Review of compliance

South Tyneside NHS Foundation Trust South Tyneside District Hospital	
Region:	North East
Location address:	Harton Lane South Shields Tyne and Wear NE34 0PL
Type of service:	Acute services with overnight beds Community health care services - Nurses Agency only
Date of Publication:	November 2011
Overview of the service:	South Tyneside NHS Foundation Trust employs approximately 3000 staff and provides community and acute health care services to approximately 180,000 people in South Tyneside and the surrounding areas. The main acute services are provided at South Tyneside District Hospital site where the following regulated activities:

	family planning; maternity and midwifery services; nursing care; surgical procedures; termination of pregnancies and diagnostic and screening procedures are provided.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

South Tyneside District Hospital was meeting all the essential standards of quality and safety.

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

Why we carried out this review

We carried out this review to check whether South Tyneside District Hospital had made improvements in relation to:

Outcome 01 - Respecting and involving people who use services

How we carried out this review

We reviewed all the information we hold about this provider, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

All of the patients and relatives who we met gave positive feedback about how the staff listened to them and involved them in all aspects of their care. They reported that they were treated with respect and that staff made every effort to meet their wishes.

Patient's comments included, "The staff spend time with me"; "They always tell me what they are going to do"; "I am always asked for my view"; "I am always asked if I need assistance"; "The staff put me at my ease"; and, "The staff are very responsive".

What we found about the standards we reviewed and how well South Tyneside District Hospital was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

We found that respect for patient's privacy and dignity was much better promoted and that they were provided with improved support to be involved in and influence their care.

Overall we found that South Tyneside District Hospital was meeting this essential standard.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

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 01:
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

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
During our visit we interviewed eight patients and had discussions with two relatives. Patients appeared positive about their experiences of care and treatment, and told us that staff were caring, helpful and respectful.

They made the following comments, "The staff spend time with me"; "They always tell me what they are going to do"; "I am always asked for my view"; "I have no worries about my care"; "I am always asked if I need assistance"; "The staff have all been nice, pleasant and caring"; "things are explained to me "; "I was asked about my diet when I was admitted and the staff listened to what I told them"; "I have plenty of time to eat my meals and I am usually offered hand washing"; "The staff put me at my ease"; and, "The staff are very responsive".

As far as these patients could recall they felt informed about their care and treatment and raised no issues of concern. Several referred to their relatives and described how the staff kept them informed and involved.

We saw that staff addressed patients by their name and engaged them in conversation by asking if they were comfortable and how they were feeling.

Call bells were placed within easy reach of patients and were audible. We observed that staff appeared to respond to individual calls in a timely manner.

All patients looked comfortable, safely positioned and well cared for, with evidence of attention to their grooming and hygiene. They were able to clarify the routines by which they were washed and dressed each day and described how their preferences were taken into account. We heard the nurses asking patients if they could carry out tasks, such as applying cream to their legs.

Privacy curtains were fully drawn around patient's beds and doors to side rooms were fully closed with signage stating 'please knock before entering' when care was being provided. The doctors and nurses asked patients if it was alright to examine them and conversations were carried out at discreet volume so as not to be overheard.

We observed a nurse responding immediately to a patient's request for pain relief medication.

All of the doctors and nurses that we observed were extremely caring and sensitive to the needs of individual patients. They took time to carefully ask questions and explain what it was that they wished to do.

Nursing staff made regular checks on patients who were frail and unwell.

We witnessed an incident on the stroke unit where two people who were being discharged did not have their personal items packed up and ready when the ambulance crew arrived. This led to a rather hurried pack up of their belongings which caused some upset for one of the patients who had misplaced an item.

We were able to observe the lunchtime meal on both of the wards which we visited. The mealtime was well organised and support was provided to both assist and encourage people to be independent with eating and drinking. We saw that each patient was given or offered a protective napkin and wipes to clean their hands before and after the meal. Where patients were slow eaters we noted that their main course was kept warm until they were ready for it.

After lunch the staff asked patients what they would like to do and offered them the choice of going to bed for a sleep or remaining in their armchair.

Staff on both wards told us about their attempts to encourage patients to make more use of communal day rooms to promote interaction and stimulation. They described events such as a Royal Wedding buffet, where the large, pleasant communal areas had been utilised. Also how they were used to accommodate family visits and social activities lead by the occupational therapists. However, overall there had been little progress in using these rooms at mealtimes or as an alternative communal sitting area.

We spoke with patients who were being cared for within side rooms as opposed to four bedded bays and received mixed feedback. Some felt somewhat isolated and missed the interaction and interest of being in a shared area. One person told us they felt lonely and chose to sleep as much as possible. Some patients were unable to mix due to their medical conditions. Others enjoyed the privacy and quiet which they experienced within their own room.

Plans were underway to introduce and utilise volunteers who would provide diversion, companionship and social activities on the elderly care unit, where patients tended to have longer stays.

Other evidence
We returned to the same two wards as we had visited in April 2011. These were a large care of the elderly ward and the stroke unit.

We met with nurses and nursing auxiliaries on both wards. All of the staff appeared keen to talk about the findings at our last review and what steps the staff teams had taken since then. Everyone told us that they had been well supported both by management and each other in accepting and appreciating improved approaches to respecting patients and involving them in their care and treatment. Their comments included, "we have a completely different approach as a team"; "things feel much better and more positive overall"; "I now stop and think"; and, "we now routinely offer condiments and hand wipes at meal times".

Staff working on the stroke unit told us they aimed to involve relatives and keep them informed about their family member's health and welfare. There was evidence in patient's records of consultation with relatives during assessment of needs and planning for discharge. A nurse auxiliary told us that positive and close relationships with families and friends was a key element in promoting rehabilitation and finding out about patient's likes and dislikes.

Several staff referred to a recent situation where they had worked closely with a relative who wanted ongoing hands-on involvement with their partner, to share meals and be together overnight. The staff described a positive experience where their commitment to giving this couple assistance with their immediate and long term needs was clearly apparent.

Several staff referred to the positive input and support from a specialist stroke nurse whose role included areas such as providing advice to relatives and taking part in doctor's ward rounds. The nursing staff also described strong working relationships with the doctors and gave positive accounts of their involvement with patients and their families.

A social worker allocated to the stroke unit told us about a new joint care planning procedure that was being piloted. We saw that this gave patients and their carer's clear, structured information on discharge. It included details of follow up appointments, tests, contact details for relevant health care professionals, goals for the individual person and their care arrangements. A stroke information booklet was also provided that contained lots of useful guidance, advice and explanations.

A range of leaflets were available to inform people, such as stroke publications and guides for carers and older people.

Findings from a privacy and dignity audit were displayed on a notice board on the stroke unit. Positive outcomes included provision of single sex accommodation, staff awareness of how to access a translator and ensuring that patients were addressed appropriately and included in conversations about their care and treatment.

The staff we spoke with were aware of the areas for development identified from the audit. They said a leaflet on patient privacy, dignity and respect was now routinely given out on admission. We saw that this gave details about practices within the Trust and assurances about how people could expect to be treated during their stay.

Information was also displayed about the 'vision' of the unit. This included promoting privacy and dignity, meaningful and concise staff handovers, provision of patient centred care and agreement of realistic goals.

Staff we spoke with felt that their patients were offered choices and that routines were flexible and carried out at the individual's preferred pace. Staff gave excellent accounts of individual examples such as preferences between bathing and showering, who liked to use soap on their face, and how staff managed hygiene care when people were physically unable to take a bath.

Staff were also knowledgeable about consent and patients who no longer had capacity to make their own decisions. The nurses clearly took their roles as advocates and promoting people's best interests very seriously and again gave strong examples of their experiences.

Most of the staff team felt they were provided with sufficient information to enable them to provide continuity of care and all felt there was good team work. However they had mixed views on the handover reports for the nursing auxiliaries who were not always involved in verbal handovers between shifts. One auxiliary had just returned from leave and had to rely on a 'communications' board in order to tell us about someone's care needs. It was apparent that this matter was under discussion at team level and that varying solutions were under consideration.

Staff working on the elderly care unit told us about improvements to practice in recent months. They said patients were encouraged to give informal feedback about the quality of the service they received. The nurses described how they made use of the visiting hours to approach patients and their relatives and answer any questions.

A change had been made to ensure that medication was no longer given out during mealtimes. This ensured that all staff were available to support patients with their eating and drinking needs during mealtimes.

Nurses on this unit told us that team relationships had improved and that everyone had become more aware of the importance of their actions and approach to the patients. They were confident that attention to detail and making time to listen to patients had improved. They had found that they were increasingly able to rely on the staff team to maintain standards.

There were plans to change staff shift patterns. This would enable staff to work both day and night shifts so they could be involved in care provision across the 24 hour period.

All the staff on this unit were involved in shift to shift verbal handovers which they said helped to ensure clear communication.

We examined patient's records on both units and found improved evidence of individual's preferences. Examples included gender of staff to provide personal care, preferred diet and music liked by a patient who was unable to communicate. We also saw improved recording that demonstrated patients and their relatives were involved and consulted about care and treatment. Where necessary alternative methods were used to gain consent and check the level of understanding of patients unable to communicate verbally.

Charts had been introduced to verify when patients had been assisted to meet their personal hygiene needs and included help with nail care, spectacles and their teeth or dentures. The records showed the level of support provided by staff and what patients were able to do independently. New 'care standards documentation' was also in place. This had sections to record the patient's preferred name, to make entries relating to privacy and dignity and updates provided to the patient and relatives. These records also indicated whether the patient had capacity to agree to their daily nursing care plan.

The ward manager of the elderly care unit said he was looking to introduce 'This is me' leaflets, a form produced by the Alzheimer's Society that provides professionals with information about responding to the person with dementia as an individual. More training for staff on caring for people with dementia was being organised.

Some staff had received training on the Mental Capacity Act 2005 and Deprivation of Liberties safeguards and described a 'rolling programme' for all staff. The senior staff we spoke with understood the processes of capacity assessments, involving other professionals and making decisions in the best interests of patients. However statements about individual's capacity to give consent, and best interest decisions by trained staff to provide treatment, were not always formally documented. Management agreed to review this issue.

All of the staff told us about useful training and team discussions which had taken place since our last review. One told us, "I have picked up on changes in how to do things; it's made me stop and think about how I have been doing things". Other feedback included, "Our approach to maintaining people's privacy and dignity is much better", and, "I can take time to listen to and talk with patients – I love my work".

After our last review the Trust provided us with a comprehensive compliance action plan which included 32 individual planned improvements together with varying timescales for completion.

Helen Ray, Executive Director of Clinical Services, and the nurses in charge of each unit helped to provide updates as to what had been achieved and what work was still underway. It was identified that the completion timescales for the end of September 2011 had been met and those which were ongoing remained either ahead or well on target.

Examples of improvements which had been fully introduced were a review of auxiliary nurse training, the addition of relevant patient and carer experience feedback to all ward and departmental meetings, all staff reminded of the need to wear name badges,

a review of staff responsiveness to patient's calls for assistance and spot check observations of staff and patient interaction by the Matrons.

Examples of ongoing improvements included staff training in areas such as customer care, the planned use of volunteers, post discharge follow up, the introduction of a 'record keeping audit tool' and plans to review patient and carer feedback with reports back to ward managers and Matrons.

It was apparent that all delegations of staff had contributed to making significant improvements in the approach to patients and involving them in their care. Staff were committed and enthusiastic about maintaining and further developing high standards of person centred care, treatment and support.

Our judgement
We found that respect for patient's privacy and dignity was much better promoted and that they were provided with improved support to be involved in and influence their care.

Overall we found that South Tyneside District Hospital was meeting this essential standard.

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

Document purpose	Review of compliance report
Author	Care Quality Commission
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