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

Macclesfield District General Hospital

Victoria Road, Macclesfield, SK10 3JF
Tel: 01625661501

Date of Inspection: 12 February 2013
Date of Publication: March 2013

We inspected the following standards as part of a routine inspection. This is what we found:

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<td>Care and welfare of people who use services</td>
<td>✗ Action needed</td>
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<td>Safeguarding people who use services from abuse</td>
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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 12 February 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information we asked the provider to send to us and reviewed information sent to us by local groups of people in the community or voluntary sector.

What people told us and what we found

During this unannounced inspection we visited three wards and the Patient Advice and Liaison Service (PALS). We visited a 21 bed, surgical day case ward (Ward 2) which on the day of the inspection was being utilised as a medical ward, we visited a respiratory ward (Ward 4), which had temporarily extended its bed numbers to 34, and a 28-bedded Orthopaedic ward with occasional elective surgical patients (Ward 5).

All parts of the hospital we saw during our visit were clean and we observed staff to be professional, treating patients with consideration, dignity and respect.

We met 13 patients over three wards, reviewed eight patient records and met ten members of staff during the course of our visit.

We saw that patients consented to treatments and were provided with sufficient information to make informed decisions.

Staff informed us that the trust had taken action to address the gaps in staff levels across the trust with investment to increase staffing levels already taking place. However we found that the balance of permanent staff to agency or bank staff on one ward impacted on the delivery of consistent care to patients. Patients we spoke with found the staff on ward 2 to be exceptionally busy whilst on the other wards this was not the case.

We found of the eight patient records reviewed, some incomplete initial assessments and gaps in five records of the patients risk assessments or their reviews.

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

What we have told the provider to do

We have asked the provider to send us a report by 03 April 2013, setting out the action
they will take to meet the standards. We will check to make sure that this action is taken.

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

**More information about the provider**

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

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

<table>
<thead>
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<th>Consent to care and treatment</th>
<th>Met this standard</th>
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<tr>
<td>Before people are given any examination, care, treatment or support, they should be asked if they agree to it</td>
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Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

We conducted an unannounced visit on 12 February 2013 to Wards 2, 4 and 5 at Macclesfield General Hospital.

Ward 2 was converted from a short stay five day per week ward to a 24-hour inpatient ward on the day of our visit. We spoke with five patients on the ward and reviewed three care plans. We reviewed one patient's records and found they had a diagnosis of Dementia. On discussion with one staff member, it was clear they knew the patient and were aware of their dementia care needs but another member of staff was not. We were told by the trust that to assist staff where there was a diagnosis of Dementia or Alzheimer's Disease a forget-me-not flower logo would be discreetly used, with this placed either over the patient's bed or on the bed notice board. The provider may wish to note that in this instance we found no 'forget-me-not' in place and across the three wards visited this appeared not to have been fully implemented.

One patient told us when we asked about consent: “I have given consent-I signed a form”, they also said: "I discussed my treatment with the staff" and "I insisted on knowing all the details." They informed us that they had discussed with staff the treatment options.

On Ward 4 a medical respiratory ward we saw that literature about various treatments was available to patients. We spoke with three staff members who told us that patients were given specific information about any procedure prior to gaining their consent and had a discussion with the medical staff or nurses to include any additional questions they had. This gave patients the opportunity to consider and discuss any potential risks to ensure that people were appropriately informed prior to consenting to any treatment. The staff said that the doctor would discuss the patient's health, the benefits and risks of any treatment and of any alternative treatments if available.

The ward manager told us that in general, consent processes were completed by the medical staff on the ward. They said that for any invasive procedures consent forms were completed with the patient or their advocates' involvement. Patients were asked to sign...
consent forms if they agreed to the treatment and a copy was given to the patient. They
told us there was a new system in place, a 'Dementia Screening Tool,' in which the doctors
at admission asked the question: "Have you been forgetful?" designed to alert staff to
whether the patient required additional support. We saw in one patient’s initial assessment
in the care and treatment documentation that this had been asked and the staff recorded
their response.

The staff said that they could access information via the intranet about consent with trust
policies and guidance in place. The ward manager said that they would access
independent advocacy services through the social worker who attended the ward each day
or via the contact list in the trusts policy.

We spoke with five patients, one of whom told us that where consent was required staff
had: "Explained it" to them and when appropriate another patient said they had: "Signed a
consent form." We saw welcome leaflets with full information about who worked on the
ward and the roles undertaken by various staff. Other leaflets included, privacy and dignity,
information governance and making advance directives about Cardio Pulmonary
Resuscitation.

We visited ward 5 an orthopaedic ward with occasional elective surgical patients. We
spoke to five staff and asked them about consent. One said: "Patients who are to have an
operation, the operation is explained to them and then the consent is gained and signed
for. We try to keep patients independent." The ward manager told us patients gave
informed consent and that staff were mindful of patient's preferences for example gender
specific staff preferences regarding their care.

We spoke with three patients about consent and one said: "They ask me before they do
anything", another said: "I'd expect them to ask me, I think they do and I'd tell them if I
didn't like it."

The trust provided us with information about the staff induction programme, 'Clinical
Mandatory Training' that covered areas such as consent and record keeping. We were
also provided with evidence of various staff attendance at additional training entitled an
'Overview of The Mental Capacity Act and Deprivation of Liberty Safeguards' and saw that
further dates were planned for this training on 20 and 21 February 2013.

We saw an activity report for 1 October 2012 to 31 December 2012 provided by the Local
Authority Mental Capacity Lead to the trust on referrals made for an IMCA service. We
saw that referrals were made by doctors, consultants and others which included those
made from Macclesfield District General Hospital location. We saw minutes from two best
interest professionals and family meetings held in 2012 whereby decisions were recorded
and agreed by those present.

We saw that the trust had completed a clinical audit of 24 records on four wards, which
included wards 2 and 5. It recommended changes to the consent form to ensure that the
signed copy was always given to the patient once it was completed. Recommendations
were also made for the consent forms to be redesigned by April 2013. Consent training
was also reviewed which they hoped to provide in the future as e-learning.

Each ward we visited had a hard copy of the Mental Capacity Act (MCA) 2005 including
Deprivation of Liberty Safeguards policy available for staff to access. These are legal
requirements that need to be followed if patients at the hospital do not have the capacity to
make decisions about the care and treatment they receive to ensure these are made in
their best interest. The trust also had guidance in place for staff in respect of 'Best Interests Decision Making.'
Care and welfare of people who use services  

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

Our judgement

The provider was not meeting this standard.

Care planning, risk assessments and reviews of patient's needs were not always sufficient to promote the welfare and safety of the individual or other people using the service.

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

Reasons for our judgement

We looked at patient records across all three wards we visited. We saw staff interacted with patients in a positive way and they respected patient's privacy and dignity.

Staff described 'Comfort care rounds' on each of the wards we visited. This involved staff visiting and speaking to each patient usually every 2 hours and asking the patient how they were, if they needed repositioning, a drink, pain relief or to use the bathroom. This meant that nursing staff had a good picture of what help a patient had received in the previous hours.

Matrons completed monthly 'Matrons Assurance Care Indicators' whereby five patient records were randomly selected and audited, as well as completing environmental checks and observations. We sampled four of these documents from ward 4 dated between October 2012 to January 2013 and found that where the audit identified records that were incomplete or required review this was brought to staffs attention and action was taken.

We also saw that the NHS Safety Thermometer checks took place. This is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. There are five key indicators including falls and pressure ulcers. On Ward 4 the percentage of patients with harm free care for the months of October to December 2012 was 100%.

Ward 4 staff told us that they were 'piloting' a 'Board Round' in which medical staff and other health and social care professionals attended the ward each morning at 9am to discuss patient care, treatment and discharge planning. This meant that relevant information was shared appropriately with the staff responsible for the patients' care. We saw evidence that staff handover arrangements were in place to review patients' care and treatment.

We spoke to five patients on ward 4, all were happy with the care they received. One patient told us: "The staff are wonderful. The food is good. It would be nice if all hospitals could be like this." The provider may find it useful to note that one relative found
communication between them and the ward staff at times could have been better.

We saw evidence on ward 4 of daily record keeping checks completed by the ward manager. They included checks of patient care plans and risk assessments such as nutrition, falls and skin integrity. It was clear from the documentation that staff were expected to complete some assessments within six hours of admission, falls and manual handling risks within 24 hours and the Malnutrition Universal Screening Tool, within 48 hours. Staff told us that the trust policy was that risks would be reviewed weekly or if the patient had any health improvement or deterioration.

We visited Ward 2 which was very busy. The ward manager told us this was due to the numbers of non permanent staff on the ward who required support and guidance on the ward routines from the permanent staff.

We reviewed three patient records and found gaps in the risk assessments completed in each. Examples in one care plan included a falls risk assessment and pressure ulcer assessment completed 05/01/2013, reviewed 19/01/2013, manual handling had not been reviewed since 05/01/2013. We also found no specific care plan of how the patient's dementia care needs were to be met.

In the second record, falls risk assessments were completed on 01/02/2013 but were not reviewed and the patient's history included that of falls at home. The patients' daily record noted patient 'confusion' on 03/02/2013, 06/02/2013 and 09/02/2013 but the communication assessment read that there were no concerns regarding confusion. We read in the notes about the plans for discharge, which on speaking to the patient they were clearly unaware of.

The third record had an incomplete initial assessment and the ward manager told us the patient had transferred from another ward. We found the communication assessment conflicted with the daily records. The assessment said no signs of confusion, but staff wrote there were episodes of intermittent confusion in the daily notes 01/01/2013. We spoke with the patient and observed that their call bell was still coiled and stored behind their chair. The patient said: "I don't know which buzzer to press. I pressed this one (the bed remote control) and no one came so I went to the door and shouted them." A health care assistant told us agency staff had admitted the patient and that was why they did not have the call bell and was still in a hospital gown. The ward manager told us they had not been in their supervisory role due to ward staffing levels and therefore the daily record audits were not completed, which would have identified gaps in patient records.

We spoke with five patients and one said: "The care is much improved since the last time I was here." They also said; "Staff are busy-they come when they can but if I need the commode it's agony waiting. I have told them." We observed patients asking for help and having to wait because there were no staff available to support them as they were busy with other patients. When staff were free they attended to the patients who were waiting.

We also visited ward 5, spoke with three patients, five staff members, and reviewed two patient records. One patient told us: "On the whole it's not too bad-I get sore waiting in the chair for them to put me back to bed. The food is not too bad-it's edible." Another patient said they were "Very happy" with their care. The provider may wish to note that in one care plan the dementia pathway was not completed and a body map was completed that showed bruising but this was undated.

During the visit we found some incomplete risk assessments and reviews that had not
taken place as expected. This meant there was the potential risk of patients changed needs being overlooked by staff. The permanent staff to bank or agency staff ratio on one ward appeared to impact on the ability of staff to provide care and support in a timely way.
Safeguarding people who use services from abuse  
Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

During our visit we observed that patients were treated with dignity and consideration by the staff. We observed that patients appeared relaxed, confident around staff, and comfortable in their presence.

We spoke with 13 patients across the three wards we visited, they told us they felt safe and raised no concerns about adult abuse during our visit. Patients we spoke to knew how to make a complaint and were confident that they would be listened to.

We spoke with 10 staff members (Including ward managers, nurses, a rehabilitation assistant and healthcare assistants), about their understanding of good safeguarding practice, their duty of care, their responsibility to keep patients safe and what action they would take in response to concerns. All the nursing staff we spoke with had completed training in safeguarding adults. Staff told us they had not witnessed any poor practice on the wards where they worked.

Staff we spoke with were able to tell us what action they would take in response to concerns and how they would ensure patients' safety. Staff demonstrated a good understanding of what constituted abuse and were able to give examples; they were equally able to demonstrate what action they would take.

We observed that staff could access via their intranet computer system the trust's policies and procedures and the ward manager demonstrated that these included safeguarding procedures.

We saw paper copies of the Mental Capacity Act 2005 were accessible to staff, which for example were on the staff office notice board on Ward 4. We were told that staff could access the Local Authority safeguarding procedures 'No Secrets' Guidance.

Staff told us as part of their 'Statutory and Mandatory' training they attended both adults and children's safeguard training and refresher training to ensure their learning and development was up to date with current practice. The trust told us there would also be e-learning training in place for safeguarding vulnerable adults from April 2013.
Staff were able to demonstrate their understanding of adult abuse and how they reported safeguarding concerns. We saw the trust’s procedures clearly advised staff what to do if they had a concern or suspected abuse. Staff told us that safeguarding would be reported, they completed referral documentation, and they contacted the safeguard named nurse lead. We were told it was usually a matron who held the adult safeguarding bleep. They told us that they would contact the social work team and security or the police where appropriate to do so.

The Care Quality Commission has had regular meetings with trust managers during 2012. As part of these meetings, managers have explained the trust’s assurance framework and how incidents relating to safety, quality and standards were investigated and addressed. We have been provided with notes of meetings from the safety, quality and standards committee and these have given us assurance that incidents are taken seriously and there are appropriate processes in place to investigate them and ensure action is taken to address them and to help prevent them happening again.

The trust told us that their community staff adhere to the Local Authority policy for both Cheshire East and Cheshire West and Chester. We saw that a representative of the trust attends both Local Safeguard Adult Abuse Board meetings.
Staffing

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were insufficient numbers of staff who were familiar with the patients and the running of the ward. Patients did not always receive continuity of care when there was a greater use of temporary agency and bank staff.

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

Reasons for our judgement

The trust told us the dependency levels of patients, the skill mix and experience of staff were closely monitored, particularly at times of high occupancy levels. To ensure patients care needs were met the trust monitored staffing levels including the use of agency and bank staff. Information we received confirmed that the trust had taken action to address the gaps in staff levels across the trust with investment to increase staffing levels already taking place with staff currently on their induction.

Staff on all three wards we visited told us they had staff vacancies and were enabled to use agency staff or their bank staff when needed. New nurses had been recruited but were either in the process of their induction or had yet to commence employment. The ward manager on ward 4 told us each new member of staff received an induction before starting work on the ward and had two weeks supernummary status on the ward. They said until recently ward 4 had had staff vacancies but that staffing had now improved. The staff on ward 5 raised no issues or concerns around staffing levels.

Ward 2 changed from a surgical ward to a general medical ward in response to the need for medical beds. Arrangements were put in place by the trust for a named medical consultant to be "attached" to the ward. They completed a ward round each day, with the consultant's foundation one and two doctors, designated as the junior doctors for the ward. This they called the 'Buddy Ward' system. The ward manager told us that this worked well.

During our visit to ward 2 we asked to see the staff rota and saw evidence of requests for staff to complete additional shifts pinned on notice boards. We saw there had been gaps in the rota due to staff sickness, maternity and annual leave but records confirmed that there were effective measures in place to ensure there were adequate numbers of staff in place. The ward manager informed us that staff from agencies and using bank staff meant that these staff were unfamiliar with the routines of the ward. This meant the permanent staff then spent time supervising bank and agency staff and so had less time available to provide care and support or complete checks and audits to ensure a quality service.
The ward 2 manager told us they had also been counted in the ward staff numbers for the past three weeks rather than being supervisory. The consequence of this being they were unable to complete other duties such as daily audits. They told us that other weekly and monthly audits were being completed. On ward 2 we saw evidence within the patients' records, of risk assessments not being fully completed or reviewed including a patient transferred from another ward. Therefore, some patients were at risk of not receiving the care they needed because their needs were not fully assessed or risks reviewed and a there was a lack of staff continuity to meet patients’ needs.

Patients we spoke with told us they considered staff to be busy and on two of the wards we visited patients told us they had had to wait longer than anticipated to receive care and support. One patient on ward 2 commented: "I'm very pleased with everything they've done but you don't ever see the same nurses, it's a different one every day." Another patient said: "Generally they are very good but they are too busy and they need more staff." They also told us: "They (the staff) come when they can but if I need the commode-it's agony waiting. I have told them." A patient on ward 5 told us: "The lady opposite has been very upset and distressed she keeps trying to get out of bed. I've pressed the buzzer twice but no one came so both times I went to get someone." Their relative said: "I also went to get help for the lady opposite and the nurse said 'It's not my station' but then helped."

On ward 2 we observed a healthcare assistant who was based on the ward trying to support two agency staff who were not sure where things were kept. When we asked to see patient records, we had to speak to four staff before we found a staff member who knew where they were stored.

We saw one patient ask for help and when no one came, they got up and unsteadily started to walk to the toilet. We asked a member of staff if the patient was okay to walk and they said "I don't know, I'm agency staff." They then went to ask a permanent staff member if the patient was okay to walk unsupported.

We observed a confused patient wandering towards the "women's unit" adjacent to Ward 2. They were intercepted by a pharmacy technician who dissuaded them but they needed more support. They went to the nurses' station but everyone was too busy to immediately assist. They shadowed the wandering patient a while longer and then asked again for help and a nurse stopped what they were doing to assist. The nurse then assisted the patient with a notably appropriate, sympathetic manner.

Staff were invited to training but we were told by the ward manager that: "Study leave is restricted because they can't get time off." They said that they had had to 'drop stat and mand' training on 'only one occasion', but verified that the staffs mandatory training was up to date for all staff on the ward.

Staff confirmed on all three wards a lack of attendance at ward meetings they told us they did not attend because they lacked time. The ward managers told us that staff meetings had been attempted at various times of the day but there was a lack of staff attendance. Instead of meetings, the ward managers used various forms of communication including memos and newsletters. The ward manager on ward 2 said: "On a Monday we do a keeping in touch session, which captures both day and night staff."

The provider may wish to note that on ward 2 there was an out of date information board which read "How are we doing?" and, 'The ward is currently under review by the clinical matrons' it stated that updates will be in place in December 2012.
Supporting workers

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

Suitable arrangements were not in place to support staff to deliver care and treatment to people safely as staff supervision sessions did not take place.

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

Reasons for our judgement

The trust provided us with information in respect of their learning and development policy. We saw that all new staff with the exception of foundation year one and two doctors and medical locumts received a corporate one-day induction as well as core statutory and mandatory training. This incorporated the appropriate training as expected. We saw that six elements of the training were available as an e-learning option. Statutory training is training for which there is a legal requirement to attend, and mandatory is training that the trust considers is essential for staff to attend. We noted that before other forms of training and development would be considered, staff were required to complete their statutory and mandatory training obligations.

Clinical staff attended 'Clinical Statutory and Mandatory' training annually which included amongst others; dementia care, consent, customer care and communication, basic life support and 'slips, trips and falls.' The February 2013, 'Finance, Performance and Workforce dashboard' stated that the trust aimed for 90% of staff to have attended core statutory and mandatory training within a 12 month rolling year period and had to date achieved 79.5%. New staff to the trust also completed a one day corporate induction and the trust had achieved the 90% target.

The staff we spoke with on all three wards told us they had received appropriate induction training. Staff said they attended the statutory and mandatory training and were informed when their annual training updates were due. We were told that additional training was regularly offered but could not always be taken up as the time to attend the training was in their own time with time to be taken back where available. A few staff recalled that they had completed the dementia awareness workbooks as part of their induction and that it was mandatory. Staff told us they were able, from time to time, to obtain further relevant qualifications and one staff member told us they were to apply to the trust in respect of support for further academic qualifications.

Staff we met who had worked for the trust for over a year had received a performance appraisal within the last year. However, overall attendance at statutory and mandatory training, and the percentage of staff having a performance appraisal in the previous 12
months were behind target. Trust managers told us that this was monitored and remedial actions were in place.

The provider may wish to note that all staff we met told us that they were not in receipt of regular one to one supervision. The trust confirmed it did not currently have a documented policy on nursing clinical supervision, however they felt there were many opportunities both formal and informal for the principles of clinical supervision to be used. The trust provided us with a copy of the 'Nursing, Midwifery and Allied professionals strategy in which they state the trust will implement a model of clinical supervision in all areas, reflecting specific the needs of individuals, services and professional practice in the years 2012 to 2015, which included mentorship and coaching and clinical supervision to be delivered by 2013.

As part of its assurance framework the trust monitors workforce indicators. At the time of our visit staff sickness, absence and staff turnover, overall trends 'showed neither improvement nor decline.'

Staff told us that staff meetings were not regularly attended but that they received regular communication in the form of handovers, memos and newsletters. The observations we made during our visits to the three wards were consistent with this feedback. The majority of the staff we spoke with said they liked working on the ward and there was a good team spirit.
Complaints

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

As part of our inspection we looked at the trusts complaints systems. East Cheshire NHS Trust has a complaints policy in place and provides information on each ward and in the hospital reception area entitled "Customer Care Service." The literature guided people through the process of how to voice concerns and help with how to complain.

The trust also had policies on 'Promoting a Culture of Openness' encouraging staff to report all patient safety incidents. Also that of 'Management and investigation of incidents, complaints and claims including the analysis if data', whereby staff can report concerns via incident reporting or following the trusts; 'Raising concerns at work' guidance.

Staff on all three wards told us they would encourage and support patients to make complaints, if they wished to. They told us they would inform people about the Patient Advice and Liaison Service (PALS) if they were unhappy about their care or treatment. The Patient Advice and Liaison Service (PALS) is one of the first points of contact for any patient or relative with concerns or complaints.

We spoke with 13 patients on three wards who told us that would feel comfortable about complaining if they felt the quality of care was below their expectations. One patient when asked said: "I don't really know how to make a complaint-but I would speak to the staff, this is a good hospital." Another patient said: "I have no need to complain."

The trust holds regular 'Safety Quality and Standards' meetings in which complaints incidents and claims are discussed. The trust reports quarterly on complaints, incidents, claims and patient experience reports. It reported between October 2012 to December 2012, 45 new complaints. The trust reports monthly on the number of complaints received against the National NHS Complaints Categories as part of Department of Health's mandatory reporting requirements. As an example these include; communication, staff attitude/behaviour and clinical treatment. The trust set themselves a zero target for communication complaints by 2015. To achieve this when complaints are received they are appropriately recorded, investigated and concluded and dependant on the outcome any learning for the trust is derived from these findings. We saw that the analysis and learning from complaints has led to additional staff training and weekly ward briefings entitled 'Keep in Touch', which the ward manager when visiting ward 2 told us they held every Monday.
The trust endeavoured to complete complaint investigations within 35 days. Where this was not possible we saw evidence on their electronic reporting system 'Datix' that correspondence was forwarded to the complainant with an explanation. Between October 2012 and December 2012, 54% of complaints were responded to within the timescales agreed with complainants. The reasons for response delays were also being audited and monitored by the trust.

In addition to providing written responses to complaints, the trust encouraged meetings with the complainants to help resolve outstanding issues. All complainants were offered the opportunity to meet with the staff involved with the complaint. It was clear that a small proportion of complainants had chosen to accept this offer. If a complainant is dissatisfied with the trust's response to a complaint, they may request a review from the Health Service Ombudsman.

We met with the PALS staff in their office at the Macclesfield District General Hospital location. We asked them about the number of complaints received, the categories of complaint and how these were reported on and managed. During the period October 2012 to December 2012, the Customer Care Team dealt with 263 enquiries. The PALS staff were able to show the subject categories and we saw that clinical treatment and appointment dates were the top two enquiries. PALS staff told us they also operated an outreach service over daytime visiting for patients where they met with patients for their convenience on the wards.

We saw that no concerns were raised through external agencies such as General Practice through the Central and Eastern Cheshire Primary Care Trust in this period.

We saw evidence of the learning and action plans the trust put in place following complaints. We found that people had their comments and complaints listened to and acted on, without the fear that they would be discriminated against for making a complaint.
This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Nursing care</td>
<td>Care and welfare of people who use services</td>
</tr>
<tr>
<td>Personal care</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Care planning, risk assessments and reviews of patient's needs were not always sufficient to promote the welfare and safety of the individual or other people using the service. Regulation 9 (1) (a)</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
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</tbody>
</table>

<table>
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<tr>
<th>Regulated activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Nursing care</td>
<td>Staffing</td>
</tr>
<tr>
<td>Personal care</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>There were insufficient numbers of staff who were familiar with the patients and the running of the ward. Patients did not always receive continuity of care when there was a greater use of temporary agency and bank staff. Regulation 22.</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td></td>
</tr>
</tbody>
</table>
Regulated activities | Regulation
---|---
Diagnostic and screening procedures | Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010
Nursing care | Supporting workers
Personal care | How the regulation was not being met:
Surgical procedures | Suitable arrangements were not in place to support staff to deliver care and treatment to people safely as staff supervision sessions did not take place. Regulation 23 (1) (a)
Treatment of disease, disorder or injury

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

The provider's report should be sent to us by 03 April 2013.

CQC should be informed when compliance actions are complete.

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

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

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

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

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

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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

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

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

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

You can tell us about your experience of this provider on our website.
How we define our judgements

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

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

✓ Met this standard
This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

✗ Action needed
This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

✗ Enforcement action taken
If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

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

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

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

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

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(Registered) Provider</strong></td>
<td>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'.</td>
</tr>
<tr>
<td><strong>Regulations</strong></td>
<td>We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.</td>
</tr>
<tr>
<td><strong>Responsive inspection</strong></td>
<td>This is carried out at any time in relation to identified concerns.</td>
</tr>
<tr>
<td><strong>Routine inspection</strong></td>
<td>This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.</td>
</tr>
<tr>
<td><strong>Themed inspection</strong></td>
<td>This is targeted to look at specific standards, sectors or types of care.</td>
</tr>
<tr>
<td>Contact us</td>
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<tr>
<td>Phone:</td>
<td>03000 616161</td>
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<tr>
<td>Email:</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
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<tr>
<td>Write to us at:</td>
<td>Care Quality Commission</td>
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<td>Citygate</td>
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<td>Gallowgate</td>
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<td>Newcastle upon Tyne</td>
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<td>NE1 4PA</td>
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<td>Website:</td>
<td><a href="http://www.cqc.org.uk">www.cqc.org.uk</a></td>
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</tbody>
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