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

North Middlesex University Hospital NHS Trust

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

- Respecting and involving people who use services: Met this standard
- Care and welfare of people who use services: Met this standard
- Cleanliness and infection control: Met this standard
- Supporting workers: Met this standard
- Assessing and monitoring the quality of service provision: Met this standard
### Overview of the service

North Middlesex University Hospital serves a population of more than 500,000 people living in the London Boroughs of Enfield and Haringey and surrounding areas. The hospital has approximately 360 beds and provides a range of specialist care. The accident and emergency service sees between 400 and 500 people every day.

### Type of services

- Acute services with overnight beds
- 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
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury
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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'.

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### Summary of this inspection

#### Why we carried out this inspection

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

This was an unannounced inspection.

#### How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 27 August 2013, 28 August 2013, 29 August 2013 and 30 August 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 received feedback from people using comment cards. We reviewed information given to us by the provider and were accompanied by a specialist advisor.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

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

We carried out inspections of the hospital over a four day period with a team of ten inspectors, three specialist nurse advisors and an expert by experience. We visited the accident and emergency department (A&E), out-patient clinics and two wards for older people. We inspected an additional three wards and the operating theatres in respect of their cleanliness and standards of infection prevention and control. We spoke separately with individual doctors in training at the hospital as well as nurses, health care support workers, receptionists, therapists and other allied health professionals. We met with the Chief Executive, Medical Director, Director of Nursing, Head of Education and Career Development and the chair of the trust board.

We spoke with more than 50 patients and relatives about their experiences. Most people were happy with their care. They told us their privacy and dignity had been respected by staff and they had received clear explanations of their care and treatment. Staff assessed patients' needs and planned and delivered care compassionately and safely. Typical comments we received from patients included: "the night staff were great, very attentive and the nurses were constantly checking on me" and "I'm well looked after, the staff are wonderful." We found all areas of the hospital we visited to be clean. A patient told us, "I think it's a wonderful hospital. It's always clean."

Staff received appropriate training and support to enable them to provide the care and
treatment that patients needed. The trust was well-led and responsive to people’s needs. Systems were in place to assess and monitor the quality of service that patients received and ensure care was provided safely and effectively.

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

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**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.

Patients' privacy, dignity and independence were respected. Patients' views and experiences were taken into account in the way the service was provided and delivered in relation to their care and treatment.

Reasons for our judgement

We inspected the accident and emergency department (A&E), five out-patient clinics and two wards for older people at the hospital over the course of two days. In all areas we received positive feedback from patients and relatives about the way they had been treated by staff. Everyone told us their privacy and dignity had been respected and most patients said they had been treated with consideration.

In A&E we spoke with the parents of three children, ten adult patients, a friend of a patient and two relatives. We also received feedback via comment cards about patients' experiences in the department on the day of our visit. One typical comment we received was "I was impressed with my wife's treatment in the A&E, the nurse in triage was very thorough and caring." Patients were given appropriate information and support regarding their care and treatment. Most patients told us they had received clear explanations of the care and treatment. For example, a patient told us they had been seen by a doctor and had found them "really, really helpful." They went on to say that "the doctor explained everything, talked about the condition and I've been given a diagnosis."

On two wards for older people, Charles Coward and Michael Bates, we spoke with 18 patients and nine relatives. Although some patients were not sure whether their care and treatment had been discussed with them in detail they all said they trusted the skills and judgement of the doctors and nurses treating them. Others told us their care was explained in a way they could understand, for example, a patient told us "everything is explained in clear words." Another patient said, "staff talk you through your treatment." Most relatives we spoke with said that that treatment had been explained. One relative told us their father was "getting very good care" and they were kept "well informed."

In out-patients we found patients were very positive about the consultation process and had been given clear information about treatment options, including the risks and benefits. Some typical comments made by patients included, "the staff are lovely, very obliging. You're not frightened to ask them anything" and "the consultant was very thorough and
talked through everything." A few people told us they had been prescribed medication and
the purpose of this had been explained to them, including possible side effects. Some out-
patients said staff were sometimes rushed but most felt that staff had time to talk with them
and address any concerns they had. Patients said they had been given information on
what to do if their condition worsened.

Staff told us they gave patients time to talk and to ask questions and provided information
orally and in written form to take away with them. An out-patient, who had a cast on their
arm told us, "staff gave me a leaflet and told me to get in touch if I had any symptoms that
concerned me." We saw leaflets available for patients and relatives on the wards covering
a range of topics including infection control, bereavement and how to make a complaint.
On the wards meal menus were provided in different formats, including braille, a pictorial
version and in a number of different languages.

The privacy and dignity of patients was respected in all clinical areas we inspected. For
example, in out-patients we saw that consultations took place behind closed doors and
staff and patients told us that curtains were pulled around beds when patients undressed
and were being examined. We saw that reception staff did not discuss personal
information in a way that meant patients could overhear other patients' private treatment
information.

On Charles Coward and Michael Bates wards we saw that curtains were pulled around
patients' beds when personal care was provided. Patients were encouraged to wear their
own clothes as a way of increasing their privacy and dignity. We saw a staff using a
document that was completed for patients with dementia. The document recorded ten
important things about the person and their life including their likes and dislikes and what
made them happy or sad. However, when we reviewed patients' records we saw that only
a few had been completed. We fed this back to senior staff who told us it was sometimes
difficult to obtain information about the patient to be able to complete the form but they
would ensure staff were encouraged to complete them. Charles Coward and Michael
Bates were both single sex wards which helped preserve privacy and dignity.

Everyone told us they were treated respectfully and with consideration by staff. For
example, in out-patients a patient told us "if staff see you looking around they come up to
you and ask if you're OK." Staff were described by patients and relatives as "polite,"
"wonderful" and "helpful." We observed that receptionists were pleasant, friendly and
professional when greeting new arrivals in out-patient clinics. We observed numerous
positive interactions between patients and staff on both wards. For example, staff took
time to talk to patients and support them with their lunch in a compassionate and relaxed
way.

Patients' diversity, values and human rights were respected. Turkish interpreters were
available in all areas of the hospital when needed as this was a commonly spoken
language in the local community. Interpreters could be obtained for speakers of other
languages. We saw an interpreter on Charles Coward ward who was assisting staff to
communicate with a patient. Meals designed to meet patient's cultural and religious needs
were offered to patients including Halal, Kosher and African-Caribbean meals. Patients' needs in respect of their spiritual and cultural needs were assessed on admission. The
hospital had a multi-faith area and chaplains and representatives from a range of religions and faiths could be contacted for patients and relatives.

Staff throughout the hospital, including at senior management and trust board level,
demonstrated their knowledge of the health needs of the local community and
understanding of the diverse nature of the patients using hospital services. We saw many examples of actions taken to address the needs of different communities and cultures and flexibility in the way services were delivered.
Care and welfare of people who use services  
Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We spoke with patients and relatives in all areas of the hospital we visited including A&E, five out-patient clinics and two wards for older people, Charles Coward and Michael Bates. Most people were happy with the care and treatment they had received. For example, in A&E a patient told us "I'm really satisfied with service, staff are really helpful and always trying to find out a solution." Another patient commented, "the night staff were great, very attentive and the nurses were constantly checking on me." Parents using the paediatric A&E were equally positive with one parent commenting, "I could go to another hospital but prefer to come here because I'm seen quickly and staff are more helpful." Another parent said, "even in busier times, it is still quite pleasant. Staff are approachable and you can ask questions."

Most patients on Charles Coward and Michael Bates wards were positive about the care and treatment they had received. For example, one patient said, "I'm well looked after, the staff are wonderful" and another told us "I can't fault the treatment." A third patient told us the care was "fantastic, the staff are absolutely great."

Some patients suggested there could be improvements in the way care and treatment provided. For example, a few patients who had attended out-patients on several occasions told us they were not sure who they were going to see at each appointment and had seen different doctors at different visits. One patient told us "I'm not sure who it is I'm seeing today" and another patient said, "I would prefer to see the same person each time." Some other patients in out-patients were frustrated by the length of time they had to wait for the results of blood tests before seeing a doctor for their scheduled appointment. When we fed this back to senior managers they told us this problem had already been identified and a plan was being devised to improve the system and decrease waiting times.

Patients’ needs were assessed and care and treatment was planned and delivered in line with their individual care plan. On Charles Coward and Michael Bates wards patients' needs were assessed on admission. We saw from the patient healthcare records we reviewed that risk assessments were carried out in a number of key areas including for falls, skin integrity, and malnutrition. A trust-wide documentation audit conducted in July 2013 found that 96% of patients had a falls risk assessment completed within 24 hours of admission. Risk assessments were reviewed weekly or sooner if a change occurred in the
patient's condition. Care plans were in place for those patients assessed as being at risk of pressure ulcers. Staff knew how to use pressure relieving mattresses and equipment to protect patients' skin integrity. Patients were referred to a specialist tissue viability nurse when concerns were identified. Staff said the tissue viability nurse attended promptly after a patient was referred. Systems were in place to obtain specialist equipment and mattresses at short notice, out of hours and at weekends.

Venous thromboembolism (VTE) assessments (to identify the risk a blood clot forming within a vein) were carried out by doctors when patients were admitted. Patients identified as being at risk were prescribed anti-embolism stockings or anticoagulant therapy. When we reviewed the records of patients on the wards we saw that doctors had conducted individual VTE risk assessments on all patients and identified the level of thrombosis risk. However, it was not always clearly documented on the clerking proforma whether anti-embolism stockings had been prescribed. We fed this back to the Medical Director who said he would address the issue.

Patients' nutritional needs were assessed using a recognised scoring system. Patients at risk of poor nutrition were provided with meals on red trays which alerted staff that they may require additional assistance with their meals. We saw from records we reviewed that some patients had nutritional and fluid balance charts in place to monitor what they were eating and drinking and ensure their needs were met. However, although the majority of these were completed we did note some gaps in recording and the total volume of individual fluid intake and output in a 24 hour period were not always recorded. We told senior managers about this and they agreed to ensure the matter was addressed.

Relatives were encouraged to visit and help patients with their meals. We observed staff helping patients at the lunch time meal. They assisted patients to wash their hands before the meal and those with red trays received individual support. Staff were proactive in opening cartons and placing meals and drinks within reach, which ensured patients were able to take adequate nutrition and were hydrated.

In A&E we reviewed the healthcare records of a number of patients who had been discharged from the department on the day of our inspection. The standard and clarity of documentation was appropriate and notes were clear and concise. However, we noted that although there was an opportunity for staff to record the level of pain experienced by patients within the assessment documentation, pain scores had not been recorded in the records we reviewed, even where pain had been noted as a presenting complaint. In the majority of cases pain relief had been given to the patient although the effectiveness of this was not recorded and it was, therefore, not clear whether the patient's need for pain relief was completely addressed. We told senior managers about what we had found and they said they would discuss pain assessment and documentation with staff in A&E.

Patients on the wards told us that staff responded "pretty quickly" when they used the call bell. Patients were quick to praise the night staff in particular. For example, a patient told us "the night nurses don't keep you waiting, they are very good." Many patients commented, and we observed, that they did not need to use the call bell as staff were often in the bays and checked regularly whether they needed anything.

We saw many positive, caring and compassionate interactions between staff and patients on the wards for older people during periods of structured observation. We saw that patients were given time to do things for themselves and were not rushed. Staff were proactive in approaching patients to check whether they needed anything and responded promptly to requests for assistance. Staff were gentle in their approach and sensitive to the needs of patients with dementia. Relatives of people with dementia were given a
'carer's passport' which allowed them to visit outside normal visiting hours to help and reassure the patient.

On the day of our inspection we noted that a few patients had been in A&E since the night before and were waiting for beds to become available so that they could be admitted to a ward. Staff told us that older patients spending the night in A&E had been transferred from an A&E trolley to a bed in the department in order to mitigate the risks of damage to their skin integrity and make them more comfortable. Assessments of skin integrity were carried out regularly in A&E and patients encouraged or assisted to change their position.

Despite a large volume of patients attending A&E on the day of our inspection the service was able to respond promptly to most patients arriving by ambulance. We spoke with five ambulance crews and they were positive about the time it took to transfer patients. We saw that most patients arriving by ambulance were transferred to the care of A&E staff within a matter of minutes. Ambulance crews said they sometimes had to wait 20 to 30 minutes to handover patients but it was very rarely longer than this. They felt assured that all information about a patient was being handed over to A&E staff and considered the department to be one of the better A&E departments in London.

There were arrangements in place to deal with foreseeable emergencies. All resuscitation trolleys that we checked were well stocked with functioning equipment for use in an emergency. The emergency drugs which we checked were all within the expiry date. Records of checks of resuscitation equipment in different clinical areas showed they were being completed on a daily basis, although we noted that in A&E that there were three gaps in the recording of checks of the adult resuscitation trolley in August 2013. All staff told us they received annual update training in adult life support techniques and all staff in paediatric A&E had received paediatric life support training. Staff we spoke with confirmed that they knew how to respond to emergencies.
Cleanliness and infection control

Met this standard

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. Patients were cared for in a clean, hygienic environment.

Reasons for our judgement

During the inspection we visited A&E, out-patient clinics, operating theatres and five wards: S1, S3, AMU, Charles Coward and Michael Bates. All wards and departments we visited were clean, bright, and in a good state of repair. There were no offensive smells, and there was no obvious dust on equipment or under beds. The main entrance and corridors were wide, light and bright, and floors were clean. All the patients we spoke with during our inspection were positive about levels of cleanliness and hygiene. For example, a patient in out-patients told us "I think it's a wonderful hospital. It's always clean." Patients on AMU told us they considered the ward was "brilliantly clean." The toilet was described as "always clean and spotless." Another patient described their ward as "spotless, it smells lovely and clean, every morning and evening it's cleaned."

There were eight operating theatres, seven of which had laminar flow ventilation. This reduced the number of infective organisms present in the air and reduced the risk of post-operative wound infection. Theatres were cleaned between each operation and patients colonised with MRSA were placed at the end of the daily theatre list to avoid cross infection. Re-usable medical devices used in theatres were decontaminated off-site by a third party. Staff confirmed that single-use devices were disposed of safely and were never re-used. Local infection control policies were up-to-date and were kept in the department where they were accessible to staff.

Staff told us personal protective equipment, including gloves and aprons, was readily available in all clinical areas. We saw that gloves and aprons were stocked outside each bay on wards. All glove dispensers we examined were clean and well stocked with different sizes of gloves. Patients told us that they saw staff wearing gloves when carrying out procedures.

Patient equipment, including intravenous fluid stands, resuscitation equipment and bedframes were clean and dust-free. Staff we spoke with on the wards confirmed that equipment was cleaned before and after use. Patients had their own cuff for measuring blood pressure and their own disposable sling for use with a hoist. Staff told us, and we observed, that green tape was applied once commodes were cleaned indicating they were ready for use by another patient.
There were sufficient hand washing facilities and paper towels available on the wards. Most hand gel dispensers were working and appropriately placed at the entrance of wards and departments. We saw that clinical waste was disposed of appropriately and bins for the disposable of needles and sharp medical devices were not over-filled.

Clinical staff displayed good hand hygiene practice in wards and departments we visited. We observed staff washing their hands after each patient interaction. We saw that staff were bare below the elbow, with ties tucked in, in most areas of the hospital. However, in A&E, although most staff were appropriately dressed, two consultants were seen wearing ties, long sleeved jackets and shirts. We informed the Medical Director of this and he said he would address the matter with A&E consultants directly.

The infection prevention and control team undertook a programme of verification audits, focusing on the wards with lower reported scores in infection control audits. The team also checked levels of cleanliness in clinical areas using a fluorescent spray to highlight dirty surfaces. Ward staff described a good relationship with the infection prevention and control team and said they were visible in the clinical areas and responsive when contacted.

Matrons performed regular inspections, including at the weekend, where they looked at standards of cleaning, performed spot checks of equipment and commodes, and checked staff awareness of infection control policies and procedures. Weekly hand hygiene audits were performed in all clinical areas and results were posted where staff could see them. All results we saw displayed showed compliance rates with the appropriate hand hygiene of 95% and above.

There was a system in place to minimise the risk of spread of infection from patients with suspected communicable diseases. Staff were aware of isolation procedures and action to be taken in the event of diarrhoea and vomiting. Patients with infections were cared for in isolation in single rooms and we saw clear signs on the doors identifying when patients were being isolated. For example, on S3 ward we noted that a patient with a suspected infectious disease was being nursed in isolation. There was a prominent, laminated poster on the door of the room explaining precautions staff needed to take to minimise the risk of cross-infection. Face masks were clearly visible and available outside the room for staff to use. However, the provider may wish to note that in a similar situation on ward S1 one staff member was not clear how to care for a patient with a suspected infectious disease safely and effectively. In addition, information on the precautions staff and visitors were required to take was not clearly communicated. We told the Director of Nursing about our findings and he acted immediately to ensure the matter was rectified.

Staff told us that they received regular infection prevention and control training during team meetings and mandatory training sessions. Training included aseptic non touch techniques (ANTT), a tool used to prevent infections in health care settings. Staff were observed using aseptic techniques when obtaining blood samples which minimised the risk of cross infection.

Appropriate guidance on infection prevention and control was provided to staff, patients and visitors. The trust had an infection prevention and control annual plan in place, the implementation of which was being monitored by the infection prevention and control committee. A recent progress report showed that a number of infection control policies had been reviewed and approved since April 2013. Information on infection prevention and control was available for patients and visitors in all clinical areas we visited. Infection prevention and control policies were cascaded via the matrons and ward managers to all staff and were available on the intranet.
Supporting workers

Met this standard

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

Our judgement

The provider was meeting this standard.

Patients were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Patients and relatives we spoke with in all clinical areas we visited were confident in the knowledge and skills of staff. In out-patients most people were very positive about their care and treatment and said staff were very caring. Everyone told us they had confidence in and trusted the health professionals they had seen. For example, a patient told us, "the nurses and doctors take time to understand my needs." Patients on Charles Coward and Michael Bates wards said they felt they could trust the nurses and doctors.

New staff in all areas underwent an induction period where they shadowed other staff before being judged competent to work independently. Induction covered the roles and responsibilities they were to undertake, an introduction to the routines of the clinical area and safe and appropriate use of the equipment available. Staff we spoke with confirmed they had undergone an induction and confirmed this was the case for all new starters. New staff were assigned a mentor or preceptor who signed a checklist to show when they had achieved the required clinical competencies. For example, for new nurses on the older people's wards, competency assessments were carried out in a number of areas including medicine administration, use of a syringe driver, clinical observations and the safe use of medical equipment. A wound care booklet was completed and signed by the tissue viability nurse or ward manager to confirm the nurse had the necessary skills to care for wounds effectively.

Staff received appropriate professional development. Staff we spoke with in different areas told us they had undergone recent training pertinent to their role including in safeguarding vulnerable adults, moving and handling people, dementia awareness, child protection, end of life care and aseptic non touch techniques (ANTT), which was important in preventing the spread of infection. In A&E training for senior staff included patient safety, dealing with a major incident, safeguarding adults and children, and paediatric and adult life support. Staff said they had the skills they needed to carry out their roles safely and effectively. This helped ensure staff were able to deliver care to people safely and to an appropriate standard.

New courses were developed or sourced following an analysis of staff training needs identified through annual appraisals or in response to skills deficits identified in incident and complaints investigations. For example, the Head of Education and Career
Development explained how ANTT training for junior medical staff had been developed and provided following the review of two cases of MRSA in April 2013. A six month competency based course for healthcare support workers was being developed in line with recommendations from the Francis Report. Learning from the Francis inquiry was being shared with staff at mandatory patient safety study days.

We spoke with a number of doctors who were training in the hospital in a range of different specialities. They told us they received good support from registrars and nurses. They were all assigned clinical and educational supervisors, whom they met with periodically. All new doctors underwent a two day induction before they began work in their clinical area. Several junior medical staff confirmed they had received training in safeguarding children, ANTT and hand hygiene. Several doctors mentioned the induction had been more extensive than they had received at other hospitals. All doctors considered they had good learning opportunities and experiences throughout the course of their day to day work. Some departments provided structured teaching and lectures which were protected time for junior medical staff. One doctor described this as "fiercely protected time." However, in other departments, such as medicine, doctors told us the time was not protected and they were required to carry a bleep at training sessions and could be called away at short notice.

All staff we spoke with said they had received an annual appraisal in the last year and had a professional development plan in place. This showed there were arrangements in place to support staff to deliver care and treatment to an appropriate standard.

Staff felt listened to by managers and no one told us they had experienced any bullying or harassment at work. Staff felt able to raise concerns and were aware of the whistleblowing policy. We overheard one ward manager praising a member of staff for their contribution to the well-being of the patients.

The trust reported slippages in terms of the number of staff who were up to date with mandatory training. The trust was aiming for 90% of staff to be compliant with mandatory training for 2013/2014. The overall position in August 2013 was that 60% of staff were up to date with the required training. A mandatory training recovery plan had been put in place which described the actions being taken to increase staff compliance and ensure 90% were compliant by the end of March 2014.

We noted that the trust had taken action to address identified shortfalls in infection control training for consultants. Extra training had been arranged for consultants in order to ensure they had undertaken the required training by April 2014.
Assessing and monitoring the quality of service provision

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

Met this standard

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that patients received. Risks to the health, safety and welfare of patients and others were identified, assessed and managed effectively.

Reasons for our judgement

Patients were positive about their care and treatment in all areas of the hospital we visited. On Michael Bates ward one patient said they did not think they would get better care "at a private hospital." Another patient told us they would recommend the ward to others and "couldn't fault the care provided." In paediatric A&E a parent told us care and treatment was "to a high standard, I feel happy with it."

Patients, their representatives and staff were asked for their views about their care and treatment and they were acted upon. Staff told us they used electronic patient experience trackers to ask patients about their experiences in the hospital. The results were displayed in the relevant wards and departments so that staff could see what was working well and where there were any shortfalls or suggestions for improvements. Action plans were formulated in response, aimed at bringing about improvements in care and treatment.

We reviewed reports of feedback from patients obtained via electronic trackers in the areas we visited for the month of August 2013. Feedback showed high levels of patient satisfaction in all areas. For example, 92% of patients on Michael Bates ward reported they would recommend the ward to friends and family. One hundred per cent of patients on Charles Coward rated the quality of care provided on the ward as 'good', 'very good' or 'excellent'. In A&E, 46% of patients rated the quality of care as 'excellent', 26% as 'very good' and 16% as 'good'. We noted the trust's commitment to improve the patient experience which was evident in board meeting minutes and in minutes of sub-committee meetings. For example, individual patients' stories were reported, describing the patient's experiences of care and treatment at the hospital. External speakers had delivered a presentation to senior managers on the health needs of people from the local Polish community and difficulties this group experienced in accessing health care.

The trust carried out a programme of audits as a way of monitoring the quality of care and treatment provided and the implementation of trust policies. For example, the trust had identified, through audit, a shortfall in staff correctly completing patient fluid balance charts and failure to record the total intake and output over a 24 hour period. An action plan had been put in place to address the concerns. Monthly documentation audits undertaken
since the action plan had been implemented showed an improvement of more than 30% in appropriate completion of fluid balance documentation between May and July 2013. This showed that audits were being used effectively as a way of improving the quality of care and treatment provided to patients.

There was evidence of learning from incidents and investigations and of appropriate changes being implemented. The Director of Nursing reviewed all incidents that occurred in the hospital on a daily basis. The serious incident annual report had been presented to the trust board in June 2013 and this showed that that themes arising from serious incident investigations had been analysed. The report outlined the learning from serious incidents and actions taken to minimise the risk of similar incidents occurring in future.

Staff in all clinical areas we visited told us they knew how to report incidents and the types of events, near misses and incidents they needed to report. Junior medical staff told us they had been encouraged to report incidents. However, a few staff in out-patients told us they were reluctant to report minor incidents as they were worried it would cause a delay to patients being seen or they were concerned about the repercussions for other staff. We reported this to senior trust managers who said they would speak to staff about the importance of reporting all incidents.

Staff told us that incidents and learning from incidents were discussed in team meetings and other forums to ensure learning from these took place. Staff provided examples of changes made in response to learning from incidents, for example, wards disposable slippers had been replaced with red socks with non-slip soles that had reduced the frequency of patient falls on the wards.

The trust had taken appropriate action after two cases of MRSA bacteraemia were identified in April 2013. Reviews of the cases had raised concerns about the way blood had been taken from patients. In response, the trust implemented a programme of education and training for junior medical staff in aseptic non touch technique (ANTT) and subsequently incorporated the training into their induction programme.

The provider regularly reviewed service delivery and made improvements where this was required. For example, staff confirmed there had been a recent increase in staff on the wards for older people following a review of staffing levels using Royal College of Nursing guidance. This had made a significant difference to the quality of care provided. An increase in the number of night staff by 50% had led to improvements that were reflected in positive comments we received from patients on the wards, particularly about night staff.

The conclusions of local and national reviews carried out by expert bodies were taken into account and changes made to the care provided to patients where appropriate. The trust had developed an action plan to address key recommendations from the Francis Report in order to ensure services were safe, effective and delivered compassionately. Staff were aware of recent national inquiries and reports and could describe changes and improvements that had taken place in response to recommendations.

Trust board members visited the wards and clinical areas and spoke with patients and staff about their experiences. Trust board meeting minutes in June 2013 reported visits by the Chief Executive and a non-executive director to clinics and wards. Staff confirmed that the Director of Nursing and Chief Executive were visible in the hospital and regularly visited patient areas. This helped the senior trust management to maintain effective oversight of service delivery.
There was a clear committee structure in place to support the trust board and lines of communication between the board and frontline services were effective, ensuring that key messages were cascaded to staff and information flowed back to the board. An external view of the effectiveness of the board had been sought and actions were being taken to strengthen the membership. The Chief Executive and senior management had a clear understanding of the challenges and risks faced by the trust. They understood the need to maintain the quality of current services, whilst at the same time effectively managing significant changes in service provision involving A&E and maternity, which were due to take place in November 2013. Staff we spoke with in all areas of the hospital were positive and enthusiastic about the planned changes and felt involved in service redesign and development. Staff told us they felt able to raise any concerns they had about the quality of care and treatment provided and were confident they would be listened to by senior staff. Junior medical staff in anaesthetics told us they were able to raise concerns anonymously in a book kept in the department.

Many ward managers we spoke with demonstrated positive leadership skills. They described improvements made in care delivery and staff attitudes through setting and communicating clear expectations of standards of behaviour. Staff were held accountable if their behaviour fell below the standard required. Managers told us this had resulted in a significant decrease in the number of complaints received about the attitude of staff. Some managers, for example in A&E, were very involved in direct patient care. They were well informed in respect of challenges faced by patients and staff and able to respond quickly to changing needs.
About CQC inspections

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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