Inspection Report

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

Peterborough City Hospital

PO Box 404, Bretton Gate, Peterborough, PE3 9GZ

Date of Inspections: 20 February 2013
08 February 2013
04 February 2013

Date of Publication: April 2013

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

Care and welfare of people who use services	✖ Action needed
Meeting nutritional needs	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Peterborough and Stamford Hospitals NHS Foundation Trust
Overview of the service	Peterborough City Hospital is an acute 611 bed hospital. It provides a range of acute care services on an inpatient and outpatient basis.
Type of services	Acute services with overnight beds Community healthcare service Hospice services Long term conditions services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning 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 Peterborough City Hospital had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Meeting nutritional needs
- Staffing
- Assessing and monitoring the quality of service provision

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 4 February 2013, 8 February 2013 and 20 February 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 we asked the provider to send to us and talked with other regulators or the Department of Health. We took advice from our specialist advisors and were accompanied by a specialist advisor.

What people told us and what we found

Patients' existing care needs were not always assessed and care was not always adequately planned to make sure they received the care they needed. Information about the need of people who could not communicate easily was not available and this meant that ward staff did not always know the best way to take care of patients.

Patients were provided with a choice of meals and staff members assisted them appropriately with eating and drinking if this was required.

There were enough staff members available to care for people properly.

There were systems in place to regularly check and monitor the way the service was run. However, this did not identify that existing care needs information was not available and actions put into place was not fast enough to reduce risk to patients.

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 03 May 2013, 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

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not always experience care, treatment and support that met their needs and protected their rights.

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

People's needs were not adequately assessed and care was not adequately planned in line with their individual care needs.

We received information of concern prior to our inspection in relation to the care provided to people with reduced capacity and ability to verbally communicate. Information provided to us by the trust about these concerns identified that assessments of people's existing care needs, in relation to how they were able to eat and drink and one person's ability to consent to treatment, had not been completed.

During our inspection we examined 20 people's care records to determine how care needs were assessed, planned for and delivered. When patients had attended a pre-admission outpatient clinic assessments of their physical abilities had been completed. For those patients who had not attended the clinic or who had been admitted as an emergency we noted that there were limited assessments of their ability in managing activities of daily living (ADLs).

We examined records for patients with a learning disability or dementia to assess the information staff obtained about their existing care needs. We found that although medical and nursing notes acknowledged that people had a medical diagnosis of learning disability or dementia, this was often the only information that was recorded. One person had their specific learning disability diagnosis recorded. This did not provide staff members with adequate information about their dementia or learning disability to be able to meet their care needs.

Staff members on one ward had completed a 'This is me' form with the spouse of one person who had dementia. This provided staff members with information about the person's preferences, their usual behaviour and what would upset them. A staff member also confirmed that it had enabled them to increase staffing numbers in order to

accommodate the person's needs. However, this was the only 'This is me' form that had been completed for any of the patients with dementia whose records we examined.

Overall we found the assessment of people's existing care needs was variable. Some assessments were completed by nursing staff during the pre-admission appointments and other assessments made by therapy staff, such as occupational therapists and physiotherapists or dieticians. However, therapists' assessments were often not completed until patients had been admitted for several days. Some patient records we examined had no information at all about the help patients usually required to meet their care needs.

Assessments were completed to assess people's level of risk for such health related issues as their nutritional status or risk of developing pressure sores. These assessments had been reviewed and appropriately identified the level of risk for each person. They indicated staff should then follow a particular plan, although there was no guidance in people's care records or medical and nursing notes to indicate what these plans were.

Care bundles or clinical pathways were in place for a number of different nursing care tasks, such as intravenous cannula, urinary catheters and for the specific reason for patients' admission. These bundles identified actions staff members were required to take to ensure the person's needs were met. Most bundles did not identify things that each person could do for themselves or detail how ward staff should support the person.

We specifically looked in care records for information about people's existing care needs where that person was less able to communicate and how they were supported while in hospital to eat and drink. We found only one clinical pathway that detailed the patient's existing care needs and the assistance the person required. Records for people with learning disabilities or dementia did not contain care plans or guidance for staff about how to manage these needs. For example, for one person with learning disabilities there was no information regarding how they communicated their needs or their level of understanding of language. The person did not have capacity to make decisions regarding their treatment. There was no care plan for staff in relation to another person's specific learning disability that included an eating disorder, although the trust have since confirmed that a food plan was available with the patient. There was no nutrition care plan for one patient with dementia and entries in medical and nursing notes identified that they had a reducing ability and desire to eat.

We spent time observing how staff members cared for and interacted with people. We found that staff members were polite, gentle and caring. Most people and visitors we spoke with said that staff members were, "Nice" and that they helped with everything they needed them to.

We spoke with the relative of one person and a mental health nurse accompanying another person, who both had concerns about how staff members had provided care. The person's relative said that they did not feel able to leave their relative as they were not confident that the patient would receive adequate attention as this was their experience while they had been at the hospital. The mental health nurse told us that when the patient had first been admitted ward staff had not provided any assistance with the person's personal care needs. This had resolved after it was established that care of the patient on the ward was not the role of the mental health nurse.

We found that other records, such as and safety and wellbeing charts, were kept to show hourly checks had been made on patients, as required in a recent government incentive. We also found that food and fluid records were not always fully completed. One patient's

fluid chart had not been completed for four consecutive days and another person with a documented reduced ability and desire to eat had incomplete food intake records. These did not provide accurate records, or show that plans of care had been followed.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

People were provided with a choice of suitable and nutritious food and drink.

The hospital had a menu that was regularly changed so that patients did not receive the same meal options if they were inpatients for any great length of time. There were at least two meals offered on the main menu and light alternatives were available if patients wanted something else. We were advised that a member of the catering staff asked patients for their meal preference for the next day. This responsibility was passed to a member of the ward staff for those patients less able to communicate.

However, the provider may find it useful to note that we spoke with two patients and their relatives who said that the portion sizes of meals were too large and there was limited ability to obtain smaller portions. They also commented that there was difficulty obtaining meals or snacks at any other time during the day and said it could take up to 45 minutes for the food to reach the patient. This may not meet the needs of patients who required smaller, more frequent meals.

People were supported to be able to eat and drink sufficient amounts to meet their needs.

We spent time observing the lunchtime meal in one ward and the support that staff members gave to patients. This showed that there were enough staff members to assist patients with their meals and to assist them to eat if necessary. This was generally managed well and staff members were able to dedicate their time to helping patients to eat. We noted that most patients were assisted appropriately and the mealtime was spaced over a period of one and a half hours. This was unhurried and ensured there was adequate time for patients to eat before the meal was removed.

Three meals were heated at a time and then delivered to patients before further meals were made available, which ensured that patients received hot food. A second member of the catering staff delivered drinks to patients at the same time that meals were delivered.

The trust had a 'protected mealtime' policy and most patients were undisturbed during this time. There was one person, however, who was taken to a therapy appointment as their meal was delivered.

Patients were provided with appropriate crockery and cutlery for their needs and they were provided with physical assistance from staff members if this was required.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs.

Patients we spoke with said staff responded quickly to their call bells and acknowledged them if they were not able to attend straight away. All of the patients said they felt there were enough staff available.

We visited five wards across the adults section of the hospital. We spoke with staff members regarding staffing numbers and most staff confirmed that the hospital was adequately staffed. However, on one ward that we visited staff members could not be located as they were with patients. We examined vital signs (temperature, pulse, blood pressure and respiration) charts and noted that these had not been recorded since 06:30 that morning. We were advised that taking these recordings were sometimes reduced to twice a day, however we found no medical instructions or nursing rationale in patient records to confirm this. The ward manager confirmed that an additional health care assistant would be of benefit on day shifts.

All other wards that we visited had vital signs charts completed during the day and all wards completed patient checks a minimum of two hourly, if not hourly as required by a recent government instruction. Call bells were answered promptly on the wards we visited.

The trust confirmed that nursing and health care staffing levels were determined following the move to the Peterborough City Hospital site in November 2010. Additional staffing levels were determined on a day to day basis by each ward manager. The trust had recently commissioned a report to look at available staffing tools and benchmark the trust's staffing levels with other similar sized trusts to ensure staffing levels were safe.

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 a system to regularly assess and monitor the quality of service that people receive, however issues were not always identified and actions were not always taken quickly enough to reduce risks to people using the service.

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

We examined the trust's governance systems to assess how well they identified and managed risks to patients.

Complaints and concerns made to the trust were monitored through a quarterly complaints, litigation, adverse events and PALS (CLAEP) report to the board. We examined the report for quarters two and three and found that a selection of the complaints received had been discussed in the report. This discussion included action that had been taken and lessons that had been learned from the investigation. We noted that the board had commented about the time taken to investigate and respond to some complaints, which continued to be in excess of six weeks. The report stated action was being taken to improve these timescales and we noted that there had been improvement since we highlighted the excessive timescales in our inspection in October 2011.

We spoke with staff on one ward regarding how they managed complaints. They told us that they tried to resolve issues at the time but that they would refer anything that couldn't be resolved on to higher management. Staff told us that they had little feedback to show how the issue had been resolved and any actions or recommendations that had been made. They did not know whether the trust board were made aware of any issues.

The Trust had a number of mechanisms to regularly assess and monitor the quality of services provided. For example, matrons used a balanced scorecard approach for each of their clinical areas, which checked that care records and risk assessments for health related issues, amongst other things, had been completed. Each clinical directorate (surgery, medicine, etc) had their own governance meeting to discuss clinical quality and ensure action took place to improve any areas of concern. The Director of Care Quality and Chief Nurse received copies of all reports and any adverse results were discussed as part of quality assurance in different meetings across the trust.

However, the mechanisms had failed to identify that risk assessments and care plans for

patients' existing care needs were not being completed on a regular basis. We found, for example, that food and fluid records were not always fully completed. One patient's fluid chart had not been completed for four consecutive days, but no action had been taken to address this. Another person's food intake records had not been completed after they had initially refused a meal. The person had dementia and their records indicated they had a reduced ability and desire to eat.

The trust notified us in October 2012 that they had requested external reviews from two professional bodies following an increase in incidents in the maternity and women's health department. They received the reports shortly prior to our inspection and confirmed they were working on an action plan. The trust was also working closely with Monitor (the foundation trust regulator) with regard to their financial deficit and turnaround.

We looked at actions the trust had taken following an inspection at its other location in August 2012 and whether changes had also been required at Peterborough City Hospital as a result of this. The trust identified the need to look at records and allocated the Patient Safety Manager to lead a review, although initially this did not provide any result due to the low number of hours allocated to the work. Shortly prior to our inspection the trust recognised this and assigned the task of identifying shortfalls in record keeping on a part time basis.

We spoke with the person tasked to complete the work, who confirmed they had already identified records that were missing and record keeping that had either not been completed fully or at all. During the period of our inspection the trust confirmed this position had increased to full time in order to speed up identifying shortfalls and improve records and record keeping.

There were a number of systems and processes in place to monitor and analyse patient safety, although despite these the trust was not performing well against some patient safety indicators. For example, an increase in the number of patient falls had been identified and the trust was exceeding the number of Clostridium Difficile (C.Diff) infections determined by the Department of Health. Our discussions with staff showed that contributing factors had been identified, as had possible reasons, although preventable actions had not had the desired effect. The trust stated that although the number of falls remained at a higher than expected level, the number of serious injuries sustained was lower. C.Diff infections were not generally a result of cross contamination and antibiotic prescribing was scrutinised. However, records indicated that antibiotic scrutiny was not part of board or quality group discussions.

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 Surgical procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Patients existing care needs were not always assessed or adequately planned for to ensure they received the care they needed. (Regulation 9 (1)(a), (b)(i), (ii))
Regulated activities	Regulation
Diagnostic and screening procedures Surgical 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: Issues identified were not always addressed quickly enough to reduce the risk to the health and safety of patients. (Regulation 10 (1)(b), (2)(b)(iii), (v))

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 03 May 2013.

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

This section is primarily information for the provider

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 dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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