect and dignity at all times.

Involvement in care and decision making

We saw that patients were given information about their conditions and how to manage them, and told to be aware of any possible side effects and reactions after their treatment. Patients told us they felt they were involved in their treatment and knew what was happening at each stage. We saw that the staff used a checklist system to ensure that they had given patients comprehensive information and this acted as a failsafe mechanism to ensure that all information was passed on.

Trust and communication

We saw that staff related well to patients and that they communicated in ways which met patients' needs. We asked about situations where patients may not be able to communicate fluently in English. The unit had access to a telephone interpretation service, Language Line. However, we were told that this was not often necessary.

Emotional support

We observed care which was provided in an empathetic and caring manner and patients reported to us that they felt the service was supportive to them. We saw that there were information leaflets available in the reception area which referred to information people could gain from other places, for example, there were leaflets about dementia.

We saw that people were given advice about health education during their consultations and that people were asked about smoking cessation, alcohol use and childhood immunisations so that they could be signposted to other services if necessary.

Are accident and emergency services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

We found that the service in the MIU met patients' needs effectively. People told us that they felt the service was a useful local resource. Due to the geographic location of the MIU at Queen Mary's Hospital, we were told that the service has built links with another neighbouring hospital (Kingston Hospital) as it is geographically closer than the main St George's Hospital site. This meant that these links ensured people had a more local service which was responsive to their needs.

Good

Accident and emergency

Vulnerable patients and capacity

There was less formalised learning which related to adult safeguarding rather than safeguarding of children. We asked about how issues related to adult safeguarding might be raised. The service had information about key contacts in local authorities. Staff gave us a specific example of when they raised a safeguarding concern relating to an adult who had been identified as vulnerable which had been flagged to the relevant local authority to investigate. This meant that the MIU had appropriate ways to report safeguarding concerns relating to children and vulnerable adults despite not having received formal training in doing so.

Access to services

We saw that the service monitored the ethnicity and demographic data when they were treated at the MIU to ensure that the service met people's needs across the local communities. The service had access to a telephone interpreting service. The manager told us that the team meetings had focused on issues which were specific to some local communities to increase understanding and learning, such as the issues of female genital mutilation and private fostering. These were issues that the patients had raised with staff at the MIU.

Leaving hospital

We observed that patient information was updated during and after consultations and treatment at the MIU, ensuring distribution to the relevant GP or services. The consultation notes were typed up during the consultation and this information pre-populated a letter which was sent to people's GPs with the possibility for the clinician to include relevant additional information. This meant that the patients GP received timely information. We saw that letters to GPs were checked regularly to ensure they were sent in a timely manner and they were stored in an area away from the public view behind the reception desk.

The service provided an audit of x-rays to ensure that every x-ray was followed up. This meant that discharges from the MIU were safe because information was passed on to the relevant clinicians both within and externally to the trust. We saw that the MIU, with its own records system, highlighted people's previous attendances so that the information could be used to ensure that their treatment was safe.

Learning from experiences, concerns and complaints

We saw that comments were collected regularly at the MIU and this information was fed back internally during meetings with staff to ensure that any learning could be progressed. There had not been any recent complaints in the service.

Are accident and emergency services well-led?

Good

Vision, strategy and risks

We spoke with staff and patients at the MIU and found that there was a clear understanding of the purpose and scope of the MIU. However, staff told us that they felt a detachment from the trust which was based at St George's Hospital. Staff told us that they were very proud to work at Queen Mary's Hospital and felt more of an affinity with the community services rather than the acute services so felt that they were something of an anomaly within the trust with little understanding from the senior management about where they sat in the whole organisation.

Governance arrangements

We saw that the MIU collected data and information about its performance through audits which covered many areas of its operation. The service was efficient at a local level. However, some of the targets were based on A&E services which differed significantly from the remit of the MIU. This meant that the unit could not achieve all the targets set for a full A&E department. Also, staff told us that they were not always best served by the training updates which had been established for A&E teams, as the needs of MIU patients differed. The manager told us that they had ensured that staff were able to locally source and pursue training which better met their needs.

The local governance arrangements at Queen Mary's Hospital were effective and the manager of the MIU told us that they felt supported by their peers at the hospital.

Leadership and culture

We saw that, locally, the MIU was led effectively. One member of staff told us that they "had a feeling that the acute trust didn't want us". However when we discussed this with the senior managers at the main trust site we were

told that they had tried to ensure that Queen Mary's hospital retained its own identity. The manager told us they had established links with their peers at Queen Mary's Hospital and across the trust to ensure that they were able to receive and provide support to their staff teams. An example of how this worked was the staff shadowing shifts in other places to increase learning, such as at the urgent care centre at St George's Hospital. This had been instigated locally rather than at the trust level. They also told us that had developed stronger links with community services based at Wandsworth Prison. This meant that the local leadership was looking at opportunities for the service to learn. However, there was a feeling of detachment from the acute-based services.

Patient experiences, staff involvement and engagement

We saw that staff had access to regular supervision and support. We saw that training was provided to staff at an organisational and local level which ensured that knowledge and skills were up to date. Staff told us that they had access to regular appraisals which ensured that their professional development goals were met. We saw that appraisals had been completed within the past year and that staff had regular meetings with their managers to discuss performance and clinical issues.

We were told that there is a local aim for staff to have one-to-one meetings with the manager on a six-weekly basis at least to discuss issues related to clinical practice and development goals, as well as managerial issues. While in practice this may not always be at six weeks these were occurring and staff did receive supervision from their managers. During our inspection we saw that one new member of the administrative staff was receiving an induction which ensured that they would have an understanding of the systems in place before they started working independently.

Good

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

Inpatient surgery is not provided at the Queen Mary's Hospital site. Day surgery patients only are treated in a unit at the hospital. Procedures are carried out under sedation; general anaesthetics are not used in the day surgery unit. Patients are discharged on the same day that the procedure, such as endoscopy and minor surgery is carried out. We toured the department and spoke to patients and staff working in the unit.

Summary of findings

There were arrangements to enable safe practice in day surgery services. There were safe procedures in place for infection control.

The service is effective and their work is based on evidence-based practice. The unit has achieved accreditation with the Joint Advisory Group on Gastrointestinal Endoscopy which assesses quality of practice in patient care, quality and safety and staff training.

Staff in the unit were caring and patients felt they had been well looked after. Management practices within the unit were good and staff felt supported. At a wider organisational level there was fewer acknowledgements of their achievements.

Good

Surgery

Are surgery services safe?

Good

Safety and performance

The unit has strict eligibility criteria which were applied to everyone booked for surgery at the Queen Mary's site. This was rigorously applied as the site did not carry out surgery under general anaesthetic; patients and the surgical team have to be assured that the procedure can be undertaken with local anaesthetic or sedation.

Learning and improvement

The trust report to the Strategic Executive Information System (STEIS) any serious incidents (requiring investigation) and Never Events (incidents that should never happen). St George's Healthcare NHS trust has reported two Never Events, but none of these were at Queen Mary's. Between December 2012 and November 2013, 286 serious incidents occurred at the trust; only five were recorded at Queen Mary's Hospital. These consisted of two grade 3 pressure sores, one fall, one failure in referral process – Cardiology and one report of wrong side surgery. The day surgery unit completes the World Health Organisation safety checklist as a result of the incident.

We noted that staff demonstrated insufficient awareness of the Mental Capacity Act 2005 and its potential relevance for their work in dealing with vulnerable patients. Staff were unable to describe the hospitals procedure for patients who were assessed as potentially lacking capacity to consent to treatment.

Systems, processes and practices

Staffing levels and hygiene practices enabled a safe service. There were clear arrangements for infection control. The decontamination room was well-equipped and safe procedures were followed. We saw the outcome of a check by a member of the infection control team which commended staff in the unit for the high standards of cleanliness.

Patients commented positively on the cleanliness of the environment.

Safe practices were followed in relation to moving and handling, fire safety and the prevention of slips and falls.

Monitoring safety and responding to risk

Internal audit systems were in place to monitor the quality of the service. The department has links with the main surgical suite and has adapted audits used in that area for the unit.

We were told that the unit uses an accepted system for reporting and learning from serious incidents. Complications which may develop as a result of surgery were considered and action taken to minimise the risk. For example, action was taken in line with accepted good practice to minimise the risk of deep vein thrombosis in patients.

Are surgery services effective?
(for example, treatment is effective)

Good

Using evidence-based guidance

The unit uses the British Society of Gastroenterology guidance for endoscopy and conforms to current guidance in the decontamination process of endoscopes. We saw how endoscopes are cleaned and decontaminated in line with this guidance at the unit.

Performance, monitoring and improvement of outcomes

The unit has achieved accreditation with the Joint Advisory Group on Gastrointestinal Endoscopy which assesses quality of practice in patient care, quality and safety and staff training. All staff had received specialist gastrointestinal nurse training.

Staff, equipment and facilities

There is continuity of care as low nursing staff turnover in the service allows consistency. The unit had sufficient equipment on site for the types of surgery undertaken. All staff were aware of the process for the cleaning and decontamination of equipment.

Multidisciplinary working and support

The team worked well with the main unit at St George's Hospital and liaised appropriately with medical secretaries.

Are surgery services caring?

Good

Surgery

Good

Are surgery services responsive to people's needs?
(for example, to feedback?)

Compassion, dignity and empathy
Patients told us they felt cared for in the day surgery unit. One person said that felt there were given time to prepare for and recover from the procedure; they had never felt rushed. They said they felt staff were kind and friendly. One person said, "no one wants to have this [procedure] done, but they make it so much easier".

We found staff were compassionate and displayed empathy in their work. For example, we were told that when patients had to be told upsetting news about their conditions and prognosis, they were given time to absorb the news and arrangements were made so they did not have to travel home by public transport.

Staff were respectful of patients who were awake or sedated while their procedure was being undertaken. Staff had limited awareness of what actions to take if they were concerned about the patients mental capacity.

Involvement in care and decision making
Patients were sedated for the procedures undertaken at this unit. Staff were aware of this and that patients may still be able to hear what was said during the operation. Staff were sensitive to the needs of these patients. Patients were involved in their care as they were able to have input throughout their care.

Trust and communication
Patients told us that when they had mistakenly missed an appointment it was easy to rearrange another at a convenient time. There were concerns that people in the waiting area were able to overhear conversations held in the reception area and this may breach people's confidentiality.

Emotional support
Patients who attended the day surgery unit had day surgery services only and while nurses were reported as being kind and attentive there was no evidence to suggest that they did not provide emotional support to patients.

Good

Meeting people's needs
We heard that the service was responsive to people's needs arising from diversity issues. For example, if patients preferring female staff because of cultural and religious needs, then arrangements were made for this to be provided.

Vulnerable patients and capacity
Most patients remained awake during their procedure and as such retained their capacity. However staff were aware of the psychological impact of surgery and took this into account when speaking with patients and in their behaviour within the operating theatre.

Access to services
Arrangements were being made to offer appointments on a Saturday to meet the needs of people who found it difficult to attend during the week.

Leaving hospital
Patients were supported to make arrangements following their surgery and advised about what to expect on discharge. They were given information and advice about the impact of sedation and how best to manage it. For example, people were advised not to drive for a period after their surgery and informed that the sedative had an amnesiac effect.

Learning from experiences, concerns and complaints
We were informed that practice had been amended in response to patient feedback, for example, in the provision of refreshments that met a range of people's needs. This was the only area of improvement identified by patients.

Are surgery services well-led?

Good

Vision, strategy and risks
Staff we spoke with were familiar with the values of the trust and felt their work demonstrated the principles.

We were informed that the service was sometimes hampered in their work by being on a different IT system to

Good

Surgery

St George's Hospital. This had an impact on the communication between the sites. We were told that arrangements to integrate the computer systems were being made but it was unclear when this would be complete.

Governance arrangements

The department reported incidents, accidents and issues of concern through the appropriate channels. The senior team fed back lessons learnt in other areas so that all staff were kept informed of the reasons as to why practice may change. The department kept its own risk register which contained the risks identified. This was seen to be appropriate. Regular auditing occurred and action were taken to address deficits.

Leadership and culture

Staff told us they enjoyed their work and felt well supported by their manager within the unit. However, they felt their achievements had not been acknowledged and recognised at the wider trust management level. The manager of the unit was clear that their role was to provide services which are safe and that patients are cared for and informed.

Patient experiences, staff involvement and engagement

Patients we spoke with felt they had a positive experience at the unit. Staff told us they felt committed to the work of the unit and pleased with their achievements. Staff felt supported by managers within the unit and were familiar with senior staff within the trust. .

Learning, improvement, innovation and sustainability

The work of the unit is based on best practice in the field and the manager ensured that they are informed about improvements through team meetings and the provision of information. We saw that guidance from bodies such as NICE and royal societies was available to staff.

Good

Outpatients

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Good

Information about the service

Queen Mary's Hospital runs a range of outpatient services for children, young people and adults, including urology, ophthalmology, podiatry, orthopaedic, cardiovascular, prosthetic, orthotic, wheelchair and sexual health services. Approximately 3,000 patients a week are seen in the outpatients departments.

During our inspection we visited the prosthetic, orthotic, wheelchair, urology, spasticity management and sexual health outpatient departments. We spoke with people attending clinics, staff members at all levels, we observed waiting areas of the clinics and interaction between staff and patients. We spoke with members of the wheelchair user group and the Roehampton limb user group.

Summary of findings

There were arrangements to enable safe practice across the outpatient services. There were clear arrangements in place for infection control.

Care and treatment was evidence-based and achieved good outcomes for people, enabling them to have a good quality of life. People were treated with kindness and respect and supported to make choices with regard to their care.

Overall the service is responsive to people's needs but facilities for children should be improved in the orthotics clinic. The outpatients department is well-led with high levels of patient and staff satisfaction.

Good

Outpatients

Are outpatients services safe?

Good

Safety and performance

Staff we spoke with felt there was little concern about their personal safety in the outpatient departments but noted that there was a policy to ensure that no one worked alone. They felt that the reception staff were vigilant in ensuring that there were no safety issues in the waiting areas.

Learning and improvement

Any serious incidents (those requiring investigation) and Never Events (those incidents so serious that they should never happen) were reported to the Strategic Executive Information System (STEIS). While St George's Healthcare NHS trust has reported two Never Events, none of these took place in outpatients departments at Queen Mary's Hospital.

We asked some staff working in outpatients departments about the relevance of the Mental Capacity Act 2005 to their work. Staff felt this was an issue which was rarely raised in their departments. We were concerned that this represented a training need for staff so they could recognise situations where it may have relevance.

Systems, processes and practices

There were safe arrangements for taking samples of blood and other fluids and for the disposal of needles. Safe arrangements were in place for dealing with spillages and staff were familiar with them. Training was available to staff on safety issues.

Environment

The environment in each of the outpatient clinics we visited was safe. None of the departments we saw were overcrowded and sufficient seating was available in waiting areas. Consultation rooms that we viewed were spacious and did not present risks to people with mobility needs. Senior staff checked the safety of outpatient clinics using a checklist which addressed a range of issues, including safety signage and staff knowledge of emergency procedures.

Monitoring safety and responding to risk.

There were clear arrangements for infection control. We observed that hand hygiene gels were available and used in the outpatient departments by staff and some patients. Monthly infection control audits were conducted and results were displayed on noticeboards accessible to patients. This demonstrated transparency and openness. Several people commented on the cleanliness of the environment in the clinics we visited and said they found this a positive feature of the hospital.

We saw electrical appliances being tested during our visit and were told this was part of a planned programme to ensure the safety of equipment.

Anticipation and planning

Staff received annual life support training. Equipment for dealing with medical emergencies was available in a cardiology outpatient department and staff in a neighbouring clinic were aware of this. Staff in another clinic (spasticity management) were unaware of the location of emergency equipment. All staff should be aware of the location of resuscitation equipment so that the patients receives prompt treatment. In the event of an emergency, the accepted protocol was to call an ambulance and arrange a transfer to St George's Hospital.

Are outpatients services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Using evidence-based guidance

Care and treatment within outpatients departments was based on recognised evidence-based guidance. For example, in the urology clinic, care was based on the European Association of Urology Guidelines and in the sexual health clinic, the British Association for Sexual Health and HIV guidelines were observed.

We were told that National Institute for Health and Care Excellence (NICE) guidelines and approved care pathways were used in the outpatients departments.

Audits of the wheelchair outpatients service have focused on how to learn from analysis of current practice and improve outcomes for people using the service. Goals were set as a result of the audits and progress was monitored at monthly team meetings. Staff reported to us that they had seen improvements in the service provided. The wheelchair users' group was consulted about changes and improvements to the service and ensured that the user voice was represented.

Good

Outpatients

Performance, monitoring and improvement of outcomes

In the wheelchair outpatient department, a monitoring system called productive community services (PCS) was used to assess the effectiveness of the service. The PCS system was based on four criteria: care quality; client experience; productivity; and staff wellbeing. Analysis of the initial implementation of the system showed it has produced benefits and increased the effectiveness of the department. For example, it was identified that a significant amount of time was spent on dealing with inappropriate referrals. Action was taken to address this issue by raising the awareness of referral criteria with stakeholders. This resulted in time saved which could be more effectively used on patient care.

Staff told us they found the implementation of the monitoring system useful in improving working practice and increasing clinical time available.

Staff, equipment and facilities

Daily monitoring of the adequacy of staffing levels took place and, where necessary, arrangements were made to address shortfalls. There were few concerns from daily staff monitoring in community services and no alerts had been identified.

Multidisciplinary working and support

We heard about effective multidisciplinary working at Queen Mary's Hospital in the outpatients departments. A multidisciplinary approach to care ensured that the range of people's needs were addressed. A prosthetic clinician told us that the team included other specialists, including physiotherapists, orthotists, social workers, psychologists and occupational therapists.

Are outpatients services caring?

Good

Compassion, dignity and empathy

Staff respected patients' privacy and dignity. Consultations with clinicians took place in private rooms with doors closed. Chaperones were provided, when required, for women who were seeing male clinicians.

Patients considered the outpatient prosthetic service to be especially caring and supportive. A person who used the prosthetic service told us, "all of my care has been first class" and told us they had received practical and emotional support which they described as "excellent".

In one reception area (orthotics) part of the waiting area was close to the reception desk. One person told us they had overheard conversations which they felt should have been kept private.

In the sexual health clinic reception area, people felt that the waiting area was suitable for its purpose. It was comfortable, a radio was playing at a reasonable volume, and the area was large enough to ensure waiting patients could sit with distance between them. One person told us they felt this reduced the potential for embarrassment.

We observed that a patient had mistakenly come to a clinic on the day prior to their arranged appointment. The receptionist showed a caring manner to the person who had a difficult journey to the hospital. They demonstrated compassion in their attitude, showed concern for the person and tried to find an appointment for them that day.

Involvement in care and decision making

People told us they felt involved in their individual care and felt that clinicians in the outpatients departments listened to their needs and wishes regarding their treatment. In the sexual health clinic, we heard that people were always asked if they had any further issues that they wished to discuss. People felt this gave them the opportunity to raise any issues of concern and one person told us they felt this was caring and recognised the sensitive nature of the consultations in this clinic.

A person told us they felt very involved in their care and "at all times my treatment and care is on a 'choice' basis." They were offered the opportunity to choose whether to be an inpatient or to attend outpatients. Another person said they felt the care was provided "with" them, not "to" them.

Trust and communication

In several departments, for example, prosthetics and sexual health, we heard that efforts were made to ensure that people saw the same clinician on each of their visits. This helped people to develop trust and confidence that clinicians were familiar with their needs. Several people commented to us that staff turnover was low and this assisted in the development of trust in the clinician they dealt with.

Good

Outpatients

We felt that staff demonstrated respect for people in the interactions we observed and in the manner in which they discussed people they saw in the outpatients departments. A person told us they felt respected and were "never talked down to [by staff], we are all on the same level".

Emotional support

People told us that they felt that staff understood the emotional impact of their conditions. Staff demonstrated awareness of this in their concern to help them achieve a positive outcome, for instance in the provision of equipment which met their needs. Staff spoke of their commitment to providing a good service; one person said, "I try to be very patient-focused" and said they felt other members of their department worked similarly.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

The premises and facilities in outpatients departments were generally good, but in the orthotics department there were areas that could be improved. We noted that the waiting space in the orthotics department was inadequately signposted. This meant that receptionists had to direct people to the larger waiting area and this distracted them from other tasks.

We were told that 5 to 10% of the patients attending the orthotics clinic were children. The needs of these patients had not been adequately catered for. For example, although parents and children could be waiting for appointments for a period of 45 minutes, there were no toys or books to keep children amused in the waiting area. This caused unnecessary stress.

The room used to make plaster moulds for orthotics patients was bare and did not contain any items to distract patients, particularly children. It was important that plaster moulds were made with accuracy to enhance the efficiency of the orthosis. We heard that a piece of equipment called a spinal casting frame would increase the accuracy of moulds, but that this was not available.

Queen Mary's Hospital has a workshop on site staffed by technicians who make and adapt prostheses and orthoses. The presence of technicians on site meant that some people could have an assessment and receive a device, or have an adaptation carried out, without unnecessary delay. People benefitted from the promptness with which their needs could be addressed.

On an organisational level, patient representative groups of wheelchair users and of people who used prosthetic limbs, met with staff within the relevant departments to discuss issues of concern. Examples of issues the user groups had been involved with included the number of beds reserved in Gwynne Holford ward for patients who had amputations and the tendering process for wheelchair repair services.

Interpreting services were made available, when requested, for people whose first language was not English.

Vulnerable patients and capacity

Staff in the orthotics clinic, where there were a significant number of child patients, were knowledgeable about child protection procedures. They had raised concerns with child protection authorities where appropriate.

People's privacy had been taken into account in the sexual health outpatients department. The patient database was separate to the rest of the hospital's records so that people could only access the records on a "need to know" basis. The clinic is located on an upper floor of the hospital in a particularly quiet area, reducing the chance of meeting people attending the hospital for other reasons. Most of the people we spoke with felt their privacy was protected by the arrangements. One person felt their confidentiality could be further protected by the use of a number system rather than receptionists stating their names at the reception desk. One person told us that, on one occasion, they had been asked for the name of their partner for this information to be stored. The person said this was unexpected and made them feel uncomfortable. They did not feel they received an adequate explanation for the query.

Access to services

People told us that generally there were able to arrange appointments without unreasonable delays. A triage system was used in outpatient departments to ensure that priority was given to patients with high-priority needs. In the prosthetic department, a duty system operated so that a prosthetist could provide immediate attention to people

Good

Outpatients

with urgent needs. People with complex needs were identified through the triage system and longer appointments were arranged to ensure that needs could be fully addressed without causing delays to other people. In some clinics, appointments were available on a Saturday to meet the needs of people who were working during the week.

A system was in place to ensure that people attended appointments. Patients were contacted prior to their appointment to remind them and confirm their attendance. This had been effective in reducing the percentage of people who failed to attend appointments and increased people's uptake of the service. This system did not operate in the sexual health clinic to protect people's confidentiality.

We were informed that people using the wheelchair outpatients department were able to make appointments easily and did not experience delays. However, there was feedback that the time from assessment to the supply of equipment had increased from six weeks to three months due to increasing demands. This meant that people's needs were not being met promptly.

Other people felt that delays were caused by a changed system which did not allow a consultant to refer directly to another consultant within the hospital. This was changed due to a change in national guidance. The system required that a request be made to the person's GP and then they should make the referral. One person we spoke with felt this had had a poor impact on patients as it introduced further delays to their needs being addressed.

Learning from experiences, concerns and complaints

We saw a report relating to complaints received in outpatients departments between October and December 2013. The report showed a low level of complaints. The report provided evidence that the service investigated raised concerns and responded to issues by promoting change. For example, if there were concerns about the attitude of staff to patients, this was raised with them by senior staff and, when appropriate, training needs were identified and addressed.

Are outpatients services well-led?

Good

Vision, strategy and risks

Staff were aware of the values of the trust and felt that these were demonstrated in their work. We observed staff and saw that staff in the prosthetics department felt proud to be part of a unit with a long history which is nationally recognised.

Governance arrangements

Staff in the outpatient departments were able to demonstrate the arrangements for reporting on incidents and how they received feedback. Staff were able to identify where practice had changed due to an incident occurring or to describe an incident which had occurred in other areas of the hospital. This demonstrated that good governance systems were in place.

Leadership and culture

We met senior staff in outpatients clinics who demonstrated commitment to their departments and to providing good patient care. Staff told us they felt the clinics were well-led and they felt supported by managers. In the prosthetics clinic, staff expressed pride that their department had a national reputation for excellence and could meet individual, complex needs.

Patient experiences, staff involvement and engagement

Patient surveys we saw showed high levels of satisfaction with the outpatients departments. This echoed the feedback we had from patients during our visit.

We heard that staff had been invited to staff engagement events called Listening into Action. While it was felt that this should be an effective forum for staff engagement, some staff felt constrained by the presence of managers at the events and felt unable to speak freely.

Learning, improvement, innovation and sustainability

Staff retention in outpatients departments was reported to be good, with several staff, including managers, informing us they had worked in their department for many years. People told us that they appreciated the consistency of clinical staff and saw it as a sign of staff being committed to their work.

Community inpatient services

Information about the service

Queen Mary's Hospital has two inpatient wards on site. Gwynne Holford Ward provides rehabilitation and support for up to 18 people aged over 18 who have had limb amputations or who require neuro-rehabilitation. Mary Seacole Ward provides rehabilitation and support for up to 42 older people.

People are referred to the service either directly from acute hospitals or via their GP through the acute admissions avoidance (AAA) pathway. The site also houses the Bryson Whyte rehabilitation unit and the Douglas Bader gym which is a community facility.

During this inspection, we visited both the inpatient wards and spoke with about 30 staff members, about 20 patients and some family members of patients on the wards. We also reviewed information received from the trust and comments card we collected on the ward.

Summary of findings

This aspect of the trust is currently not being rated as community services inspections are in the piloting phase of development.

We found that the service provided by the inpatient community wards was generally safe. However, we found that there was a poor general understanding and implementation of the principles of the Mental Capacity Act 2005.

We found that staff had access to some training and support and that the services had systems to learn from incidents, accidents and complaints at a local level. However, there were some significant gaps in recording intentional rounding activity which could affect the safety of patients on Mary Seacole Ward, specifically regarding pressure ulcer management.

We saw that the service was effective as there were systems in place, such as incident reporting and complaints monitoring, which ensured that lessons were learnt. The hospital monitored the effectiveness of initiatives to enhance the patients' recovery and experience through tools which were in line with best practice an example of this is the monitoring of protected mealtimes.

Patients told us that they felt respected and well cared for. We observed care which ensured that patients were treated with dignity, and most family members we spoke with told us that they were happy with the care that was provided at Queen Mary's Hospital.

We found that multidisciplinary teams worked effectively together and that they were able to ensure that people received care and treatment which was appropriate to ensure that their rehabilitation was facilitated. We found that a specific AAA pathway, which allowed GPs to refer directly to Mary Seacole Ward, was a useful community resource which improved the wellbeing of people who used the service.

The local leadership at Queen Mary's Hospital was responsive to the needs of staff and patients on the inpatient wards. We found that there was an understanding, by the leadership, of the challenges

faced at the hospital and there was a plan and vision to move the services forward. However, some staff felt there was a detachment from the acute trust based at St George's Hospital.

Are community inpatient services safe?

Safety in the past

We received information from the safeguarding lead in the trust which confirmed that there was a policy in place regarding processes for ensuring that staff were aware of safeguarding policies. Most of the staff we spoke with were aware that there was a safeguarding policy and they told us that they had received mandatory training relating to safeguarding.

Learning and improvement

We asked staff on Gwynne Holford Ward if they had had access to mandatory training which included training related to moving and handling patients. One member of staff, who had been using hoists to move patients, told us that they had not had any formal training in moving and handling and would like to access this. We asked for information from the ward to check that staff who carried out moving and handling and who used hoists had received training and were told that two members of staff had not had any formal training but had undergone local competency training signed off by the matron and back care facilitator. We were told that training related to mental capacity and adult safeguarding "used to be mandatory" by the matron on Gwynne Holford Ward.

Staff from Gwynne Holford Ward and Mary Seacole Ward told us that sometimes training was harder to access because it was offered at the St George's site. The matron on Gywnne Holford Ward told us that the lack of mandatory training had been due to there not being onsite training offered at Queen Mary's Hospital. This meant that some staff at Queen Mary's Hospital had not had access to training which had a direct impact on the care delivered to patients. A member of the nursing staff told us, "Lots of training is at St George's".

We spoke with a matron and ward manager on Mary Seacole Ward and asked about ways the staff team implemented learning from incidents, accidents and complaints which had occurred. We were told about a serious incident which had occurred and the learning from that incident had led to additional information about checked equipment being added to the hourly 'intentional rounding' nurses carried out (checks which took place at regular intervals to ensure that patients were safe). This meant that an incident had led to a change in the

processes to improve patient safety. However, when we spoke with the Head of Nursing, they told us that these changes had not yet been rolled out across the trust to St George's Hospital which meant that there was a risk that information learnt from one ward or area did not transfer to other areas.

Systems, processes and practices

We asked staff on Gwynne Holford Ward and Mary Seacole Ward about their understanding of the Mental Capacity Act 2005 and how this was used in practice in a ward setting. Most of the staff we spoke with displayed poor understanding of the practical way the Act would be used on a ward level. For example, senior nursing staff told us it would be the doctor's role to assess capacity without explaining the circumstances when it would be appropriate for a member of the nursing staff to make a judgement. One member of nursing staff told us that "doctors or social workers" would assess capacity without having an understanding of when it would be more appropriate for local decisions to be taken by nursing staff in line with the Mental Capacity Act 2005 Code of Practice. One member of staff in the day rehabilitation unit told us that a family member could consent to treatment on behalf of a patient who lacked capacity to make a decision. We asked how staff learnt about the Mental Capacity Act across the wards we visited and were told by staff that there was an e-learning tool which could be used.

We looked at patient notes and records on the two wards we visited. We did not see any consistent approach to documenting decisions regarding people's mental capacity to make specific decisions. We did not see evidence that the two-stage test of mental capacity had been undertaken, even in notes of people where capacity was identified to be an issue. We also did not see any consistent recording of tests related to cognitive impairments such as standard Mini Mental State Examinations or Montreal Cognitive Assessment which are ways that cognition is assessed. We saw that one set of notes on Mary Seacole Ward stated, "unable to assess capacity as refusing to cooperate" and that a meeting was detailed where a discussion about a patient's discharge was discussed with their family, possibly against their will, but no capacity assessment or clarification of a best-interest decision being made was noted. This meant that the implementation of the Mental Capacity Act was not embedded at a local level and there was a risk that people would not be offered the protection of a robust, documented decision about their capacity to make specific decisions and clear protocols about how best-interest decisions were made when someone lacked the capacity to make decisions.

We saw one set of notes on Gwynne Holford Ward which detailed a mental capacity assessment which had taken place and a best-interest decision where staff had consulted the trust lead for safeguarding as they had had concerns about a particular situation. We saw that the specific circumstances of the individual patient had been taken into account and their care plan had changed specifically to ensure that a less restrictive option was taken. This was an example of excellent practice.

We saw that the quality of medical and nursing records was generally very good on both wards and that they were kept in a comprehensive, legible and chronological order. We saw that therapy notes were particularly clear and comprehensive in terms of meeting the specific needs of patients who had rehabilitation needs.

We checked the cleanliness of the wards and areas of the rehabilitation service. We found that the appropriate checks had taken place and that care and treatment were delivered in a safe, clean and hygienic environment. We saw that, on Mary Seacole Ward, each bay had a regular 'deep clean' which ensured that the environment was clean and hygienic. Patients told us they found the ward clean and one person told us it was "spotless".

The ward matron on Mary Seacole Ward told us that pressure ulcers from grade 1 upwards were monitored on the ward. We looked at the documentation and the intentional rounding notes in relation to two patients on Mary Seacole Ward who had pressure ulcers to see how they were monitored. We checked the nursing records for one person who had a grade 4 pressure ulcer. We saw that guidance had been written in their notes from a tissue viability nurse which had indicated a management plan for that person stating they should be moved out of their bed for mealtimes. However, while we were on the ward, we saw that the records indicated that they had been moved to a chair at 9.30am and remained on that chair without any positional changes until 1.30pm. This meant that there was a risk that their pressure ulcer was not being correctly or safely managed.

We looked at the data relating to new pressure ulcers which were identified on Mary Seacole Ward for the period

between January and November 2013 which was the most recent information we had access to. We saw that in this period, 10 new pressure ulcers had been identified, of which eight were grade 2 and two were grade 3. This showed that the information of the prevalence of pressure ulcers was collated and that there had been incidents over the past year which required monitoring and checks to ensure that they were managed safely.

We also checked the nursing records in relation to fluid charts for specific patients where there had been recommended restrictions on fluid intake. We saw that there were gaps in the recording which meant that specific guidance in relation to advice regarding patient care was not being followed.

Out of the nine sets of nursing notes we checked on Mary Seacole Ward, we found that two had gaps where positional changes were not indicated for patients with identified pressure ulcers. Of the two sets of notes regarding fluid restrictions, one set did not record this correctly and another was incomplete. Apart from these gaps, the nursing records were clear and well organised. However, these gaps in recording meant we could not be assured that the care delivered was safe.

Some nursing staff on Mary Seacole Ward identified concerns about the lack of medical cover at night. One member of staff said, "I've had lots of incidents happen at night time, and I wish we had medical advice here. We can't even prescribe paracetamol – we have to call St George's. Sometimes we have to send people to St George's in the middle of the night". One of the junior doctors, who had started a rotation on the ward a few days prior to our inspection, told us that they were not sure who to hand information over to at the end of their shift at 8pm.

Locally on the wards we saw that staff used a central Datix software system to record incidents and information about the resolution of incidents was fed back to the team.

We were told that there was a monthly, site-specific safety forum which took place at Queen Mary's Hospital. Staff took information about services to this meeting and the information from this meeting was fed back to the senior management at the trust so safety issues could be escalated. We were told that this forum shared learning from serious incidents and staff were asked to highlight unsafe actions which they might have seen or been aware of.

Monitoring safety and responding to risk

We spoke with the ward manager and matron on Mary Seacole Ward and they told us that they had clearly established procedures in place to request additional staff. We were told that the staffing levels were being reviewed in response to the increasing number of patients on the ward and that additional staffing had been temporarily engaged. This meant that the service was responsive to additional risk factors. We saw that additional higher level leadership roles had been put into place on Mary Seacole Ward to support the staff team.

We asked staff how safety levels were monitored. We were given information about recent "mock" CQC inspections which had been carried out and had picked up on some infection control issues, resulting in changes being made on a local level.

Anticipation and planning

We saw that staff had an understanding of care pathways which related to the needs of the patients on the respective wards. However, we saw that the records related to mandatory training did not reflect that this training was taking place at least annually.

Staff told us that they felt supported in their role. We saw that the current vacancy level for nurses on Mary Seacole Ward was 42%. This meant that there was a high level of agency and bank (overtime) staff who were used on the ward, creating the potential risk of a lack of consistency of staffing. However, we were told that vacancies (including one on Gwynne Holford Ward) had been recruited to.

Are community inpatient services effective?

(for example, treatment is effective)

Evidence-based guidance

We asked the ward managers and matrons how they ensured that evidence-based guidance was implemented at ward level. We observed the wards to see how processes were implemented. We saw that the wards used malnutrition universal screening tools to ensure that people's nutritional needs were met. We observed protected mealtimes on Mary Seacole Ward on two days and we saw that these times were respected and used well to ensure that people who needed assistance to eat

received it. We checked that there had been a recent audit of protected mealtimes in July and August 2013. This reflected that protected mealtimes were used effectively on Mary Seacole Ward.

We saw that the trust had implemented a Butterfly Scheme which is a way of alerting staff to people who have cognitive impairments or dementia so that they know what type of support to provide. We saw that the staff knowledge of the use of the scheme varied and that information was indicated on a board which was centrally located and not on patients' individual beds. As a lot of temporary staff were used on Mary Seacole Ward, there may be a risk that some people who should be alerted by this scheme would miss the information.

Monitoring and improvement of outcomes

We asked how complaints were managed on the wards. We were told that the trust manages complaints in the division centrally and we saw that information regarding complaints was taken to a patient experience committee which met bimonthly, and where divisions report biannually so that this information could be passed on to the more senior trust management. This meant that learning from complaints could happen within and across divisions in the trust. For example, we saw the minutes of the patient issues committee from February 2014 for the community services division and saw that complaint summaries were discussed and noted, including the issues which had been identified from the complaints and the actions taken as a result. This indicated that some of the outcomes of practice were monitored and learning took place across the division and the trust.

We asked about auditing that took place at ward level which assured the quality of the services provided. We were told that peer audits took place regularly – for example, falls audits took place twice yearly and this information helped to ensure that services were effective.

We looked at the safeguarding adults audit which had been provided by the trust centrally in April 2013 as that was the most recent information we had access to. We saw that 65 people in the trust took part in the audit at a range of different grades and levels. However, we did not have information about which divisions those audited worked in. Of those audited, 92.3% had accessed the trust's safeguarding policy on the intranet. However, five respondents had indicated that they did not use the policy.

This audit showed that 86.2% of those audited had received some training on the Mental Capacity Act 2005. Of those audited, 33.9% indicated that they had received training in the previous year (to April 2013), 37.5% had received training between one and two years prior to the audit and 28.6% had received training more than two years prior to the audit taking place. We saw that there was an action plan which had been implemented as a result of this audit which indicated that there would be a review of training in September 2013 around the Mental Capacity Act's deprivation of liberty safeguards and other aspects of the Act where knowledge was weaker. When we spoke with staff on the wards we visited, they told us that they had access to e-learning training related to the Act, but their awareness and understanding was poor.

This issue had been identified as a goal in the action plan which was devised following the safeguarding adults audit, but we did not see evidence of it in practice through our discussions with staff on the wards and by looking at medical notes recording issues relating to patients' mental capacity.

Sufficient capacity

We saw that there was a review of the skills mix and number of staff based on Mary Seacole Ward. We saw that team meetings took place on this ward monthly and that the minutes of these meetings addressed ward-specific issues as they arose.

We asked about team meetings on Gwynne Holford Ward and the ward matron told us that, instead of having regular team meetings, the ward had daily meetings where information was shared in relation to the "productive ward" system so that information about some of the targets, such as management of infection control, were discussed daily. During these meetings, issues which related to specific patients were also discussed and these meetings were minuted. The ward matron told us that they felt that this was an effective system which worked on the ward as information was shared broadly and all staff took a role in managing the meetings. We looked at the minutes and saw that issues relating to clinical need were discussed.

Multidisciplinary working and support

On both the wards we visited we saw evidence of strong multidisciplinary working and a visible presence of a

number of therapists. We also visited the day rehabilitation service and observed a session which reflected the integration of physiotherapists and occupational therapists as a part of the rehabilitation team.

All the staff we spoke with, including medical, nursing and therapy staff, told us that they felt the multidisciplinary team working was effective. We saw that patients had access to rehabilitation facilities onsite, including a rehabilitation gym and sessions which were geared to specific rehabilitation goals.

We saw that both wards had support from social workers who were based on the hospital site. This meant that multidisciplinary work was effective and facilitated the rehabilitation goals of the inpatient wards at Queen Mary's Hospital. One member of staff told us that, while the support from the social workers based on the site was extremely positive and helpful, there could be difficulties accessing the same level of support from social workers who are based in neighbouring boroughs.

Are community inpatient services caring?

Compassion, dignity and empathy

We spoke with about 25 patients and their family members and most people told us that they were provided with good care. Some of the comments about Mary Seacole Ward were: "we felt included in the care planning"; and "the staff have gone out of their way to help – lots of nice little touches". Someone also told us, "I will miss being here". On Gwynne Holford Ward, patients told us "staff are wonderful, caring and safety conscious – they don't let you progress until you are ready" and "the doctors are lovely". Two family members raised concerns with us about Mary Seacole Ward where they told us they did not feel their family members were getting sufficient support with eating and drinking.

We observed care on both of the wards and in the day rehabilitation centre. We saw care being provided in a kind and compassionate manner. We observed a physiotherapy session where staff explained to a patient exactly what assistance they were providing and why it was useful to them.

We observed two lunchtimes in Mary Seacole Ward and saw that staff were respectful of patients, providing them with gentle and supportive assistance to eat when it was required. Patients told us that they felt that they received care which was supportive and kind.

We saw that when people were provided with personal care, or when staff had conversations with patients, they used the curtains around people's beds to ensure that their privacy and dignity were respected.

Involvement in care

We observed care delivered by nursing, medical and therapy staff who explained to care to patients, which demonstrated that people were involved in their care.

We saw that the documentation in the medical records generally ensured that consent was documented. Staff we spoke with on both of the wards were aware that consent was necessary and were clear when they explained to us how they would ensure that patients consented to their treatment.

We did not see a consistent way that people who had cognitive impairments were monitored. For example, we did not see evidence of a standard recording of capacity or cognitive impairments using tools such as the Mini Mental State Examinations or Montreal Cognitive Assessment which are standard tools to determine levels of cognitive impairment. Also, we did not see that there was a broad understanding of how and when mental capacity would be assessed.

We saw that, on both wards, there was a lot of information about the ward on display boards. For example, on Mary Seacole Ward we saw that there was a board which recorded when and where activities would be taking place. And we saw a board with information about dementia.

Gwynne Holford Ward had leaflets providing information specific to the needs of patients on the ward – for example, there were leaflets about phantom limb pain which was appropriate for people who had had amputations.

One patient on Gwynne Holford Ward explained to us that they had a good understanding of their care and treatment plan. They told us they had come to the ward before their surgery and had met with the doctor on the ward so, when they were discharged, they were familiar with the setting and some of the people responsible for their care. This was good practice.

Community inpatient services

Both wards had boards which indicated the names and photos of staff who were working, which meant that patients knew who was providing care to them. We observed a pulmonary rehabilitation and education session at the day rehabilitation unit. We saw that patients were given advice on how to manage their health and to retain and promote their independence.

On Mary Seacole Ward we saw that there was information available about the most recent NHS Friends and Family Test, together with an action plan which demonstrated what had taken place as a result of the feedback from patients – for example, noise on the ward was identified as an issue and when we were on the ward we saw signs indicating a specific 'quiet time'. This meant that the service listened to the expressed needs of people who used it.

One patient told us that they would like access to Wi-Fi on the ward and that this was not currently possible.

Trust and respect

We asked staff how people who were not able to communicate in English had their needs met by the service. Staff told us on both wards that they had access to interpreter services when they were necessary. Most staff showed an awareness of situations when it may not be appropriate to use family members to interpret for patients.

We observed that patients were treated with respect by staff members. We saw that, during lunch times on Mary Seacole Ward, tables were put in the middle of the wards so that people could eat communally if they chose to. We also saw a separate lounge being used as a dining room if people wanted a different lunchtime experience.

We saw that there was effective use of communication within the multidisciplinary team, ensuring information was passed to all members of this team. Staff had access to translation services for people whose first language was not English. Staff were aware of the issues in using family members to translate when there were sensitive issues to be discussed with the patient.

Emotional support

We observed staff providing emotional support to people. We asked staff on Mary Seacole Ward about support which would be offered to families in the event of the death of a family member and we were told that families were given an leaflet with useful telephone numbers and contacts for bereavement services.

We saw that patients on Gwynne Holford Ward had access to a psychologist who was based in the multidisciplinary team and would be able to discuss issues relating to the loss of a limb following an amputation. This meant that people were provided with support around their emotional needs and that the inpatient services at Queen Mary's Hospital were caring.

Are community inpatient services responsive to people's needs?

(for example, to feedback?)

Meeting people's needs

We saw that staff ensured that information was passed between different services which were involved with people's care. The staffing teams on both of the inpatient wards worked well in multidisciplinary teams. We saw that both teams had regular meetings with the full team which included medical, nursing and therapy staff. One locum junior doctor who had been on the ward for three days told us that they know who to hand over to at 8pm when they went "off shift" as there was no medical cover at night at Queen Mary's Hospital.

We saw an example of good practice on Mary Seacole Ward where nursing staff updated patients' notes in the bays with the patients so they were able to observe and interact while they were completing their records. This ensured that they were able to respond to patients who needed assistance. We asked staff on Mary Seacole Ward how they were able to ensure the service met the needs of people with different cultural and religious needs. Queen Mary's Hospital had a multi-denominational chaplaincy service that people were able to access. We saw that people had access to meals which would meet their cultural need, for example, Halal food. One patient told us "I am a practicing Christian and the hospital has done a good job in supporting me with this".

We saw that both wards were able to offer gender-specific care when it was requested which ensured that people who had particular preferences regarding personal care had their wishes respected.

Access to services

We spoke with the discharge coordinator on Mary Seacole Ward, who told us that they managed the beds on the ward. As well as receiving referrals from acute hospitals in

the local area, the hospital had an acute admissions avoidance (AAA) pathway which allowed GPs to make referrals directly to Mary Seacole Ward to ensure that acute admissions could be avoided and we were told that people who were referred on this pathway were prioritised. We spoke with the coordinator of this service who was based at the Bryson Whyte rehabilitation unit. This service ensured that people in the local community had a more responsive and appropriate service and it worked effectively to meet the needs of patients.

Vulnerable patients and capacity

We asked staff about their understanding of the use of the Mental Capacity Act 2005 in practice and found that many nursing and medical staff we spoke with had poor understanding of this. We asked staff about the training they had received in this area and some members of staff told us that this was a part of safeguarding training. We asked specifically about situations when capacity would be assessed and found that there was not a consistent response in terms of understanding the way that the Mental Capacity Act was implemented.

We spoke with the clinical director at Queen Mary's Hospital and asked about care pathways for frail older people. We were told that, currently, there are limited specific liaison services in the geriatric services across the trust. However, there were plans to recruit an orthogeriatrician for the care of elderly orthopaedic inpatients.

Leaving hospital

We spoke with the discharge coordinator on Mary Seacole Ward who explained the process for discharging and how planning for discharge started from admission. We saw that there was a hospital social work team who worked with the inpatient wards and that the ward and hospital liaised with different local authorities to facilitate discharge. Staff on both the wards told us that they worked well with the social work teams on the site. However, there were sometimes more difficulties liaising with social work teams in neighbouring local authorities. We saw that there were therapists based on site to ensure that discharge planning was effective and patients told us that they had had home visits with occupational therapists to ensure that equipment was in place for them to be discharged safely.

We saw that between 1November 2013 and 31 January 2014 there had been 130 discharges from Mary Seacole Ward at Queen Mary's Hospital, 14 of which (10.8%) had been readmitted to St George's acute hospital within 28 days of discharge. This demonstrated that most discharges were effective.

Learning from experiences, concerns and complaints

We saw that a serious incident which had taken place on Mary Seacole Ward had led specifically to a change in processes on the ward which indicated that learning from the incident had taken place. We also saw that information about how to make complaints was visible on both the wards we visited. We looked at the most recent information provided in February 2014 of the patient issues committee. This demonstrated that information about complaints was discussed at the divisional level and this information fed into the Trust Board. We saw that data relating to complaints was collated. We saw that the older person and neuro-rehabilitation sub-division within the community services division had received five complaints in July--September 2013 (quarter two 2013/14) of which only one (20%) had a response within 25 working days; there had been six complaints in October–November 2013 (quarter three 2013/14, up to 21 January 2014) of which three (50%) had had a response within 25 working days. We saw that the main themes were highlighted in the report as relating to nursing care (three complaints). We saw from the information provided to the patient issues committee that systems were in place to ensure that learning from incidents and complaints took place locally, at a ward level and at a divisional level. We saw that the data from the NHS Friends and Family Tests were fed back at a divisional level and the information was provided through the patient experience committee.

We spoke with the ward manager on Gwynne Holford Ward who told us that, when they had had a poor result for the Friends and Family Test, the head of nursing came to the ward and was supportive. The ward manager told us that they looked at their practice to learn from their Friends and Families scores to ensure that they learnt from patient feedback.

Community inpatient services

Are community inpatient services well-led?

Vision, strategy and risks

Staff we spoke with on the ward told us they felt that they had a good idea of where the trust was heading. We spoke with the divisional and ward leadership at Queen Mary's and found that those who were leading at a local level had an awareness of the local issues and plans to take forward and make improvements. For example, the ward matron on Mary Seacole explained that there is consideration being given to split the ward into two areas to improve the patient experience. The lead clinician on the Queen Mary's Hospital site who was consultant geriatrician told us that there were plans to expand consultant geriatrician workforce as that was a current concern. However, they expressed concerns that, apart from the additional provision of an orthogeriatrician, there had not been confirmation of the plans for improvement.

We found that most staff on the wards, through all levels, had an understanding and knowledge of the trust's vision and were aware of the executive level leadership. However, we were told that the 'middle management' was not always as visible on the Queen Mary's site. Staff told us that they felt there was some disconnect between Queen Mary's site and St George's with access to training and IT support being less visible at Queen Mary's.

Quality, performance and problems

We saw that, while local improvements and communication channels were strong, we did not see evidence that learning at Queen Mary's Hospital – for example, the changes made to the 'intentional rounding' charts (documenting round-the-clock care) following a serious incident on Mary Seacole Ward, had affected changes across the trust. Although, we were told that there were plans to roll out the learning which had taken place on the older adults wards in the trust. There was a risk, though, that the learning would remain on one site where there had been issues raised. Staff we spoke with identified IT problems as a trust-wide issue and the specific lack of IT support at Queen Mary's was mentioned by some staff. We saw that the issue of slow IT connections for community staff was raised on the trust IT risk register in 2011 and remains on the risk register with a high risk score.

Leadership and culture

On a ward and divisional basis, we saw that leadership was noticeable and strong. On Gwynne Holford Ward we saw that the staff group updated the information on their 'productive ward' daily as a team and felt responsible for ensuring a productive and up-to-date ward. The matron on Gwynne Holford Ward told us that the trust had invested in a band 7 leadership programme which they found helpful because it had allowed them to network with other band 7 nurses across the trust in different locations. It had also helped to build a more cohesive identity across the community and acute divisions within the trust. We also spoke with a ward manager who had participated in this programme and had found it very helpful. Most staff we spoke with at all levels were proud to work for St George's Healthcare NHS Trust. One healthcare assistant we spoke with on Gwynne Holford Ward told us, "I feel proud to work at St George's. It has a very good reputation".

Patient experiences and staff involvement and engagement

Staff told us that patients can give feedback at any time, through a variety of ways, including using patient experience touch-screen devices on discharge. We saw patients using this system during our inspection at the hospital.

We asked staff how information flowed down in the trust, and one member of staff said "we often hear important information on the grapevine". Other members of staff told us they didn't feel they always got feedback from the senior management in the trust.

We saw that the results of the NHS Friends and Family Tests were on display on the ward and that this information was used to inform changes such as the "quiet time" which was in effect on Mary Seacole Ward.

We looked at the Patient-Led Assessment of the Care Environment (PLACE) which had taken place at Queen Mary's Hospital on 17 May 2013 where cleanliness was rated at 99.8%, food at 94.7%, privacy, dignity and wellbeing at 86.3% and facilities 90.6%. We were told this outcome was monitored by the board at Queen Mary's Hospital.

Learning, improvement, innovation and sustainability

We looked at the staff turnover rate within the community services division and saw that it was 14.2%. The staff

turnover rate within adult and diagnostic services, which covers a broader remit than the community inpatient wards, was 18.09%. We were told that the vacancy rate on Mary Seacole Ward was 42% and, despite the posts having been recruited to, there was not a consistent, stable staff team on the ward. This impacted on the care staff were able to provide as temporary staff while used required induction.

The ward matron on Gwynne Holford Ward told us that the mandatory training updates were "very overdue" due to the lack of onsite training at Queen Mary's Hospital. This meant that there were gaps in the reinforcement of training across staff groups on the ward. Most staff we spoke with told us that they felt they would be able to raise concerns with their managers. We saw staff were encouraged to report incidents in a way that led to organisational learning at a local level.

We asked staff how they gained information about the trust and its strategy and most staff were aware of information available on the intranet which they had access to. We saw that there was evidence of some positive pathway planning such as the AAA pathway which promoted a direct referral link for local GPs to support people to receive rehabilitation support and avoid the need for older people to be admitted to acute hospitals. We looked at the occupancy rates of the wards: for January 2014, the amputee rehabilitation occupancy rate was 86.8%; for neuro-rehabilitation it was 81.1%; for elderly rehabilitation it was 96.3%. This meant that there was some scope for admissions and discharges to be facilitated within the hospital. This information allowed the service to plan for the future needs.

We were told that there were plans to increase the neuro-rehabilitation facilities on the Queen Mary's site.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers People who use services and others were not protected against the risks associated with obtaining the consent of patients with limited capacity as not all relevant staff understood the requirements of Mental Capacity Act 2005 and how this relates to vulnerable adults in terms of best interest decisions and informed consent. Regulation 23 (1) (a) **(b)** HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises.