

Review of compliance

Royal United Hospital Bath NHS Trust
Royal United Hospital Bath

Region:	South West
Location address:	Combe Park, Bath, Somerset BA1 3NG
Type of service:	Acute services
Date the review was completed:	March 2011
Overview of the service:	<p>Royal United Hospital Bath (part of Royal United Hospital Bath NHS Trust) is an acute hospital on the edge of Bath just over a mile from the centre of the city. The trust covers a local population numbering around 400 thousand people in Bath, North East Somerset, South Gloucestershire and Wiltshire.</p> <p>The hospital has 565 beds, and the service includes an accident and emergency department, eight operating theatres, with one theatre available for 24-hour support, and diagnostic and clinical support. The trust employs around 4,500 staff, some of whom are based at local community hospitals.</p>

	The hospital provides care to people served by the three primary care trusts of Bath and North East Somerset PCT, Wiltshire PCT and Somerset PCT.
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Summary of our findings for the essential standards of quality and safety

What we found overall

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

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

Why we carried out this review

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

- Respecting and involving people who use services
- Care and welfare of people who use services

We wanted to respond to some information that we had received from healthcare professionals and people who are carers of people who had been patients at the hospital. The patients all had a form of cognitive impairment, including Downs Syndrome, autism, other learning disabilities, or degrees of dementia.

The information we received told us that hospital staff were not providing acceptable care to these people due to the people's limited ability to communicate verbally or otherwise. The concerns were that staff were not trained sufficiently in communication skills or in caring for people with cognitive impairment.

How we carried out this review

We reviewed the information we hold about this provider, surveyed people who use services, carried out a visit on 22 February 2011, observed how people were being cared for, talked to people who use services, talked to staff, checked the provider's records, and looked at records of people who use services.

We visited the hospital to determine how the staff care for people who have limited or no ability to communicate verbally and/or otherwise, and who are admitted as patients for other often unrelated health problems.

We visited four wards at the hospital and talked to staff and observed care delivered to patients. We talked to staff about their training for caring for people with cognitive impairment.

What people who use the service experienced and told us

On the day of our visit there were no patients known to the hospital staff we talked with who had learning disabilities. We were therefore not able to talk specifically with people with learning disabilities or their carers, or observe care. We were able to observe the care of people with dementia, but were only able to get limited information from these people. We met and talked to one carer who was visiting a person with dementia. This person told us that staff had been “marvellous” and that they made him feel welcome when he visited, which he did regularly. He said that staff were happy to allow him to help with the care of the patient, and that he wanted to help where he could.

We found staff to be engaged in their roles, dedicated, experienced and skilled. The hospital was largely full and staff on the wards that we visited told us that they had their full complement of staff on duty. The hospital was also dealing with an outbreak of norovirus, which was being contained.

We found areas of training for dementia awareness that could be improved on the wards that were not dedicated to older people. We found that in terms of learning disabilities that the hospital already had put a programme in place to deliver improved care and support following a peer review of this area.

In all the wards we visited we had concerns around the assessment made to determine if a patient had the capacity to make their own decisions. The records to demonstrate how this had been assessed were not readily available. We also found inadequate records in relation to decisions taken over whether to attempt to resuscitate people. We had concerns over the lack of any detail in recording the decisions and how and with whom they had been made.

Overall, we found that the hospital was taking steps for the most part to ensure that it respected and involved the people in their care. The hospital was taking steps to mostly ensure that people experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights. We saw good evidence of this during our visit and from staff and patients that we met and talked with, and in the practice and care we observed.

We found some areas that require improvement for caring for people with an impaired ability to communicate and make their own decisions.

What we found about the standards we reviewed and how well Royal United Hospital Bath was meeting them

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

Overall, we found that the hospital was taking steps for the most part to ensure that it respected and involved the people it cares for and treats. We saw good evidence of this during our visit, and from staff and patients that we met and talked with and practice we observed.

We are concerned that the hospital is not adequately putting people who have cognitive impairment at the centre of their care by involving the person or others acting on their behalf in decisions made in their best interests. This is because we found that the hospital was not always ensuring that it properly documented those

assessments it made of a person's capacity to take their own decisions. We also found that the hospital did not always properly document those assessments it made of a person's suitability for resuscitation.

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

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

Overall, we found that the hospital was taking steps for the most part to ensure that people experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights. We saw good evidence of this during our visit and from staff and patients that we met, talked with, and practice and care we observed.

We found that the hospital was not ensuring that all appropriate staff were trained in awareness of caring for and communicating effectively with people with cognitive impairment. We found that the hospital was not ensuring that the welfare, privacy and dignity of vulnerable patients were always protected.

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

Action we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

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

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

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

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

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

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

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

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

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

Outcome 1: Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us

During an unannounced visit to the Royal United Hospital Bath NHS Trust we visited three of the four wards which comprise the older people's unit. We also visited a ward that cares for people recovering from major surgery, major trauma or who are acutely unwell.

We found some good evidence of how the hospital respects and involves people who use the service. This included providing information to people who use the service. We also saw and discussed the availability and ongoing development of information adapted for people who have communication difficulties, and those who care for them when at home, or act on their behalf.

We met and talked to staff who were able to demonstrate to us how they communicated with the wide range of people who use the service with differing needs and diversities, and involved them in their care. Staff told us how they also consulted with people who act on behalf of people who cannot always make their own decisions in order to involve them in the delivery of care and to take account of their holistic needs.

Staff we spoke to on the older people's unit told us that many of the patients on the three wards had some form of cognitive impairment, primarily dementia. The trauma ward also had two patients diagnosed with dementia.

To learn more about how staff made decisions about care and treatment for people who have cognitive impairment, we looked at a sample of patient notes. We found that these notes contained a DNAR (Do Not Attempt Resuscitation) decision, called a DNAR proforma. The staff we talked to on the older persons' wards indicated that most of the people on the ward with dementia had this decision taken on their behalf.

We found that the DNAR proforma were inadequately completed. We were told the DNAR orders are applicable only in the event of the patient suffering cardiac arrest and requiring cardiopulmonary resuscitation (CPR). We found that in those DNAR proforma documents that we reviewed, that the completion of the required sections was not in line with hospital policy.

For example, hospital policy (Resuscitation Ethical Guidelines policy – July 2009 p. 5 – 'the policy') states that "decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team and documented carefully".

Also, contrary to the policy we did not find any clear evidence to demonstrate that the decision had been discussed with or explained to the family or those close to or representing the patient. We met and talked to the husband of a patient on one older persons' ward and he said he had no recollection of being involved in any DNAR decision that had been made for his wife. Some staff we talked to told us that they were not actively involved in the DNAR decision and their views were not routinely sought.

The policy goes on to state that "decisions must not be made on the basis of assumptions based solely on factors such as the patient's age, disability, or on a professional's subjective view of a patient's quality of life". In the documents we reviewed we found one word answers of "frailty" and "dementia" given to summarise the clinical problems. The guidance notes printed on the reverse of the document require this section to "be as specific as possible".

We talked to nursing and care staff on the older person's wards about their understanding of DNAR decisions. Staff told us that they felt they had not had sufficient training or experience in this area of practice. Nursing and care staff also did not feel comfortable or confident with communicating these decisions to patient's relatives or carers when a doctor was not available to do so or had not done so.

Although the DNAR documentation was not adequately completed in line with the policy, we did not find any evidence that this resulted in patients not being resuscitated when this was appropriate.

As a high proportion of the patients who were being cared for on the older people's ward had dementia, we also looked at files for assessments of the patient's mental capacity. We did not easily find these assessments. In those files we looked at, we only found an indication on the DNAR proforma in answer to the question "does the patient have capacity to make and communicate decisions about CPR" of 'NO' being circled.

Our judgement

Overall, we found that the hospital was taking steps for the most part to ensure that it respected and involved the people it cares for and treats. We saw good evidence of this during our visit, and from staff and patients that we met and talked with and practice we observed.

We are concerned that the hospital is not adequately putting people who have cognitive impairment at the centre of their care by involving the person or others acting on their behalf in decisions made in their best interests. This is because we found that the hospital was not always ensuring that it properly documented those assessments it made of a person's capacity to take their own decisions. We also found that the hospital did not always properly document those assessments it made of a person's suitability for resuscitation.

Outcome 4: Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us

During a visit to the Royal United Hospital Bath NHS Trust we visited three of the four wards which comprise the older people's (OP) unit, that predominantly, but not always, care for older people. We also visited a ward that cares for people recovering from major surgery, major trauma or who are acutely unwell.

Our visit was made to look specifically at how the hospital cares for and communicates with people who might have a cognitive impairment due to learning disability or dementia.

The OP unit has a high ratio of people who dementia. The trauma ward will admit patients who are post-operative or have suffered a major trauma, but have an underlying condition that affects their cognitive abilities. On the day of our visit the trauma ward had two patients suffering with dementia, but there were no patients known to the hospital staff we talked with who had learning disabilities.

In our conversations and observations, we found nursing and care staff who were experienced, caring and dedicated. We talked to a junior doctor who told us that the staff he worked alongside during his rotation on the OP unit were "caring, dedicated and patient".

Although we met some staff in the trauma ward who had undertaken specific training on working with people with dementia, this was not the case with all staff.

Two of the three staff on the trauma ward we asked specifically said that they had not received any dedicated training on communicating with people with cognitive impairment and relied on common sense. We asked what this common sense would lead them to do in certain situations and we were given thoughtful and intelligent answers. Staff agreed that this practice would be reinforced and enhanced through specialist training in communication for people with cognitive impairment, and that they would welcome this.

Staff confirmed that dementia awareness training in the OP unit was reasonably well attended among these more specialist staff, but it had not been delivered to all staff. Staff told us that dementia awareness training on non-specialist OP wards, to respond to the need to admit more people from the rising population of older people with dementia, was not as far-reaching as necessary.

We met and talked to staff on the OP unit who told us about their specialist training in dementia that extended into other areas of care, such as manual handling and nutrition.

Some of the information that led to this visit concerned a younger adult patient with learning disabilities who had been placed on an OP ward. We were told by staff on the OP unit that they had admitted people younger than their usual demographic age (65+) with learning disabilities and/or challenging or aggressive behaviour in the past. Staff told us that this was generally as they were considered probably best trained to deal with these patients. Staff told us that the hospital explained to the relatives and carers of younger patients placed on the OP ward that this was often necessary for more specialist care. The ward had recently admitted a 52-year-old male patient with learning disabilities and challenging behaviour, and this patient had caused disruption in the ward and “scared” many of the vulnerable confused female patients.

Therefore the hospital does not always place people where the rights of other patients and their privacy, dignity and vulnerability are fully considered.

During our visit we observed care and communication with people with cognitive impairment. One patient we observed was offered a hot drink by a volunteer working on the ward at midmorning. We observed that due to the patient not being able to communicate easily, that no drink was provided. The patient would not be offered another drink before lunchtime. It was therefore probable that the patient did not receive a drink for at least five hours. A doctor reviewing the patient at lunchtime observed that the patient “was a bit dry”. The patient was then given something to drink.

We saw no evidence to demonstrate that the volunteer alerted staff to the patient not being given a drink. Equally, staff had not appeared to alert the volunteer as to what to do if a patient was not able to communicate in the usual manner.

We therefore saw evidence of staff not being able to communicate adequately with patients with cognitive impairment to ensure that the patients were receiving care that centred on them as an individual.

People with learning disabilities and dementia, for example, often have difficulty in understanding the usual direction and information signs in hospitals and elsewhere. Large colourful signs with words but also pictures for toilets, bathrooms and

bedrooms are being used in the OP unit at the RUH. This is a recent development, and although there was no particular evidence as yet that these signs are making a difference, the signs are generating interest with nursing staff in other wards, and therefore maybe adopted elsewhere.

We found that staff on the OP unit were knowledgeable and keen to learn about recent guidance, published research, and advice on caring for people with dementia. The OP wards had recently competed for and been awarded some significant charitable donations designed particularly for people with cognitive impairment.

The hospital was therefore taking steps to identify and respond to the different needs of people with learning disabilities or dementia.

We observed the handover meeting on two of the OP wards when the afternoon shift was changing. Handover was conducted at the nursing station where staff were able to pass on and record various needs and attributes of the patients on the ward. This was carried out quietly and was uninterrupted. Continuing the handover process on one of the OP wards, staff stood at the entrance to a bay and discussed each patient in turn. On another, staff stood at the foot of each bed of the patient to discuss the patient. One patient told us that she did not know what staff were “doing at the end of my bed” and said that “I do not like them doing that”. It was noted, however, that the staff spoke quietly and were not broadcasting private and confidential information that could be overheard by others.

We were told by RUH management that the hospital would be looking into other ways of carrying out handover and ward rounds that were more inclusive for the patient and their carers. This will better protect the rights and privacy of people who are cared for and treated at the hospital.

We were told by staff on the OP ward that some of the concerns reported to us were most likely related to incidents occurring at least a year prior to this review. During the last year some significant changes and improvements had been made. Patients were now not woken very early in the morning to suit the staff working hours and priorities. Staff were also better trained to use de-escalation techniques and diversionary tactics to avoid the use of sedation medicines to calm unsettled patients. Manual handling training for people with dementia had also led to improvements to practice and care. This will ensure that people receive safe and appropriate care that reflects their individual needs.

Some of the information that led to this visit concerned people who have learning disabilities and their experience at the hospital. We discussed with staff how they interacted with the families and carers of these patients in order to better understand the ways to communicate with and care for the individual. Staff told us that they relied heavily on carers and family to help make the person feel safe and reduce anxiety. Staff were asked if they knew of specialist people within the hospital that could also provide advice and support. Some staff thought that the hospital did not have a learning disability lead nurse, but others knew that a nurse had recently been appointed.

Staff told us that caring for people with learning disabilities could often be

challenging, but that for them they felt it was all part of the role. Staff said that they would work closely with the patient's carers and follow their advice where appropriate. Staff also told us that they do not have the resources to provide the one to one, 24-hour care that some of these patients may have at home. If staff have a number of high dependency or demanding patients on the ward, priorities can be very difficult to manage. Staff said that this is sometimes why challenging patients are sent or moved to wards that might not otherwise be appropriate, such as the OP ward. Staff told us "we do our best" but competing priorities mean that they are often faced with "difficult choices".

During our visit to the hospital we met with the sister in quality improvement and developmental lead on people with mental health and learning disabilities. This is a new (January 2011) substantive post for the hospital and has been created following the South West Learning Disability Peer Review that was carried out in October 2010.

The hospital provided us with the action plan that had been approved following the review and issued to staff in January 2011.

The action plan is detailed, but includes the following objectives:

- Information for people with a learning disability and their carers
- Reasonable adjustments and service delivery
- Involvement of people with a learning disability and their carers
- Capacity, consent, safeguarding and the law
- Leadership and management
- Organisational learning

Actions within these objectives included the setting up of a health information group, and the first meeting took place in early February 2011. Development of an accessible complaints process and more information in the 'easy read' format. This work is ongoing.

Training staff to work with people with learning disabilities is being planned. It will include learning disability awareness induction training for all staff and in regular mandatory training. This is described as a "long-term area of work".

A '*See it my way – living with a learning disability*' presentation was delivered in September 2010, but it was not explained how many staff had attended this training.

The hospital is looking into a patient experience tracker for people with a learning disability and this is due to be completed in April 2011.

Our judgement

Overall, we found that the hospital was taking steps for the most part to ensure that people experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights. We saw good evidence of this during our visit and from staff and patients that we met, talked with, and practice and care we observed.

We found that the hospital was not ensuring that all appropriate staff were trained in awareness of caring for and communicating effectively with people with cognitive impairment. We found that the hospital was not ensuring that the welfare, privacy and dignity of vulnerable patients were always protected.

Action

we have asked the provider to take

Improvement actions

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

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983 Surgical procedures Diagnostic and screening procedures Management of supply of blood and blood derived products Termination of pregnancies Nursing care	17	1: Respecting and involving people who use services
	Why we have concerns: We are concerned that the hospital is not adequately putting people who have cognitive impairment at the centre of their care by involving the person or others acting on their behalf in decisions made in their best interests. This is because we found that the hospital was not always ensuring that it properly documented those assessments it made of a person's capacity to take their own decisions. We also found that the hospital did not always properly document those assessments it made of a person's suitability for resuscitation.	
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983 Surgical procedures Diagnostic and screening procedures Management of supply of blood and blood derived products Termination of pregnancies Nursing care	9	4: Care and welfare of people who use services
	Why we have concerns: We found that the hospital was not ensuring that all appropriate staff were trained in awareness of caring for and communicating effectively with people with cognitive impairment. We found that the hospital was not ensuring that the welfare, privacy and dignity of vulnerable patients were always protected.	

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

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

The provider's report should be sent within 28 days of this report being received.

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

What is a review of compliance?

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

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

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

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

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

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

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

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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