Inspection Report

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

North Devon District Hospital

Raleigh Park, Barnstaple, EX31 4JB

Tel: 01271322577

Date of Inspections: 10 December 2013
09 December 2013

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

Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✓ Met this standard
Staffing	✓ Met this standard
Supporting workers	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Northern Devon Healthcare NHS Trust
Overview of the service	The North Devon District Hospital (NDDH) provides acute hospital services to the people of North Devon and neighbouring towns and villages in North East Cornwall and Mid Devon, a core population of around 165,000 people. The NDDH provides a full complement of secondary care services including diagnostics, treatment and follow-up care, along with A&E, cancer care, orthopaedic surgery, paediatric and maternity services.
Type of services	Acute services with overnight beds Community healthcare service Doctors consultation service Dental service Diagnostic and/or screening service Doctors treatment service Hospice services Long term conditions services Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Rehabilitation services Residential substance misuse treatment and/or rehabilitation service Urgent care services
Regulated activities	Diagnostic and screening procedures Family planning Management of supply of blood and blood derived products Nursing care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

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 carried out a visit on 9 December 2013 and 10 December 2013, observed how people were being cared for, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with carers and / or family members 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

This inspection took place over two days with three compliance inspectors, two specialist advisors and an expert by experience. We talked with 50 patients in areas of accident and emergency department (A&E), recovery, medical and surgical wards and the acute stroke unit. We talked with visiting relatives and friends of patients who reported positively about the hospital. We also talked with a range of 60 staff from all areas. This included consultants, middle grade and junior grade doctors, ward managers, nurses, heath care assistants, hospitality staff, volunteers, workforce development managers, tissue viability specialist nurse, directors of nursing and medicine and the End of Life Care consultant.

Patients expressed a high level of satisfaction about the care support and treatment they had received in all areas of the hospital. Comments included "You could not ask for better treatment, this is second to none." One person told us "I have had a long history of health issues, but I cannot fault the doctors nurses and care staff here. Everyone goes out of their way to make sure you have what you need." Another patient told us, "I couldn't have asked for better care. I feel they are the professionals and know exactly what they are doing".

We had received some information of concern earlier in the year about how patients were managed from recovery to critical care. We had asked the trust for information and we were satisfied with their response. In this planned inspection we included a specialist in this field to look at practices within critical care. We found the way patients were being managed was in keeping with clinical guidance and best practice.

We had information of concern about consultant cover in A&E following our last inspection. Although we were satisfied with the trust's response at the time we included a specialist in this area to ensure staffing levels were meeting people's needs. We found there were sufficient staff who worked flexibly to meet the seasonal demands to the department.

We found patients care and treatment was well planned by a staff group who were well trained and supported to do their job.

We found improvements were needed to ensure people's rights were upheld when considering emergency treatment for patients who lacked capacity.

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

What we have told the provider to do

We have asked the provider to send us a report by 06 February 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

More information about the provider

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

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

Our judgements for each standard inspected

Consent to care and treatment ✖ Action needed

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was not meeting this standard.

The trust did not always act in accordance with legal requirements in relation to "do not resuscitate" orders. This meant there was a risk that inappropriate action could be taken which was not aligned with the wishes of patients or in their best interests.

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

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. We reviewed 36 sets of patient records across various ward areas. We saw they included entries from the doctors, nurses and members of the multidisciplinary team, such as physiotherapists and occupational therapists. We saw that consent to care was documented prior to nursing and therapies interventions. For example, staff had documented that consent had been given verbally for the provision of personal care or for a physiotherapy assessment. We also saw consent was gained and checked pre operatively for patients.

Curtains were pulled around to provide privacy to people. We heard staff explaining what they wanted to do and people giving their consent to the suggested care and treatment. For example, we saw a junior doctor provide privacy by drawing the curtains, introduce himself, and ask if he could examine a patient's limb. Where patients had difficulty understanding, we heard staff repeat the explanations clearly and in another way. One patient said "Staff always explain why they are doing something and ask if they can" whilst another added "The doctors have been each day and they always make sure I understand." We observed a ward round with a senior consultant and a junior doctor. Patients were involved in discussions about proposed treatment or tests needed and patients were asked if they had any questions. In one instance we saw the junior doctor spent a longer period explaining what procedures they hoped to complete to aid recovery. This meant that people understood and were able to give consent to treatment before staff undertook any procedure.

Patients we spoke with on the acute stroke unit told us that staff were approachable and that their care and treatment had been explained fully to them in a way they could

understand. One person told us, "They (staff) tell me what they are planning to do and why. I can ask any questions I need to and they answer as best they can". Another person said, "They (staff) explained everything to me and gave me time to think about things".

We saw two patient records which demonstrated that the Mental Capacity Act had been considered and mental capacity and best interest assessments had been completed. These were for specific decisions about on-going care, for example blood tests or blood transfusions. The decisions made about the care and treatment for one patient with a learning disability, were made in the patient's best interests and by a multidisciplinary team including the trust's learning disability nurse specialists. The learning disability nurses visited the patient daily to help advocate on their behalf.

The trust had a 'consent on admission form for nursing staff'. We saw this had been completed for some people to show they had been given an explanation of what their care pathway was likely to include, for example which staff may assess, visit or treat them. This ensured that patients were given relevant information in order to make informed decisions about their care and treatment.

We spoke to one person in A&E who told us staff had fully explained what was happening, and had given him time to agree or ask further questions before, for example, blood tests were performed. They told us staff were "Very good and listened". Patients were kept informed of the length of time to expect to wait before being seen. Three other patients in A&E were not fully aware of their plan of care, what was going on or likely to happen to them. These were patients who had been in the department between two to three hours. One patient and their relative stated they had purposely asked staff for information. We were told by the relative staff were "Caring and able to answer their questions" This meant some patients may not have had full information about future treatment and whether they wished to consent to this.

We spoke with staff about how they managed care for people who lacked capacity. Staff told us they had a form to complete when undertaking an assessment to carry out a task in a person's best interests. We saw that one person had lacked capacity to make decisions at the beginning of their admission, but now had full capacity. We reviewed the notes and whilst comment was made that care was provided in the best interests, the trust's own forms had not been used.

We looked at four Treatment Escalation Plans (TEPs) where patients had capacity to make decisions, and this was evident on the forms. We saw that some patients were admitted with TEPs from the community via their GP. These were placed in the front of current notes for quick reference. We saw one TEP that appeared to have been re written by a F1 (junior) doctor, but had not been signed by a senior doctor as was the trust's protocol for such forms.

Eight other TEPs we saw where patients lacked capacity, did not follow the Resuscitation Council guidelines. These guidelines included recording the assessment of capacity in the clinical notes, summarising the main clinical problems or stating why cardiopulmonary resuscitation (CPR) would be inappropriate. They also included summarising discussion with the patient or detailing communication with the appropriate relative or advocate. The trust's own guidance included ensuring a Mental Capacity assessment was completed in conjunction with the TEP form, where patients lacked capacity. These had not been completed for some patients. For example, in one person's records we saw that prior to admission they had been "fit and well" living at home. They had capacity to consent to

daily interventions by nursing and therapy staff. We saw that daily records for this person stated, "slightly muddled", "pleasantly confused" and "pleasantly muddled". A member of the nursing team told us the person had capacity to make "time specific decisions about day to day issues" but would not have the capacity to make "major life changing decisions". The TEP form for this person stated that they did not have the capacity to make a decision regarding resuscitation or treatment escalation. However, there was no mental capacity assessment to support this decision and no best interests' decision had been recorded. Other parts of this TEP form were blank, for example the rationale for treatment decisions and resuscitation status. This did not fully protect people who may lack capacity.

We saw two examples where the TEP form stated "to be discussed with family" but there were no other entries within the clinical notes to show this had occurred. We discussed these issues with the medical director and end of life consultant. They told us the forms were a clinical tool used to make clinical decisions about treatment in an emergency situation. Where discussions with relatives were indicated, these were to explain their clinical decision, not to gain the relative's consent. We heard how the trust had recently completed a serious event audit following a complaint via the GP about a patient who had been discharged with a TEP which had not been fully discussed with the family. We also heard one of their junior doctors was in the process of completing an audit on TEP forms to test whether they were being completed in line with guidance. The trust hoped to develop some trust wide learning materials from this. This showed the trust were aware of issues with completing TEPs and were taking actions to address this.

We saw an example where the learning disability liaison nurse had challenged the TEP form for someone with learning disabilities. She had requested the medical staff to update the TEP with more detailed information, which had been done. Overall we concluded where patients lacked capacity the trust did not evidence they always acted in accordance with legal requirements in relation to 'do not attempt resuscitation' orders. This meant inappropriate action could be taken that did not align with patient's wishes or in their best interests.

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

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. During this inspection we looked at how care and treatment was being delivered in A&E, recovery and critical care, surgical and medical wards and in the acute stroke unit.

Almost without exception patients and their visitors gave a positive response about the care and treatment they had received. Comments included "Can't praise it highly enough…doctors, surgeons, nurses, fantastic, fantastic, fantastic" "It's not like what you read in the papers… It's living in the Ritz compared with what they say in the papers."

Many of the people we spoke with had been inpatients on a number of occasions and many had also been in other local hospitals. They were very complimentary about the care they received at NDDH, from admission via A&E to stays on the wards. There were no complaints about waiting times for call bells to be answered or for pain relief. Everyone said staff came very quickly and they felt safe. Families said they trusted the hospital to meet the needs of their relative and several people commented on how much the hospital had improved recently.

We had received some information of concern which indicated the way patients were being managed from post-operative recovery to intensive care had changed and may have placed people at risk. We asked the trust for some information about this, and we were satisfied with their response. However we decided as part of this planned inspection, to ask a specialist in critical care to check patient safety and welfare across the two areas. The specialist spent time in recovery and in the intensive care unit (ICU) observing practices, reviewing clinical notes and talking to staff, including senior consultants, junior doctors, nurses and health care assistants. The change in practice of allowing high dependency unit (HDU) patients to recover from their anaesthetic in recovery, rather than being transferred directly to the HDU was safe, appropriate and in keeping with practice elsewhere in the country. The new practice was preferable to the previous practice. There were no concerns raised by any members of staff regarding this. The relationship between critical care and recovery unit staff seemed to be close and supportive. In summary we found no evidence to support the concerns raised.

We saw the trust completed national data relating to critical care. The results of this data showed below average mortality rates, infections, delayed discharges and non-clinical transfers out. Out of hours discharges were average and unplanned readmissions were slightly above average. There were bed pressures which meant three patients in the last two months had been discharged earlier than was ideal, but this did not compromise their safety or care and treatment.

Patients needing emergency assessment and treatment attended the Accident and Emergency (A&E) Department. We saw that recent building work had been undertaken to improve the flow of patients through the department. This had involved constructing a separate area for ambulance admissions and a separate area for the delivery of nurse led care. The provider may wish to note the reception desk was at a height that would was inaccessible to wheelchair users in a wheel chair, and the children's waiting area was not welcoming or nurturing for young people.

Staff we spoke with told us patients received a rapid Early Warning Score (EWS) assessment and would be triaged before decisions were made as to the appropriate area for treatment. We spoke to one patient within the department who confirmed they had been triaged within five minutes of their arrival. This meant that patient's needs were assessed and treatment planned rapidly following presentation to the hospital.

The Medical Assessment Unit (MAU) received patients directly from A&E. Staff aimed to transfer patients to a different ward or to discharge home as soon as reasonable and usually within 48 hours. During the week, there were one or two consultants on duty each day supported by other medical staff. Regular ward rounds occurred to assess each patient and identify what tests or treatment were needed before decisions were made to discharge or transfer the patient. To support this, a discharge liaison person was in post. Staff we spoke with told us this was proving beneficial and one relative said "Staff have kept us well informed (about what was happening)".

We saw that the EWS had been recorded on admission and continued to be reviewed. Of the 12 sets of notes we reviewed in MAU, we identified four patients who had a high EWS of 6 or more. The provider may wish to note that medical advice was not obtained in three of the four cases. Staff we spoke to had a varied understanding of when the EWS should be used to call for advice. In areas such as respiratory care, EWS scores were raised due to the use of oxygen, which automatically increased the score. The nurses in this area were experienced and understood when to alert clinical support for a raised EWS of above 6. This meant in most cases clinical staff would have been alerted to patients whose health needs had deteriorated. In MAU clinical staff may not be alerted quickly enough, although we saw doctors were reviewing patients routinely for transfers to other wards on MAU.

We saw that staff completed a Pressure Ulcer Risk Assessment Tool (PURAT) on each patient when admitted to a ward. There was a requirement for this to be completed within six hours of admission. Staff on MAU told us this had rarely happened in A&E, and that most people came from A&E on trolleys with no additional pressure relieving care in place. We saw one instance of where someone had been assessed as being at risk of developing pressure damage and a bed was brought down to the A&E department for them. One patient we spoke with told us "I think the A&E beds are made of wood, they are so hard." Once patients were assessed, we saw airwave mattresses and pressure relieving equipment in use. Staff we spoke with told us they always inspected the skin on admission to the ward, completed a body map and an incident form if any skin damage was noted. We heard from staff in two wards how patients sometimes arrived from A&E on

a trolley already showing some markings to their pressure areas. The trust may wish to note pressure risk assessments were not always completed at the admission stage of A&E.

Staff we spoke with told us a high score for the PURAT triggered the instigation of comfort rounds and sometimes additional pressure relieving equipment. There was some confusion amongst nursing staff as to what additional pressure relieving apparatus should be used and when. Some staff said they used common sense, whilst others told us they would ask another staff member for guidance. Staff told us that whilst gels for heals and troughs to protect heels were usually available, the need for airwave mattresses often required staff to call other wards to find one that could be made available. Not all staff were aware of the policy and procedure for when specialist mattresses were to be considered. The trust had 40 airwave mattresses, with an additional one for use from the out of hours clinical team. We were informed that additional mattresses could be hired in for use, though this would often take 24 hours. We heard from the tissue viability (TV) nurse specialist how they were currently involved in a study looking at whether additional pressure relieving equipment affected the outcome for pressure sores. We heard how all beds within the trust had high specification mattresses to support and prevent pressure areas. Where there was a high demand for specialist mattresses the TV specialist nurse would assist with assessing patients and prioritising those in most need. This meant patients assessed needs were being monitored and equipment put in place when needed.

We saw comfort rounds in progress both in MAU and across orthopaedic and general surgical wards. These include a review of nutrition, hydration, continence and position changes one to two hourly. In the notes we reviewed, we saw that these had been conducted at regular intervals. Where patients had been assessed as at high risk of developing pressure damage their care plan included comfort rounds and regular changes to the patient's position. Where patients had developed pressure sores in hospital, a serious event audit was completed to look at whether the damage sustained could have been prevented.

We saw evidence that other risk assessments such as for falls, moving and handling, nutrition and swallowing had been completed. This meant that people's risks were identified when planning their care.

The provider may wish to note we found care plans were generic pre-printed documents, for areas of care related to personal care, confusion, dementia, and pressure area care. We did not see consistent evidence of personalised care planning when we reviewed patients' records. One person had a pre-printed care plan for confusion and dementia which did not provide personalised information about how the person's dementia and confusion affected their daily living activities. This patient's records contained the Alzheimer's document 'This is me', which aimed to improve the experience for patients with dementia. However the document had not been completed to assist staff's understanding of this patient's needs, preferences, likes, dislikes and interests. This could present a risk of the patient not receiving care in a personalised way. However, we saw individualised care delivered. For example, observation frequencies altered to meet the patient's needs. We pathway tracked one patient with limited mobility on one ward who told us "I've had a lovely shower and hair wash today. I feel so much better for it. She (the nurse) was really helpful."

The acute stroke unit provided specialist care to 14 patients delivered by a multidisciplinary team including a dedicated consultant, associate specialist, junior medical

staff, nursing staff and a multidisciplinary therapy team (MDT), including physiotherapy, occupational therapy and speech and language therapy. The quality of care was audited against national standards to enable the trust to benchmark the quality of their stroke service. We reviewed the results from the second pilot report which compared the trust's performance against national bench marks. We saw that in some areas the trust was performing better than the national bench mark, for example, the use of thrombolysis (the use of drugs to break up a blood clot). The proportion of applicable patients who were assessed by a nurse within 24 hours and at least one therapist within 24 hours was better than the national bench mark. As was patients with all relevant therapists within 72 hours and had rehabilitation goals agreed within five days. We heard the trust was aware of and focused on improving areas where the national bench mark was not achieved. For example, the number of patients scanned within the first hour and 24 hours of admission. The trust was almost meeting the target for the proportion of patients directly admitted to a stroke unit within four hours of arrival at the hospital.

We were told where possible patients were admitted directly from the emergency department (A&E) to the specialist stroke unit. Where this was not possible, due to capacity issues, the consultant, associate specialist and other members of the multidisciplinary team provided care, treatment and support to patients affected by stroke in other parts of the hospital. We heard from the associate specialist on the stroke unit that early rehabilitation was an important factor in patient's recovery. Records shown to us by the trust demonstrated that the majority of patients were seen by the physiotherapist and occupational therapist within agreed targets of 72 hours and four working days respectively and rehabilitation goals were set by the MDT within agree targets. This meant patients had access to recovery therapy in a timely manner to help with rehabilitation.

A key element of the national stroke strategy was the implementation of early supported discharge (ESD). The associate specialist told us this service was "working well" and that the ESD team had good links and communication with the stroke unit. The EDS team provided support and treatment in people's homes which continued for up to six weeks after discharge to support rehabilitation. We were told about the 'step down' service which was provided in partnership with a local community hospital. This enabled people to be discharged from the acute stroke unit and continue their rehabilitation under the care of the consultants and MDT at a different location.

We looked at the records of four people on the acute stroke unit. An integrated care pathway for acute stroke was used for all patients admitted to the ward. This document contained assessment details; This included key indicators for treatment such as swallow screening, brain scan, aspirin treatment and interventions by therapy staff, such as physiotherapy, occupational therapy and speech and language therapy. From the records we reviewed we saw that patients' condition and needs had been assessed and care plans were in place.

We saw that people were asked for their feedback. The friends and family test question as to whether the service would be recommended to friends and family was asked in the Accident and Emergency department. People were given a token to indicate if they would recommend the department. We saw that most people had been satisfied enough to indicate they would recommend the department to friends and family. We also saw a volunteer who spent time asking patients about their views and experiences in all areas of the hospital. This feedback was given to the ward areas within 48hrs. This showed the trust valued the views of patients.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet patient's needs.

Reasons for our judgement

Following our last inspection in March 2013, we received some information which indicated there might not be enough staff available with suitable skills and experience to cover the A&E department during weekends and evenings. We asked the trust for details about how consultant, middle grade and junior doctor cover was organised and were satisfied with their response. However we decided as part of this planned inspection we would ask a specialist advisor to look at staffing arrangements and how care and treatment was being delivered in A&E.

Following the department's redesign a second work force review had been completed and we saw additional nurses had been recruited into post as of September 2013. This had increased staffing to seven trained nurses on average per shift, which was in line with the workforce review. A locum doctor to the department commented on staffing saying that "staffing (nursing) was really good here, especially given the department's small size, and was overall considerably better than a lot of other departments (they) have worked in". A junior doctor stated they felt "well supported" and that seniors were "approachable" and there was never any pressure to make decisions alone.

It was acknowledged that there had been difficulties recruiting to middle grade doctor positions, following a national picture, especially compounded by the geographic position and size of the trust. A consultant commented that the trust had taken "innovative" steps to create a 'clinical fellow' aspect to the position to make it stand out and be considered more attractive to recruits. This had been positive in both successful recruitment and in the results of two pieces of research work the department was now involved with. The middle grade doctors were now on the rota for each shift and any historical practice of being on call has been stopped.

The A&E department had been operating below its funded consultant number for over a year which had meant a pressure upon existing consultants and the need to use locums. When locums were used high standards were placed upon their quality and suitability over and above the need to back fill the position. Locums that were used were generally already experienced and familiar with the department and staff creating a small pool of staff that were used. Staff reported they enjoyed and liked the locums because they often spent more time on the 'shop floor' as they were not having to commit to the administration

of the department. The general manager had said that as of March they would be back to full substantive consultant cover, above the previously funded level of five to five point seven full time equivalents.

A consultant for the department commented that there was a good supportive relationship between the consultants, especially supporting the on call and working time arrangements. They said that one of the strengths of being a small hospital and department was close working and understanding.

A consultant explained that the A&E department operated a unique way of responding to the seasonal demands of tourism upon it. They operated a 'high' and 'low' season of cover, increasing the hours consultants worked within the department during the 'high' season where increased demand was anticipated. The season was split into 10 weeks high, 42 low, and high/low dates were determined by the staff each year, based upon predicted variables such as school holidays and Easter. We found no concerns about staffing levels or skills of staff within A&E. Although the provider may wish to note some staff expressed concern about the fact the trust did not currently employ security service staff to deal and respond to agitated, violent or threatening patients. The trust relied on the services of the local police and could call upon the services of the mental health outreach team if appropriate.

In recovery, where previous concerns about the skill mix of staff had been highlighted by historical information received by CQC, we found staffing levels in the main recovery were adequate. There were four operating theatres and staff levels in recovery were between four and six, start times were staggered to enable a maximum number of staff with peak activity. There was one nurse looking after one patient until the patient satisfied the discharge criteria. Observations were performed every five minutes for the first 30 minutes and then every 10 minutes depending on the needs of the patient; these were documented. This was in line is with up to date guidance for discharging patients from recovery.

The theatre manager completed an annual staff review which was shared with us. We saw that national guidance was used to assess the requirements of the department and to ensure sufficient staff were available. The preferred staffing ratio was one to one for the initial recovery period. Staff working in theatre recovery told us there were usually enough staff on duty to meet the demands. We were told about the flexibility between recovery and theatres which enabled theatre staff to work in recovery when demand was high. Staff told us the role of the co-ordinator within the department was valuable when managing staffing levels. We found there was a review in progress of the contingency plan for increased demand on critical care services, which included recovery. The purpose was to ensure that critically ill patients were managed safely without compromising their care and treatment. This showed the trust monitored and reviewed staffing levels to ensure the expected standard of care was met.

In the Intensive care unit (ICU) the staffing ratios were usually in keeping with current recommendations. There were occasions, such as with sickness, when the supernumerary nurse would be involved in general nursing care. If the dependency of the patients made this unsafe this was reported and attempts were made to bring in extra staff through pain and resuscitation nurses (both had had critical care training) and agency. There were six beds on the Critical Care Unit and the more usual problem was the lack of a bed. In this case the lowest risk patient (HDU) would be transferred to recovery and be looked after by

a critical care nurse (if one was available) or a recovery nurse. If looked after by a recovery nurse, medical and nursing staff input was given by the critical care unit to these patients. We concluded there were sufficient staffing for the number and needs of patients in critical care.

Daytime consultant cover for critical care did not meet the national core standards for continuity of care. We saw two consultants worked every other morning. The afternoon was covered by the consultant who was on call. There was a very uneven distribution of workload. This rota also meant the frequency for ITU working, decision making and keeping skills up, for the majority of consultants, was low. We also noted second ward round at weekends and seeing patients within 12 hours was variable depending on the consultant on call.The provider may wish to note the absence of a critical care outreach service. We saw systems were in place to alert clinical staff of patients who were deteriorating but it was unclear how this was fed back to the critical care team.

On the stroke unit we were told that a specialist stroke consultant was available at the hospital Monday to Friday. Over the weekend period, a consultant on call at the hospital dealt with patients who had had a stroke. A protocol had been developed specifically for the treatment of patients with a stroke to ensure a consistent approach in treatment in the absence of a specialist consultant. The associate specialist told us that medical cover on the ward was "good" and there was "always" a junior doctor available. One member of the nursing staff told us that doctors were available after 5pm and over the weekend and that they responded to requests to attend patients in a timely way. They added, "I have never seen such a good multidisciplinary team". Another senior member of the nursing team told us that some discharges could be delayed if there was no specialist stroke cover for the unit over a weekend or bank holiday weekend as other doctors might be reluctant to make a decision about patient discharge.

Staff on the stroke unit told us there was usually sufficient staff, including therapy staff, available. We saw that a reduced number of therapy staff were available over the weekend. We were told that two physiotherapists worked Saturday mornings to ensure the 72 hour target for assessing patients was met. We were told on occasion staff numbers could be affected, usually due to un-planned sickness. We noted on other ward areas physiotherapists were only available for emergency treatment such as chest therapy, but any on-going therapy to get patients more mobile was generally only offered Monday to Friday. We heard this was also the case for occupational therapist, speech and language therapists and dieticians.

We had received information from a family about their relative who had learning disabilities who had been admitted to NDDH in the previous month. The concern had been expressed about lack of therapists to complete a swallowing assessment, and the person went four days without being able to eat, which the family felt had compromised their health and recovery. The trust may wish to note the lack of therapist cover seven days per week was cited by trust staff as holding up discharge of some patients over the weekends.

Several members of staff spoke to us about the newly recruited overseas staff and the impact their induction had had at times in relation to being supported, which they felt took "a lot of time". However they recognised the value of having additional staff in the long term. We heard overseas staff had a full induction and were supernumerary for as long as needed for their competencies to be in line with existing staff.

We heard from medical and surgical ward staff how staffing levels had been increased

following work force reviews. In most wards this meant they had one trained nurse per bay of six patients plus one nurse to coordinate care and treatment for the shift. We also heard how health care assistant numbers had increased by at least one per shift for most ward areas. Some wards had chosen to use this extra staff member more flexibly. Two wards for example had used their additional health care assistant as a discharge care coordinator. Staff reported this was working well and eased the workload from nurses when planning for discharges.

The acute medical ward had been following the Enhanced Recovery Programme for several months in order to maximise patient independence. There was open visiting and patients were encouraged to dress in their own clothes and to be up and about if at all possible. On this ward and others we observed during the two days, there seemed to be sufficient staff, volunteers and students to encourage engagement and activity by the patients; staff included the chaplain, physiotherapists, speech and language therapists, and a lady selling papers.

Patients and visitors gave positive feedback about staff skills and numbers. One patient said "I just have to ring and they are there". Another said, "They (staff) are busy but they always have an eye on you and they are always asking 'do you need anything'. They are very attentive, especially the sister".

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

We spoke with a range of staff and asked them about the training, support and supervision they received. Staff told us they knew how to access training, and undertook the majority of their training on line. Where taught sessions were delivered, staff told us they had no difficulties accessing these. All staff told us they were given time to attend and undertake their training. During our inspection, we saw staff released to attend both immediate life support and fire training.

We spoke with several new members of staff who had been recruited from overseas and also to two newly qualified nurses. All confirmed they spent a period of time being supernumerary. This meant they could be observed and supported to carry out their roles safely. All of those we spoke with told us they felt supported to be able to carry out their roles and to develop professionally. One student nurse described their formal learning as a newly qualified nurse as ''Exceptionally good'' We heard about the Trust's induction programme for all new staff, which involved training in all aspects of health and safety and meeting with key board members of the trust.

We heard about specialist training in areas where patient care was complex and staff needed additional skills. For example in the A&E department the trust offered trauma training for their nurses as a designated trauma centre department. Paediatric specific training (PILS/EPLS) had been delivered to all band six and seven staff with plans for it to now be offered to band five staff. This was the same case for advanced life support (ALS). These were externally accredited and delivered within the trust's own practice development department.

Staff working in the recovery department told us they were well supported to do their job and they received regular training. Nursing staff told us they received sufficient training to meet their professional registration requirements. We heard that a 'bespoke' induction programme was in place for new staff working in recovery. Staff were given a number of supernumerary shifts where they worked with experienced staff in order to develop the skills and competencies required. The length of the supernumerary period was tailored to the individual. We saw that each member of staff working in recovery had a personal development portfolio. Some were completed better than others, in that some gave more

detail about the training and supervisions undertaken across the year.

In ICU 14 staff had completed a recognised intensive care course; two staff had completed a coronary care course and five staff had completed a 'clinical decision making in emergency situation specialist intensive nursing' module. We heard that eight staff had completed or were currently undertaking 'core skills for care of critically ill adults'. We saw that staff competencies were reviewed in relation to the use of equipment. This showed specialist training was provided to ensure staff had the right skills.

All staff we spoke with told us they had annual appraisals. When asked, some staff also spoke of having regular supervision sessions, though others were less clear. Ward managers used a variety of methods of communicating with staff. All undertook 1:1 return to work interviews, some held occasional 1:1 supervision sessions and some held them very ad hoc. Some ward managers held ward meetings, whilst others sent their teams newsletters highlighting any issues. We saw back copies of newsletters for one ward which identified issues such as audit results and actions to address them. This meant that most staff received updates on information and performance reviews, though many did not recognise them as such. We saw some ward managers had good records in relation to having formal one to one supervision sessions with nurses and health care assistants. We heard from the medical director there was a formal process in place for all doctors of all grade to have supervision and this was used as part of their revalidation with the general medical council.

The trust audited all areas to ensure staff had support and supervision on a regular basis. Most wards were achieving good scores for percentages of staff who had completed core training, and variable scores for recording supervisions. Where areas were not preforming to targets the work force development team got involved to provide support and additional training in the ward area.

We spoke with one staff member who was completing a phased return to work following a prolonged period of sickness. This had been designed to meet their needs and support them back into the workplace. This meant staff received appropriate professional development and support.

We saw core training had been offered on line and through direct teaching. This included all aspects of health and safety so staff had the right skills to do their job safely and effectively. We heard how since the trust had moved to a new electronic system for e-learning compliance in core training had increased by 12-20%.

We heard how the trust had recently set up focus groups for all staff to have their say about what the core values of the trust meant to them. This was advertised via the trust's electronic system, and the results of these focus groups had been fed back to the board. This showed the trust valued staff views and opinions. We also heard how the trust was working in conjunction with a local paper to award staff as 'heroes in health'. Patients and public were able to nominate and vote for staff who they felt had showed compassion and caring. This showed the trust were finding ways to reward staff for delivering quality care and treatment.

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

We included this outcome as CQC had recently received some information of concern which indicated records had not been well managed by the trust. We had sent this information to the trust for them to respond. As part of this planned inspection we looked at a number of records relating to patient care. We were also sent further information and records by the trust following the inspection.

Patient's personal records including medical records were accurate and fit for purpose. We saw there were two main files for patients, one held within a trolley in the ward bay area. Medical notes kept here were accessible for the use of all staff providing care and treatment. The other file was kept at the end of the patient's bed. This file contained risk assessments, care plans and any observations completed by nursing staff. In all records we viewed, there had been daily entries about what care and treatment had been delivered for each patient.

Staff records and other records relevant to the management of the services were accurate and fit for purpose. Staff records such as supervisions were held in locked filing cabinets in the ward manager's office. Other personnel records were held centrally within the trust by their human resources team.

Records were kept securely and could be located promptly when needed. Patient notes and files in use on ward areas were not locked as nurses, doctors and therapists needed to have regular and constant access to these to update and review. We saw evidence of authority to access medical records being challenged by staff. We asked for two sets of patient notes of patients who were no longer in-patients at the hospital. These were located promptly and were accurate, including all information and records relating to the patients' treatment within the hospital.

Records were kept for the appropriate period of time and then destroyed securely. We saw the trust had a stated policy and protocol for how records were maintained. This included details about how long records should be held for. We heard from the work force development team, all staff were expected to complete training in governance management and records, so they fully understood their duty in maintaining accurate

records. We saw from data provided by the trust 71% of staff trust wide had completed this training. This was below their target of 95% Some areas were achieving better than others.

Staff we spoke with understood the importance of maintaining accurate records and also understood the need for confidentiality. We found no evidence during this inspection to support the information of concern in relation to records.

Staff we spoke with told us that patients came to the wards from A&E with their medical records. Staff in A&E told us they had 24 hour access to medical records. We did not see any temporary files in use. This meant that staff had access to detailed information about the patient's previous medical history.

We discussed the process for writing discharge letters with two staff in A&E. The proforma in use allowed for only a limited description. The department used a restrictive electronic discharge summary to share information with the patient's general practitioner. Staff reported this as often being "inadequate" and limited and so either made a call or hand wrote a letter. We were shown a poorly photocopied template which was faded with aspects cut off through copying. Compared to the more detailed report and summary that was available on wards this identified a gross difference in standards. Some doctors reported they would copy hand written notes into the patient record giving the patient the other copy; others faxed them to the surgery. The provider may wish to note the discharge summary for A&E patients did not facilitate good communication between the hospital and the patient's GP, although as described staff had found ways to ensure records were shared in the interest of patient care and safety.

Some ward areas used an electronic system of recording their bed state. The provider may wish to note that where some of these were located in corridors, patient names could clearly be seen. This may breach patient confidentiality. Some wards had used bed numbers only, which maintained patient confidentiality.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: The trust did not always act in accordance with legal requirements in relation to "do not resuscitate" orders. This meant there was a risk that inappropriate action could be taken which was not aligned with the wishes patients or in their best interests. (Regulation 18)

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

The provider's report should be sent to us by 06 February 2014.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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