Inspection Report

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

Weston General Hospital

Weston General Hospital, Grange Road, Uphill,
Weston Super Mare, BS23 4TQ

Tel: 01934636363

Date of Inspections: 26 June 2013
25 June 2013
24 June 2013

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

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Weston Area Health NHS Trust
Overview of the service	Weston General Hospital serves the population of North Somerset and the surrounding areas. The hospital provides a full range of acute medical and surgical services. There is a 24 hour emergency department, an intensive care unit, 11 inpatient wards and a private patient suite. The maternity unit is a midwife led unit for low-risk births. The Seashore Centre provides day care and community services for children and young people. The WISH unit provides contraception and sexual health care.
Type of service	Acute services with overnight beds
Regulated activities	Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Weston General Hospital had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Assessing and monitoring the quality of service provision

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 24 June 2013, 25 June 2013 and 26 June 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by other regulators or the Department of Health, reviewed information sent to us by other authorities, reviewed information sent to us by local groups of people in the community or voluntary sector and talked with other regulators or the Department of Health. We talked with other authorities, talked with local groups of people in the community or voluntary sector and used information from local Healthwatch to inform our inspection.

What people told us and what we found

This inspection was to check that action had been taken to address the two warning notices issued when we last inspected the hospital on 16 – 18 April 2013. These related to people not being treated with dignity and respect and people's care and welfare needs not being met. We also checked on the hospital's quality monitoring systems. The compliance actions issued at the time of the April inspection for three other areas of non-compliance will be followed up later in the year.

At this inspection we visited 11 wards and the emergency department. We spoke with 70 patients, three relatives and 19 staff. We looked at 36 patient records.

We found a significant improvement in the way patients were treated. Patients said "Staff always pull the curtain around my bed when providing personal care and give me reassurance" and "The staff are very respectful and always ask before they do anything". We observed staff cared for people in a respectful and considerate manner.

Patients were happy with the care and treatment provided. Patients said "The call bell, food and drinks are all put within my reach and they come quickly when I need them" and "The care has been first class and I've been looked after really well". Records confirmed that patients received appropriate and timely assessments and care was delivered in line with their individual care plans.

We found improved quality monitoring arrangements had been made in response to our previous inspection findings.

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

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

At our last inspection we found suitable arrangements were not in place to ensure the dignity and privacy of patients. Vulnerable patients were not being treated with consideration and respect.

At this inspection we found a significant improvement in the way patients were treated. We did not observe any incidents of poor care practice. On all of the wards visited we received favourable comments from the majority of patients.

The great majority of patients were complimentary about the care provided by staff. Patients told us "Nothing is too much trouble for them", "Staff always pull the curtain around my bed when providing personal care and give me reassurance" and "The staff are very respectful and always ask before they do anything".

We spoke with 70 patients in total and of these just five expressed any level of dissatisfaction. The patients who expressed some dissatisfaction attributed this to individual members of staff but were not willing to identify them. Overall they said they were happy with the care provided. We were told "Some staff are more polite and caring than others" and "I have experienced some very good care and some poor care". We spoke with the relevant ward sisters who said they would discreetly speak with the patients to see if they could address their concerns.

At our last inspection we had particular concerns about the treatment of vulnerable patients with sensory impairments such as hearing or vision difficulties. At this inspection we spoke with relatives of one older patient with hearing impairment. One of the relatives said "Staff are aware of our relative's hearing difficulty and speak loudly into their better ear. Our experience is very good, everything has been done well". We observed a discreet sign above the patient's bed that indicated to staff they had a hearing impairment. Their care plan also identified the patient's communication needs and how staff should communicate with them.

We observed a patient on another ward with severe learning difficulties. They were unable to speak but appeared to understand what staff were saying to them. We observed staff caring for them in a kind and considerate manner. Staff told us they were able to communicate by interpreting the person's eye movements and hand gestures. They told us they had discussed the person's care needs with staff from the care home where they lived and with a relative. For example, by positioning the person in a certain way they were able to eat their meal rather than having to use a feeding tube. This was documented in the patient's care plan record.

Another patient told us "The attitude of staff is right, they are caring and respectful. I've seen patients who can't fend for themselves getting good care".

On another ward one of the patients said "They have some very difficult patients on this ward that can be downright rude. But staff still manage a smile and talk to them nicely". The staff nurse explained that there was a patient on the ward who could display challenging behaviours. They needed constant one to one support from staff. We observed two staff assisted the patient with washing and dressing. We heard the patient crying but became less agitated as staff continued to give reassurance and speak to them in a considerate and sensitive manner. The individual needs and treatment plan for this complex patient were recorded in their care plan.

We observed examples of patients being treated with consideration and respect on all the wards visited. We observed patient's privacy and dignity was maintained by pulling curtains around the bed whenever personal care was delivered. Patients told us staff responded quickly when they needed assistance to the bathroom or other support. We heard staff speaking respectfully to patients and regularly reassuring or encouraging them.

Ward staff spoken with told us they had been briefed on our previous inspection findings at team meetings and by written communications. A number of nurses and healthcare assistants told us they welcomed the increased emphasis on nursing values and compassionate patient care. They now felt more empowered to speak out when they witnessed poor care practices.

We asked the director of nursing what changes had been made since our previous inspection. She said a significant change had been the introduction of the Wednesday Ward days for all matrons and senior nurses. Every Wednesday morning the senior nurses who were not ward based completed a ward round, or worked clinically, where they observed the care provided and challenged any poor practice.

After the Wednesday morning ward rounds, the senior nurses met together to discuss any lessons or other issues that had come to light. We attended the Wednesday senior nurse meeting during our inspection and observed a lively and informative discussion. The hospital's lead nurse service improvement told us she completed weekly observational audits of the wards. The results of the audits were discussed at the Wednesday senior nurse meetings. She said she had noticed a real improvement in staff attitudes "everyone wants to pull together now".

The director of nursing said she tried to walk the wards every day and also spent some shifts working as a nurse on the wards delivering personal care to patients. The other members of the hospital's executive team had also sponsored two wards each and carried out regular ward visits to observe the care provided.

One ward sister told us "The director of nursing leads by example. She is seen on the ward washing patients. She emphasises the importance of nursing skills. We are feeling proud to be nurses again and morale has improved. People need care and we are carers first of all. That is what nursing should be about".

At this inspection we observed ward sisters and nursing staff were much more visible on the wards. This had a beneficial impact on the standard of care experienced by patients.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

At our last inspection we found shortfalls in the assessment of patient's needs, and in the planning and delivery of care. At this inspection we found significant improvement in the way patients' needs were assessed and how their care was planned and delivered.

Patients told us "The call bell, food and drinks are all put within my reach and they come quickly when I need them" and "I've got no complaints everyone's been very good". A patient admitted to the stroke ward said "The care has been first class and I've been looked after really well. I can't speak highly enough about the staff in the accident and emergency department and on the ward".

The patient told us they were seen quickly in the emergency department (ED) because they had a suspected stroke. They were given various tests and a brain scan to assess their condition. They said the ED staff constantly checked on them throughout the night and could not have been more attentive. They were admitted to the stroke ward during the night. They said the care and treatment on the ward could not be faulted. In particular they praised the encouragement and support provided by the occupational therapists and physiotherapists. This had enabled them to regain movement in their affected limbs as well as their confidence.

We were told of similar good experiences by several other patients on different wards. Many patients had been admitted to the wards from the ED. Patients told us they felt "in safe hands" while waiting to be admitted onto the wards. They said they were kept fully informed about their planned treatment and when and where they were going to be admitted to. They said communication between the ED and the admitting wards was very good.

A ward sister told us that all wards held morning 'board meetings'. These meetings were used to assess bed capacity and whether any patients were fit for discharge. A white board on the wall showed each patient's current condition status from the medical, nursing, physiotherapist and occupational therapist perspective. When all healthcare professionals were satisfied with the patient's progress they were assessed as fit for discharge.

Wards also held weekly multi-disciplinary team (MDT) meetings to discuss each individual's care and when appropriate their discharge plans. To facilitate discharge planning a social worker attended the weekly MDT meetings. One patient who was ready to be discharged home told us "I have been admitted to the hospital before. I can see things have got better. My experience this time has been really good from admission through to discharge".

We observed examples of good care across all of the wards visited. On one ward we observed a very ill patient who was unconscious and receiving oxygen. A healthcare assistant was providing one to one care and we observed them sitting by the patient's bed offering regular reassurance and attention. We checked the patient's care records and saw evidence of good care planning including involvement of relatives in contingency planning should the patient not respond to treatment. We observed the patient's care was being delivered according to their care plan.

On a different ward we observed another patient with a dementia receiving one to one care. The sister told us the patient was medically fit to go home but she did not think they were safe to be discharged. A Mental Capacity Act 2005 best interest meeting had been arranged so that relevant health and social care professionals could discuss an appropriate discharge plan to ensure the person's safety and welfare was protected. This showed care and treatment was planned and delivered in a way that ensured people's safety and welfare.

On another ward we observed a nurse on a medication round. The nurse was heard asking patients if they were in pain and if so to rate the pain on a scale of 1-10. We heard the nurse say to one patient "Let's try this first. If it doesn't work we can go to the other medicine." This was an example of care and treatment being delivered to meet the needs of the individual patient.

In total we looked at 36 patient records across all the wards. We saw that care needs assessments were completed within 24 hours of the patient's admission to the ward. There was now a single evaluation summary that made it easier for staff to see the patient's overall care needs. We found a big improvement in the recording and monitoring of care provided.

There was clear guidance for staff to follow and direction to further guidance for specific conditions and nursing interventions. The daily evaluation sheets showed clearly what interventions had taken place and the patient's progress during that shift. Several nurses told us they found the new care planning system was a big improvement. They had a clear understanding of the needs of the patients they were caring for and knew what nursing interventions were required.

We visited the emergency department (ED) and spoke with the medical consultant, a staff grade doctor and the emergency nurse practitioner (ENP) in charge on the day. They told us things had improved since our last inspection but this was largely down to the seasonal reduction in emergency admissions. At peak times there were still pressures on inpatient beds and delays in off-loading ambulances. Some changes had been implemented to relieve the pressure on the ED, such as direct GP referrals to the medical assessment unit and the high care unit. We will review the impact of planned staffing initiatives in the ED when we follow up on our compliance actions later in the year.

The director of nursing told us the hospital wards had been reconfigured since our last

inspection. There was now a dedicated medical admissions unit which assessed patients within 24 hours and then discharged or admitted them to an appropriate ward. The wards were now concentrating on particular specialisms which ensured improved care.

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

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

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people received.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

Reasons for our judgement

This standard was not reviewed at our last inspection on 16 – 18 April 2013. At our last inspection we found several areas of non-compliance. This standard was included in this follow up inspection to check if changes had been made to improve the effectiveness of the hospital's quality monitoring systems.

The Trust had an established corporate governance framework with a delegated committee structure to oversee all aspects of quality, finance and risk. We looked at the latest monthly integrated performance report to the Trust Board. This showed performance and monthly trends against key performance indicators. Overall, the trust performed well against most of these high level indicators although some areas for improvement were flagged up.

This included pressures due to the increase in emergency admissions, waiting times to be seen in the emergency department and an increase in cases of clostridium difficile infections. The Trust had initiated a number of service transformation projects to identify and implement new ways of working. An example was the direct referral by GPs for a CT scan for suspected stroke patients with direct admission to the stroke unit for thrombolysis treatment. Specialists in infection control from the NHS Trust Development Authority were providing the Trust with additional assistance and advice on control and prevention of infections.

Prior to our inspection in April 2013 the Trust had identified a shortage of nursing staff and a need to review the emergency admissions pathway. Plans had already been agreed for a substantial increase in nurse numbers and a complete reconfiguration of the hospital's wards. In this regard, the quality monitoring systems had identified problems and remedial action was planned.

However, the quality monitoring systems had failed to identify or effectively react to the

serious concerns we found regarding the privacy and dignity and the care and welfare of patients. The director of nursing outlined several changes to their quality monitoring arrangements made in response to our previous inspection findings.

A new Clinical Audit and Effectiveness Committee had met for the first time in May 2013. This committee had been established to closely scrutinise the quality agenda and promote high standards of clinical practice, audit and review. Particular emphasis was being placed on National Institute for Clinical Excellence (NICE) guidance and quality standards. The effectiveness of the Trust's clinical audit programme was also being scrutinised. Together with the existing Drugs and Therapeutic Committee and the Risk Management Committee, the new Clinical Audit and Effectiveness Committee would ensure all areas of clinical governance were closely monitored and reviewed.

A number of other initiatives had been implemented. These included 'Ward Wednesdays' where every Wednesday morning all of the non-ward based senior nurses carried out ward observational visits and then met with the director of nursing and ward sisters to discuss any issues and share learning across the wards. Hospital matrons now had to report to the director of nursing on a daily basis to confirm they had visited all of their wards and flag up any issues found.

There were now weekly audits to ensure nursing documentation was properly completed and the results were reported and discussed at the Ward Wednesday meetings. The Trust's executive and non-executive directors were 'sponsoring' two wards each and visiting weekly to check on patient experiences. It was planned that representatives from the hospital's Patients Council would also participate in future ward visits.

We looked at the Trust's complaints policy and reviewed a number of the complaints and the resultant actions. The policy contained timescales for responses to complaints and details of the next stage if complainants remained dissatisfied. Each complaint had a learning from experience action plan with a designated lead person, timescales and evidence of successful completion. This showed the hospital took account of complaints and comments to improve the service.

We looked at the hospital's monthly serious incident summary report. This provided a summary of all serious incidents, lessons learned, action taken and arrangements for sharing learning. There was evidence that learning from incidents and investigations took place and appropriate changes were implemented.

There was evidence that patients and their representatives were asked for their views about their care and treatment. The Trust carried out monthly patient satisfaction surveys and the results were reported to the Trust Board. The levels of patient satisfaction had dropped over the winter months but had improved in the latest report. The Trust had a Patients Council consisting of 16 voting members who were appointed through a formal application and selection process. The chair of the Patients Council held a non-voting seat on the Trust Board. The Patient Council met monthly and reported to the Trust's Quality and Governance Committee. Issues considered by the Patient Council included the Trust's procurement process to identify a future strategic partner, CQC's last inspection report and plans for members to join the Trust's executives on observational visits to the wards.

We looked at the most recent minutes for the Risk Management Committee, the Health and Safety Committee, the Infection Prevention and Control Committee and the Drugs and Therapeutic Committee. We could see that a wide range of clinical and non-clinical risks

had been assessed and action had been taken to minimise the potential risks. The Trust maintained a corporate risk register that prioritised the identified risks and the actions to address or mitigate these risks. This meant there were systems in place to identify, assess and minimise risks to patients, staff and visitors.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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