Care Quality Commission

Inspection Report

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

South Tyneside District Hospital

Harton Lane, South Shields, NE34 0PL

Tel: 01912024000

Date of Inspections: 25 November 2013
22 November 2013
21 November 2013
20 November 2013
19 November 2013

Date of Publication: December 2013

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
Requirements relating to workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	South Tyneside NHS Foundation Trust
Overview of the service	South Tyneside District hospital provides a range of inpatient and out-patient services such as medical, surgical, maternity and children's services, alongside emergency care for the people of South Tyneside and surrounding areas. The hospital has 390 beds.
Type of services	Acute services with overnight beds Community healthcare service
Regulated activities	Diagnostic and screening procedures Family planning Maternity and midwifery services Nursing care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 19 November 2013, 20 November 2013, 21 November 2013, 22 November 2013 and 25 November 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 sent to us by commissioners of services. We reviewed information sent to us by other regulators or the Department of Health, reviewed information sent to us by other authorities, reviewed information sent to us by local groups of people in the community or voluntary sector and talked with commissioners of services. We talked with other regulators or the Department of Health, talked with other authorities, talked with local groups of people in the community or voluntary sector and were accompanied by a specialist advisor. We used information from local Healthwatch to inform our inspection.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

We undertook this visit over three days on site and visited the following areas; Accident and emergency, Children's services, human resources, community nursing at Palmers Hospital, outpatients, the cancer unit, pharmacy, Wards 19 & 20, pathology and mortuary services and customer services. We spent a further two days receiving evidential documents from the Trust. A team of four inspectors were accompanied by two professional advisors and an expert by experience.

We found that patients' needs were assessed and their treatment plans were discussed with them. Patients told us they felt well informed about what was happening with them regarding their care and discharge arrangements. Overall people told us the care and treatment they received was good.

We saw staff were recruited in a safe and effective manner and the human resources department undertook checks to make sure people applying to work for the Trust had appropriate qualifications, checks and references prior to commencing employment.

The hospital was well-led. The hospital had a thorough system of checks to monitor the

quality of the care provided at ward level and there was a clear route to ensure that any issues or risks were raised to the executive team.

Some patients said they didn't know how to make a complaint but we saw there was an action plan in place to improve this.Patient records that we viewed were up to date and provided information in relation to the care and treatment provided.

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.

The hospital ensured people's rights to dignity were upheld, they promoted choice for people and provided information about peoples treatment or condition.

Reasons for our judgement

We looked at the information we held about the Trust from external surveys and reports from other agencies. The majority of the information we had regarding this outcome showed that the Trust was at the same level as other similar Trusts.

Prior to this visit we were given some information regarding issues of privacy and dignity and overcrowding in the phlebotomy, pharmacy and INR (Internationalised Normalised Ratio) clinics ran by the Trust. INR is a test of blood clotting, which is primarily used to monitor warfarin therapy. We explored the issues of overcrowding in INR clinics and phlebotomy, both of which the Trust acknowledged were busy outpatient clinics. We visited the INR clinic at the Moorlands day unit and spoke with reception staff and four patients receiving the service. There were 25 patients scheduled to be seen in a two hour time frame by a pharmacist. Firstly all four patients told us they were given a choice of clinic they wished to attend and that although the service was busy, they had not had to wait more than 20 minutes and if there was any delay then it was explained to them by the reception staff or the pharmacist between appointments. Patients told us they were well informed about their care and given information about managing their condition. We asked for information about complaints for this service and were told there had been no formal complaints within the last 12 months. The phlebotomy service had carried out a quality improvement event called a "Kaizen" in response to concerns about patient flow. We spoke with the Clinical Business Manager for the area who said this process had enabled the service to review staff hours, examine the patient length of wait in detail and look at increasing patient areas to avoid overcrowding. Firstly the service increased its opening times and made an additional phlebotomy lab therefore reducing walking distance from the outpatients departments and enabling more people to be seen more quickly. In February 2013 after the implementation, average waiting times had gone from 39 minutes to 11 minutes. The number of formal and informal complaints from patients had also dropped dramatically and in the last 12 months up to our visit there had been only two formal and three informal complaints. The manager also told us that new staff were being recruited to the service so that from January 2014 the service would also have a full complement of

staff.

In children's services we saw recent changes had been made to the accident and emergency unit to provide a separate unit for children. This provided a more appropriate space for them as it was focused their needs and was less clinical in the way it was arranged and decorated. We saw some instances when staff involved patients and their relatives and reassured them about their anxieties. For example, one person was worried about having the sibling of the patient (aged under one year) being in the unit, the nurse discussed the treatment plan with the medical staff and then with the patient so she could make the decision to have the sibling taken home.
We spoke to four people in the childrens wards who were all happy with the care of their child. One told us it was not possible to say if they were involved in their care as they had only just arrived but said they had been dealt with professionally and they had been told what the next stage would be. One person in the special care baby unit said, they could not be more positive about the support they had received, they said "It has been a very positive experience, we have had really good information and the plan has always been explained.
There was some evidence within care records that relatives had been consulted and given explanations about medical conditions and treatments including one person who had been given information about their child's medication needs.

Staff described how they ensured patient privacy, this was particularly important as the children were encouraged to spend time in the communal reception area which had a large television screen and toys.
A medical consultant explained the system for ensuring there was always a consultant available for all of the children's services which he told us greatly assisted the continuity of care.
In childtren's services there was range of leaflets was provided for patients and visitors giving information about the service and general children's health issues. These were only available in English, however when asked about this staff said that they could get an interpreter and make information available in other languages where necessary. There was also information on how to raise concerns or complaints called "Listening, acting and improving".
We spoke with people on the wards and in the accident and emergency department (A&E) and the emergency assessment unit (EAU). Our judgement reflects the feedback we received from them at that time as being very positive. People told us "The staff keep telling you what's going on, they're so kind and really lovely". One person in the ED told us he had been assessed very promptly and someone had explained what investigations would be undertaken, such as blood pressure, temperature and pulse, blood tests. People who had to wait were made aware of how long via a message on an electronic screen in the main reception area which was updated every two hours.

Patients' diversity, values and human rights were respected. We noted the environment supported patients' privacy. We saw that patients were accommodated in single sex bays in the ward areas we visited. Toilets and bathrooms were designated for male or female. We observed that personal care and consultations were conducted in private with fixed screening used at the bedside. The provider may find it useful to note that the patient treatment area on the haematology and oncology unit did not have any screens /blinds on the bay windows. This meant patients receiving treatment could be seen from the corridor when visitors and others were walking past this area.

We saw in the accident and emergency, haematology and oncology departments we

visited that patients were given appropriate information and support regarding their care or treatment. For example we saw leaflets were available for patients and visitors about specific medical conditions. There were also leaflets explaining what happened on leaving hospital and what services would be available, such as patient support groups.

On wards 19 and 20, we looked at a random sample of care and treatment records. From our review of these records the initial nursing and medical assessments on admission and subsequent daily multi-disciplinary monitoring and reviews implied that the majority of people who used the services were able to understand and were involved in the care, treatment and support options available to them.

We found on Ward 19 where patients were too ill on admission or who in the opinion of the medical staff did not have the capacity to make their own informed care choices, entries following discussions with their relatives were not always clearly and consistently documented in all the records we looked at. We were not able to see clearly from the medical records whether this patient had been actively included and involved in these decisions and or whether these decisions had been made in the patient's best interest. Examples included one of the elderly care wards we visited in relation to the decision orders not to resuscitate (DNAR) in the event of cardiac and respiratory arrest. Four of the forms we looked at did not show that decisions had been discussed with patients or their families which could mean those patients' rights and wishes were not always respected. We were assured by senior nursing staff that all staff were clear on the current resuscitation status for each patient and it was acknowledged that entries in relation to the patient's capacity and best interest decisions to support the care and treatment choices would be discussed further with members of the multi-disciplinary team.

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.

Patients using the service received effective, safe and appropriate, care treatment and support that ensured their specific and individual needs were met and their rights protected.

Reasons for our judgement

Across the hospital wards and departments we visited, people had positive comments about their care experience and described staff as "'definitely respectful...exceptional you are given time to talk about things."

We spent time in the Children's accident and emergency unit observing the way the staff organised the delivery of the care and supported the children and their families. We spoke with the staff and four people who were accompanying their children in the unit. There were five nurses on duty during our visit, one of which was a paediatric nurse practitioner, a senior paediatric nurse, three nurses and a health care assistant. All but one of these nurses were on the staff rota from 9am to 9pm, which one nurse told us gave them continuity through the day. The medical staff working on the unit during the day were the paediatric consultant Dr X, a registrar and a senior house officer. We noted that the staff were able to meet the needs of the patients and appeared busy but not hurried and had time to exchange pleasantries with the patients and their families. The night medical cover was provided by a registrar or an advanced nurse practitioner and on call senior medical cover provided by the consultant.

We were told about meetings carried out in the unit; these included multi-disciplinary meetings which discussed issues such as safeguarding, midwifery information and chronic disease management. There were also clinical risk management meetings. We spoke with nursing and medical staff about the communication systems including these meetings; they confirmed that they found these to be useful and that they had the opportunity to have their views included in the discussions. This meant that staff were enabled to air their views on the running of the unit.

Nurses told us there were working on developing the culture of compassionate care being promoted following the Francis report.
We visited the special care baby unit, this had been recently moved. This unit was well designed to meet the needs of the babies and their families. There were two babies in this unit. We spoke to the parents of one of the babies, they told us "Nothing could be better, they have been awesome".

The community paediatric service included a rapid access clinic and specialist nurses who worked with children with chronic conditions such as epilepsy. There was information to show how information was transferred between nurses.

A relative we spoke with told us they thought the service was "Really good, we got straight through to see the doctor".

Recent changes had been made to the way that the adult community nursing service was managed and operated. As part of this change community and district nurses from different locality areas had been moved from various bases and were now all accommodated in a single building at Palmers Hospital. Teams based there included an acute care service, community matron's service, intermediate care service and a palliative care service This had provided a more appropriate space as it allowed for better direct communication between the teams and staff told us that it had significantly improved communication and joint working between the hospital and the community One district nurse gave us an example of going along the corridor to speak to the community matron about a patient she had seen the day before. We also spent time with the urgent care team; a service ran by community nurses on a 24 hour 7 day a week system to respond to people in the South Tyneside area. The aim of the service was to provide responsive care that prevented admission to accident and emergency and to provide on-going support via a seamless transition with other community services such as the intermediate care team. This meant people could be treated quickly in their own homes.
In the accident and emergency department we spoke with nine patients about the care and treatment they received. Comments included, "The care is alright," They look after me very well. One relative told us, "Everyone you meet has been so helpful." "I'm pleased with the care my husband has been receiving they have looked after him so well." Patients' needs were assessed and care and treatment was planned and delivered in line with their individual care plan. The documentation included multi-disciplinary assessments undertaken by other healthcare professionals for example the dietician, occupational therapist, physiotherapist and speech and language therapist.

On wards 19 and 20 staff told us and our own observations confirmed that detailed information concerning patient needs were provided on handover sheets which were passed on to staff starting a new shift. This meant that staff had up to date and accurate assessment of each patient at the beginning of their duty. We saw risk assessments were in place such as for mobility, nutrition and skin care. This meant staff had guidelines to make sure people using and working at the hospital were safe.

On the in-patient wards we visited, staff used a system which involved making regular checks to ensure that patients were safe and receiving the right care and support. This included two hourly ward rounds where staff would speak to patients and relatives about any care issues they would like to discuss.

Most patients we spoke with had positive comments about their care experience and described staff as "Wonderful" and "providing good care". Patients told us the nursing and medical staff gave them information about their condition and they were given plenty of opportunity to ask questions and had their questions answered in a way that they understood. One patient said; "The doctor explained to me again yesterday what I had to do and what I had not to do".

We received some negative comments from people on Wards 19 and 20 regarding not receiving adequate support to have a shower or bath and just being supported to have a

wash and not being assisted to have hearing aids put in but one patient said; "My care is given with dignity, the nurses normally tell you what they are going to do before they do it."

In the Accident and Emergency department people were seen within the four-hour national waiting time limit. Care was taken to manage safety concerns for medical patients, particularly those who were frail and elderly. We saw there were suitable levels of observations by staff and there was a visible presence of staff to attend to patients quickly. We saw staff responded efficiently when patients used their call bell alarms. Two patients we spoke with were very satisfied with the care they had received and felt that they had been "treated as an individual with dignity and respect". They told us "the staff were very caring and supportive". This was supported by the patient satisfaction surveys which were found to be very positive.

On the wards and departments we looked at the care files for nine people. Care plans reflected the individual needs of the patients. The provider should note not all of the entries we read had been signed and dated by staff. We found the care records included assessments by the nursing team prior to any interventions taking place. Care plans were individualised according to the treatment patients were receiving. From all the records we looked at we saw that people's health and welfare needs were assessed on admission and plans of care were developed to address people's health, personal and social care needs. Individual needs and preferences, lifestyle profiles and activities of daily living were documented. We were told that care plans were audited frequently.

There were effective arrangements for safe and planned discharges in place.
People were generally kept informed about their treatment. There were processes in place to inform the hospital pharmacy; and people who had been prescribed medication were visited by the pharmacist before they were discharged from the hospital. This ensured that they had clear instructions about their medication, and how to take it. The care records included details of the person's expected discharge from hospital and what support needs they would require on discharge. This meant all the staff knew how to support each patient." There were effective arrangements for safe and planned discharges in place. On the ward we also saw discharge notes with a follow up section with written information around appointments with consultants and physiotherapists. One patient told us; "The physiotherapist was great and I know what I need to do when I get home." This meant each person's expected discharge and future care arrangements were carried out in a planned way.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

There were effective staff recruitment and selection procedures in place to ensure the protection and wellbeing of patients using this Trust.

Reasons for our judgement

We spoke with the director of human resources, the divisional personnel manager and administrative staff who were based on the hospital site. We saw electronic recording systems that showed how appropriate checks were undertaken before staff began work. We saw that before commencing employment, the Trust carried out checks in relation to staff's identity, their past employment history, qualifications, authorisation to work in the UK (where applicable) and a Disclosure and Barring Service check (DBS) check. We also saw a system that prompted qualified staff such as nurses and doctors, and their line managers to uphold their annual professional registration when it was due for renewal. We were told that if staff allowed these to lapse, they were immediately suspended from practice. This meant that patients were protected from staff who were not qualified to practice.
We spoke with one staff member who had recently been promoted into a new role. She recalled that as part of the recruitment and selection process she was requested to provide references one of which she said had to be from her current manager as well as providing appropriate evidence of her qualifications and clearance. She stated she had a month's induction into her new role and this involved working with a variety of people in her community setting. She was also able to direct her own learning and so spent time with the local authority social services referral team and a GP practice so she could understand their role in relation to the services she would provide. Other staff told us they received a corporate induction which was a four day programme as well as a local, on-the-job induction carried out by their line manager when they start work in their new post, providing departmental and job role specific information.

We spoke to the human resources department recruitment team regarding the interview and selection process for new staff. We asked if there were current role specific interview selection questions and found that it was down to the interviewing managers to devise appropriate questions. We spoke with one community matron who had recently recruited to a nursing post. She told us that interview questions they had in the department were "old" and so the panel had met prior to the interviews and devised a set of questions to fit the role that included current practice changes such as the implementation of the Francis Report. The community matron told us they had received recruitment and selection training "ages ago" but said they were booked on training for January 2014. We were told that; "Recruitment decisions are crucial" but we were told that only 1.52% of recruiting

managers within the Trust had received recruitment and selection training. We raised this in our feedback session at the end of our visit with the executive team as an area for improvement.

We spoke with staff in children's services about how they were supported to maintain their clinical skills and competencies. We were told that they were looking at having core competencies for all staff and then specialist competencies and advanced competencies for the advanced practitioners. These were discussed with staff as part of their annual appraisals, supervisions and were therefore reviewed annually. Staff could access mandatory training in house and could access specialist training both within the hospital and at other hospitals. This meant that staff were trained and supported to carry out their specific roles...

We saw records relating to staff induction and training and we saw that all statutory courses were covered. A training matrix showed when staff had received training and when any mandatory updates were next due. This meant that staff were given training and support to carry out their roles.

The hospital ensured there were processes in place for staff to be supervised and supported and there was a recorded appraisal system in place. Community nurses had a lone worker devise which when activated had a tape recorder/microphone to a security worker who could listen to the conversation and make the judgement as to the safety of the worker and take action to protect them if necessary. This showed the Trust took measures to ensure staff safety.

Staff we spoke with across the site told us that they were kept informed about developments relating to their area of work and the Trust more generally. Where staff were experiencing organisational change such as in pathology services, three staff we spoke with told us they were kept informed via meetings and records about the timescales and change processes as they happened. Some staff we spoke with in the pathology department were anxious about forthcoming changes as the service was moving to Queen Elizabeth hospital in Gateshead and although these staff were no longer managed by South Tyneside Trust, at our feedback session, senior managers said they would pass on these concerns to the management team at the Gateshead Trust.

Other staff we spoke with, including domestic staff, receptionists, staff nurses, student nurses and newly qualified nurses told us they received good support from the Trust and from the ward managers. Staff in the paediatric department said there was; "Good communication amongst the team at all levels' and that there was a 'good rapport now amongst staff'. One of the community matron's said; "We have a very strong team, supporting each other clinically and professionally".

The managers of all wards were positive about their role and expressed satisfaction with their roles and the good support and communication they received from the Clinical Business Managers and Executive Team of the Trust. Ward managers told us they had no problems with having direct access to senior management for support and advice. We saw that where programmes of change were happening for example in the pathology department that was moving to a new location, that people were kept informed of those changes via regular meetings, minutes of which were shared with staff.

The Trust told us they had put measures in place to reduce staff sickness which during 2013 had impacted paediatric services and other areas at the hospital. The Trust had put

in place a more robust expert advice programme to manage sickness and absence that included four staff trained to undertake functional capacity assessments and mandatory training for managers which included managing stress in the workplace. Sickness levels had fallen at the Trust to 4.8% at the time of our visit with a target of 4.6% by the end of the financial year. The Trust was also using data to quickly establish sickness/absence trends and to target hotspot areas with a monthly absence panel monitoring individual complex cases. This meant that the service was taking measures to reduce the impact that staff sickness could have on the running of the service and to encourage well-being and health amongst its employees.

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 hospital was well led. The quality of the service offered was regularly monitored and processes were in place that identified, assessed and managed risks relating to the health, welfare and safety of patients and staff.

Reasons for our judgement

As part of this visit we viewed the pharmacy department following concerns that were raised regarding the suitability of the building. We were accompanied by an inspector from the Health and Safety Executive. We were shown round the building by the lead pharmacist and spoke with pharmacists and technicians. The building was described as "not really fit for purpose" by staff. We found that the Trust were compliant with the minimum legal requirements but there were certainly improvements that could be made. We found the electrics in the store area were in need of attention and from talking to staff they reported there has been on-going issues with temperature in the pharmacy store. These had been recently rectified with the repairing of the heater. The one area where there was still an issue was the aseptic area where the provision of additional heating is difficult due to the need to disinfect the area. Staff told us they had a mechanism to raise health and safety concerns via the staff health and safety representative and staff meetings We reported these issues to the clinical business manager at the time of our visit for action. We discussed the re-location of the pharmacy building as we were aware that this was being planned and we saw how staff from the pharmacy team had been involved in this. The executive team discussed with us the plans for the re-location of the pharmacy in 2014.

South Tyneside NHS Trust had a number of different ways in which it assessed and monitored the quality of service delivered. We looked at performance reports, audit schedules, the organisation`s quality accounts, risk management/governance systems and patient experience/satisfaction reports.
Currently risk management was undertaken using a software package known as Datix for developing and strengthening the Trust's risk management strategies. This system was found to be comprehensive allowing staff on each of the ward / department areas to report clinical and non-clinical incidents. Incidents were reviewed by the head of operations supported by clinical business managers who inputted the information from each incident on to a computerised system. This allowed for a report to be generated and shared with each directorate and the Trust board members. All untoward incidents were reviewed and investigated. A report was then produced with recommendations and an action plan

drawn up. This was then passed down to areas for implementing a "lessons learnt" approach.
A random sample of incident forms were reviewed on wards 19 and 20. The majority were fully completed. The incident forms were signed by the reporter, the manager and the head of operations and this was evident from the incident forms we reviewed. The organisation was currently using the risk management matrix from the National Patient Safety Agency (NPSA).

Audits had been carried out in the Children services including an audit of patient/relative experiences.

Children's services were in the middle of the strategic review as a result a number of staff were new into their post. There was a plan in place to relocate all of the child care facilities onto the ground floor and therefore located closer to each other. These changes were planned as a result of a review of the services and the identification of improvements which could make it more effective. Recent reviews of some of the operational protocols had resulted in some changes being made; an example was the review of the pre-alert logarithms for the call out of the resuscitation team. We saw core care plans for the more common illnesses patients presented with and these were based on the National Institute for Clinical Excellence (NICE) guidelines.

Staff told us they felt well-supported. They told us that they felt proud to work at the hospital and there was a common feeling of 'ownership' and sense of community. This indicated satisfaction with how the service was led.

We held a focussed discussion group with key members of the Trust management team. This included the chairman, chief executive, five directors and the lead governor. We talked about quality, risk, serious and untoward incidents, accountability, involvement and service improvement.

The board and executive directors were open and frank with their views. The executive directors appeared clear about their portfolio responsibilities and associated issues. Examples of pragmatic solutions to complaints, risks, patient and staff feedback issues were given. There was evidence of Board self-assessment and a focus on the operating environment and the associated risk arenas e.g. arising from changes in commissioning and also the population demographics re: accessing health care. The board communicated an appreciation and acknowledgement of potential future risks and their intended actions to mitigate the impact of such risks. The board reiterated the point that their Cost Improvement Programme (CIP) was led from bottom up and that the quality impact assessment of CIP's was discussed regularly with staff, trade unions and commissioners. There was an awareness of factors which may impact on CIP proposals and the need to modify these plans was communicated e.g. the need possibly to allocate more resources to the root cause analysis investigation of pressure ulcers and also the need to meet minimum staffing level requirements (as a result of the Mid Staffs investigation). In relation to the staffing issue, the Trust confirmed that funds had been ringfenced to recruit an additional 57 nursing staff members following a major review across hospital wards and community teams that acknowledged increased activity and the complexity of care presented which had a major impact on how care was delivered. This meant that the service reviewed and planned how it would deliver it care in the current economic climate.

Evidence of board horizon scanning and being accessible to staff and patients was

demonstrated through the commitment to board walkabouts, the use of information from patient and staff survey consultation, and awareness of clinical and internal audit issues. From discussion with the board they appeared fully cognisant of the strategic and operational delivery challenges for the Trust. The board were aware of the predominant themes arising from incidents e.g. medication errors. The board also discussed how they had endeavoured to respond to listening to hard to reach groups including disadvantaged children, people from ethnic minorities and people with learning disabilities. The board communicated a very real sense of being in touch with the business issues, changing commissioning and operating environment and the associated risks. A collaborative approach with governors was confirmed by the lead governor. A theme of being accessible and listening to both patients and staff was clearly communicated from the topic discussion.

Documents provided by the Trust showed how trends and themes of concern were monitored and acted upon by the clinical governance sub groups. The groups such as patient safety and risk management looked at a variety of risks and concerns from incident forms and complaints to target areas of significant concern. We saw minutes of these meetings where actions were clearly identified, delegated and given timescales for completion. There was also a monthly incident review group, the aim of which was to review information relating to adverse events, including near misses, which would aid the Trust in focusing on improvements in safety.

We discussed the issue of delays by the Trust in reporting notifications on the National Reporting Learning System during the course of the last year. This had occurred over a specific time period and during our discussion with the quality and risk manager at the Trust it became apparent this was due to an IT system change in reporting that had led to some issues with uploading to the national system. The Trust also reported that following discussion with the local Clinical Commissioning Groups (CCG) the reporting of pressure area care incidents at levels 3 and 4 would now be reported immediately instead of each case awaiting a tissue viability panel discussion. Wards and departments carried out a root cause analysis when any serious untoward incidents were reported and the Trust had a range of methods as to "learning lessons" from incidents and complaints.

Another focus group met with clinical business managers and divisional directors who said they had a good understanding of the governance process. They told us they felt confident that any incidents or near misses would be looked at to determine lessons to be learnt and to identify any improvements which could be made to improve the outcomes for people using the service. They told us there was a strong emphasis on the management and reduction of risk and that they could not identify any improvements which could be made to the systems and processes to make this more effective. We were given examples of improvements following a review of quality and staff engagement which included the introduction of white boards, which we saw in wards and departments that monitored patient flow from any desktop computer. We were also told about the new staff e-rostering process which enabled staff to input requests for leave and off duty and the system could flag where further cover was required to ensure staffing levels were maintained. This was at pilot stage and will be rolled out throughout the Trust. Managers said it meant staff were more engaged in the duty rota planning.
The general consensus from this meeting was that managers felt they felt they had a voice and there had been a general improvement in communication within the hospital and with stakeholders.

We met with the local Healthwatch for South Tyneside prior to carrying out this visit and

they told us that feedback from people said they don't know who to complain to when things go wrong or find the complaints procedure too difficult to contemplate. We spoke with lots of patients and visitors to the hospital on this visit and their general consensus was they also didn't know how to make a complaint although several said if they had an issue they would raise it with the nearest staff member at the time. We noticed there was not enough clear information on display to help people find out how to raise an issue. For example in areas where we visited including paediatrics and outpatients there was a leaflet titled "Listening, acting and improving" however this was several pages long and not clear in telling people how they could complain. There was a system to record informal issues that patients and visitors raised and all ward managers and heads of department told us they preferred to deal with things; "Quickly and as they cropped up". We saw that there were 273 complaints and issues raised in the last 12 months and the customer services team acknowledged that making improvements to help and support people to make a complaint was a priority. We saw an action plan that detailed how this would happen with actions, named responsible persons and timescales for implementation. Some of the outcomes included improving how doctors and nurses were perceived by patients in how their attitude and communication and to increase the number of volunteers on wards who could build relationships and listen to concerns. The department also said the uptake of a training programme for investigating complaints for managers was "mixed". We would advise that the Trust seek to ensure managers have the appropriate level of training before undertaking complaint investigations.

The Trust had sought the experience of people via the use of "patient stories"as part of its listening programme. Over 4,800 stories had been completed with patients across the Trust and the plan was to share any actions arising from this with the public via notices in clinical areas and via the Trust website.The "Choose Safer Care" initiative also collated feedback from patient experience, incident reporting, complaints, audits and peer reviews to prioritise action areas and to provide prompt feedback to wards and departments so they can focus on improvement in real time.

People could also leave feedback on their experience of South Tyneside District hospital on the Patient Choice website. The customer services department who monitored the website and who told us that any issues were passed to the chief executive to approve a response and that a meeting was offered to anyone who wished to take their complaint or concern further.

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Accurate records relating to patient care and treatment were held securely.

Reasons for our judgement

We reviewed the patient records on the accident and emergency unit. All key points of care were added onto the system by the designated nurse for that patient and the contemporaneous records (written by the medical staff) were scanned and added to the electronic records and then kept in the patient's file. The electronic records were all protected by a password system which allowed limited to appropriate staff. These passwords were changed at least monthly and could be changed by the operator if they were concerned about the password being compromised. In this way records were secure and confidential.

All staff had an email account so information could be shared directly with them. Staff across several areas told us there was regular communication about service changes, updates from the Trust and emails relating to people's training needs sent to them via email.

The electronic Hydra recording system was used by the urgent care team in the community to monitor each patient contact which was given a colour code. Red was contact within 2 hours, amber within 24 hours and green within 48 hours. This enabled a clear prioritisation of workload for the team and enabled them to monitor their responsiveness effectively. Other wards and departments at the hospital also used electronic recording systems but we were told in several locations that IT systems were not fully integrated with each other within the Trust and staff felt this sometimes led to a repetition of notes and information about patients and an increased workload in some instances.
The records that we looked at in paediatric accident and emergency were not fit for purpose but this was because of the adult 'Casualty Card' template that was being used. The team were looking to change these in the near future and also to make these documents more relevant to the new care pathways that had been developed to deliver safe and effective care.
On wards 19 and 20 we saw the nursing and medical records for each patient were being stored separately. Medical records were being stored in a mobile trolley whereas nursing records were stored outside each of the bay areas. The mobile trolley in use on Ward 19 was not secure or lockable. All the nursing risk assessment documentation for example; falls, nutrition, bed rails, pressure areas and the early warning monitoring charts were kept

at the patient's bedside for staff to update and complete in a timely manner.
In all areas we visited, records relating to patient care and treatment had been satisfactorily completed whether electronically or in paper format. Records relating to personnel issues were well maintained and securely stored and enabled human resources staff to confirm that recruitment checks were carried out in a timely manner. We also noted that during the course of our visit, records relating to meeting minutes at all levels, board papers, audits and risk registers were promptly available to us.

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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