Inspection Report

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

Chesterfield Royal Hospital

Chesterfield Road, Calow, Chesterfield, S44 5BL

Tel: 01246277271

Date of Inspections: 27 November 2013
26 November 2013

Date of Publication: January 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Respecting and involving people who use services	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed
Records	✓ Met this standard

Details about this location

Registered Provider	Chesterfield Royal Hospital NHS Foundation Trust
Overview of the service	Chesterfield Royal Hospital NHS Foundation Trust is the main provider of acute services and accident and emergency for Chesterfield and north Derbyshire.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Management of supply of blood and blood derived products Maternity and midwifery services 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

We carried out this inspection to check whether Chesterfield Royal Hospital had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Assessing and monitoring the quality of service provision
- Records

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 26 November 2013 and 27 November 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and reviewed information sent to us by local groups of people in the community or voluntary sector. We talked with other regulators or the Department of Health, were accompanied by a specialist advisor and 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 visited three inpatient wards and one outpatients department in the hospital over two days. We spoke with a total of 61 people using the service and 18 of their representatives. We spoke with 29 staff, including clinical and care staff and senior managers.

We found that the provider had taken action since our last inspection in relation to ensuring the privacy and dignity of people using the service. We found many examples of people using the service being treated with consideration and respect. People told us, "I've had nothing other than kindness and a great deal of patience." and, "They (the staff) draw the curtains around you if you need anything doing or if they want to talk to you." However, this was not consistent. People on one ward told us they had to wait a long time for help to get washed and dressed and to use the commode. People using the outpatients clinic said some of the doctors did not treat them with respect.

Most people we spoke with told us they had been given appropriate information in relation to their care and treatment. A visitor said, "The doctors don't use too much technical language, so you understand what they're saying." Some people using the outpatients department told us they did not always get all the information they needed.

We found that the provider's systems for assessing and monitoring the quality of the

services provided were not effective. Areas for improvement were identified but action taken in response was not always effective in making the necessary changes.

We found that the provider had taken action since our last inspection to ensure that people's personal records were accurate and up to date. The records we looked at generally had sufficient information in relation to the care and treatment of people using the service.

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

What we have told the provider to do

We have asked the provider to send us a report by 14 January 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

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 not meeting this standard.

The privacy of people using the service was generally well respected. The dignity of some people was not always maintained. People were not always provided with appropriate information in relation to their care and treatment.

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

Reasons for our judgement

At our last inspection in June 2013 we found people using the service were not always treated with consideration and respect. We found that people were encouraged to express their views in relation to their care and treatment. However, we found that people's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care. We told the provider that action was needed. The provider told us in July 2013 about the action already taken and the action planned to achieve compliance by the end of August 2013.

At this inspection we found that the provider had made improvements in relation to ensuring the privacy and dignity of people using the service. We spoke with four ward matrons who told us about their new role as privacy and dignity leads. They told us they reinforced good practice and challenged poor practice in relation to respecting people's privacy and dignity. They said they felt that staff were generally getting better at promoting the privacy and dignity of people using the service. We found that each ward we visited had a suitable room for people to use when they required privacy for sensitive discussions with staff.

We found many examples of people using the service being treated with consideration and respect. One person on an inpatient ward said, "They're golden, these nurses. They've got so much patience and they treat everyone here with the same respect, even when people can't talk to them." A visitor told us "They (the staff) have been very respectful to me as well as my partner and they've made sure I understand everything." Another visitor said, "X (person using the service) is always clean and well dressed, which must be quite difficult to do because X has dementia and can get quite aggressive when people try and help." We observed staff speaking courteously and respectfully to people and visitors. We

saw staff using curtains to provide privacy during care or treatment.

However, some people we spoke with on one inpatient ward felt their dignity was not always maintained. We spoke with one person at 11am who appeared distressed and who told us they were still waiting for help to get dressed. Two other people in the same area told us they had waited a similarly long time for help to get dressed on the previous day. Four other people said that there were sometimes delays in answering call buzzers, especially during the night. One of these people told us they had waited a long time for help to use the commode during the night, "Bursting for a commode and had to wait ... only just made it I'd waited so long." We observed on this ward that a person was assisted onto a toilet while the toilet door was still open. We saw that the provider's own assurance data and 'Friends and family' feedback corroborated our findings for this ward.

In the outpatients department most people told us that the nursing and care staff were always polite and respectful. One person said, "I think the staff here are very kind. They've got a lot of people to get through and they're good with everyone." We observed staff speaking courteously to people, directing people to the appropriate waiting area, and keeping people informed about long waiting times for some of the clinics.

However, four people we spoke with told us that some doctors in the outpatients department were not always so respectful. One person said that on a previous occasion they had been given bad news about their diagnosis in a very insensitive way by a doctor, causing distress to the person. We had also received similar information before our inspection from a person who had complained to the provider about the attitude of doctors in the outpatients department.

Most people we spoke with in the outpatients department said they thought their dignity was upheld and their diverse needs were taken into account. However, one wheelchair user and their relative told us they felt 'in the way' because there was no designated space for wheelchairs in the waiting areas. This meant the wheelchair had to be placed in front of a static chair, which also prevented the relative from sitting alongside the person. Two other people using mobility aids told us they found manoeuvring in tight spaces in the waiting areas, corridors and consultation rooms was not easy and they found this embarrassing.

We observed that the outpatients department was cramped for the number of people using the service on the day of our visit. We saw that people had to stand in some of the waiting areas as there were not enough seats. We observed that there was not enough room for all the pushchairs in the paediatric waiting area and so some families chose to sit in the other waiting areas. We saw that the children sometimes became fractious when not in a child-friendly environment.

People we spoke with who had attended the outpatients department before said they were used to long waiting times for clinic. One person said "When I come to (the clinic) I just cancel out the whole day because you never know how long you'll be waiting." One parent told us they were unhappy that they were not being told how long the wait for the consultation would be. They said "I don't mind if it's going to be a long wait, so long as I know how long. I've got other children that need picking up and I can phone round if I know how long we'll be."

Several people we spoke with said that when they had to wait for long periods of time, they were hungry and thirsty and only water was available for refreshment. One person said, "I

do bring my own drink in now, but I can see other people struggling, especially older people who can't get to the coffee place up the road."

People we spoke with on the inpatient wards felt they had been given appropriate information in relation to their care and treatment. One person on an inpatient ward said, "The doctor told me what he thought the problem was and he explained it to me. I'm waiting for a scan now and he says he'll come back and let me know what they find. He's made it all very clear for me." A visitor told us, "The doctors don't use too much technical language, so you understand what they're saying."

Most of the people we spoke with in the outpatients department were happy with the information and explanations given about their assessment, diagnosis and treatment. One parent of a child who was a new patient said, "I think the doctor explained it all very well. We had a few questions and they all got answered." Some people had been given leaflets about their condition and said they found them useful. One person said, "When you get home it's good to have a read about it all. You've got time to let it sink in then." Although a few felt they had not been given sufficient information. One person said, "We got a leaflet last time, but we can't read it, so it's not much use to me." A parent told us they felt they had not been given enough information about the medication prescribed at a previous appointment and they had to ring their GP to clarify how to use it.

Some people in the outpatients department told us the information given depended on which doctors they saw. One person said, "There are some doctors who explain everything to you and answer all your questions, but some just want you out of the door as quickly as possible. It just depends who you get." Another person said, "I've seen two different doctors in the past six months and they've told me two different things…who do you believe?" The same issue was raised by the person who had complained to the provider about their care and treatment in the outpatients department.

Three people who were attending for the first time told us they were unhappy about the information sent to them about the location of the outpatients department. One patient had gone to the wrong hospital that morning and one parent had to telephone their GP to find out where the clinic was. We looked at the appointment letters sent to these people and saw that the information provided was not clear.

People using the service were encouraged to express their views. The provider collected information about the experience of inpatients and outpatients through surveys. The experiences of inpatients were also collected by a ward assurance system and through the 'Friends and family' surveys. Some people we spoke with in the outpatients department did not know how to make complaints or comments about their care and treatment. We saw that information about how to make a comment or complaint was not readily available in the department.

Assessing and monitoring the quality of service provision ✖ Action needed

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 not meeting this standard.

The provider had systems in place to regularly assess the quality of service that people received. However, the systems were not always effective in relation to monitoring the quality of the service or assessing and managing the risks to the health and welfare of people using the service.

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

Reasons for our judgement

We did not intend to look at this standard at this inspection. However, we found evidence that the provider's systems for assessing and monitoring the quality of the services provided were not always effective. This meant that people using the service were not protected against the risks of unsafe or inappropriate care or treatment.

We found that people using the service were regularly asked for their views about their care and treatment. There was also regular quality monitoring covering all aspects of the service provided, such as infection control, meals, and records. The results were used to inform managers and staff about the standard of the service provided. However, we found a lack of effective action taken to address areas where concerns or deficits were identified.

We looked at the monthly audits carried out of inpatient wards against the CQC essential standards of quality and safety. We saw the results for July, August and September 2013 for the inpatient wards we visited. We saw that the results for two wards for 'Records' were significantly worse in September. The audits completed did not always show what was intended to be done to improve things. Remedial actions were sometimes recorded but did not always specify the person responsible for taking the action or the date by which the action was to be completed. Some had details of the issues observed, rather than a description of the action to be taken. For instance, one stated, "Not all care plans clearly indicate level of support required. Nursing evaluations do no (sic) reflect whether or not adequate nutrition has been provided." Another stated, "Inconsistent hours on essential rounding chart." The two wards had action plans in place to address these results.

However, the action plans were not SMART – that is, not specific, measurable, attainable, relevant and timely. In addition, the action plans did not address all of the deficits identified.

We looked at the results of the ward assurance audits for the inpatient wards we visited. These checked a sample of patients' notes and other records and were carried out monthly. The audit used a green, amber or red rating to indicate the standard achieved. We saw that two wards we visited had scored red for some aspects of documentation for the previous three months. However, the action plans in place did not always address these areas. We saw that data from the ward assurance audits were presented to the provider's Quality Delivery Group in October 2013. Four areas were highlighted in relation to the introduction of new documentation, sharing good practice, clinical supervision and staff awareness of standards.

During our last inspection we reviewed the provider's audit of Do Not Attempt Resuscitation (DNAR) forms carried out in April 2013. DNAR forms are used to record the reasons why and how a decision has been made not to attempt cardiopulmonary resuscitation for a specific person. The audit concluded that documentation of the involvement of patients, relatives, and multi-disciplinary team members remained poor and there was little consistency in the completion of the forms. The provider carried out a further audit in June 2013. This found that the forms were not always fully completed in line with national guidance. The audit report commented that some of the findings were worse than previous audits and that, "Our recommendations are much the same as they have been in recent years." This indicated that action taken had not been effective in addressing the issues found. We spoke with the provider's Head of Clinical Governance who told us that further action had been taken. This included more audits and reminding doctors of their responsibilities in completing the forms.

The provider recently commissioned an independent review of its quality governance and is putting in place new ways of working to address the findings of the review.

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

At our last inspection in June 2013 we found that records of people's care and treatment were not accurately maintained. This meant that people were not protected from the risks of inappropriate or unsafe care and treatment. We told the provider that action was needed. The provider told us in July 2013 about the action they had already taken and the action they planned to take to achieve compliance by the end of August 2013.

At this inspection we found that records were generally kept securely and could be located promptly when needed. We saw that people's medical records were stored in trolleys on the inpatient wards we visited. The trollies had lockable flaps, though these were not always used because staff needed frequent access to the records. People's nursing records were kept at the end of their bed. We saw that people's medical records in the outpatient department were kept in locked storage until required. We saw that there was a system to keep track of where each record was within the hospital. Staff we spoke with in all areas we visited told us people's medical records were usually available when needed.

We found that people's personal records were mostly accurate and had appropriate information in relation to their care and treatment. We saw that new nursing care documentation was being introduced on the inpatient wards. This documentation included more detail regarding people's needs and personal preferences. We found that the new documentation was not fully in use and that some staff were unsure about how to complete it. The role of documentation champion had been created for each inpatient ward. The role included educating and supporting staff in using the new documentation. The role also included checking that people's records were accurately completed.

We looked at the nursing care records for 20 people on the inpatient wards. We found that the care records were up to date and mostly included sufficient detail of the person's needs and how these were to be met.

At our previous inspection we found that some records were not well completed and this was putting people at risk of receiving unsafe or inappropriate care. These records included assessments of the person's nutritional needs, assessments of their risk of skin damage, and records of food and fluid intake and output. At this inspection we found that

completion of these records had generally improved.

We looked at the medical records for 12 people in the outpatients department. We saw that the records were updated during or immediately after the person's attendance in the clinics. The records included relevant information, such as their contact details, medical history and any allergies.

The provider should note that we found Do Not Attempt Resuscitation (DNAR) forms were not completed in line with national guidance. DNAR forms are used to record the reasons why and how a decision has been made not to attempt cardiopulmonary resuscitation for a specific person. Guidance on completion of the forms is produced by the General Medical Council and the Resuscitation Council (UK). We saw seven DNAR forms and only one of these was fully completed in line with the guidance. This meant that people may not be protected against the risks of unsafe or inappropriate care and treatment.

We also saw that unsatisfactory completion of records was noted in the provider's own audits. We have judged the provider as compliant with this standard because we found them largely compliant during our inspection. We have reported on the lack of effective risk management in relation to records elsewhere in the section "Assessing and monitoring the quality of service provision."

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: The registered person had not made suitable arrangements to ensure the dignity of service users or to provide service users with appropriate information in relation to their care and treatment. Regulation 17(1)(a)(b)
Regulated activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider did not operate effective systems to monitor the quality of the services provided, or to assess and manage risks relating to the health, welfare and safety of service users. Regulation 10(1)(a)(b)

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

The provider's report should be sent to us by 14 January 2014.

This section is primarily information for the provider

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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