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

Darlington Memorial Hospital

Hollyhurst Road, Darlington, DL3 6HX Tel: 01325380100

Date of Inspections: 24 October 2013
23 October 2013
22 October 2013

Date of Publication: November 2013

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>✓</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>✓</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>✓</td>
</tr>
</tbody>
</table>
## Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>County Durham and Darlington NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of the service</td>
<td>Darlington Memorial Hospital is the main hospital for treating seriously ill and injured patients for the South of County Durham as well as Darlington. It provides major acute services to a population of approximately 130,000. The hospital provides a full range of outpatient clinics and diagnostics, inpatient surgery, children's services and consultant led maternity services. It also handles emergency trauma surgery and other major surgery. The hospital is situated within walking distance of Darlington town centre.</td>
</tr>
</tbody>
</table>
| Type of services | Acute services with overnight beds  
Acute services without overnight beds / listed acute services with or without overnight beds  
Community healthcare service  
Domiciliary care service  
Dental service  
Diagnostic and/or screening service  
Community based services for people with a learning disability  
Community based services for people with mental health needs  
Hospital services for people with mental health needs, learning disabilities and problems with substance misuse  
Rehabilitation services  
Urgent care services |
| Regulated activities | Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Family planning  
Maternity and midwifery services  
Personal care  
Surgical procedures  
Termination of pregnancies  
Transport services, triage and medical advice provided remotely  
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'.

<table>
<thead>
<tr>
<th>Summary of this inspection:</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>How we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>What people told us and what we found</td>
<td>4</td>
</tr>
<tr>
<td>More information about the provider</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our judgements for each standard inspected:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>6</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>13</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>About CQC Inspections</th>
<th>27</th>
</tr>
</thead>
<tbody>
<tr>
<td>How we define our judgements</td>
<td>28</td>
</tr>
<tr>
<td>Glossary of terms we use in this report</td>
<td>30</td>
</tr>
<tr>
<td>Contact us</td>
<td>32</td>
</tr>
</tbody>
</table>
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 22 October 2013, 23 October 2013 and 24 October 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 commissioners of services, reviewed information sent to us by other regulators or the Department of Health, talked with commissioners of services and talked with other regulators or the Department of Health. We were accompanied by a specialist advisor.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

The inspection team consisted of one compliance manager, three compliance inspectors, two specialist professional advisors (one in Accident and Emergency (A&E) and one in Infection Prevention and Control) and an expert by experience who obtained patient views. The inspection focused on two main areas. Firstly, how people experienced care and treatment from the moment they attended A&E, to inpatient care and through to the point of discharge to their home. Secondly on the management and organisational processes the hospital and its staff had in place with regards to infection prevention and control.

We visited A&E and wards 14, 21, 31, 33, 34, 44, 51 and 52. We spoke with 50 patients and / or relatives during the inspection; 30 in A&E and 20 on the hospital wards and reviewed the records of more than 20 patients. We spoke with ward sisters, nurses, healthcare assistants, catering and domestic cleaning staff. We spoke at length with the trust's lead managers involved in infection prevention and control. This included the Director of Infection Prevention and Control (DIPC) and the infection prevention and control lead nurse. We also spoke with senior staff within facilities, estates, endoscopy, sterile services, theatres, catering, microbiology and pharmacy.

We found the A&E department appeared calm and well-ordered on the days we were there. Overall we observed patients were treated with dignity and respect by the nursing and medical staff on the days of inspection. This was reflected in the comments we received from patients, both within A&E and from patients who had been admitted onto the
wards.

Comments from the patients we spoke with in A&E about how well they'd been kept informed were mixed. Some patients within the minor injuries streams said they'd been kept well informed about how their treatment was progressing, whereas others said they weren't aware of the different systems operating within the department. Comments included "We have had triage sorted out, been seen and just been discharged….We have had plenty of information and understand what is wrong. We have been treated with respect; the whole experience has been very good" and "Not been informed by anyone from the department as to what is happening." Comments from patients within the major injuries stream were largely positive and included "They (the staff) are polite and very pleasant" and "My experience here has been marvellous."

We found patients had their health care needs assessed and received appropriate treatment to meet them; both within A&E and on the hospital wards. Patients told us staff were friendly and helpful. Comments included "I rang the buzzer during the night as the man opposite was confused and trying to get out of bed. They (the staff) came directly no problem", "I think the staff are well trained to do their job" and "I am happy with the care I have received."

The overall structure and governance in relation to infection prevention and control was judged to be positive. We found there were effective systems in place to reduce the risk and spread of infection. We saw clinical and patient areas were kept clean. We saw domestic staff were cleaning across all areas during our inspection. We saw staff regularly washed their hands and used disinfecting hand cleaner. We saw dispensers of hand cleaner at the entrance to the wards and at the entrances to bays and side rooms. We saw people who entered the wards for treatment or to visit people were encouraged to use these cleaners to help prevent the spread of germs.

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

Accident and Emergency Department (A&E)

We were given a tour of the department by the matron and shown all areas including reception, waiting room, triage, minors, majors, paediatrics and the resuscitation room. The department appeared calm and well-ordered on the days we were there.

Overall we observed patients were treated with dignity and respect by the nursing and medical staff on the days of inspection. We followed a patient who presented at reception and was assessed by the triage nurse as suffering from a neck injury. The triage nurse was concerned and called a doctor to the triage room to give a medical opinion. It was decided the patient needed to be immobilised and a cubicle was required. The patient needed to have a neck collar applied and an X-ray was ordered. The patient was taken into a cubicle in majors and immobilised. We saw the patient was informed of the next process and full explanations were given by the staff. The patient stated they were “very happy” with the initial treatment received.

We observed patients who arrived by 999 ambulance who were promptly greeted by a nurse and triaged. We observed no significant delays in general however one patient arrived by ambulance at a time when all majors cubicles were full. The patient was suffering from breathing difficulties and was on an airway pressure machine which needed to be plugged into an electricity socket. As all cubicles were full in the department, the patient had to remain on the back of the ambulance for 40 minutes until a cubicle had cleared. The patient was given an explanation of why there was a delay. We questioned the effectiveness of this with the matron and were informed that a clinical incident would be completed regarding this delay. Throughout this time the patient was attended to by trained medical staff. This meant the patient was not harmed and was admitted to the hospital following assessment.

We saw the examination bays in the department had either curtains or doors for privacy. We were told by a member of staff these were usually kept open so staff could monitor
patient safety. We found this was not always explained to patients and some of the people we spoke with told us they would prefer the doors closed. We saw when examinations were being carried out, medical staff closed doors and curtains before commencing. This meant the provider was attempting to maintain people’s right to privacy at the same time as monitoring their safety.

We saw there was a risk the privacy and dignity of patients who arrived either by ambulance or walked into the department could be compromised. This was due to the single use of the main entrance and exit. We saw ambulance patients on stretchers mixed with patients who self-presented. We spoke with the matron who said this was not ideal and this issue would be resolved once building work was completed in the future. We were informed that when patients arrived as a trauma or in a serious condition such as cardiac arrest then screens would be used. This was to limit other patients or members of the public observing these patients arriving and passing the waiting areas. This meant the provider was taking steps to attempt to maintain people’s privacy and dignity.

We observed the reception area and saw the layout did not always promote the privacy and dignity of patients registering. This was confirmed by the two reception staff we spoke with. They said they did on occasion ask patients to move from the reception area when it became busy in an attempt to maintain people’s privacy. They said this could cause congestion in the main corridor where ambulances arrived.

We spoke with 20 patients or relatives in the minor injuries and children’s waiting areas. They told us it was taking 1-3 hours to get through the system dependant on their condition. We checked with the reception staff regarding the pathway that patients could take. It was explained they had a protocol around conditions and would refer to that regarding whether patients were put in the ‘See and Treat’ or ‘Assessment’ queue. The provider may find it useful to note that some patients said they were not aware there were two systems in operation. This meant some people were frustrated, as it appeared to them that people were ‘jumping’ the queue.

Comments from patients still within the minor injuries assessment and treatment systems were mixed and reflected the inconsistency of information provided mentioned previously. One patient said “I have been seen by the nurse and told to wait here, I assume for the doctor next. I haven't been given a waiting time and it is now coming up to 2 hours. My pain level is about the same but no one has actually asked me.” Another patient said “We have seen the nurse now and are waiting for x-ray; apparently there is quite a wait.” We spoke with this patient at 1110hrs and saw they went to x-ray and returned at 1210hrs.

Another patient said “We have had triage sorted out, been seen and just been discharged. Treatment today was much nicer than last time (we were here last week). We have had plenty of information and understand what is wrong. We have been treated with respect; the whole experience has been very good.”

Other comments included "Not been informed by anyone from the department as to what is happening", "I was told there was about an hour’s wait and also told I was ‘See & Treat' whatever that is. I have been seen by nurse and now waiting for x-ray" and "It would be good to have an overview of how it works, particularly for new patients."

We spent time in the ‘major injuries’ area of the department. We spoke with some of the people who were receiving treatment. All the people we spoke with told us the staff were polite and courteous. One person told us “They (the staff) are polite and very pleasant"
and another said "My experience here has been marvellous. I have been in this hospital before, and I haven't had to wait as long to be seen this time. They haven't spoken with me yet about what is happening. Last time they did talk to me about treatment options. So far I have been happy with my experience this time."

We looked at the care records for 12 people. All records within the department were recorded electronically on a system which had been implemented recently. Each of the records we looked at noted that clinical staff had spoken either with the patient or their families. We saw patient records contained information about the reasons for attendance, any tests and investigations that had been carried out or planned and a differential diagnosis. A differential diagnosis is the distinguishing of a disease or condition from others with similar signs and symptoms.

Some of the patients we spoke with told us they had seen a doctor but didn't really understand what was going to happen to them. Other patients told us they were kept fully informed about what was happening and what medical staff thought might be the problem. One person told us "I've been told I need to have surgery" and another told us "They've told me what's wrong with me. I have to stay in hospital for a few days."

We spoke with 9 patients on wards 14 and 33 who had been admitted to the hospital through A&E. Everyone we spoke with on both wards gave positive feedback regarding their experiences of A&E. Some patients did report that the process through A&E and waiting for a bed had taken up to 6 hours. One person said "I was in a room to begin with then I was assessed and they asked if I was OK to sit in the waiting area whilst they found me a bed. They were very busy and I didn't need the cubicle. I felt I had enough information. The staff were very good especially the junior doctor, (they) were excellent." Other comments included "we were given plenty of information, staff explained what they were doing and checked if that was OK" and "Staff very helpful, everything fully explained by both doctors and nurses."

Overall we found patients were observed to be treated with consideration and respect.

Ward 14 – Medical Assessment Unit

During our inspection we visited this ward, spoke with patients and staff and reviewed the medical records of some patients.

We spoke with the ward sister who told us where a person lacked capacity to consent, ward staff would contact family members to discuss their care. If the person did not have a next of kin, the doctors would undertake a best interest decision on behalf of the patient. If the person had an advocate on admission, then ward staff would seek their views of what the person would want or what was in their best interest. The ward did not have anybody who had been subject to a best interest decision at the time of our inspection.

We saw that clinical staff had assessed patient's cognitive abilities and screened for dementia on admission. Where the person's score on the dementia screening indicated concerns, a referral was made to the psychiatric liaison team for further assessment.

The ward sister told us that they had access to the learning disability (LD) nursing team in the hospital. The LD co-ordinators can come to the ward and act as advocates for people with learning disabilities admitted to the ward. She told us that staff were trained in the
needs of people with learning disabilities, with all staff completing e-learning, as well as essential (mandatory) training.

We saw people were kept informed about what was happening at twice a day ward rounds (mid-morning and mid-afternoon). Where people were still unclear, their linked nurse would explain in more detail. Handovers took place at bedside. Measures to promote dignity and respect included closing curtains during ward rounds, talking individually to patients, and staff being aware of the volume of and moderating their voices. This meant people were given appropriate information and support regarding their care or treatment.

The ward sister told us care planning took account of people's individual diversity. Any cultural, religious, linguistic or disability needs would be considered as part of the assessment of areas of daily living and be built into care plans. This meant the provider was taking steps to ensure people's human rights were respected.

Ward 31 – Orthopaedics

During our inspection we visited this ward, spoke with patients and staff and reviewed the medical records of some patients.

We saw people on the ward were usually in single sex, six bed units with a communal bathroom. We saw there were curtains that could be pulled around all the beds although these were usually kept open. We spoke with the nurse in charge who told us they did not leave curtains around beds because they liked to monitor patient safety but when doctors came to see patients or treatments and examinations needed to be carried out curtains were closed immediately.

We spoke with some of the patients on the ward who had been admitted via A&E they told us they were happy with the way they had been treated. One person told us "They (the staff) were lovely. They're all really good here." Another person told us "They treated me very well."

We asked patients if they felt they had been respected. They all told us staff were polite and asked if it was okay to carry out examinations. People we spoke with told us doctors talked to them about their medical conditions and checked to make sure they understood what they had been told.

We saw patient records included details about people's religious and ethical beliefs and these were clearly recorded so patients were not given any foods, treatments or tests that may cause offence. We saw patient records also recorded patient choices in relation to their personal situation. For example if they did not want people told they were in hospital, or the reason for their admission.

We looked at the records of patients who had had surgical procedures. We saw thorough checks were carried out prior to surgery including blood tests, blood pressure and temperature. In addition we saw surgeons and anaesthetists had carried out examinations to ensure it was safe to operate. All the results were recorded clearly on patient notes along with pre-operative assessments.

We saw surgical notes were also kept in the patient records giving details of everything that happened in the theatre, anaesthetics used, complications, if any, and staff involved in
the procedure. We also saw signed patient consent forms, and records of discussions about potential risks.

We saw patient records included discussions about discharge from hospital and checks to ensure people had the right amount of help and support on discharge. One patient who had been admitted to the ward had discharged themselves against medical advice. In the case of this patient there was evidence of a discussion with the patient giving recommendations and explaining the risks if they left. There was also a record of what the patient was told to do if there was a re-occurrence of symptoms.

All of this meant people were involved and kept informed about their treatment and the provider was attempting to maintain their privacy and dignity.

Ward 33 - Surgery

During our inspection we visited this ward, spoke with patients and staff and reviewed the medical records of some patients.

We saw the wards six bed units were single sex and each had a communal bathroom. We saw there were curtains that could be pulled around all the beds although these were usually kept open. We saw patients were able to have the curtains pulled to give them privacy if they preferred and when any treatment or examinations were carried out curtains were also pulled.

We saw patient records included details about people's religious and ethical beliefs and these were clearly recorded so patients were not given any foods, treatments or tests that may cause offence. We saw patient records also recorded patient's personal home situation. For example if they had a home, lived alone and any difficulties they could encounter if they were discharged from hospital.

We saw patient records were kept in a central location on the ward and the reason for admission on that occasion was separated from the main patient file so it was easier to review the relevant information.

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All of this meant people were involved and kept informed about their treatment and the provider was attempting to maintain their privacy and dignity.

Ward 34 – Orthopaedics
During our inspection we visited this ward, spoke with patients and staff and reviewed the medical records of some patients.

We looked at the care records for four people who had received treatment on ward 34 at the time of our inspection. None of these patients were due to be discharged imminently. The ward sister talked us through the documentation they used to keep the patient, their family and representatives informed throughout the discharge process. Ward staff used a standard discharge letter form. This recorded the treatment the patient had received whilst in hospital; instructions for post-operative care or on-going treatment needs; list of prescribed medication and contact details for the ward. The sister told us that patients were encouraged to contact the ward to seek advice in case of concerns, for example to give advice on wound healing. We saw this letter also included a section to let people know the arrangements for support from District Nurses, where this support was required on discharge from the ward. Where a person was being discharged back to a care home, the back of this letter also allowed ward staff to include specific information, advice and instructions to care staff, such as equipment needed for moving and handling or pressure care.

We saw evidence in the four care records we looked at that the planning process for discharge was started on admission to the ward. This allowed staff to put arrangements in place to prepare for eventual discharge. The ward sister told us that patients were discharged across the week, including weekends, and that the decision to discharge a patient was based on clinical need.

We saw that for one of the patients records we looked at where the patient lacked capacity to make their own decision, a best interest decision had been taken in relation to surgery. A record was made of this best interest decision.

The ward sister told us that they tried to keep patients informed about what was happening. The linked nurse had a responsibility to keep people informed. It was also the coordinators job to make sure this had happened.

The ward sister told us they had a philosophy on the ward, 'If it is not good enough for your parents, it is not good enough for the patients.' She said she felt this ethos needed to come from the top.

We spoke with four patients on ward 34. No one raised any concerns with us. One patient one told us, "I signed to say I consented to the operation I had. The staff are respectful. They are lovely. I've been to the hospital a number of times, and I've never had any concerns. They do talk to me about what is happening, and keep me up to date. They haven't yet talked to me about when I will be discharged from the hospital."

Another patient said "I was asked if I would recommend it [the hospital], and I said I would. Staff talked to me about my care and treatment. They asked me what I thought. I said, you get on with it, you are the experts. I am kept informed about what is happening. The staff are respectful. It can be difficult to keep your dignity when you are in hospital, but staff do everything they can to give you as much privacy and dignity as possible."

All of this meant people were involved and kept informed about their treatment and the provider was attempting to maintain their privacy and dignity.
Ward 41 – Medicine

We spoke with the ward sister who told us that where someone was assessed as appearing cognitively impaired, staff would speak with families to determine whether this was normal presentation for the person or how they had been over the last 12 months. This helped to clarify if any confusion was due to an on-going medical condition or was unusual for the person. Where dementia screening identified concerns, and a referral had not already been undertaken by ward 14 (medical assessment unit), a referral would be made to the psychiatric liaison team. This team undertook assessments to rule out any medical reason for confusion, such as a urinary tract infection or head trauma.

We saw evidence that a do not attempt cardio pulmonary resuscitation (DNACPR) form was in place in one of the two care records we looked at. This was in place prior to the person’s admission to hospital. However, due to the medical concerns identified, this had been countersigned by the consultant on the ward. This had not yet been discussed with the family, but we saw notes that this was planned to take place when the family visited. This meant the provider had attempted to make suitable arrangements to involve patients and their families in decisions relating to their treatment.
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

Accident and Emergency Department (A&E)

We found people’s needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

On the days of our inspection we saw the department was under control and waiting times to see a doctor or nurse practitioner were under 2 hours and reasonable. We observed no long waits during the inspection.

Patients who arrived had their needs assessed by way of the triage nurse or by being assessed by the nurse practitioner for minor issues. The Manchester Triage System (MTS) was used in this department. The MTS is a 5-point triage scale used to triage patients presenting to emergency departments. It is used for distinguishing between patients with high and low unadjusted risk of short-term death, as well as those who will stay in hospital for at least 24 hours and those who will return home. We observed patients being assessed by the triage nurse and this was effective and safe. Paediatric patients were allocated to a separate waiting area for children only.

We spoke with the matron and senior sister on shift and asked what pathways were in place for patients, for example those suffering from a stroke or myocardial infarction (MI). We were shown the trust pathways for stroke and MI which were based on guidance from the National Institute for Health and Care Excellence (NICE). All pathways were in date and easy to locate. This meant people’s care and treatment reflected relevant research and guidance.

We spoke with the matron and senior sister on shift about staffing levels within the department. They said the substantive nursing numbers were of concern. We were informed that there should be 8 registered nurses on shift with 4 healthcare assistants in the day.

We saw from the staffing rotas the department regularly used a number of efficient nursing agencies and used nurses trained in accident and emergency. The charge nurse on duty
said the use of such nurses potentially increased risk to patients, as some required orientation if they had never worked in the department previously. The charge nurse stated the department were 'crying out for staff'. We saw this issue had been added to the departmental risk register. We were informed there had been delays within Human Resources (HR) in the recruitment process, however this was improving. We spoke with the Director of Nursing about this, who confirmed there had been issues but these were being addressed. We saw evidence of this issue having been discussed as the Board of Governor's meetings to confirm this. This meant the provider was aware of and had responded to this potential risk.

During the inspection a red 'call out' bag was observed in the reception area alongside a defibrillator. This was used as an emergency snatch bag if patients collapsed on the hospital premises in the past. The bag contained syringes, IV lines and first aid equipment alongside a range of emergency drugs. On inspection, we found the drugs included in the bag were all out of date; some by 3 years. We raised this with the matron and nurse in charge who removed the bag with immediate effect. This meant any risk to patients in relation to this matter had been removed and resolved.

We spoke with 20 patients or relatives in the minor injuries and children's waiting areas. They said generally they had no complaints about their treatment once it was underway. Comments included "experience so far been alright", "Quite happy with treatment so far. Have been well looked after" and "(patient) has been given pain relief and the nurse been to check it is working, treatment very good."

There was a separate area for children and their families. There were two examination rooms which were staffed when in use by either the doctor or a nurse. We saw this area had staff allocated to it, but they would work within the rest of the department as required if the area was unoccupied.

We spoke with 9 patients and relatives on wards 14 and 33 about the care and treatment they had received in A&E. Feedback was mostly positive about their experiences of the department. A relative we spoke with said "They were very good in A&E. They spoke to mum then reinforced what they said to us so we were able to talk things though with mum as needed. Mum has been treated with dignity and respect all the way through the process. This is her first time in hospital, she has always been frightened but she said she feels safe so we think that says a lot."

We looked at the care records for 12 people. We saw the records of patients in the A&E department were written clearly and accurately. We saw in the records people were seen according to their suspected conditions and how urgent their care needs were. People we spoke with told us they were seen quickly by a nurse who carried out an initial assessment and saw a doctor later. We saw there was evidence in each of the care records we looked at that pain relief had been offered at initial assessment, unless there was a clinical reason why this should not be offered. We saw for each person relevant tests were requested and undertaken (such as x-rays, bloods and urine samples). There was evidence that the results of tests had been reviewed by a doctor prior to a diagnosis being given. We saw these had been used to develop a treatment plan for each person.

There was evidence that regular observations of patients had taken place whilst on A&E, including monitoring of early warning signs and Glasgow Coma Scale (GCS) score. The GCS allows healthcare professionals to assess how severely someone's brain has been damaged following a head injury. A diagnosis for each person was recorded prior to their
discharge or transfer to another ward. We saw that a medical and social history was recorded for each person, where clinical staff were able to take this. We saw two people had been under the influence of substances during their time on A&E and therefore staff had been unable to take a detailed history from the patient.

We saw the care records for three people detailed special needs (two people with dementia and one person with learning disabilities). We checked whether this information had been transferred to the wards on admission, and in all three cases we confirmed this had happened. We spoke with ward staff who confirmed that a verbal telephone call was made by A&E staff prior to transfer to a ward, to confirm the suitability of admission to wards. This included information about the person's diagnosis and any special needs identified. This meant that people's needs had been established and could continue to be met after admission to hospital wards.

Overall the patient's safety and welfare was protected.

Ward 14 – Medical Admissions Unit

During our inspection we visited this ward, spoke with patients and staff and reviewed the medical records of some patients.

We spoke with patients about the care they had received on the ward. Comments were positive, and included "I rang the buzzer during the night as the man opposite was confused and trying to get out of bed. They came directly no problem", "I think the staff are well trained to do their job" and "A member of staff sat with the lady over there all night as she was confused. They really looked after her." This showed patients were satisfied with the care they (and others on the ward) had received.

We spoke with the ward sister on this ward. They told us most of the referrals for beds on this ward came through the Accident and Emergency Department (A&E). The referral would be received by telephone from A&E staff, and would give details of the person's needs and initial diagnosis. The summary notes of the patient's time in A&E were then sent with the patient on admission to the ward. This meant that clinical staff had access to all clinical and patient information prior to starting any care or treatment on the ward.

We looked at the care records for two people who we had tracked through looking at their care records from admission to A&E onto admission on ward 14. We also tracked the care records of two people who had transferred from A&E to ward 14 and then onto ward 41. We saw that records kept on the ward were mainly in paper form, but the results of some tests were recorded electronically.

The sister told us that each person was reassessed on admission to the ward. This was to check that a person's needs had been fully identified and to undertake any relevant assessments, not already carried out prior to transfer from A&E. This also gave an assessment at the point the person was admitted to the ward, to give a benchmark for any future improvements or deteriorations, to enable staff to quickly react to changes in a person's need.

An assessment was undertaken against areas of daily living, such as nutrition, breathing, elimination, skin integrity and sleeping. This was supported by a series of risk assessments (for example history and risk of falls, an assessment of pressure care and
skin integrity known as a waterlow assessment, and an assessment of the person's suitability for the use of bed rails). The records we looked at showed these assessments were completed for each person at the time of admission. In ward 14 these records were recorded in an admission pack, which covered all the assessments that needed to be undertaken, a record of observations (such as blood pressure and temperature and a body map to record any injury or skin integrity issues identified on admission) and the nursing and doctor's clinical assessment of the person's health. We saw this also included the outcomes of tests to check for MRSA or urine infection taken routinely on admission to check for any infections at an early stage. We saw that where assessment indicated a risk, a relevant care plan had been developed for the patient. The risk assessments for patients were checked at least weekly, but more frequently if a person's needs changed or risks were present. We saw the ward had in place care pathways for falls, learning disabilities and end of life care. This meant care and treatment was planned and delivered in line with people's current needs.

We saw that staff also recorded the views of the patient on the reason for admission, and where this was not possible, the views of family and friends was sought. This meant clinical staff could evaluate the level of comprehension the person had in relation to their health. We also saw that where someone had been living at a residential care home prior to admission to hospital, a record was kept of any information which was supplied by the care worker and if possible a history for the patient was taken from the care worker.

An indication of the level of pain a person was experiencing was taken on admission to the ward. Pain levels were checked as a minimum with the patient at every drug round (morning, lunchtime, tea and evening time), but more frequently if the person was presenting or appeared to be in pain.

We saw that daily notes were kept by staff relating to the patient, how they had been and any support provided in relation to care plans.

The ward sister told us that they practiced evidence based treatment and they followed NICE guidelines. Regular training was in place to ensure staff's knowledge and skills were kept up to date. Updates on clinical practice were also included in the ward monthly meetings. This meant processes were in place to ensure as far as possible that people's care and treatment reflected relevant research and guidance.

Ward 31 - Orthopaedics

During our inspection we visited this ward, spoke with patients and staff and reviewed the medical records of some patients.

We spoke with three people who were being treated. They told us staff on the wards were friendly and helpful. One person told us "They're smashing" and another told us "The staff are brilliant here. Lovely."

People we spoke with were asked if they had signed a consent form prior to having surgery. Everybody we spoke with said they had signed a form and we saw evidence of this in patient files where consent forms were kept. These forms also showed that people had been advised of the risks associated with surgery and possible complications. In addition we saw forms were completed when people had medical cannulas inserted. These gave details of when the cannula was inserted, the size, where it was inserted and
whether the patient gave consent.

We saw the records of patients admitted to the ward were clear and comprehensive. When people were transferred from A&E to the ward they were sent with a summary of their admittance to A&E.

We saw when people were admitted the staff on the ward carried out an initial assessment of the patient's condition and also completed their own medical history and confirmation of the patient's symptoms. In addition patients were asked about lifestyle choices and were checked to establish if these may lead to increased risks or complications.

We saw all patients on the wards had individual care plans in place and risk assessments carried out. Care plans included observations and how often they should be carried out, mobility and movement and how much assistance people would need if they wished to move, in and out of bed, and communications giving information about whether people needed interpreters, information in braille or easy to read formats.

We saw patients who required surgery had additional care plans and risk assessments completed. These were for the time the patients were in theatre and the recovery room and included anaesthetic assessments, details of all drugs and gases used, the planned procedure (complete with sketch) and allergies the patient may have.

We saw medical staff spoke with patients about their conditions and discussed the results of treatments and investigations that had been carried out.

Ward 33 - Surgery

During our inspection we visited this ward, spoke with patients and staff and reviewed the medical records of some patients.

We spoke with patients about the care they had received on the ward. Comments were positive, and included "Buzzers are answered promptly" and "Seems to be enough staff haven't had to wait if I needed a nurse." One patient told us "I wasn't sure about the tablets they wanted to put me on. I told the nurse and she said she would get the pharmacist to come and talk to me". We saw the pharmacist did speak to this patient while we were on the ward. This showed patients were satisfied with the care they had received.

We saw the records of patients admitted to the ward were clear and comprehensive. When people were transferred from A&E to the ward they were sent with a summary of their admittance. This included the reason for admission, method of transport, details of examinations, tests and treatments, detailed history and any medications prescribed by the patient's GP or the A&E staff.

We saw when people were admitted the staff on the ward carried out an initial assessment of the patient's condition and also completed their own medical history and confirmation of the patient's symptoms. In addition patients were asked about lifestyle choices and were checked to establish if these may lead to increased risks or complications.

We saw all patients on the wards had individual care plans in place and risk assessments carried out. Care plans included observations and how often they should be carried out, mobility and movement and how much assistance people would need if they wished to
move, in and out of bed, and communications. This provided information about whether people needed interpreters, information in braille or easy to read formats.

We saw patients who required surgery had additional care plans and risk assessments completed. These were for the time the patients were in theatre and the recovery room and included anaesthetic assessments, details of all drugs and gases used, the planned procedure (complete with sketch) and allergies the patient may have.

We saw medical staff spoke with patients about the reason for their admission and discussed the results of treatments and investigations that had been carried out. We saw staff also spoke to people about any further treatment that may be required and what the outcome was hoped to be.

We saw people were asked to sign consent forms prior to surgery being carried out. The consent form they signed showed the surgery offered and any risks or complications that could occur if surgery was carried out. In some cases people were given cannulas. These were used when people needed regular intravenous fluids and pain relief. Where cannulas were used we saw a sheet was included in the patient file giving details of when the cannula was inserted, the size, where it was inserted and whether the patient gave consent.

This meant care and treatment was planned and delivered in a way that was intended to ensure people’s safety and welfare.

Ward 34 - Orthopaedics

During our inspection we visited this ward, spoke with patients and staff and reviewed the medical records of some patients.

We spoke with four patients on this ward. They were all happy with the care and treatment that had been provided. Comments included "It’s all very nice here. You can't fault them (the staff). They are all busy. I haven't wanted help, and I've never had to press the buzzer. If you want medication for pain you can get it. I have a patch, so I don't need anything else." Another person said "I am happy with the care I have received" and a third person said "I don't think there is anything different that I would have wanted them to do for me. The staff always offer you pain relief. I have seen the physiotherapist. They are due to come again today." This demonstrated that people were satisfied with the care they had received.

We looked at the care records for four people who were being treated on ward 34 at the time of our visit. We saw an assessment of need was conducted within 4 hours of admission to the ward. This included an assessment of areas of daily living, and supporting risk assessments. We saw that where assessment indicated a risk, a relevant care plan was developed for the patient.

As ward 34 often admitted patients who were post-operative, we saw that an assessment of the risk of venous thromboembolism and other common post-operative complications were undertaken following operative procedures. We saw evidence that these assessments and any results from tests undertaken were reviewed by a doctor post operatively.
The ward sister told us, and we saw evidence in all four care records that each of the care plans were evaluated daily by ward staff. This meant care was being provided to people based on their current needs.

The ward sister told us that patients were encouraged where possible to mobilise on the day of surgery. If the patient had been given spinal anaesthetic this might not be possible, but they would be mobilised as soon as they could be.

The ward sister told us that there were a number of ways that care planning processes took account of relevant guidance and research. She said staff had individual special interests that they would keep up to date with and share knowledge across the team, for example infection control, manual handling, health and safety. The Trust also produced regular bulletins with updates and the unit had staff meetings two monthly, where practice was discussed. This meant processes were in place to ensure as far as possible that people's care and treatment reflected relevant research and guidance.

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

Ward 41 – Medicine

We looked at the care records for two people who were on this ward at the time of our inspection. They had originally been admitted through A&E and then transferred to ward 14 and then onto ward 41.

We spoke with the sister on this ward. She told us that most of the referrals for beds on this unit came from ward 14, the medical assessment unit. Referrals were received via telephone from ward 14 staff. We saw that the records from the person's stay in A&E and on ward 14 transferred with the patient on admission to ward 41. This meant clinical staff had access to information about the person's health, medical and other needs whilst they had been in hospital. Within four hours of admission nursing staff undertook an assessment of the person's needs.

We saw assessments were undertaken against areas of daily living, such as nutrition, breathing, elimination, skin integrity and sleeping. This was supported by a series of risk assessments (for example an assessment of pressure care and skin integrity known as a waterlow assessment and a nutritional risk assessment tool known as MUST). We saw that these assessments were updated on a regular basis, and at least weekly.

We saw that where assessment indicated a risk, a relevant care plan was developed for the patient. We saw that daily notes were kept by staff relating to the patient, how they had been and support provided in relation to care plans.

This meant care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.
Cleanliness and infection control  

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed.

Reasons for our judgement

During the inspection we spoke at length with the trust's lead managers involved in infection prevention and control. This included the Director of Infection Prevention and Control (DIPC) and the infection prevention and control lead nurse. We spoke with senior staff within facilities, estates, endoscopy, sterile services, theatres, catering, microbiology and pharmacy. We visited wards 14 (medical admissions unit), 21 (paediatrics), 31 (orthopaedics), 33 (surgery), 34 (orthopaedics), 44 (medicine), 51 (medicine – relocated from 43), 52 (elderly/stroke) and A&E. We spoke with ward sisters, nurses, healthcare assistants, catering and domestic cleaning staff, patients and their families or people visiting them.

The provider had an ‘in-house’ Infection Prevention & Control (IPC) team for infection prevention and control advice and services. The IPC doctor and supporting microbiologists who provided the service were identified and their contact details were available to the hospital staff.

The IPC team structure identified the Director of Infection Prevention & Control (DIPC), who was also the Executive Director of Nursing, and a range of infection control nurses, tissue viability nurses and link practitioners at ward and department level. There were clear references to the DIPC’s role in policies and the DIPC attended infection prevention and control committee meetings. We saw evidence of this within the committee meeting minutes.

The terms of reference of the IPC committee outlined the objectives of the committee, membership and how often it met. The membership of the committee included the medical director, microbiologists, consultant in health protection, representatives from estates, facilities, pharmacy, decontamination, occupational health and all three Care Group Clinical Representatives. This meant the provider had processes in place for the dissemination of information to staff at ward/department level, and for matters to be brought to the attention of the committee by ward/departmental staff.

We saw the committee met quarterly and we reviewed the minutes of these meetings for November 2012, February, June and September 2013. We saw discussions, concerns and
actions were documented. The investigations into IPC incidents were reported and any action for improvement and learning agreed. Actions were produced following every meeting; this formed the basis for improvements to the service.

This committee, along with the Health Care Associated Infection (HCAI) Reduction Group and other sub committees fed into the Quality & Healthcare Governance Committee (QHGC) where infection prevention and control matters were discussed. The results of audit programmes fed into this committee to provide the hospital with assurance that policies, practices and procedures were reviewed and action plans and development programmes were initiated and monitored. In addition there was a 'task and finish group' which addressed any priority areas devolved from the HCAI Reduction Committee.

We saw the DIPC annual report (April 2012-13) outlined the IPC priorities for the previous year. The IPC work programme (April 2013-14) outlined the IPC services such as the provision and review of all infection control policies and practices, staff training, audit, and surveillance. This had been developed by the senior IPC nurse.

We saw there was no identified strategic direction outlined for 2013/14 in relation to IPC; for example an IPC strategy document. We spoke with the DIPC who explained that IPC was one of the domains within the Quality Strategy for 2013-2018 and the work programme addressed the trusts' identified risks. They confirmed the detail of the IPC strategy was yet to be developed.

The IPC programme dated 2013-14 identified priorities for the current year. These included Health Care Associated Infection (HCAI) reduction, antibiotic stewardship and prescribing management and link nurse development. The IPC plan identified in some detail the audit programme from April 2013 to March 2014. It identified action to be taken, the lead person and completion date for audits. Evidence of audits undertaken were seen, for example Surgery & Diagnostics. The results of audits were fed back to the IPC committee. We found the audits focused on inpatient wards. We spoke with the IPC senior nurse who explained that since the Trust reorganisation into the three care areas, IPC audits priority were the inpatient ward areas. The link nurse initiative also focused on the ward areas, encouraging ward staff to be involved in the IPC programme.

We spoke with the DIPC who told us the Trust threshold was for no more than 44 post-72 hour Clostridium difficile infections in 2013-14. To date in 2013-14 the trust had 15 cases, with 5 of those being at Darlington Memorial Hospital. This meant the provider was on target to achieve its objectives in this area. The DIPC was able to demonstrate actions taken to support the reduction of Clostridium difficile cases in recent months. There had been one case of MRSA Bacteraemia for the year so far and a root cause analysis had been carried out to identify any lessons to be learned. These lessons were fed back into the IPC committee and the QHG committee. This meant systems were in place to manage and monitor the prevention and control of infection.

We saw the antibiotic stewardship group had introduced a process (choice and compliance) for prescribing antibiotics where antibiotic prescriptions had to be reviewed at 3 days and 5 days. This was in line with Department of Health 2011 best practice guidance. They had introduced weekly antibiotic compliance audits. We reviewed four sets of patient's notes on four separate wards and saw that the choice and compliance process was fully implemented.

We saw the NHS Safety Thermometer programme was in place and the hospital had had
few reported Urine Tract Infections (UTI). The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and ‘harm free’ care. There was a catheter protocol and pathway in place in line with NICE 2011 and RCN 2012 guidance and a quarterly review was carried out. Observations of 4 sets of patient’s notes on different wards identified that the catheter pathway was fully implemented into the patients care plan.

As part of the inspection we looked at the environment of the hospital. In general the ward areas were divided up into a number of 6 bed bays with a central corridor housing the support facilities. There were patient rooms available for single occupancy. There was a protocol for isolation within these rooms should this be required. Individual patient bays were a reasonable distance from each other. The patient furniture in use such as beds, lockers, tables and chairs were all visibly clean. The curtains around each cubicle were clean and were changed if visibly dirty, for IPC purposes or every 3 months.

In general all areas visited appeared to be clean apart from a cleaner's room in A&E which had a very dirty bucket sink and utility sink with visible dirt. We spoke with the cleaner who explained it was lime scale however it was visibly dirty when we visited early in the afternoon. The return visit the following afternoon was no better. The bucket sink and utility sink remained as dirty as the previous day. Discussions with 2 cleaners identified that the room should be cleaned by the late shift if there was time.

There were adequate clinical wash hand basins in place and all accessories such as hand wash and alcoholic gel were clean. Clinical waste bins were in place and sharps containers were dated and changed according to local policy. Personal protective equipment (PPE) for staff, such as aprons and gloves were outside the entrance to every ward bay in line with current IPC practice. Patient toilet and shower facilities were visibly clean. This meant that staff were fully involved in the process of preventing and controlling infection.

The ward kitchens were equipped mainly with stainless steel appliances; the fridge, beverage areas, work surfaces and floor were visibly clean. The fridges had a record of temperature monitoring identifying they were within accepted parameters for food storage. There was a hand wash basin with accessories such as hand wash soap and paper towels.

The treatment room / clean utility rooms were compact with a drugs fridge, utility sink / clinical hand wash basin and accessories. Clinical waste bins and sharps containers were all in place and managed according to local policy. Some clean utilities had a utility sink but no hand wash basin. In general there was a clinical hand wash basin in the treatment rooms. Clinical equipment such as dressing trolleys were visibly clean. The drugs fridges were clean and had a checklist identifying that the temperature was taken daily and was within accepted parameters. We saw commodes were all cleaned in accordance with the Trust's cleaning protocols and labelled as clean; this was a new initiative. PPE was available including eye wash kits.

At the time of the inspection, staff and patients from ward 43 had relocated to ward 51. This was to allow ward 43 to be refurbished. We spoke with some patients who had been on ward 43 / 51 for more than 3 days. They said they were very happy with the cleanliness of the ward. One person had been a patient on the ward previously and had been happy with the cleanliness of the ward on previous occasions this year.
We saw there were areas on the ward with damage to walls and flooring. Staff explained they had raised a requisition with estates however these requests were prioritised by estates and it took some months for some concerns raised to be addressed. In some instances requisitions had been made "months ago". The response from all wards visited was the same, in that this problem was not unique to one ward. It is not possible to adequately clean walls and flooring that has been damaged. We spoke with the Director of Estates & Facilities who identified the patient environment as being an area of concern. They explained that the hospital was showing signs of its age and that other areas took priority, such as updating the fire alarms system.

We visited the endoscopy department, and despite it being such a compact area it was visibly clean. The endoscopy decontamination area consisted of one room. It had 4 lancer free standing washers within it. The air handling for this area consists of extract ventilation only as in a sluice area. This meant there was potentially a small risk of recontamination of clean instruments by any airborne particulates. The current guidance contained within The Choice Framework Policy & Procedure (CFPP) 01-06 Decontamination of Flexible Endoscopes allows for single room endoscopy decontamination. Whilst the unit meets the CFPP essential requirements, the guidance states there should be a plan to move forward towards best practice.

We saw there were policies and procedures in place for the management of laundry and these were monitored operationally and by staff in the Facilities Department. Discussions with staff identified that they were clear about the various procedures in place for clean, dirty, soiled and infected linen. We saw there was a contract for waste management and a waste policy in place. An annual waste audit was carried out in July 2013 and the results reviewed. Our observations during the three days identified that waste was being managed in accordance with the Trust's waste policy.

We saw catering was provided in house in line with the Food hygiene regulations 2006, EU Regulations 852/2004 and the Food Safety Act. The catering department had a 'cook and chill' kitchen which provided ready cooked meals to the ward. We spoke with two of the catering staff who worked on the wards. They told us they had completed induction and training when they commenced work at the Trust. They also said they had completed food and hand hygiene training and had regular updates.

Cleaning services were provided in house 7 days a week from 7am to 7pm. Accident and Emergency had 24 hour cover and there was also access to a rapid response team across the hospital. The wards/departments had their own dedicated cleaners who reported to the facilities manager and associate director of facilities. Their role was to manage the various housekeeping tasks on the ward/department on a daily basis.

We found although there were cleaning checklists which identified rooms and furniture to be cleaned, there were no documents at ward/department level identifying cleaning schedules, frequencies, specifications, materials, or detergents in line with NHS Cleaning Manual guidance. We asked the domestic cleaning staff on each ward we visited and none of them were able to produce cleaning schedule documentation as detailed above. We were later told that these cleaning schedules should have been available at ward level. The Trust's cleaning policy document outlined responsibilities for cleaning, but at ward/department level this was not available to staff, apart from one or two areas where there were instructions for cleaning bed bays. The NHS cleaning manual outlines cleaning specifications, frequencies, processes, materials and detergents. It is usual to have this information available to staff at ward/department level, and it covers both domestic and
clinical cleaning. The IPC Annual report had identified that the Trust would develop protocols for cleaning equipment.

The Trust had an in house unit (CELL) where electrical equipment such as pressure relieving mattresses and syringe pumps were loaned from. CELL was part of the medical physics department which was an accredited unit (ISO 9001: 2008). The unit had a system in place to loan equipment out to wards and departments. It also decontaminated it when it was returned to the unit. We saw staff in the unit signed out equipment and could track its use back to previous patients. The equipment was decontaminated in accordance with its standard operating procedures.

Decontamination of reusable medical devices such as surgical instruments and equipment was undertaken at an accredited in house sterile services unit. We saw there was a system in place for tracking reusable medical devices used on patients.

We found the trust provided its own laboratory services. The unit had Clinical Pathology Accreditation (CPA). There were standard operating procedures for use of the laboratory facilities and clear guidance on how to contact the laboratory for information or advice.

We saw visitor information regarding cleaning their hands was available and alcoholic gel was provided. Information was provided in appropriate formats on infection prevention and control for visitors and patients. For example, posters, leaflets, and other service user focused material was available on MRSA, Clostridium difficile, Norovirus and infection control information. This meant suitable accurate information on infections was provided to patients and their visitors.

We saw the trust used a software system known as Safeguard to record all incidents, including incidents of infections. There were detailed incident forms to record any infections that occurred whilst the patient was in the hospital. These infections were discussed at the IPC committee and where there were serious infections, the microbiology department and advisors were involved. There was a system in place to carry out root cause analysis (RCA) to attempt to determine the cause of serious infections/incidents, to learn from these and review practices. We saw evidence in the records to demonstrate this system had been followed.

We spoke with staff from the Learning and Development department about the process for monitoring staff training. They explained that it was the responsibility of all ward and department managers to ensure their staff were trained in IPC. There were good processes in place to remind staff about mandatory training, including with emails and on pay slips. They said staff were prevented from attending other training until their mandatory training had been completed.

There were IPC policies and procedures which were available on the Trust intranet. There was a staff sign off process in place to ensure that staff had read and were familiar with all policies. There were procedures available to staff related to infection prevention and control precautions for staff safety in particular in relation to sharp injuries. There procedures were being revised to take account of the most recent European Council Directive 2010/32/EU on the prevention of sharps injuries.

We found the provider had an Occupational Health Policy. The policy outlined the service provided by this department which included a pre-employment assessment. This involved an assessment of staffs’ vaccination and immunisation status. Information was available to
staff on how to access occupational health advice or information including opening hours and out of hour's procedures.

Accident and Emergency Department (A&E)

The department appeared tidy and clean during the inspection. We asked the matron to produce the cleaning and stock check list. The department was unable to produce evidence to confirm that areas had been cleaned and stocked on a daily basis. There was no cleaning specification for A&E.

We spoke with people who had attended A&E during our inspection. Everyone we spoke with told us medical staff always washed their hands prior to carrying out any treatment or examination and also following these. We saw staff used disinfecting hand cleaner after washing hands and after carrying out some activities.

Staff were provided with Personal Protective Equipment (PPE). This included disposable gloves and plastic aprons. We saw staff wearing PPE when carrying out tasks and witnessed the disposal of these items when they had completed the task. All PPE was disposed of in the clinical waste bins that had been placed in the department.

We saw domestic staff working in the department throughout our inspection. We saw staff mopping floors and wiping surfaces. People being treated in the department told us they had seen cleaning being carried out. One person told us "They mopped up and cleaned the surfaces" another person told us "They've been around cleaning in here this morning."

Overall, we saw clinical and patient areas were kept clean. We saw domestic staff were cleaning across all areas during our inspection.

Wards 14, 21, 31, 33, 34, 44, 51 and 52

We saw staff on the wards carrying out tasks like changing beds and taking blood used Personal Protective Equipment (PPE) like latex gloves and plastic aprons. We saw holders attached to the wall outside bays contained supplies of PPE with additional supplies held in ward store cupboards. We saw staff disposed of these items after use in clinical waste bins that were kept on the ward.

We saw staff regularly washed their hands and used disinfecting hand cleaner. We saw dispensers of hand cleaner at the entrance to the ward and at the entrances to bays and side rooms. People who entered the ward for treatment or to visit people were encouraged to use these cleaners to help prevent the spread of germs.

We saw single use medical equipment was stored in sealed bags and used items were correctly disposed of in clinical waste bins or in sharps boxes. We saw all the wards had a sluice room where reusable items could be cleaned prior to reuse. Sharps boxes that were full were correctly sealed, signed and stored prior to disposal meaning the risks of cross contamination were reduced.

The ward sisters we spoke with told us that staff completed essential (mandatory) training on infection prevention and control on a regular basis. This included annual hand hygiene assessments.
Overall we found there were effective systems in place to reduce the risk and spread of infection.
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.
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.

<table>
<thead>
<tr>
<th>Judgement</th>
<th>Description</th>
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<tbody>
<tr>
<td>Met this standard</td>
<td>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.</td>
</tr>
<tr>
<td>Action needed</td>
<td>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.</td>
</tr>
<tr>
<td>Enforcement action taken</td>
<td>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.</td>
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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:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Regulation</th>
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<tr>
<td>Respecting and involving people who use services</td>
<td>17</td>
</tr>
<tr>
<td>Consent to care and treatment</td>
<td>18</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>9</td>
</tr>
<tr>
<td>Meeting Nutritional Needs</td>
<td>14</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>24</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>11</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>12</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>13</td>
</tr>
<tr>
<td>Safety and suitability of premises</td>
<td>10</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment</td>
<td>16</td>
</tr>
<tr>
<td>Requirements relating to workers</td>
<td>21</td>
</tr>
<tr>
<td>Staffing</td>
<td>22</td>
</tr>
<tr>
<td>Supporting Staff</td>
<td>23</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>10</td>
</tr>
<tr>
<td>Complaints</td>
<td>17</td>
</tr>
<tr>
<td>Records</td>
<td>21</td>
</tr>
</tbody>
</table>

### Regulated activity

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

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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