

Review of compliance

Cambridge University Hospitals NHS Foundation
Trust
Addenbrookes and the Rosie Hospitals

Region:	East
Location address:	Addenbrooke's Hospital Hills Road Cambridge Cambridgeshire CB2 0QQ
Type of service:	Acute services with overnight beds Diagnostic and/or screening service Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Date of Publication:	July 2012
Overview of the service:	Addenbrooke's Hospital is a large teaching hospital with many specialist departments and over 1000 beds. It is the main location for Cambridge

	University Hospitals NHS Foundation Trust.
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Summary of our findings for the essential standards of quality and safety

Our current overall judgement

Addenbrookes and the Rosie Hospitals was not meeting one or more essential standards. Improvements are needed.

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 because concerns were identified in relation to:

- Outcome 01 - Respecting and involving people who use services
- Outcome 02 - Consent to care and treatment
- Outcome 04 - Care and welfare of people who use services
- Outcome 08 - Cleanliness and infection control
- Outcome 14 - Supporting staff
- Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 25 April 2012, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

During this review, we visited two ward areas, several theatres and spoke with eight people who were receiving treatment and one relative. Overall, they were complimentary about the care and treatment they had received and felt they had received sufficient levels of information from staff about their health issues.

One person in theatres said "Staff have been very kind and reassuring. I find all these checks good, I've never been asked my name and date of birth so much."

Another person in the treatment centre said they had felt, "Claustrophobic" when the curtains were drawn around the bed spaces. Two other people made comments about the confined space around each bed although they felt staff did their best to help maintain privacy and confidentiality.

What we found about the standards we reviewed and how well Addenbrookes and the Rosie Hospitals 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

The trust was meeting this standard. Staff were respectful of people's individual needs and took steps to maintain their privacy and dignity.

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

The trust was meeting this standard. People were given the opportunity to give their informed consent to care and treatment.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The trust was not meeting this standard. We judged that this had a moderate impact on people using this service and action was needed for this essential standard. Staff did not always follow the Trust's published guidance in the use of the World Health Organisation's Surgical Safety Checklist to ensure that they delivered consistent practice within the theatre department. This meant that people who used the service may not be protected against the risks of unsafe care.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

The trust was meeting this standard. Appropriate steps were in place to monitor and reduce hospital acquired infections.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

The trust was meeting this standard. There were appropriate systems in place to ensure that doctors were monitored and supported in their roles.

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

The trust was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. People are at risk because the use of the surgical safety checklist is not consistent and the system to monitor the quality of this process has not been effective.

Actions we have asked the service to take

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

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a

variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

In a previous review, we suggested that some improvements were made for the following essential standards:

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

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

We spoke with three people who had stayed overnight at the treatment centre. They told us that staff were, "Very helpful, polite and courteous." One person said they had seen several professionals during their stay and had received a good level of information. Another person said the nurses always pulled the curtains to maintain their privacy but due to the small bed spaces when several curtains were drawn around other people they had felt, "Claustrophobic." One person told us that it was a little cramped for space and staff had confirmed that when people needed to stay for more than one night, they were moved to an ordinary ward.

Two people we spoke with said that confidentiality was a problem due to the confined bed spaces. One person said that staff were very aware of this and tried to promote privacy when having private conversations by talking in low voices and pulling curtains around the bed. Another person said that confidential discussions, "Will always be a problem in a hospital."

The trust may wish to note the comments made by people using this service.

Other evidence

We visited the Day Surgery Unit within the treatment centre because we had received

information of concern from a whistleblower who felt that people were not receiving an appropriate level of care to meet their needs and maintain their dignity. This unit was opened by the trust in 2007 and it is used for people who had a surgical procedure that required an overnight stay. There were toilets and bathrooms designated for male or female use only and these were located close to bed areas. The entrance to each bay had a set of curtains that could be drawn to give additional privacy from people passing by.

The area has five separate bays each with six bed spaces. Every bed space had a chair and bedside table. It was notable that there was insufficient space to have a bedside locker and people told us they were able to manage their belongings as they only stayed for one night.

One person who was waiting for their surgery needed to be moved by staff using a hoist as they were unable to stand. The person was being cared for in a bay with no other people so that staff had sufficient space to meet the person's needs without compromising their dignity. The person was being accompanied by a relative, who was also their main carer. Immediately after their surgery was completed the relative was approached by staff from the recovery room and invited to attend to help reassure the person who was recovering well from their procedure.

We spoke with three members of staff who acknowledged that there was less space for people in comparison to general wards although people were able to manage as they only stayed for one night. They felt that space was cramped when they were very busy and needed to attend to people. We were told the trust diverts admissions for people with more complex needs or those that required a hoist when possible and tried to limit each person to one visitor at a time.

When we visited the theatre department we saw that patients had their privacy protected during all stages. All grades of staff ensured that people were covered when they were being transferred from the bed to the theatre table and whilst being prepared for the operation.

Our judgement

The trust was meeting this standard. Staff were respectful of people's individual needs and took steps to maintain their privacy and dignity.

Outcome 02: Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:

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

What we found

Our judgement

The provider is compliant with Outcome 02: Consent to care and treatment

Our findings

What people who use the service experienced and told us

We spoke with people who were recovering from surgery. They told us they had consented to the surgery prior to the procedure and two people said they had been asked 'several times' about their consent and told us that they had been given adequate opportunities to change their mind if they wanted to. Two people told us they had been given satisfactory information about their surgical treatment prior to giving consent.

We spoke with one person who had stayed overnight at the treatment centre and they told us they had been warned about potential risks of the surgical procedure and did not think they had been made aware of any infection risks.

Overall, people were satisfied about having the opportunity to give their informed consent for their surgery.

Other evidence

We looked at several consent forms for people who were either about to receive or had already undergone surgery. These forms included the signatures of the person and the doctor who was responsible for performing the surgery. The consent forms were checked by operating theatre staff prior to commencing any surgical procedure. When people were waiting to enter the operating theatre staff confirmed and verified each person's identification and they double checked people's wristband identification.

People were then asked if they consented to and understood what treatment, or procedure was going to be provided for them. All of the people that we spoke with demonstrated that they understood the treatment they were to receive.

A relative that we spoke with in the treatment centre, told us they had a legal right to consent to the procedure on behalf of their spouse. The information provided to them had enabled informed consent to be given.

Our judgement

The trust was meeting this standard. People were given the opportunity to give their informed consent to care and treatment.

Outcome 04: Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

During our visit we spoke with five people who were recovering from surgical procedures who informed us they were very satisfied and pleased with their care and treatment. One person said, "I have only praise and no complaints about Addenbrookes. I have been looked after well." Two people told us about the arrangements for their care and treatment and said they had been well informed about their treatment, their recovery and any associated risks.

Other evidence

The trust had experienced five recent incidents, classified as "never events" within the theatre areas at the hospital. "Never events" are defined by the NHS National Patient Safety Agency as "Serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented."

We checked to see if the trust was following the Surgical Safety Checklist recommended by the World Health Organisation (WHO) and the Five Steps to Safer Surgery written by the National Patient Safety Agency (NPSA) The checklist should identify five phases of a patient's journey through the operating theatre. Each check should correspond to a specific period in the normal flow of work. Before the patient is brought to the theatre the team should meet to have a 'team brief' where all staff hear about the operations that are to take place. Then checks should be made before the patient has the anaesthetic ("sign in"), before the operation starts ("time out") and before the patient leaves the operating room ("sign out"). At the end of the theatre list staff then carry out a debrief.

The Trust did not use the Surgical Safety Checklist recommended by the World Health Organisation (WHO) and the National Patient Safety Agency (NPSA) but used an adapted version. (Guidance issued by the NPSA in 2009 stated that it was acceptable for trusts to do this.) The checklist was designed to reduce the risk of surgical related complications and improve team communication. In each theatre there was a large poster of the hospital's own adapted checklist which provided prompts for staff to follow. We found the trust also used a perioperative care record for each person that included multiple checks that staff were required to sign once they were completed. (The perioperative period begins the day before surgery and finishes a few days after surgery). In all of the checks that we saw, staff did not refer to the poster but used the consent form or perioperative care records as a prompt for the checks. This meant that staff relied on their memory to remember all the checks needed whilst the patient was in theatre rather than refer to a single checklist.

We saw one team brief for two complex theatre cases and another in an emergency theatre. The team brief is a time where all members of the team meet before the patient goes to theatre to discuss any anticipated problems and to complete some routine checks. However in one theatre we saw that one team member was missing from the discussions as they were collecting the patient from the ward at this time. Staff confirmed that this was normal practice and meant that not all team members were present for the team brief. However we were told that when staff arrive after a procedure has commenced, they would be given a "mini brief" but they did not have a set of prompts to do this in a formal way. Staff could therefore miss formal checks that include vital information about managing risks to the care and safety of the patient.

We noted that during one team brief, staff did not follow the prompts for the sign in check and time out checks. Other checks missed included surgeons estimating blood loss, discussing any risks giving patients the anaesthetic, or explaining how staff were intending to prevent patients developing a blood clot. Staff did not discuss the sterility and availability of instruments or how to keep the patients warm. We found that some checks were completed in the perioperative care record but others were not completed in line with the Surgical Safety Checklist.

The surgeon and anaesthetist acknowledged both patients had significant medical history but did not discuss that they may have problems putting in the drip or were intending to put a specialist catheter into the person's neck. There was a delay putting a drip into the first patient. The surgeon told us that the delay would add pressure to finish both complex cases in the working day. The surgeon said that surgical staff used to write the theatre lists but this was now an administration role. He added that complications were not always accounted for in the scheduling and that surgeons would not have routinely booked two complex cases together.

When we were not able to attend and observe the team brief, we asked four staff what had been discussed. Two said they had not been present at the team brief for their theatre list. Two staff in another theatre said there had been no problems identified during their team brief. However, the Operating Department Practitioner (ODP) overheard this and corrected the two staff by saying that there had been problems identified. She told us the consultant surgeon had attended the team brief and questioned which side was due to be operated on because the written theatre list did not state the same side he had just examined. We saw the theatre list, which was not signed and showed the incorrect side. We saw that the consent form had identified the

correct side. This highlights that not all staff had been involved in the team brief or were aware of significant information. We highlighted this incident to senior managers at the trust as part of our feedback. They found that the discrepancy in which side the person was due to have their surgery had been identified by staff before the person reached theatres and corrective action was taken.

During eight of the 10 checks that we witnessed the process was not formal or clearly read out to ensure the whole team were involved. Staff were not clear about who was responsible for leading the check. Two junior members of staff did not know what a sign out check was. We saw conversations occurring and staff wandering off before the check had been completed.

We saw that allergies and antibiotics were not discussed in three of the five time out checks we saw and two of the four sign in checks. There were no estimated blood losses verbalised in any of the theatre sessions we observed; which is recommended in the WHO checklist.

We asked to see three sign out checks. One did not confirm that swabs and instrument checks were correct and two did not occur at all as recommended by the hospital and WHO checklist. Patients simply had dressings applied. Staff continued with their individual roles and conversations and the patients were taken from theatre. This means that checks such as swab and instrument counts did not take place in accordance with published guidance set down by WHO and the NPSA. Checks about any specimens were not made and instructions for the patient's recovery were not discussed inside theatre as recommended by the hospital's checklist, WHO checklist and NPSA five steps to safer surgery.

We saw good examples of a consistent approach for counting swabs during the process of the operations we observed. Staff showed us the process which was consistent in all theatre areas. However, we did not always see the formal verbal confirmation that the numbers of swabs was correct which is included as part of the WHO checklist recommendations.

In the operating theatres, we saw that staff used good moving and handling techniques. Pressure relieving equipment was used in all but one case. The exception was where staff used gauze swabs under the heels. A member of staff said they did not have any gel cushions available.

We also visited ward K2 where diagnostic tests and investigations were completed as we had expected to find a WHO safety checklist in use. We asked a member of staff for the WHO checklist and were told that it was not available on that ward. We noted that a patient care document was used which included parts of the WHO checklist. This did not record whether a theatre check of the sterility of instruments or counts of any instruments had been completed.

Our judgement

The trust was not meeting this standard. We judged that this had a moderate impact on people using this service and action was needed for this essential standard. Staff did not always follow the Trust's published guidance in the use of the World Health Organisation's Surgical Safety Checklist to ensure that they delivered consistent practice within the theatre department. This meant that people who used the service

may not be protected against the risks of unsafe care.

Outcome 08: Cleanliness and infection control

What the outcome says

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

What we found

Our judgement

The provider is compliant with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us

We spoke with people who used this service but their feedback did not relate to this standard.

Other evidence

We had received information of concern about an incident where a contaminated instrument was reused for a person receiving an investigative test. We asked the trust about the incident and they told us that it had been appropriately reported as an error and investigated by the infection control team. The trust's investigation report showed that procedures had been reviewed to ensure that there is a low risk of this type of error happening again in the future.

We had also received some information concerning high rates of infections for people who had received surgical procedures, particularly for people receiving colorectal surgery. We checked the information that we hold about the trust and did not find any significant concerns about high rates of surgical infections.

We spoke with staff with responsibility for monitoring infection rates and were informed that the trust had permanent staff who monitored surgical infections. All mandatory surveillance was completed and reported to the Health Protection Agency (HPA) who contact trust's when concerns about high infection rates are identified. The last alert that the trust received was in 2010 in relation to colorectal infections. Consequently, the trust invited an advisor to review practice. This included a review of the cases and the individual surgeons performance but did not show any significant differences. The trust continued to monitor and review colorectal surgical infection rates so that they could identify and react to any issues that may contribute to infection rates and help to reduce

them.

Our judgement

The trust was meeting this standard. Appropriate steps were in place to monitor and reduce hospital acquired infections.

Outcome 14: Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:

* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us

People who used the service spoke highly of staff and told us they were all very supportive. One person said "They are all marvellous, from the ward to the cleaners. I feel very well looked after."

Other evidence

We received some information of concern from a whistleblower that suggested there were issues around working times for junior doctors and that morale was low. We also checked a report by the East of England Multi Professional Deanery which looked at the quality of academic training and the level of support for junior doctors at the trust. We found that this had identified some ongoing concerns in the area of plastic surgery.

We spoke with a member of staff who was responsible for medical staffing about the concerns raised by the whistleblower. The trust had 70 different junior doctor rotas of which, 15 were in surgery. Each one was assessed every four months to monitor issues that may affect compliance with working time directives. Within the last two years there were some working time issues in plastic surgery and the trauma/orthopaedics rotas which had been resolved. There had been no appeals made by the junior doctors and we found no evidence to support the concerns raised by the whistleblower.

We spoke with a member of staff with responsibility for medical education to discuss the report by the East of England Deanery. We found the trust had taken the findings seriously and responded with an action plan. This will be followed up again by the East of England Deanery who is responsible for monitoring the quality of junior doctors training. We will ask the trust to share any forthcoming reports with us.

Our judgement

The trust was meeting this standard. There were appropriate systems in place to ensure that doctors were monitored and supported in their roles.

Outcome 16: Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:

* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are moderate concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us

We spoke with people who confirmed that prior to them entering the operating theatre staff spoke with them to ask their name and to check their awareness of the procedure that was going to be provided.

Other evidence

All theatres had a theatre register which recorded the patient's name, details, procedure and swab count. One theatre had adapted this register to include a column to tick that the WHO checklist had been carried out. In this theatre we noted that the sign in, time out and sign out checks were incomplete. Despite this staff had signed to say the checks had been done.

Staff explained that they used a computer system to record information such as the procedure, equipment used and staff present. This did not include a field to record that the WHO checklist had been completed. We were shown an operation notes chart which had a small red stamp which asked a member of staff to name and sign once the WHO surgical safety checklist had been completed. We saw that four of these documents had been signed but when we looked at the checklist in all cases three key checks had not been completed.

We asked four staff in theatres about changes that had occurred since the never events had happened. Staff said communication had occurred through meetings, feedback sessions, communication and audit meetings. None of the staff said that changes to the checklist had taken place, but reminders to do the checks had been emphasised. Some

staff said their swab count techniques had been reassessed. None of the staff were aware of any checks by senior staff including any audits of practice. A team leader told us it had been hard work to make sure all staff competencies had been assessed. They added that they had not been asked to do formal audits performed on theatre safety checks. This means the quality of the theatre safety checks done may not have been assessed.

We spoke with the trusts' senior managers about the investigation and learning from the never events and found that the matter had been taken very seriously. They described the process they had taken to conduct an in-depth review so they could establish how the incidents had occurred and plan improvements to reduce the risk of any further occurrences. This included communications with staff, training programmes, disciplinary processes and the implementation of an action plan that was monitored weekly by a team appointed specifically for the task. We were informed that some long term actions were still 'work in progress' and this included reviewing team communication.

Our judgement

The trust was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. People are at risk because the use of the surgical safety checklist is not consistent and the system to monitor the quality of this process has not been effective.

Action we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Surgical procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	<p>How the regulation is not being met: Staff did not always follow the Trust's published guidance in the use of the World Health Organisation's Surgical Safety Checklist to ensure that they delivered consistent practice within the theatre department. This meant that people who used the service may not be protected against the risks of unsafe care</p>	
Surgical procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	<p>How the regulation is not being met: People are at risk because the use of the surgical safety checklist is not consistent and the system to monitor the quality of this process has not been effective.</p>	

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

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

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

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

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

What is a review of compliance?

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

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

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

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

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

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

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

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

Information for the reader

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