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: 07 February 2013
06 February 2013
05 February 2013

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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
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ 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

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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 5 February 2013, 6 February 2013 and 7 February 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information we asked the provider to send to us. We reviewed information sent to us by local groups of people in the community or voluntary sector, took advice from our specialist advisors and used information from local Healthwatch to inform our inspection.

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.

What people told us and what we found

This inspection was carried out on 5, 6 and 7 February 2013 with four inspectors looking at five key outcome areas. In particular; discharge planning, care of patients with dementia and how the trust engaged patients in their quality assurance processes. In total we spoke with 72 patients and 18 visitors on a variety of wards including the Accident and Emergency department (A and E), the children's ward, surgical wards, medical wards, the medical assessment unit (MAU) and various outpatient departments. Also we met the families of six children/babies. Comments from patients we spoke with were very positive and they praised the care, support and treatment they had received.

We interviewed 70 staff including a non executive director, the complaints manager, staff from the patient and liaison service (PALS), patient safety lead, medical director, finance director, corporate governance lead, tissue viability specialist, adult and children safeguarding leads, lead midwife, dementia pathfinder team, palliative lead nurse specialist, discharge coordinator, consultants, doctors at all levels, nurses, ward clerks, receptionists, student nurses, and members of the allied health care teams.

We found patients using the service were involved in all aspects of their care and were consulted about the support and treatment they needed.

Patients were treated with dignity and respect and their care, welfare and treatment was managed by staff who were trained and supported to do their job. Patients told us '' They always tell us what's happening. I'm very happy, it's excellent care''. ''You can't fault it, they always ask my permission'' and '' I've been coming since 2007. The staff are courteous, kind and professional''.

The hospital had appropriate quality assurance processes in place to monitor and improve the services they provide.

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Patients who use the service understood the care and treatment choices available to them. Where admissions were planned, patients told us about leaflets they were given about their diagnosis. The trust website also had information about procedures, operations and what patients should expect. We saw that in the patient advice and liaison service (PALS), there were information leaflets available about various conditions and support group contact details.

We met 20 patients who were having treatment in the out patients department. All 20 patients we spoke with told us they were fully informed about their treatment options. We saw a number of leaflets in the department, which patients confirmed they were given when they first attended. One patient told us "They spent at least one and half hours explaining everything to me at the first appointment'' and they showed us a leaflet covering management of fatigue symptoms. Another patient told us "They treat you as a person, not a number. They told me no question was a stupid question and just keep asking". This meant that people had access to the right information so that they understood the care and treatment choices available to them. One patient in the ophthalmology outpatients department told us ''it's first class, staff are courteous. Kind and professional. It's the finest hospital in the country''. We saw the staff keeping patients updated about what was going to happen to them and when they would be seen.

Patients who were admitted in an emergency told us what had happened to them and about the care and treatment choices available to them. For example eight patients we spoke with in A and E confirmed that nurses and doctors had explained what tests had been completed and where a diagnosis had been reached, this had been explained to them. One patient said ''I was very anxious, thought I should have called for an ambulance sooner, but they (staff at A&E) have been marvellous and explained everything to me.''

Patients expressed their views and were involved in making decisions about their care and treatment. For example, one patient we spoke with told us they were finding it difficult to

come to terms with the diagnosis they had been given. Their relation told us “They temper what they say to her, which is exactly what she wants”. We saw that at the start of treatment, the nurse worked closely with the patient to prepare them for having a needle inserted into their arm. After this was inserted, the patient told us that the nurse was covering it up because that was their wish as didn’t want to see it. Another patient told us they had decided to delay treatment around a family event and found that the medical team were “more than happy to oblige and do what I wanted them to do”.

In wards we observed how patients expressed their views and were involved in making decisions about their care and treatment. We heard for example, one patient being asked if they were ready to try to get up out of their bed. Nursing staff explained how they would support them and at each stage checked that the person was comfortable, and ready for the next move. We heard another example of a health care assistant calmly working with a patient behind closed curtains, supporting them to wash and dress independently, in readiness for their discharge home. We saw in patient notes how staff recorded they had gained a person’s consent to any care or treatment process undertaken.

Where a patient was unable to make a decision for themselves, either because they lacked capacity or due to an emergency situation; we saw in patient files their next of kin or person holding lasting power of attorney had been consulted with. We saw that decisions had been made in the patients best interests and these decisions were clearly documented. For example in one patient’s file the medical team were considering treating the patient with insulin. They had obtained information about the person’s capacity to make decisions from their carer and had consulted a learning disability link nurse about this. A ‘best interests’ meeting had been set up to facilitate a discussion and for advocates to act on the person’s behalf with regard to making decisions about the options for treatment. This meant that the person’s rights would be promoted.

We heard how consultants and junior doctors explained to patients about their progress and asked their views about pain management and other aspects of their care. Junior doctors confirmed that following ward rounds, they would check back with patients to see if they understood what had been discussed with them and whether patients had questions about their treatment or diagnoses. One patient told us “The consultant is excellent, they tell me very clearly about my progress and are honest about what the future holds.”

Patients were supported in promoting their independence. The staff we spoke with told us how they promoted patients independence whilst in hospital by encouraging them to manage their personal care and walking or moving around the hospital. They told us about making referrals to a range of therapists such as occupational therapists or physiotherapists to enable independence and mobility. Patients told us how much they valued their support. One patient told us “They (the staff) are brilliant, I couldn’t believe how much progress I’ve made with my walking.”

People’s diversity, values and human rights were respected. For example in the records we looked at for some patients we saw documents about decisions they had made about their end of life care.

Throughout the inspection we saw that patients were treated with respect and dignity when receiving treatment. Staff addressed patients by their chosen name and closed curtains around the bed when providing support. We were told that staff used an office off the ward for discussions that were sensitive to the patient.

Where patients were being moved by hospital porters we saw them being addressed

appropriately, heard patients being reassured and saw their dignity and comfort was respected. Patients wore dressing gowns and had blankets covering their legs when in wheelchairs and were kept warm with blankets if being moved in a bed. This meant that dignity was maintained.

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.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

We spoke to a total of 72 patients and 18 visitors and they praised the care, support and treatment they had received in all areas we inspected. Comments included “The staff are brilliant despite being so busy here, the care has been superb.” Another patient said “Everybody has been ever so helpful, I’ve had the best treatment available”. The general theme we found was that there was a high level of satisfaction with the care and compassion provided by all hospital staff. This was supported by our observations of patient care throughout the hospital.

Patient’s needs were assessed and care and treatment was planned and delivered in line with their individual care plan. In the patient files we looked at across all wards and in outpatient departments, we saw care plans and risk assessments which were up to date and regularly updated. This showed that care and treatment was planned and monitored.

We saw clear examples of patient’s care pathways from an initial contact with their own GP, a referral to a consultant, the outcomes of tests and a planned admission into hospital for treatment. For example, we saw one patient was admitted for initial treatment, then referred to another hospital for specialist treatment before returning to the hospital for rehabilitation and recovery care. The patient told us how they had received regular updates about their health throughout their time in hospital and treatment provided by staff was “excellent.” They said “I can’t praise the staff highly enough.”

Some patients we saw on wards were nearing discharge and their wishes and those of their relatives had been obtained about this. For example, we spoke with two relatives who were acting as representatives for a person with dementia. They told us “we’re very pleased with the care; the staff could not do enough”. With regard to discharge planning, they said “we’ve seen the consultant today and she’s explained everything. I would like him to return to the residential home he’s been living in and they’re making arrangements for this to happen”. Staff involved in managing this person’s care told us the aim was to make the patient comfortable as they were nearing the end of their life. Records demonstrated the person’s representatives had been involved in making ‘best interest decisions’ about a treatment escalation plan that would be followed if the person’s health needs changed. This meant that people’s needs were assessed and their care and treatment delivered in line with it.

Another patient with a learning disability had very detailed care records, which showed how the hospital staff, care home staff and family were working together in their best interests to get them home as soon as possible.

On a ward for patients with dementia most patients were admitted from the Medical Assessment Unit. Once someone was admitted to the ward the team estimated a discharge date and the multi disciplinary team work towards achieving this so that patients weren't kept unnecessarily long in hospital. We looked at the care notes for three patients and found that they were all up to date and detailed. They described the care and treatment needed for each patient. We met with a qualified nurse and asked them about the care of six patients. They were very knowledgeable about all the needs of the patients.

On the Medical Assessment Unit we spoke to eight patients. All of them had been admitted via A and E over the previous three days. The staff aimed to usually move patients to a different ward or discharge home within 48 hours of admission and we were told this was generally the case. One patient told us ''I'm very happy here, the staff are very professional and it's excellent care''. We looked at three care records and found that they contained up to date information on current risks. There were one or two consultants on duty each day supported by other medical staff. There were regular ward rounds to assess each patient and assess what tests or treatment was needed before deciding whether the patient could be discharged or transferred. The nurse in charge explained the necessity of keeping everyone, including the patients informed of what was happening so that patients could be moved on as quickly as possible. One patient said ''They always let me know what is happening''.

On medical wards we spent time watching patient's experiences of care. We saw staff asking patients what they would like for their meals and at mealtimes they were provided with the choices they made. We saw staff helping patients to eat and drink at regular intervals. Patients who needed closer monitoring had one to one support from staff at meal times and in between to ensure they had an adequate intake of fluids and food, where appropriate. Some patients were unable to eat or drink for medical reasons and were having intravenous fluids. We saw nursing staff closely monitoring these throughout and recording patients input and output. The people we spoke with told us they enjoyed the meals provided and said they were of "A good standard and better than expected in a hospital." This meant potential risks of dehydration and malnutrition were reduced for patients.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. Where a patient had been admitted from a residential home we saw the care homes care plan in the patient notes. The nurses told us how they used this information to help deliver the persons care as it showed their choices and preferences. We saw that the hospital care plan included some of this detail. Patient's care was seen to be provided in the way described in their notes. We saw other examples of where risk of choking had been clearly identified. We observed the patient being closely monitored and assisted during the lunchtime period to reduce this risk as had been identified within their care plan.

The trust was working to improve the care pathway for patients with dementia, so that the transition from care home/ home to hospital and return was very well planned and caused the least disruption to patients as possible. We met the dementia pathway driver team who are involved in a Kings Fund (national) pilot scheme in one part of North Devon. We also saw that where patients had dementia they had a completed 'This is me' booklet, which is a nationally recognised tool where people who are close to the patient complete their

likes/dislikes/routines etc so that staff on the ward have a better understanding of how to care for the patient. This showed that the trust takes into account good practice and research.

In A and E we saw that nursing staff were using the Manchester pathway, a national tool for assessing patient's risk and urgency for medical treatment. Patients who walked into the A and E department, were initially triaged by a nurse who assessed their trauma or medical emergency. Patients arriving by ambulance were seen by a senior doctor for an initial assessment of their condition. We saw that the A and E department had bays for serious medical emergencies, and three separate resuscitation rooms, as well as bays and treatment areas for less complex cases. We spoke with one nurse practitioner who told us that they were able to deal autonomously with less serious emergencies such as sprains or minor suturing.

Risk assessments included nutritional screening, risk of pressure damage, falls, use of bed rails, anti- embolic stocking assessment (for prevention of thrombosis) and moving and handling. These were all monitored and reviewed daily for each patient. Any changes to risk or treatment plans were clearly documented. Nursing staff we spoke with said that although the documentation had increased, all risk assessments were now within one booklet and so easy to locate and to monitor. One nurse commented ''Since CQC said we needed to improve our record keeping, the trust have upped it's game, I think we are now really good at making sure the risk assessments and care plans are in place for patients.''

There were arrangements in place to deal with foreseeable emergencies. In the majority of medical notes we looked at we saw how patients or their advocates had been consulted about emergency treatment. We saw that treatment escalation plans (TEPs) had been agreed and signed by patients or their advocates and heard from staff that they were aware of these agreements. We saw an example of one patient who had been admitted to hospital following a spate of falls leading to serious injuries. This risk was clearly identified in the notes and the plan included using a 'high/low' bed to reduce the risk of the person falling from the bed. We observed how staff worked with this patient monitoring and using distractions to coax them back to their lunch. This meant that potential risks were reduced for patients by the interventions used by staff.

Staff on the children's ward explained that they offered 'family centred care'. The ward treated children with a variety of conditions and also had a special care baby unit attached. Parents were able to stay with their child overnight; and there was also an overnight room available. The families that we met very happy with the level of care given to their children. We also met the teacher who provided education to those who are of school age; meaning children's educational needs were also met whilst in hospital.

The Deprivation of Liberty Safeguards (DoLS) were only used when it was considered to be in the person's best interest. We met one patient who had been admitted the day before and were at risk of trying to leave the ward; but would have been unsafe to do so. The nurse had already completed the necessary forms to apply for a DoLS authorisation. The process they described demonstrated a clear understanding of when these needed to be requested and ensured that patient's rights were fully protected. Staff knowledge of these safeguards had improved and the trust had already made 24 applications from 1 April 2012 to the time of our inspection compared with 27 in total in 2011/2012.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Patients who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. We spoke with 72 people throughout the hospital, all of whom told us they felt safe and were treated with respect by staff looking after them. Patient's comments included "If you weren't getting the right treatment you'd be frightened and I'm not at all.", "They put you at ease", ''I was worried about coming into hospital, but I feel really safe here''. This meant that people felt safe and were comfortable with the staff looking after them.

We spoke to both the adult and children safeguarding leads for the trust. The adult lead was also the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards lead for the trust. They both provided specialist advice for staff in the hospital. There were safeguarding policies in place and regular meetings with key staff. The leads met each month to discuss common issues and each reported to the Quality Assurance Committee, where issues of risk and quality were discussed. A member of the trust board also sat on this committee and the Director of Nursing.

We saw that the children's ward and one medical ward had a keypad security system in place to prevent people from accessing the ward without staff being aware of people's arrival. The measure also meant that patients who became disorientated could not move off the ward without people being aware. This measure was in place during our inspection and meant people were safe from intruders or from getting lost.

We spoke with 70 staff across the hospital. We heard that staff had to complete mandatory e-learning about safeguarding adults and children. Training also included the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The majority of staff we spoke with understood their responsibilities in recognising potential abuse and what they should do to report it. For example, a doctor told us they would be concerned if they saw "changes in a patient's behaviour or suspicious bruising that doesn't match the description of events" and would "seek advice from the pathfinder team without hesitation". A nurse told us they had experience of reporting suspected financial abuse a person admitted from home to the hospital. A protection plan had been put into place for when the person was discharged home. This meant that people were protected from the risk of

potential abuse because staff knew how to recognise and report it to prevent it from happening. The provider may wish to note that housekeeping staff we spoke with had not received any training in safeguarding vulnerable adults or children.

In the children's ward, we heard from staff and visitors that they had some concerns about the way bays had been configured and also where staff had left the curtains around one child unattended. The bays had three beds in each, but one bed was less visible to nurses than the other two. We spoke with the trust's patient safety lead. They explained that this risk had been identified and an action plan to reduce these risks had been documented. This included making sure children who were assessed as being most vulnerable or at risk, were placed in the more visible beds within bays and that all staff and visitors were reminded that curtains were not to be drawn around beds at night, but only used when medical or nursing treatments were being carried out. The provider may wish to note that despite these measures staff and visitors still felt that this was a risk area for children.

In A and E we saw a poster at the front desk which explained to parents/guardians of young patients that the department were required to ask some set questions to help protect children. Staff showed us a form that was completed for each child seen at the emergency department. This included a check list and indicators that may highlight a child may be at possible risk. Staff we spoke with within A and E were aware of safeguarding procedures and protocols for children and vulnerable adults. The children's safeguarding lead also explained how they worked with MASH (Devon county wide safeguarding alert system for children) and that the trust was also focussing on domestic abuse. The trust is one of eight trusts nationally involved in a programme, where an external expert will work with staff in the emergency departments to help recognise domestic abuse. One named qualified nurse will then become an expert in this area.

We heard about some proactive initiatives the emergency department had set up to further protect patients. For example we saw that for patients with suspected fracture of their hip, a common fracture in frail elderly people, there was a fast track process. This meant the vulnerable older people with this type of injury would be seen quickly, given pain relief and moved to a ward area for treatment. We heard that one lead nurse from A and E also worked closely with the falls group and complex care team so that vulnerable adults who presented frequently with injuries due to falls were assessed for care and support on discharge or at home.

We saw how staff were allocated to sections of the wards we inspected with a minimum of a nurse and health care assistant in each section. This meant that the risk of patients being neglected was minimised. The nurses told us how staff numbers were increased if patients required closer observation. This meant the provider had taken reasonable steps to support people's safety and prevent abuse such as neglect from happening.

One patient on a ward explained how there had been a patient admitted during the night from A and E who was very intoxicated with the effects from alcohol. They said that the patient presented behaviour that was challenging to the patients and staff, but that the staff had dealt with the situation very calmly and skilfully. They said they had been made to feel safe, in what was a potentially threatening environment. This showed that staff had the skills to manage patients who may present risks to others.

We spoke with one nurse who had responsibility to call all patients within 48 hours of their discharge home. This was to check that they understood any recovery plan, medications, and that the right support packages were in place for vulnerable patients who needed extra support when discharged. She told us that this new intervention had been well received by patients and she had been able to offer support and advice. This helped to

protect patients following discharge, by giving them access to advice and support about their condition and any medications prescribed to them.

Medical equipment and supplies were stored securely around the wards. Medications were always stored securely with the senior nurse holding keys to the controlled drugs store. We saw that risk assessments were in place for each patient for key areas of their care such as nutrition, skin care and falls. This meant that the risk of accidental harm was minimised.

People who use the service were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements. The patients we spoke with told us they were not restricted and could move around the ward and hospital freely. They told us they were asked to inform the senior nurse of where they were going and when they were planning to return. We saw the nurses made notes of where patients were going when they left the wards. Patients wore identity bracelets to ensure appropriate treatment was provided should they become unwell when away from their ward. This showed patient safety was considered whilst in hospital.

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.

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

Reasons for our judgement

Staff received appropriate professional development. We spoke with 70 staff from all professional backgrounds across the hospital. We were told staff had to complete mandatory e-learning as part of their induction and ongoing training. For example, three medical staff told us they had a "training tracker that is monitored". We heard from senior staff in work force development that all training was tracked via electronically held records. This meant that where staff continued to have gaps in their training needs, this was easily identified. Training records for each ward and area within the trust were closely monitored. This meant that the trust had systems in place to link people's skills and knowledge to their role and responsibilities.

Nurses told us about the training they received each year to meet their registration requirements. This included regular updates of training in core areas such as moving and handling, safeguarding, deprivation of liberty safeguarding, mental capacity acts and essential patient safety updates. Other staff such as health care assistants (HCA's) and trainee nurses told us about similar training updates to help maintain and improve their knowledge and skills.

One nurse told us they were qualified to sign off other staff learning programmes; this involved frequent observations of skills and patient treatment. They also explained how they would support the person until they met the standards expected for that skill area. The nurse told us about how staff received additional training to help manage changes in the type of patient coming onto the ward. For example when people were planned to be admitted to the ward following gynaecological surgery staff had study days on gynaecology care.

All the staff we spoke with told us about receiving regular supervision related to their role. They told us how the supervision in some wards usually occurred on the ward and was practically based during ward rounds or when delivering patient care. The trust may wish to note that not all supervision was formally recorded, and therefore not easy to check the quality and continuity of support to staff in all areas.

Staff were able, from time to time, to obtain further relevant qualifications. For example the student nurses we spoke with told us about an extensive programme of learning and qualifications which would lead to further qualifications. The HCA's we spoke with told us

about working towards diploma qualifications, with some gaining qualifications which would enable them to train as nurses. Housekeeping staff told us how they were given training opportunities such as level two and three in infection control and dementia awareness.

A team of nurses working in a specialist out patient clinic told us training was “very accessible”. We were told the trust funded each person to complete a chemotherapy course lasting six weeks in length. We were shown pre-course preparation material, which required extensive research about all aspects of chemotherapy treatment and care prior to starting the course.

We heard from staff within A&E, training and support played a key role with staff attending monthly meetings and weekly training sessions to look at key areas of trauma care for patients. We heard that not all staff within the emergency department have received updated training restraint and conflict resolution. These are training areas that help to protect staff from potential risks from violent patients. This has been identified as a key area for the trust to implement and it is on the trust's risk register that the board oversees.

We saw that the trust had looked at various ways to inform and support staff in understanding their role. A new training day had been devised for example, where staff had the opportunity to spend a day discussing a scenario around essential patient safety. We also heard that although training in understanding Mental Capacity Act 2005, has been well attended, the trust had identified a gap between theory and practice. They have set aside monies to have a seconded post from the mental health team to assist staff in the trust understand mental capacity in practice.

We were told that the trust had recently won best large employer of apprentices in the South West. This showed that the trust were providing new staff with good support and mentoring to gain qualifications.

The provider has secured high standards of care by creating an environment where clinical excellence could do well. The consultants we spoke with told us about how they attended courses run by local universities to help inform their clinical practice. They told us how they received accredited research and guidance through organisations such as the national institute for health and clinical excellence (NICE), which helped inform their clinical practice. We heard that appraisals and clinical supervisions helped to inform the process for doctor’s revalidation with the General Medical Council.

We spoke with four nurse specialists and heard about their role and responsibility in promoting best practice. For example, a palliative care team member told us that they delivered training for staff covering subjects like communicating effectively with patients and end of life care. We heard about a project looking at people’s experiences of end of life care. The specialist was involved in initiatives to embed knowledge and experience across the trust utilising nationally recognised care pathways. Another nurse specialist told us their team were members of the regional tissue viability group, which they used to share experiences and gain further expertise from. We also heard from the complaints manager how she was part of a regional professional group to look at good practice in handling concerns and themes in patient care. Staff we spoke with understood responsibility to keep up to date with clinical developments in their field as part of their professional registration.

Assessing and monitoring the quality of service provision ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.
The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

Patients who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. On wards and outpatient areas we visited during this inspection, we observed patients being consulted about their care and treatment. Patients we spoke with confirmed that they were asked for their consent to treatment, had opportunities to discuss treatment options and recovery plans and could voice their views about their daily care. One patient said ‘’ Look, on the back of the menu, you are asked to make comments about the food. In the booklet, they give you all the details about who to contact, who’s who in the hospital and then the nurse on each shift asks you if you are okay. So in answer to your question ‘are we listened to’, I would say yes, definitely.’’ Thank you cards were on display in wards and contained very positive feedback about care given. For example ‘’ You have a ward of which you can all be proud’’ ‘’ At no time did we feel that his age of XX prevented him from receiving the best care possible’’. ‘’Mum wanted you to know how kind and considerate you all were and treated her like a queen’’.

We met a group of people in an outpatients department and heard about questionnaires being used after each treatment cycle to obtain feedback about their experiences. We received information from Devon Local involvement Network (LINks) who had carried out surveys to find out about patient experiences in outpatients during October 2012. They made several recommendations as a result of survey feedback. The trust have listened to these, and during our inspection, for example, we saw that improvements had been made to information within the eye clinic. White boards had been added to help patients know waiting times and delays. LINks who are now replaced by Heathwatch have made recommendations to return to do further survey work. The trust have welcomed this external feedback.

We heard that patients could make their views known via the trust website and on monitors within the hospital. We also heard from the director of nursing about a new initiative the trust had piloted called ‘mystery shopper’. Patients coming to hospital for planned admissions or outpatient appointments were able to sign up as a mystery shopper so that they could give real time feedback about their experience. This information was

then used to improve any areas where patients had identified issues, gaps or themes. We also heard that the patient experience was used to help inform the trust broad of what patients thought of their care and treatment throughout various departments. We heard from board members that the ‘’patient journey or experience’’ had helped to demonstrate clearly areas that worked well and areas they needed improvement. The last mystery shopper was someone with a learning disability and their patient experience was recorded on a DVD for staff and the board to view.

We spoke with PALS advisor and to the complaints manager. We heard that PALS was available throughout the working week, and that advisors would visit wards, take phone calls and answer any letters. If an issue from a patient was not resolved by PALS it could be dealt with as a formal complaint. The complaints manager told us that she contacted every person by phone personally, when they made a complaint. They then worked on how to resolve concerns and complaints. This could include meetings with consultants or ward managers to discuss care and treatment a patient had said they were unhappy about. We heard that only a small number of complainants remain dissatisfied with the trust response and went onto use the ombudsman. This meant provider took account of complaints and comments to improve the service.

We heard from the director of personnel and development how the trust were working on an employer engagement strategy. This recognised that staff needed to be involved in the development of the trust and to feel listened to at all levels. The trust had done a number of things to keep staff informed about key areas, such as presentation about what it meant to become a foundation trust and sharing information about the business plan and future developments. There had also been more executive and senior staff presence on wards, with matron walk rounds, board members carrying out ward rounds and staff surveys. Most staff we spoke to said that they felt that more information had been made available to them and that their views at ward level were considered. This showed that the trust were working on ways to engage with staff and include their views in any improvement of the service.

On the wards that we visited we saw routine auditing of patient records took place weekly. The nursing staff we spoke with told us they checked another wards records. The audit looked at patients risk assessments, fluid charts, observations, care planning and patient consent. The audit also sought to find examples of good or poor practice with a section to report what actions were taken. The results of these audits were summarised in a red, amber, green (RAG) report showing overall performance. This information was used by senior nurses and ward managers to support staff to improve recording. This meant that the provider had systems in place to monitor, review and improve on essential documentation to keep patients safe.

We saw a similar audit took place for housekeeping tasks with the RAG report being posted on the ward notice board. This enabled patients and visitors to see how cleanliness and hygiene was being managed in that location. The staff showed us cleaning logs which were checked by senior workers. The housekeeping staff told us that where their cleaning was reported as consistently below 100% their managers supervised them to improve their work. A senior nurse we spoke with told us that ward cleaning rota’s were reviewed under the Trust’s A-Z of cleaning policy which involved the senior nurse; the Trust’s infection control lead and house keepers. They also told us about ward checklist which were used regularly to facilities were comfortable, commodes were clean, the resuscitation trolley was fully maintained and notes were up to date. This meant there were a number of ward based audits in place to ensure service provision was kept to a high standard.

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented. For example where investigations highlighted there were not enough staff available in the evenings a twilight nursing post had been created in one ward. This had worked well and helped to protect patients.

Safeguarding alerts and incidents were monitored monthly. There had been an increase in the numbers of staff phoning Care Direct (a local authority number to call if a safeguarding issue is raised), which the adult safeguarding lead thought was mirrored by the increase in staff recognition of safeguarding issues. The lead was meeting the local authority safeguarding manager to look at 20 cases, to see if they were reported appropriately and what the outcomes were. This showed the trust look to learn from events.

The trust had received recommendations from the coroner following an inquest and we followed these up to find out what improvements had been made to the way information was handed over and involvement of tissue viability specialists when people experience complex skin damage. We were told that a recent audit established that all of the referrals received by the tissue viability team had been dealt with within the required timescale of 48 hours. The nurse specialist told us part of their team's role was to increase knowledge and expertise across the professional staff group. To achieve this, we heard about the 'Think pink' campaign. Information had been put on the trust's website that assisted staff when making 'difficult grading choices' about potential pressure damage.

We heard that incidents of pressure damage were closely monitored through the quality assurance committee. The tissue viability nurse specialist told us the team played a key role in analysing and validating data about episodes of pressure damage that people might have experienced. Further actions were described to us, which included the development of a new 'comfort rounding tool'. In practice, this would mean that every person under the care of a team would be checked at regular intervals and these checks would be recorded. Therefore, potential risks for people would be reduced through these new measures.

People were protected because the hospital had improved handover systems. We spoke with medical and nursing staff and were shown handover information that had been generated from the computer system. We were told that the medical and nursing staff were expected to attend a multidisciplinary handover for each patient every day on the ward where they were working. Additionally, medical staff told us "Everyone's supposed to attend clinical governance meetings" and completion of treatment escalation plans had been a recent topic of discussion at one. For example, one of the medical staff told us "At the beginning of the shift I print off a handover list for all the patients on my consultants list. That way, I know exactly where each patient is in the hospital and have an update about their progress". Another medical staff told us "We go to the patient. The hospital has a policy covering people with dementia which restricts us moving the patient to other wards. This ensures that the patient gets to know one set of staff and reduces confusion for them." Therefore, teams had clearer access to information about people and would ensure that they were followed up throughout their hospital stay. This shows that the trust have actioned the coroners recommendations to improve services for patients.

We spoke with a non executive board member to check how they assure themselves as a trust board that quality monitoring was robust. We heard that the board member was the chair of the quality assurance committee. This sub group checks all quality monitoring processes, including any learning from serious incidents, quarterly reports that were produced and board walk rounds to all wards to audit areas for themselves.

We spoke with the head of corporate governance who told us that the trust is at the top of the league for smaller trusts for reporting incidents. We heard how the trust was not concerned about this as it showed that they had ‘’fostered a culture of being able to report any incident that gave rise to concern’’. We heard that any member of staff team could raise a serious incident report, but depending on the quality of the information and the nature of what the incident was about, not all were followed up or triggered a serious event audit. These were identified issues that had potential or had placed patients or staff at risk. The trust produced quarterly significant event audits that were fully discussed as part of the quality assurance committee. Where themes had emerged, risk assessments and action plans were implemented to address these. For example a key theme had been highlighted as being pressure damage and staff not accurately grading pressure ulcers. More training and in put from tissue viability specialists had been agreed as one way to tackle this.

Decisions about care and treatment were made by the appropriate staff at the appropriate level. We interviewed 70 staff from various professional backgrounds across the hospital. The majority of the staff understood their roles and responsibilities in terms of accountability. For example, we were told that all grades of medical staff had both clinical and educational supervisors. Staff told us they were always given contact information for senior clinicians and knew who to contact for advice if they needed it. We heard about protocols in the accident and emergency department requiring middle grade staff to be on site when people with trauma or more complex needs were admitted. There have been recent changes that ensured that there was sufficient cover 24 hours per day in A&E.

We have been in discussion with the trust prior to this inspection taking place in relation to their higher than average mortality rates in some specific areas. This has been detailed by national data. We had written to the trust in particular about high mortality rates within a particular disease. The data relates to the trust and not only this hospital. We have been satisfied with the trusts response and we will not be seeking further enquires about this alert. This showed the trust work with CQC and other bodies to check risks identified by national data.

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

The following pages show our findings and regulatory 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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(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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