Review of compliance

Basildon & Thurrock University Hospitals Foundation Trust

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<th>East of England</th>
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<td>Type of service:</td>
<td>Acute Hospital Services</td>
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<td>Publication date:</td>
<td>July 2011</td>
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<td>Overview of the service:</td>
<td>Basildon Hospital was one of the first 10 NHS Foundation Trusts in the country and is an associate teaching hospital. The trust provides an extensive range of acute medical services at Basildon University Hospital and Orsett Hospital serving a population of 310,000. The Essex Cardiothoracic Centre is based at Basildon University Hospital. The Centre provides specialist diagnosis for people with cardiovascular (heart) and respiratory (lung)</td>
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diseases.
Summary of our findings for the essential standards of quality and safety

What we found overall

We found that Basildon Hospital was not meeting one or more essential standards. Improvements were needed.

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

Why we carried out this review

We carried out this review to check whether Basildon and Thurrock University Hospitals NHS Foundation trust had made improvements in relation to:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Meeting nutritional needs
- Cleanliness and infection control
- Management of medicines
- Safety and suitability of premises
- Safety, availability and suitability of equipment
- Supporting workers
- Assessing and monitoring the quality of service provision
- Complaints

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 10 & 11 May 2011, observed how people were being cared for, talked with people who use services, talked with staff, checked the provider’s records and looked at records of people who use services.
**What people told us**

People told us that since their admission to hospital they had been treated with respect and dignity. Written information is not always freely available and some people said that the doctors and triage staff do not always provide them with adequate information.

People were positive about the care and welfare provision and the staff across the trust. They described the staff as caring and helpful and that there were sufficient numbers of staff on duty and in general they responded to requests for help.

People with whom we spoke were complimentary about the quality and choice of meals provided and told us they had no real complaints. They also said that the cleaning standards within the hospital were good. They said there were cleaners around a lot of the time who were working hard to keep the areas clean.

People said that the staff knew what they were doing and were helpful. People told us they would complain if they were not satisfied with the service. Two relatives confirmed that they were unaware of how to raise concerns or make a complaint but had heard of Patient Advice and Liaison Service (PALS).

Overall, the people with whom we spoke told us they found their experience at Basildon Hospital to be positive and were happy with the care, treatment and support provided.

**What we found about the standards we reviewed and how well Basildon Hospital was meeting them**

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

The care that patients receive on the wards maintains their privacy and dignity, although more consideration should be given to the waiting areas in the X Ray department. Patient feedback about their care and treatment was generally positive. We also saw examples of good personalised care.

Whilst the trust has produced information for patients, such as patient information packs, these are not used consistently by staff in all patient areas. Some patients and relatives with whom we spoke did not have this information and we saw that it was not routinely available by patients’ beds. Relevant Information provided from doctors and triage staff to people is limited at times.

- Overall, we found that Basildon Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

**Outcome 2: Before people are given any examination, care, treatment or support, they should be asked if they agree to it**

There are shortfalls in the recording and review of “Do Not Attempt Resuscitation” orders, including uncompleted sections on the forms. The assessment and recording of peoples’ individual mental capacity along with any discussion with them or their
relatives is not being actioned appropriately. Therefore, people or their advocates can not always expect to have their consent sought regarding their care.

- Overall, we found that improvements were needed for this essential standard.

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

Work has been undertaken to address the concerns about assessment, care planning and discharge planning raised by us following our review of compliance in December 2010. The new initiatives are being closely monitored by the trust’s senior managers and action plans and practice changes are being implemented, although it is too early in the project to evidence sustainability. There are improvements in the nursing documentation and risk assessment practices. The introduction of “back to basics” nursing care has been well received by patients and staff with whom we spoke. Overall patients are happy with the care, support and treatment received at Basildon Hospital.

The patient’s care records and care plans for those people with poor cognitive ability, dementia and/or challenging behaviour require further improvements to provide clear guidance for staff, as to how this impacts on the patient and how this should be managed, so as to ensure positive outcomes for people.

The system for reporting histopathology results is now satisfactory.

- Overall, we found that Basildon Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

**Outcome 5: Food and drink should meet people’s individual dietary needs**

Food charts reviewed at this visit, showed that records were much improved, as they were completed regularly and efforts were being made by staff to ensure that where patients refused a meal or ate very little, an alternative meal or snack was offered. Where people were having their fluid intake monitored as a result of concerns relating to possible dehydration, in general, the records seen were completed to a reasonable standard. However there were some anomalies and further improvements are still required.

Patients with whom we spoke were generally satisfied with the new catering system and there is a choice of menu.

- Overall, we found that Basildon Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

**Outcome 8: People should be cared for in a clean environment and protected from the risk of infection**

The areas visited were clean and there were processes in place to monitor cleanliness and infection control.
Overall, we found that Basildon Hospital was meeting this essential standard.

**Outcome 9: People should be given the medicines they need when they need them, and in a safe way**

Whilst the trust have provided lockable facilities for medications, staff are not always ensuring that the arrangements for the safe storage and security of medication in some clinical areas are followed appropriately, which may compromise the safety of patients and others, particularly on the Acute Medical Unit (AMU) East

Overall, we found that Basildon Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

**Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare**

Suitable actions have been taken in the CardioThoracic Unit to minimise risks associated with premises to ensure service users and others are protected.

Overall, we found that Basildon Hospital was meeting this essential standard.

**Outcome 11: People should be safe from harm from unsafe or unsuitable equipment**

People can be assured that equipment for resuscitation or other medical emergencies is available and accessible for use as quickly as possible. Shower cubicles on Elsdon ward are not fully accessible and should be reviewed to ensure they promote where possible, the independence and comfort of service users.

Overall, we found that Basildon Hospital was meeting this essential standard.

**Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs**

There are sufficient staff with the right knowledge, experience, qualifications and skills to support people.

Overall, we found that Basildon Hospital was meeting this essential standard.

**Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care**

We saw good evidence of improving processes for managing serious untoward incidences, although further work is needed to ensure none fall outside of the system. Compliance with time frames for investigative practices and follow up meetings since October 2010 were much better and lessons learnt are being cascaded to staff throughout the trust and to external care professionals.
An increase in monitoring and audit of care practices was seen and the involvement of ward managers and staff in the clinical areas was apparent, with positive feedback from both staff and patients. This is a marked improvement on findings in 2010

- Overall, we found that Basildon Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Outcome 17: People should have their complaints listened to and acted on properly

People can feel confident that any concerns or complaints they raise will be listened to and investigated. Response times to acknowledging a complaint are improving and written information on making a complaint is being made available trust wide.

- Overall, we found that Basildon Hospital was meeting this essential standard.

Action we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Other information

Please see previous review reports for more information.
What we found for each essential
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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

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

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

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

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety.*
Outcome 1: Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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<thead>
<tr>
<th>There are minor concerns</th>
</tr>
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<tbody>
<tr>
<td>with outcome 1: Respecting and involving people who use services</td>
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Our findings

<table>
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<th>What people who use the service experienced and told us</th>
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<tr>
<td>People with whom we spoke said the triage service in the A&amp;E department was good, but they were sent to “sit back outside” without further information as to what would happen next and how long they were likely to have to wait.</td>
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People said the receptionists in X-ray and A&E were very helpful and that they had seen written information about the hospital. Some people, though, did not know about “getting it right” leaflets or patient advisory liaison services available to the public.

A patient, who was confined to their bed, in X-ray did not know how long they would be left in the public corridor before being taken back to the ward.

People told us that since their admission to hospital they had been treated with respect and dignity and had no areas of concern. Comments included “I am very
happy with the care I have received despite having been in hospital for such a long time. The nursing staff have been great and I look forward to going home soon”, “I have no complaints, everything has been fine” and “Staff have been very respectful.”

Two people, with whom we spoke, told us there had been occasions when they had been upset with the lack of information provided by the doctors. They told us that information was often provided to their relative but not directly to them, yet they had capacity to understand the information given. Two relatives told us that since their relative’s admission, they had found there was a lack of information provided by the doctors in relation to their relative’s illness and unless they asked for information it was not provided. They told us that they found this disappointing and frustrating.

Two relatives told us they were not aware of the contents of the ‘Patient Information’ leaflets or folder and had not been provided with this information since their relative had been admitted to hospital.

Although people were not always provided with information about the ward, they confirmed that staff were able to answer any questions they may have had. People told us that on their admission, the ward had been expecting them but they didn’t remember being given any information about the ward and the services available to them.

Other evidence
Following our review of compliance in December 2010 we made an improvement action in respect of the lack of availability and accessibility of information within the hospital. The trust provided us with evidence of action plans in place to address this. These involved people who use the services, including the patient panel members, who were consulted, as to what additional information would be helpful.

The trust has identified the six most used languages from their translation service provider. They have also identified the core information that needs to be translated or provided in an easy read format. The trust told us that they currently have drafts of this information and shortly it will be available on notice-boards in key locations throughout the hospital. On their website they have also introduced a new Google translator button that translates the complaints information.

Ward managers, with whom we spoke, all felt that they had the right type of information to give to people and the formats were also suitable. They said that if they required any specific information this was generally supplied by specialist nursing staff or discharge co-ordinators.

At our last visit to the hospital in December 2010, we found that not everybody was provided with or had access to ‘Patient Information’ leaflets or folders. At this visit we found that there was little improvement. Of the 12 patients whose records we looked at, only two patients were seen to have access to a ‘Patient Information’ folder. Not all patients were aware of its existence or how to access advisory services. The information folders were not freely available in the Acute Medical Units.
Ward managers said that storage was difficult at patient bedsides.

The patient environment action team assessments (PEAT) audit results of April 2011 gave the hospital a score of good for privacy and dignity. A representative of the local involvement network (LINKS) told us that the trust is working closely with them on the “dignity in care” project and whilst there are still areas to address, the trust is being open and proactive about areas for improvement. An example is the temporary reception area in A&E where people can be overheard; private consultation areas will be offered where required.

During our visit to the wards we found that people’s privacy and dignity was upheld and that staff treated them with respect. We saw that staff used the term of address favoured by the individual patient and they received personal care in private. On each ward we saw that staff used privacy screens to maintain the patient’s dignity and privacy when receiving personal care and where patient’s had a side room, staff knocked on the door before entering their room. We observed doctors on ward rounds closing curtains before they examined patients.

On one ward we saw one patient receiving assistance, from staff, with their personal care. Staff were heard throughout to have good communication with the patient explaining what they were doing at all times. During assistance with their personal care, the patient on several occasions was overheard to be verbally aggressive with staff and to cry out, requesting that staff stop providing support. Staff were seen to respond respectfully to the patient and to deal with the patient’s distress well. The outcome of this was that the patient was supported in their personal care and their wellbeing and dignity was maintained.

We saw that the environment in the X-ray department was not fully supportive of people’s privacy. We saw several people in beds lined up in the public corridor in full view of the outpatients waiting area. At the time of our visit there weren’t any bed bays for inpatients waiting for X-ray procedures and no attempts were seen to screen these patients. Staff told us that during busy periods the lined up beds can block doorways and make access difficult. The trust submitted a quality improvement plan immediately following our visit, including observing the waiting areas and how this impacts on privacy and dignity with a review of actions taken by 06 June 2011.

In response to a concern raised by a patient, we looked at information provision in the CardioThoracic Unit, as people come long distances to attend the unit and accommodation could be a problem. The document provided was suitable and suggested a local hotel for people to stay in if they could not get one of the rooms on the unit. We were told the trust are also looking to try and increase the number of same day admissions to reduce the need for overnight stays where possible.

Our judgement
The care that patients receive on the wards maintains their privacy and dignity, although more consideration should be given to the waiting areas in the X Ray department. Patient feedback about their care and treatment was generally positive.
We also saw examples of good personalised care.

Whilst the Trust has produced information for patients, such as patient information packs, these are not used consistently by staff in all patient areas. Some patients and relatives with whom we spoke did not have this information and we saw that it was not routinely available by patients’ beds. Relevant information provided from doctors and triage staff to people is limited at times.
Outcome 2: Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:
- Where they are able, give valid consent to the examination, care, treatment and support they receive.
- Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
- Can be confident that their human rights are respected and taken into account.

What we found

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<tr>
<th>Our judgement</th>
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<td>There are major concerns</td>
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<td>with outcome 2: Consent to care and treatment</td>
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<tr>
<th>Our findings</th>
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<td>What people who use the service experienced and told us</td>
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<td>A member of the public raised concerns with the Care Quality Commission in February 2011, prior to our visit, that the hospital was not following the “do not attempt resuscitation” policy and that people were not always being consulted about it.</td>
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<td>Other evidence</td>
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<td>An incident was reported through the National Patient Safety Agency in February 2011 in relation to the “do not attempt resuscitation” (DNAR) practices within the hospital. This report indicated that capacity assessments and consultation practices regarding the decision to resuscitate were not being followed. During our visit we reviewed the documentation, at random, for ‘Do Not Attempt Resuscitation” orders on six units and wards, for sixteen cases. Overall the recording and review of such orders requires improvement, as the information to support the decision making process was generally not evident. This is not in line with the trust’s own policies and procedures.</td>
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We found shortfalls in the recording and review of such orders, including uncompleted sections on “do not attempt resuscitation” order records.

The assessment and recording of peoples’ individual mental capacity along with any discussion with them or their relatives was often omitted. Ward managers, with whom we spoke, said that they were not comfortable in assessing mental capacity and did not have available to them the basic capacity assessment form. They said that they relied on a social worker to undertake this assessment. Two members of staff said that they felt that they needed more in depth training on this subject. We did not find any documentation in patients’ individual records to show that an independent assessor had been consulted.

Doctors had completed forms to say that the decision would be discussed with relatives or legal guardians. The subsequent notes did not provide any evidence that this had occurred. Junior doctors with whom we spoke confirmed that in one case, that they had not spoken with the relatives despite a new order being completed and the box ticked to show that this would be done. Junior doctors were also keen to discuss the completion of these orders with us and for us to confirm what should be in place. Doctors clerking notes in relation to resuscitation were often incomplete along with the ‘mini mental state’ assessment. Leaflets on cardiopulmonary resuscitation are not given out to patients despite being available on the wards and units we visited.

Do not resuscitate orders were also found, in several cases, unsigned by the consultant and when signed it was often not within the 48 hour time period set by the trust. The orders were not always reviewed, when evidence suggested that they should have been and old orders had not been discontinued in accordance with the trust’s policy. The trust audited this documentation and reported the findings to the Board in December 2010 and found similar shortfalls. Actions were highlighted such as “any gaps in documentation will be immediately escalated to the consultant” and “monthly audits will continue”. It is of concern to us that in May 2011 there has been no clear progress in addressing these issues

Our judgement
There are shortfalls in the recording and review of “Do Not Attempt Resuscitation” orders, including uncompleted sections on the forms. The assessment and recording of peoples’ individual mental capacity along with any discussion with them or their relatives was either omitted or incomplete. Therefore, people or their advocates can not always expect to have their consent sought regarding their care.
Outcome 4: Care and welfare of people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

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<th>There are minor concerns</th>
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<td>with outcome 4: Care and welfare of people who use services</td>
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Our findings

What people who use the service experienced and told us
The people with whom we spoke were positive about the care provision and the staff. Comments in X-ray included “They are brilliant” and “Can’t fault them.”

One person said “I see the consultant every third day and I can raise any queries and I feel informed and involved in what is happening with my care.”

Another said “Every morning the staff ask if you are comfortable and if you have any pain and if there is anything else they can get you and I have my call bell if I need them. I have been well and truly satisfied with the hospital.”

Several patients on one of the stroke wards told us that the care and treatment they received was very good and their needs were being met.

The only negative comments were from two patients on the Acute Medical Unit (AMU) (East). They told us that most staff were responsive to their needs and answered the call bells promptly; however there were times when staff would state “Yeah in a
minute” and then forget to attend to them.

Overall, people described the staff as caring and helpful. People using the service told us there were sufficient numbers of staff on duty and in general they responded to requests for help.

Other evidence
At our last visit to Basildon Hospital in December 2010, we found shortfalls in patient’s care records, nursing care planning and assessment practices. Our findings at that time showed that records for some patients remained incomplete, records did not accurately reflect their specific care needs, there was no clear audit trail of interventions provided and in some cases, clinical instructions were disregarded. We also found that social interaction between staff and patient’s on several wards was poor and needed improvement.

In response to this, the senior management team at the trust audited the care and assessment practices across the inpatient areas in March 2011. The results of the audit highlighted poor practice in several areas that had also previously been highlighted by us. In response to these findings, the director of nursing set up additional training sessions for nursing managers and staff on care planning practices. We were told by senior managers, that 200 nurses had been trained in two days and that the new documentation was launched on 18 April 2011. This was confirmed by ward staff with whom we spoke.

The trust have also introduced comfort rounds, whereby staff routinely go round at regular intervals and ask people about their care needs such as, if they need anything and to check they are comfortable. This is documented along with care evaluation sheets and other documentation changes to refocus the staff on “back to basics” care.

The director of nursing has highlighted to the senior nurse managers that this involves a significant change in practice, attitude and culture of nurses and midwives. The trust said that the majority of staff recognise the need for the change in practice and indeed welcome it, and that it is absolutely crucial that this is implemented, evaluated and sustained throughout the organisation. We saw that the new initiatives are being closely monitored by the senior managers, and action plans and practice changes are being implemented although it is early in the project to measure sustainability.

A random sample of five health care records from each of 15 inpatient ward areas were audited on 10 May 2011 by the trust and the scores were between 97% and 100% compliance in relation to the completion of care plans, risk assessments and the evaluation of care from the previous 24 hours. Evidence of patient/carer involvement in the care plan scored 87%.

We looked at 16 patient’s care records during our visit on 10 and 11 May 2011. We found improvements have been made, since our visit in December 2010, to ensure that each patient has a care plan detailing their care and support needs and there is
a clear audit trail detailing clinical interventions provided.

Records we reviewed on Lister ward showed that the specific care needs of each patient had been clearly recorded and this included risk assessment documentation. In addition key risk assessments, including nutritional status, weight loss and swallowing assessments were completed at regular intervals. Records also showed that there was good collaborative joint working with other professionals such as dieticians, occupational therapists, and speech and language therapists. Where instructions were recorded for nursing staff to follow, there was evidence to show that this was happening. For example the clinical records for one person recorded them as having lost several kilos in weight since their admission. Records showed that appropriate assessments had been completed to continually assess the patient’s progress and clinical interventions implemented. The outcome was that the patient’s medical condition had steadily improved since their admission.

Ward managers with whom we spoke confirmed that new nursing documentation had been introduced. Some said that they had been trained on the use of the records whilst others said that some staff, but not all, had attended a meeting to learn about the new documentation. Another said that the records were self explanatory and had improved the standard of record keeping.

Ward managers with whom we spoke confirmed the introduction of comfort rounds and one said that it was definitely improving the basic standard of care provided. Staff told us that they had attended or would be attending some training on care planning and were positive about the “back to basics” approach being taken by the trust.

Recent initiatives have been introduced across the trust to improve the discharge planning process. These include the introduction of the medical clerking proforma, the nursing admission and discharge documentation pack, pharmacy discharge checklists and the introduction of the electronic discharge and handover system.

The trust had conducted an audit of the discharge policy. Although this showed general compliance there were some areas of limited assurance. These mainly involved early discharge planning following admission. The trust is aware that this is an area for development and there is an action plan with target dates for completion in June 2011.

At our last visit in December 2010, we had concerns about staff’s overall lack of understanding and awareness relating to the care and treatment of older people with dementia and challenging behaviour. At that time it was evident that few members of staff had received appropriate training in the care of people with dementia and/or challenging behaviour.

Records reviewed, at this visit, on Lionel Cosin Ward and Osler Ward showed that work has been undertaken by the trust to ensure there are positive outcomes for patients who have poor cognitive ability, dementia and/or challenging behaviour. Our observation on each of these wards was that the social interaction between
staff and patients was much better and the atmosphere much calmer and relaxed. It was clear from our discussions with staff that they had a better understanding and awareness of individual patient’s needs and were familiar with the patient’s care records and care plans.

Of those patient care records and care plans we reviewed, each included information confirming if the person had dementia and/or challenging behaviour. However, further improvements are required to ensure that patient’s care records and care plans for those people with poor cognitive ability, dementia and/or challenging behaviour, provide clear guidance for staff as to how this impacts on the patient and how this should be managed, so as to ensure positive outcomes. In addition we found for one patient that they were being referred to the psychiatric team as a result of their dementia and confusion. However on closer review of the clinical care records, there was no obvious rationale for this decision. We discussed this with two ward sisters and they were unable to confirm why the referral had been made.

Ward managers with whom we spoke said that they had a good level of support from the dementia nurse specialist who always came to see new patients. The need for training in dementia for staff was raised during our last visit in December 2010. Since this time the trust could show attendance records with 31.80% of relevant staff trained. This training is a combination of the primary care trust awareness training and some staff (approximately two per ward) who have undertaken the dementia care modules at a university. The trust is in the process of implementing an e-learning package and the plan is to have this completed by mid July 2011. This is an on-going process. Each relevant ward has at least one ‘carers champion’ and referrals have commenced for carers to be assessed for their on-going support needs.

The trust provided us with an update on their dementia care strategy. This included a plan to develop a specific pathway for mild cognitively impaired patients and for those with more advanced symptoms. Longer term, the aim is to develop a memory clinic within the trust. Treatment pathways are also being developed in association with South Essex Partnership Mental Health Foundation Trust and the primary care trust and these will be adopted within Basildon Hospital.

A nursing assessment pathway for staff is being developed. This will form a “pack” containing all the required tools for nursing patients with dementia; these include “Knowing Me”, care plans, assessment and risk tools. As the trust does not currently have a restraint policy, information is being collated from other trusts and then a policy for staff reference will be written.

In September 2010 we raised concerns about the lack of a consistent system for reporting histopathology results. The trust produced a quality improvement plan which was reviewed in May 2011. Relevant policies and standard operating procedures relating to the communication of results have been reviewed. As an interim step prior to the scoping of the new IT system, licences to the current system have been produced for the major users, such as gynaecology, dermatology and oncology to make accessing of results easier. The trust undertook an audit on 11
May 2011 to measure compliance with revised policies on communication of results and this will is to be reported to the Clinical Governance Management Group meeting on 23 May 2011. Staff in histopathology and dermatology told us that the reporting systems are much better now with less risk of error.

Our judgement
Work has been undertaken to address the concerns about assessment, care planning and discharge planning raised by us following our review of compliance in December 2010. The new initiatives are being closely monitored by the trust’s senior managers and action plans and practice changes are being implemented, although it is too early in the project to evidence sustainability. There are improvements in the nursing documentation and risk assessment practices. The introduction of “back to basics” nursing care has been well received by patients and staff with whom we spoke. Overall patients are happy with the care, support and treatment received at Basildon Hospital.

Patient’s care records and care plans for those people with poor cognitive ability, dementia and/or challenging behaviour require development to provide clear guidance for staff, as to how this impacts on the patient and how this should be managed, so as to ensure positive outcomes for people.

The system for reporting histopathology results is now satisfactory.
Outcome 5:  
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider is compliant</td>
</tr>
<tr>
<td>with outcome 5: Meeting nutritional needs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>What people who use the service experienced and told us</td>
</tr>
<tr>
<td>People told us that the food was satisfactory and that there was lots of choice.</td>
</tr>
</tbody>
</table>

One person said “There are plenty of drinks and the staff encourage you to drink and they write down how much you have had.” Another person said “The food is alright, there is enough and it is hot enough, occasionally it’s a little cool, but there is plenty of choice.” We were also told by another patient “The staff help me to sit up so I can feed myself.”

One person said “The staff are flexible with the food and they will do their best to find you something else if you don’t like the meal.” One person said “The food is fine, it’s not what you would cook at home but it is edible.”

All of the 11 patients with whom we spoke were complimentary about the quality of meals provided and told us they had no complaints.

The ‘Steam Cuisine’ system has now been in place at Basildon Hospital since December 2010 and offers patients a range of starters, main courses, salads, sandwich fillings and desserts. The overall feedback from people has been positive.
regarding this initiative. The last patient satisfaction overall score for food was 65% rated it good and 25% excellent.

Other evidence
At the time of our last visit to the hospital in December 2010, we had concerns about the inconsistently completed food charts. Of those food charts reviewed at this visit, records were improved, as they were completed regularly and efforts were being made by staff to ensure that where patients refused a meal or ate very little, an alternative meal or snack was offered.

Where people were having their fluid intake monitored as a result of concerns relating to possible dehydration, in general, the records we saw were completed to a reasonable standard. However there were some anomalies and further improvements are still required. For example the care file for one person recorded them as having their food and fluid intake monitored. Records showed that a fluid intake chart had been completed for a short period and then discontinued, however they still remained at risk of possible dehydration. We discussed this with one ward sister and they could not provide justification for this decision. The trust’s own nutrition observation audits regarding fluid balance completion show that whilst the scores are improving, they are still below 90% compliance.

The only negative comments were from staff and these related to the quality of meals required for patients who require a soft diet. Staff told us that the soft meal options are limited and there have been several less than favourable comments from patients. In addition staff reported that some patients who have smaller appetites find the meal sizes at times overwhelming.

Each of the wards visited were noted to have ‘Protected Meal Times’, whereby during mealtimes there is reduced activity on the ward so that staff can serve and supervise meals and give assistance to patients who need help to eat and drink. We saw evidence of signage being placed outside of each ward at mealtimes. The wards we visited had a calm atmosphere at these times, with nursing staff serving and assisting patients. The trust uses a ‘red tray’ system to identify those patients who either require assistance with eating or are having their food intake monitored.

Throughout our visit we saw evidence of the ‘red tray’ system being used appropriately and effectively at meal times. We also saw evidence of patients being offered drinks and snacks outside of mealtimes. We saw patients asking for drinks and receiving them in a timely manner. For those people who were not able to talk with us, we observed how they were supported to eat and drink and how their preferences were managed. This was managed positively and ensured positive outcomes for these patients.

Ward managers with whom we spoke generally felt that the protected mealtimes worked well and that the medical staff respected this time. Acute Medical Unit (AMU) staff felt that it brought particular pressures as they have time deadlines to meet for
discharges. From discussion, on the whole they managed to work around this and
the new system for meals actually gave them more flexibility. Ward managers said
that when required the kitchen would supply extra or different items and this now
included full fat yoghurts and additional fruit, for those needing to gain or maintain
weight.

Two ward managers felt that the menu was repetitive for those people who required
a soft diet and sometimes portion sizes were an issue as they were too small. One
also said that they needed more ‘build up’ type soups, for those patients who
needed to gain weight. One ward manager said that they were now on the catering
committee and overall the ward managers felt positive about bringing about any
changes and developments that are or may be required. Staff and ward managers
with whom we spoke, confirmed the use of the nutritional scoring tool and knew the
criteria for referral to the dietician team.

We spoke with the senior nurse specialists for swallowing and nutritional
assessment practices about our concerns raised in December 2010 that patients
may not always be protected from the risks of inadequate nutrition. They told us
about new initiatives including additional training now being provided for staff on
specialist feeding requirements, assessment and monitoring practices in promoting
good nutrition and hydration support.

At the time of our visit there are some vacancies for community dieticians. The trust
were looking at bringing the service in-house within the next six months to improve
the dietetic services to people who need support. Meal time surveys and spot audits
were seen, although it is too early to say how effective the new practices will be as
they are not embedded yet.

Records showed that nursing staff were completing swallowing assessments on
patients and fully recording the results. These were repeated where required. Ward
managers with whom we spoke said that staff had been trained to carry out these
assessments.

Records for six patients showed their nutritional status as having been assessed.
Where patients were assessed as having a high risk nutritional status, action was
taken to ensure that each patient had a completed nutrition and swallowing
assessment and where appropriate, interventions provided by specialist healthcare
professionals were commenced. Records showed a clear audit trail of actions taken
so as to ensure the patient’s health and wellbeing and there was evidence that
instructions recorded were being followed by nursing staff.

Our judgement
Food charts reviewed at this visit, showed that records were much improved, as
they were completed regularly and efforts were being made by staff to ensure that
where patients refused a meal or ate very little, an alternative meal or snack was
offered.

Where people were having their fluid intake monitored as a result of concerns
relating to possible dehydration, in general, the records seen were completed to a
reasonable standard. However there were some anomalies and further improvements are still required. Patients with whom we spoke were generally satisfied with the new catering system and there is a good choice of menu.
Outcome 8: Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
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<tbody>
<tr>
<td>The provider is compliant with outcome 8: Cleanliness and infection control</td>
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<table>
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<tr>
<th>Our findings</th>
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<tbody>
<tr>
<td>What people who use the service experienced and told us</td>
</tr>
<tr>
<td>People with whom we spoke told us that the cleaning standards within the hospital were good. They said there were cleaners around a lot of the time who were working hard to keep the areas clean.</td>
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</table>

One person said “They clean the beds between each patient. One patient left this morning and I could see them dusting the bed frame and surroundings before the next person came in.”

People in the temporary A&E waiting area told us the areas were satisfactory including the toilets.

<table>
<thead>
<tr>
<th>Other evidence</th>
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<tbody>
<tr>
<td>At the time of our visit in December 2010 we made an improvement action in relation to infection control monitoring in the cardiothoracic unit. The theatre manager confirmed that wall washing of theatres took place on 15 January 2011. This is now on a six-month cycle and will take place again in July 2011 as part of the ongoing planned preventative maintenance programme. Actions have also been taken regarding reaudits of infection control practices with in the cardiothoracic unit in January 2011. Areas reviewed included environment, linen, waste and sharps</td>
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management, which scored between 96% and 100% compliance in all areas.

Some of the clinical areas we looked at were busy and storage for equipment was limited. However, staff and patients with whom we spoke across the hospital were positive about cleaning standards. Several clinical areas we visited during our two days at the hospital, including sluice areas and wash areas, were found to be clean. Clinical waste and linen were being handled and stored appropriately and foot operated pedal bins were available in all areas. We saw staff washing their hands appropriately and the trust’s policy for “bare below the elbows” was being complied with.

We did not see any infection control issues in the areas of the hospital we visited. Side rooms were being used for barrier nursing and isolation practices were observed.

**Our judgement**
The areas visited were clean and there were processes in place to monitor cleanliness and infection control.
Outcome 9: Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are minor concerns with outcome 9: Management of medicines

Our findings

What people who use the service experienced and told us
People told us that they received their medication appropriately.
Two people confirmed they had been assessed to self medicate and that they had their medication in the locked bedside cabinet.

Other evidence
At the time of our visit in December 2010 we made an improvement action in relation to the management of medicines as we had concerns that the arrangements for the safe storage and security of medication in some clinical areas may compromise the safety of patients and others. This particularly related to the Acute Medical Unit (AMU) (East).

At this visit we found that the medication room on the Acute Medical Unit (AMU) (East) has been refurbished and a keypad installed. However on two occasions we found the door to the medication room to be held ‘on the latch’ and no member of staff present. This means that medication was not securely stored and was easily accessible. We also found on both Acute Medical Unit (AMU) (East and West) that
patients had lockable cupboards for their personal belongings. Several patients had their medication stored here, however the cupboards were not locked and medication was clearly visible and on show. The trust’s action plan submitted to us following our December review of compliance states “All staff to be reminded that drug cupboard doors are to be kept locked when empty. “ The quarterly health and safety audits submitted did not provide evidence of compliance with this and an audit carried out by the trust in March 2011 showed that only 43% of treatment rooms were locked.

Examples of completed self medication forms were seen. We saw that the bed side lockers for medication on Elsdon ward were locked appropriately.

Our judgement
Whilst the trust have provided lockable facilities for medications, staff are not always ensuring that the arrangements for the safe storage and security of medication in some clinical areas are followed appropriately, which may compromise the safety of patients and others, particularly on the Acute Medical Unit (AMU) (East).
Outcome 10: Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
- Are in safe, accessible surroundings that promote their wellbeing.

What we found

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<tr>
<th>Our judgement</th>
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<tbody>
<tr>
<td>The provider is compliant</td>
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<td>with outcome 10: Safety and suitability of premises</td>
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<tr>
<th>Our findings</th>
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<tbody>
<tr>
<td>What people who use the service experienced and told us</td>
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<tr>
<td>We did not obtain the views of patients on this outcome.</td>
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</table>

Other evidence

We raised concerns with the trust in December 2010 about the management of identified risks associated with unsafe premises in the Cardiothoracic Centre (CTC). These related to the lack of appropriate measures taken to make safe the revolving entrance doors, to provide adequate procedures and contingency planning for power failures within the unit and to address a breach of policy in respect of infection control.

The CTC revolving doors risk assessment was reviewed by the trust in December 2010. A decision was taken to upgrade the revolving doors with new replacement collapsible doors to allow access to anyone who may have collapsed and potentially be trapped within the span of the revolving door sections. We examined the doors and noted that appropriate measures have now been taken.

The CTC risk assessment of April 2011 in respect of power failures is satisfactory and covers all the key areas of risk raised as a concern by us on our previous visit. There is a trust wide business continuity plan in place which covers contingency
planning for power failures. This has recently been reviewed. We were told that the generators are covered by a service contract and subject to regular maintenance and inspection by the Estates Department. Vital systems have UPS/IPS back-up in addition to standby generator supplies and clinical areas benefit from dual electrical supplies that ensure that some power is retained in clinical areas should they suffer local supply faults.

Action has been taken following the breach of policy in respect of infection control; specifically the washing of theatre walls. A re-audit of the cardiac unit infection control processes have taken place and regular checks are undertaken to avoid a reoccurrence in the future.

Consumer champion “Which” has named Basildon University Hospital in its list of the country’s top 10 hospital car parks. The trust said that the 1600 space car park was built in 2008 because they asked the local community what they wanted most and a new car park was the overwhelming choice.

Our judgement
Suitable actions have been taken in the Cardiothoracic Unit to minimise risks associated with premises to ensure service users and others are protected.
Outcome 11: Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
- Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement

The provider is compliant with outcome 11: Safety, availability and suitability of equipment

Our findings

What people who use the service experienced and told us

We did not obtain the views of patients on this outcome.

Other evidence

At the time of our visit in December 2010 we made an improvement action following the concerns raised by patients regarding sufficient quantities of nebulisers in the Acute Medical Unit (AMU), which could impact on the safety of patients and meeting their assessed needs. Access to suitable shower and seating facilities, which could impact on the independent and comfort of patients, was also raised. The checking of resuscitation trolleys in some areas was inconsistent and systems to ensure that all staff are aware of changes to trolley contents were not always robust. This has the potential to pose a risk to patients in an emergency situation.

We were told that following our last visit additional nebulisers had been ordered and are now in place for Acute Medical Unit (AMU) (East) although more can always be sourced from other departments to meet immediate needs if necessary.

We visited Elsdon ward and saw that the shower cubicles are not fully accessible as
they have a high step to the front. We asked the trust to review this and look at the potential to improve access, which they have agreed to do.

We checked eight resuscitation trolleys on wards and assessment units. Since our last visit on December 2010, the standard of checking and supply of equipment has improved overall. Records showed evidence of recent audits and daily checks by staff, who are identifying when items are, for example, near expiry date. On some wards and units we found that on odd days the trolley was not checked. Ward managers with whom we spoke, were aware of the need to monitor that staff were undertaking thorough checks of this equipment.

The trust could show that resuscitation trolleys were also spot checked recently on night visits by senior managers. Some inconsistencies in checking practices have been identified through these visits and actions have been taken to improve the standard. Letters were sent to individual staff about resuscitation trolleys and it was made clear to ward sisters that they were responsible for them. The practice regarding the trolleys is also clearly defined in the policy. Whilst the trust’s own audits of April 2011 identify that resuscitation trolleys are not always up to date and that checking them is not always appropriately done, we were assured that the senior managers are closely monitoring practice and conducting spot checks to improve compliance.

It was evident that one way that the lessons that have been learnt through complaints/audits/serious incidents are being cascaded through the organisation is through the director of nursing’s (DON) regular intranet messages to staff (Blog), which we saw during our visit. We also saw examples of information being fed back from the DON to matrons through emails. They are then responsible for cascading the information to staff. They told us that they also seek to assure themselves through conducting spot-checks to follow up on practice changes and there was documented evidence to support this. Staff with whom we spoke were aware of the importance of checking the resuscitation trolleys regularly.

On viewing X-ray room three, we asked senior managers to consider a risk assessment in relation to the treatment of an emergency situation, as advanced interventional procedures are carried out in this room, which is crowded and limited in free movement due to the equipment in place. During our visit the trust produced a quality improvement plan and agreed to implement this.

**Our judgement**
People can be assured that equipment for resuscitation or other medical emergencies is available and accessible for use as quickly as possible. Shower cubicles on Elsdon ward are not fully accessible and should be reviewed to ensure they promote where possible, the independence and comfort of service users.
Outcome 13: Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant
with outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People with whom we spoke told us that there were adequate numbers of staff available and that in general they responded to requests for help.
People said that the staff knew what they were doing and were helpful.

Other evidence
At the time of our visit in December 2010 we made an improvement action in relation to staffing as some staff felt they had a negative experience working in the trust, and for some staff more pressure was felt, in areas such as maternity and the Acute Medical Unit (AMU) regarding staffing numbers and cover for breaks and/or provision of specialist support, which could impact on the delivery of care in those services. The middle management level was perceived by some staff as lacking leadership.

The trust’s board, in January 2011, noted that nursing staffing levels were to be reviewed, planned and validated in conjunction with the needs of the patients they cared for. This was in line with the annual staffing reviews against the NHS East of England “Principles for Safe Staffing Levels” document dated January 2011. A quality monitoring tool would be instigated to ensure the nursing staffing level
assessment and instigation was robust and had executive nurse approval.

The chief executive advised the board of the workforce implications facing the trust with the primary care trust’s proposal to reduce expenditure with the trust by £20 million in the next financial year. The trust told us that they will be quality impact assessing any cuts. They will also be employing a rating system to identify potential risk areas. They told us they are keen to ensure that all cost reductions projects have quality included in their assessment. Vacancies continue to increase towards the revised target of 10% across the trust. We were told that in 2008/9 the trust invested two million pounds into the nursing staff establishment. In addition, maternity was given an additional 1 million pounds to increase the establishments for midwives. In February 2011, there were four vacancies within midwifery team. Staff with whom we spoke during this visit told us that the staffing levels were satisfactory most of the time.

The deputy director of nursing told us about an increased visibility of clinical general managers and deputy directors in the hospital to provide a conduit through which concerns can be raised and staff supported. Staff told us that the senior managers were now more visible and that some of the new initiatives and practice changes were improving the work environment and care for patients. They were positive about the “back to basics” approach introduced recently on the wards.

Job competencies for clinical managers have been established and include competencies identified for leadership and management. These include planning, analytical, communication, decision making, team working, planning and organisation. Evidence was provided of the range of training courses which are available to encourage leadership development.

Clear actions have been outlined for each department in March 2011 in response to the outcomes from the national NHS staff survey. The director of nursing reported that the ultimate goal of staffing is to ensure that “The quality of patient care is maintained, the quality of organisational objectives are met and the quality of nurses’ work life is acceptable”. The action plans include the need to continue with regular appraisal and review systems. Look at flexibility in working patterns, concerns about bullying and harassment and review mechanisms to facilitate communication, feedback and open discussion.

It is too early to measure the effectiveness of these actions; however, the majority of staff with whom we spoke were positive about the changing culture within the hospital and open door policy of the senior management team. Although some nurses on one ward explained that they find the amount of paperwork difficult as by the time they have completed it they don’t always have time to do anything else.

**Our judgement**
There are sufficient staff with the right knowledge, experience, qualifications and skills to support people.
Outcome 16: Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
- Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

<table>
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<tr>
<th>Our judgement</th>
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<tbody>
<tr>
<td>There are minor concerns with outcome 16: Assessing and monitoring the quality of service provision</td>
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<tr>
<th>Our findings</th>
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<tr>
<td>What people who use the service experienced and told us</td>
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<tr>
<td>Overall, the people with whom we spoke told us they found their experience at Basildon Hospital to be positive and they were happy with the care, treatment and support provided.</td>
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<tr>
<th>Evidence</th>
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<td>We discussed with the director of nursing the developments in serious untoward incident reporting as this had been a key concern raised by us at the time of our review of compliance in September 2010. We saw evidence of compliance with time frames for investigative practises and meetings since October 2010 and lessons learnt being cascaded to staff throughout the trust through updates, emails, posters, open forums and minutes of meetings. There is a draft paper to guide staff on the importance of cascading information appropriately, to ensure people across the trust learn from all incidents, to reduce the risk of reoccurrence.</td>
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<tr>
<td>Examples of practice changes were provided by staff during our visit, for example additional training on specific medical devices. We also found reporting process up to board level is improving. The clinical governance committee is provided with the assurance of the trust’s reporting of serious incidents (SIs) through the monthly</td>
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updates and quarterly reports, which are provided to the committee and the board of
directors. The volume of reported incidents is increasing in the trust; however, the
senior managers believe this is due to pro active reporting.

The status of SIs is reported to the director of nursing every Tuesday; this is then
escalated to the executive team. The information also goes to the board once a
month and discussions are held with the primary care trust (PCT) about incident
management practices. Examples were given, such as, a concern around the need
for cardiac implant defibrillators to be removed after death. This information was
shared with the PCT to share with GPs. In addition, following capacity issues over
Christmas an Easter plan was developed to ensure the same problems did not re-
occur. There is a 100 day review as well as a 45 day review to ensure that actions
following serious untoward incidents are being followed-up.

Ward managers, with whom we spoke, were aware of any serious incidents that had
occurred on their wards and who was investigating them. In discussion about
timescales, it was apparent that the investigations were lengthy and in some cases
ward managers were unsure whether they had been concluded.

At this review of compliance we looked in detail at three incidents. Of these two had
been actioned appropriately, the third regarding “Do not attempt resuscitation”
(DNAR) practices was lacking in review and lessons learnt. The director of nursing
assured us that she would follow this up; there was some debate as to what
constitutes a serious incident and whether this particular case fitted the criteria.
Either way it was agreed that it had not been investigated appropriately, whether it
was classified as a serious incident or not.

We saw an increase in monitoring and audit of care practices, and the involvement
of ward managers and staff in monitoring the quality of care was apparent. This is a
marked improvement on our findings in 2010. There are regular clinical shift
feedback forms and evaluations of comfort rounds to encourage ongoing evaluation
of care for people. Staff, governors and the new chairman of the board with whom
we spoke were positive about the changes being introduced and the clinical
leadership within the hospital.

There was a recent serious case review in court involving Basildon Hospital in
relation to resuscitation practices. The judge was complimentary of the trust’s
management of this matter, which was all the more important given the legal and
emotional complexities involved with this case. The judge stated that the
trust behaved “scrupulously” and that the documentation provided to allow him to
make his decision was “immaculate”.

Patient feedback mechanisms are in place and the patient forum is being
encouraged to get involved in improvement projects. The board of directors receive
updates on comments and complaints from patients at regular meetings.

Our judgement
We saw good evidence of improving processes for managing serious untoward
incidents, although it is important that the control systems are developed to ensure none fall outside of the system. Compliance with time frames for investigative practises and follow up meetings since October 2010 were much better and lessons learnt are being cascaded to staff throughout the trust and to external care professionals.

An increase in monitoring and audit of care practices was seen and the involvement of ward managers and staff in the clinical areas was apparent, with positive feedback from both staff and service users, which is a marked improvement on findings in 2010.
Outcome 17: Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:
- Are sure that their comments and complaints are listened to and acted on effectively.
- Know that they will not be discriminated against for making a complaint.

What we found

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<th>Our judgement</th>
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<tr>
<td>The provider is compliant.</td>
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<tr>
<td>with outcome 17: Complaints</td>
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<tr>
<th>Our findings</th>
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<tr>
<td>What people who use the service experienced and told us</td>
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<tr>
<td>Some people with whom we spoke were aware of the “get it right” leaflets. People told us they would complain if they were not satisfied with the service. Two relatives confirmed that they were unaware of how to raise concerns or make a complaint but had heard of Patient Advice and Liaison Service (PALS).</td>
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<tr>
<td>Other evidence</td>
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<tr>
<td>At the time of our visit in December 2010 we made an improvement action in relation to the information available for people regarding complaints in the hospital and on the trust's website; this was inconsistent and poorly displayed in some areas. Sixty-two per cent of the trust's responses to complainants were outside the time frame set by the trust. Records showed that some complaints linked to investigations were taking an extended time to complete. In one case the trust had written to the complainant stating that an investigation would take 45 days to complete and it was approximately 84 days since the complainant wrote and a final letter had yet to be</td>
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sent. Whilst late, the quality of reports being sent to complainants was comprehensive and objective in approach.

The senior management team told us that 89% of complaints had been responded to within the correct time-scale for the month of April 2011 and they were continually monitoring to ensure response times continue to improve. We requested information, following our visit, on a further three complaints brought to our attention by a member of parliament. The evidence provided by the trust showed us that the time frames for responding and investigating complaints were being adhered to in line with trust policies and that the key areas raised were being addressed in the response to the complainant. We are continuing to monitor complaints management practices with the senior management team in the hospital and will follow this up again at our next review of compliance.

The trust’s website has also been updated to include information about complaints, and translation to other languages is now available. We looked at several months’ board meeting minutes. The board meeting held in April 2011 showed us that the trust is looking at trends to highlight where practice changes or improvements in service are required. An example seen in the minutes made reference to the need for communication to be improved, with patients and carer’s, a theme which was evident through the monitoring of complaints and Patient Advice and Liaison Service (PALS) contacts.

We told the senior managers that not all patients with whom we spoke were aware of the complaints system and advisory services. The trust responded that it is currently introducing posters and new information stands for information leaflets including complaints across the hospital to improve communication practices.

**Our judgement**
People can feel confident that any concerns or complaints they raise will be listened to and investigated. Response times to acknowledging a complaint are improving and written information on making a complaint is being made available trust wide.
Action
we have asked the provider to take

Improvement actions

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

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>TDDI; surgical procedures; Diagnostic or screening procedures; Maternity and midwifery services; Termination of pregnancies Management of supply of blood and blood derived products</td>
<td>17</td>
<td>Outcome 1 Respecting and involving people who use the service.</td>
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<td><strong>Why we have concerns:</strong></td>
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<td>Whilst the trust has produced information for patients, such as patient information packs, these are not used consistently by staff in all patient areas. Some patients and relatives with whom we spoke did not have this information and we saw that it was not routinely available by patients’ beds. Relevant Information provided from doctors and triage staff to people is limited at times.</td>
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<tr>
<td>TDDI; surgical procedures; Diagnostic or screening procedures; Maternity and midwifery services; Termination of pregnancies Management of supply of blood and blood derived products</td>
<td>9</td>
<td>Outcome 4 Care and welfare of people who use the service.</td>
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<tr>
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<td><strong>Why we have concerns:</strong></td>
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<tr>
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<td></td>
<td>Patient’s care records and care plans for those people with poor cognitive ability, dementia and/or challenging behaviour require development to provide clear guidance for staff, as to how this impacts on the patient and how this should be managed, so as to ensure positive outcomes for people.</td>
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<tr>
<td>TDDI; surgical procedures; Diagnostic or screening</td>
<td>14</td>
<td>Outcome 5 Meeting nutritional needs</td>
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<tr>
<td></td>
<td>Why we have concerns:</td>
<td></td>
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<td></td>
<td>The trust’s own nutrition observation audits regarding fluid balance completion show that whilst the scores are improving, they are still below 90% compliance.</td>
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<tr>
<td>TDDI; surgical procedures; Diagnostic or screening procedures; Maternity and midwifery services; Termination of pregnancies Management of supply of blood and blood derived products</td>
<td>13</td>
<td>Outcome 9 Management of medicines</td>
</tr>
<tr>
<td></td>
<td>Why we have concerns:</td>
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<tr>
<td></td>
<td>Whilst the trust has provided lockable facilities for medications, staff are not always ensuring that the arrangements for the safe storage and security of medication in some clinical areas are followed appropriately, which may compromise the safety of patients and others, particularly on the Acute Medical Unit (AMU) (East).</td>
<td></td>
</tr>
<tr>
<td>TDDI; surgical procedures; Diagnostic or screening procedures; Maternity and midwifery services; Termination of pregnancies Management of supply of blood and blood derived products</td>
<td>10</td>
<td>Outcome 16 Assessing and monitoring the quality of service provision.</td>
</tr>
<tr>
<td></td>
<td>Why we have concerns:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Three incidents were looked at, two had been actioned appropriately, the third regarding “Do not attempt resuscitation” (DNAR) practices was lacking in review and lessons learnt.</td>
<td></td>
</tr>
</tbody>
</table>

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

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

The provider’s report should be sent within 14 days of this report being received.

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

The table below shows the essential standards of quality and safety that are not being met. Action must be taken to achieve compliance.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>TDDI; surgical procedures; Diagnostic or screening procedures; Maternity and midwifery services; Termination of pregnancies Management of supply of blood and blood derived products</td>
<td>18</td>
<td>Outcome 2 Consent to care and treatment</td>
</tr>
</tbody>
</table>

**How the regulation is not being met:**
There are shortfalls in the recording and review of “Do Not Attempt Resuscitation” orders, including uncompleted sections on the forms. The assessment and recording of peoples’ individual mental capacity along with any discussion with them or their relatives is not being actioned appropriately. Therefore, people or their advocates can not always expect to have their consent sought regarding their care.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

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

The provider’s report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
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<tbody>
<tr>
<td>Author</td>
<td>Care Quality Commission</td>
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<td>The general public</td>
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