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

Stafford Hospital

Weston Road, Stafford, ST16 3SA
Tel: 01785257731

Date of Inspections: 27 February 2014
26 February 2014
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We inspected the following standards as part of a routine inspection. This is what we found:

- Care and welfare of people who use services: Met this standard
- Safeguarding people who use services from abuse: Met this standard
- Staffing: Met this standard
- Assessing and monitoring the quality of service provision: Met this standard
- Records: Action needed
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- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Staffing
- Assessing and monitoring the quality of service provision
- Records

Information primarily for the provider:

- Action we have told the provider to take

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Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 26 February 2014 and 27 February 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by other regulators or the Department of Health, talked with commissioners of services, talked with other authorities and talked with local groups of people in the community or voluntary sector. We were accompanied by a specialist advisor.

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

A team of five CQC inspectors, one colleague from NHS England, one colleague from the local commissioning group, a specialist adviser in accident and emergency care and an expert by experience visited Stafford Hospital on 26 and 27 February 2014.

As part of this inspection we looked at the care provided to people who were elderly and may have dementia. We looked at care / treatment people received whilst in the accident and emergency department and then their care on several wards in the hospital. We looked at how the hospital reviewed the quality of care and treatment provided to people. This included investigations into people's poor experiences of care and treatment within the hospital.

During our inspection we spoke with 41 patients, 12 relatives and 48 staff.

The majority of people we spoke with (38 of the 41 people) were positive about the care and treatment they received at the hospital. Three people told us about improvements that they thought were needed. One patient told us, "I feel I have been well treated since I came into hospital. Staff have been kind and considerate. The nurses are really busy but stop and talk to me if I have any concerns. When the doctors talks to me I feel that he listens to what I say and respects my point of view". Another person said: "I feel treated with dignity and respect".
People who were in-patients during our visit told us that they were informed about the treatment they needed and would receive. One person told us, "Everyone has been great. The doctors explained all the treatment I would have".

People we spoke with made positive comments about the staff. One person said, "I have heard so many bad things about this hospital and did not know what to expect, but I have not been able to fault the staff or the care I have received".

We had been told before we visited the hospital, that the trust which managed the hospital had been experiencing difficulties in recruiting and retaining nursing and medical staff. We were told that as a result of this the trust had needed to employ large numbers of bank and agency staff to ensure that there were sufficient staff available to care for people. The trust had also told us that they had reduced the total number of beds available in the hospital and had stopped elective surgery in the hospital. The trust's management team praised the commitment of the staff to ensure that wards and department were covered and risks to people were minimised.

Staff we spoke with were informed about the hospital's staffing difficulties and gave us examples of their commitment to people's care.

We found that the hospital had systems in place to check the quality of care and treatment that was provided. We found there was a need to ensure that complaints and serious incidents were dealt with more promptly. The trust could make improvements to these processes to ensure they always gained the most learning from them.

We found that care records were not always available or consistently completed. The lack of essential information meant there was an increased risk that people may not consistently receive the care they needed.

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 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.
**Care and welfare of people who use services**

Met this standard

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

**Our judgement**

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

**Reasons for our judgement**

During our inspection, we visited wards 7, 8, 10, 11, 12, the accident and emergency department, paediatric assessment unit, the acute medical unit (AMU), the discharge lounge, the critical care unit, and the surgical day case unit. We spoke with 41 patients and 12 relatives who were visiting at the time of the inspection.

On the day of our inspection, 38 of the patients we spoke with were positive about the care they had received in the hospital. One person told us: "They explained what was going to happen and the times it should happen. I have been well treated with staff checking up on me every now and again to make sure that I'm ok".

People we spoke with told us that they were involved with decisions about their care and treatment. We saw positive interaction between staff and people who were in-patients in the hospital. Staff were seen to be friendly, polite and respectful. One person told us: "The medical staff have kept me informed about my condition/care and they listen to my concerns. I have no worries about the treatment or the care I have received". Another person said: "When the doctor talks to me I feel that he listens to what I say and respects my point of view".

We saw that patients had a drink accessible to them and if they were unable to eat or drink the reason for this had been explained to them. We observed that patients looked well cared for and when needed people were assisted to eat and drink. When we visited we found that people received the care they needed.

We saw that people had a staff call bell within reach. We asked them if they had needed to ring for staff and if staff gave them the assistance they needed. The majority of people we spoke with said that they had rung the bell for staff assistance during their stay. All but one person we spoke with said that when they had rung for assistance staff had come quickly and provided them with the assistance they needed.
We asked people during our inspection if they thought that staff treated them with respect and if their privacy and dignity were promoted. People confirmed they were treated with respect and their privacy was respected. One person told us: "I feel treated with dignity and respect. Whenever someone comes to talk to me they always pull the curtains around the bed so it's nice and private, I know people can hear what is being said but there is nothing to be done about that. The doctor explains in plain English what was wrong with me and what they proposed to do. I was told that I can wear my own clothes when I'm not in bed that makes me more comfortable". We observed that staff ensured people's dignity was maintained, drew the curtains around them and explained to the person what they wanted them to do and why. We saw that there were signs on the privacy curtains reminding people and staff to ask if it they may enter. We also observed an emergency situation and noted that the person's privacy and dignity were maintained at all times. This meant that people's privacy and dignity were respected and maintained.

We were told that there was a doctor within the accident and emergency department who had advanced life support training at all times. The provider may wish to note that we found there were very low numbers of nursing staff who had undertaken advanced life support training (seven staff) and even lower numbers of nursing staff who had undertaken advanced paediatric life support training (three staff). During the night whilst the department was closed medical support was provided by a junior doctor. However it is of concern that on occasions, whilst the department is closed to new admissions, people may arrive into the department by private transport and required immediate, life-saving, treatment without delay. This meant that there were times the provider did not have nurses on duty with this training.

The staff we spoke with were knowledgeable about people in their care. They told us that they assessed patients' medical and support needs and their risk of falls, pressure ulcers and nutrition. We saw that a nursing assessment booklet was available for each person whose records we looked at. However this assessment record was not always fully completed. It was evident from speaking to permanent ward staff they were informed about people's needs, but there was a risk that this may not be the situation if staff were unfamiliar with the ward or department. This meant that there was a risk that people may not consistently receive the care they needed.

Staff told us about actions which would be undertaken if people were identified to be at risk. Staff told us that if a patient was identified to have a pressure ulcer either at the time of their admission to hospital or during their stay a referral to a specialist would be made to minimise the risk of skin deterioration and to promote skin healing. People who had a pressure ulcer had records which showed that this had been undertaken.

We looked at the records of people who were identified to have pressure ulcers or who were at risk of developing pressure ulcers. We saw that the nursing assessment booklet identified a need for an additional care pathway to minimise further skin deterioration. A care pathway provides information for staff about the care needed for an identified need or risk such as the risk of sore skin or pressure ulcers. We saw that this additional care pathway was not consistently available despite the identified need. However we found that people had received the care they needed.

As part of this inspection we looked at the treatment and care provided for people who were elderly and may have dementia. The trust had told us they had a dementia project nurse who was raising the awareness of dementia care within the hospital. Staff we spoke with told us that they had received dementia awareness training. We observed that staff
provided reassurance and when needed reminded people to eat or that they had a hot drink. We saw one health care assistant reminding a person with dementia about their drink and helping them to hold their cup to enable them to have their drink. This meant that staff were knowledgeable and responsive to the needs of people with dementia.

People with dementia may have limited communication or understanding. It is important that staff have as much information as possible about people to ensure that they receive the treatment and care they need. If people have difficulties communicating or understanding this can be a challenge to staff to look after them and keep them safe. Information provided by the trust identified that they had developed a booklet called "About me" that was used to provide information about people who may have dementia.

The matron in the accident and emergency department told us when a person who may have dementia was admitted to the department they asked whoever accompanied them to complete the "About me" booklet. The "About me" booklet gave information about the person, their past medical and social history. This booklet when completed provided essential information about the person to enable staff to provide the care and treatment they needed in a way they preferred. We found that the majority of people whose care records we looked and had dementia did not have this booklet available. This meant that staff may not be fully informed about the person and may not provide the care they needed or wanted.

The hospital's accident and emergency department was consistently failing to meet national targets for admission to the hospital / discharge from the department. We reviewed the accident and emergency arrangements and spoke to staff about the challenges they faced to meet national targets. We were told that there were eight bed/trolley spaces for people who might be very ill and this was not sufficient to ensure that people were assessed and received timely treatment and care. We also found that due to increased demand on beds the hospital's "ambulatory care unit" was no longer available for use for people who could be discharged within 12 hours after receiving urgent treatment. The senior consultant for the department told us that these and other issues needed to be addressed to ensure that the hospital could provide timely assessment and when needed treatment for people.

A comparison is made between all hospitals in the country about the number of deaths that occur due to specific conditions, this is called mortality information. The mortality rate of this hospital compared favourably with other similar hospitals and conditions in the country.

Staff told us that the majority of children were seen within the Paediatric assessment unit, however some children were admitted via the accident and emergency department. Medical and nursing staff raised their concerns about the lack of facilities available for children in the accident and emergency department. We saw that there was a small separate waiting room with a small box of toys available for children. There was one separate consulting room but this was small and provided insufficient space for a trolley. The lack of space for a trolley meant that doctors were unable to examine and assess children who may need to lie down in this area.
Safeguarding people who use services from abuse  ✔ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

Before the inspection we were made aware of several incidents that had necessitated a safeguarding referral. We found that some but not all of these referrals had been made by staff within the hospital. We discussed these incidents with senior hospital staff before our inspection and were told about actions that had been taken. During our inspection we checked the actions that had been taken to ensure that people were fully protected from harm.

An organisation providing care or support to vulnerable people must make sure that staff know how to keep them safe. They must ensure that staff understand the signs of abuse and how to raise their concerns with the right person. All the staff we spoke with said that they had received training in safeguarding people which was updated annually. In addition staff who provided direct care to children had undertaken additional training of how to protect children. The staff we spoke with confirmed that they had undertaken this training. Staff were able to tell us about signs of abuse and actions they would take if they needed to raise concerns. This meant that staff knew how to protect patients from abuse or the risk of abuse.

Staff told us about "whistle blowing procedures". Permanent staff told us that they were able to either tell senior staff verbally about their concerns or complete an electronic incident form. Staff provided examples of incident notifications they had made, which had included people who had pressure ulcers or had fallen. We were also told that staff completed incident reports if they felt that people were at risk of harm due to inadequate staffing levels. We were told that this notification was immediately sent to the ward manager and when needed, an advisor such as a falls specialist or tissue viability nurse specialist would also visit the person. Staff confirmed that they received the support from specialists when needed and that actions were undertaken on an immediate basis to minimise any risk. We were told that a more detailed report was completed which may also make suggestions for improvements to reduce the risk of harm to patients. This enabled the hospital to learn from incidents and reduce the risk of similar incidents in the future.

The management of the hospital told us that staff were informed of the outcome of the
concerns they had raised. Staff we spoke with mainly confirmed this. We were told that where causative factors were poor staff practice which had resulted in disciplinary action only the lessons to be learned were shared. The staff we spoke with were confident that their concerns would be investigated and when necessary improvements would be identified and addressed.

Staff we spoke with told us that if people required one to one care because they had behaviour that may challenge, this support was provided by an agency staff member who had received additional training in the management of violence and aggression. One staff member said that they felt this support could be better provided by their own staff who had this training. We discussed this with the chief executive and management team who assured us that this would be further explored.

Staff we spoke with were able to tell us about actions they had taken when people lacked the capacity to make safe or appropriate decisions. Staff told us that when required they had used advocacy services or had requested support for the person from an Independent Mental Capacity Advocate (IMCA). The IMCA service was established by the Mental Capacity Act 2005 to help particularly vulnerable people who lacked capacity to make serious medical decisions. We found that appropriate arrangements were in place to ensure that care and treatment was provided in people's best interests.
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

The trust that managed the hospital told us and other relevant bodies before our inspection, about difficulties they were having to recruit and retain both medical and nursing staff. The trust told us that they were particularly concerned about the loss of senior nursing staff who were able to take charge of a ward. The trust management told us that risks had increased as the loss of staff was continuing. At the same time there was increased demand on hospital beds due to illness that usually increased during the winter sometimes referred to as winter pressures.

The trust told us that problems recruiting and retaining staff were due to adverse media attention and uncertainty about the trust's and hospital's future. The trust management told us about actions they were taking to reduce risks to people; this included a reduction in overall number of available beds in the hospital, a stop of elective surgery throughout the trust, requests made for nurses and doctors from other trusts.

The trust management told us that to reduce the risks to people who used the service they had ensured that only experienced staff, employed or seconded to the trust from other hospitals, were in charge of wards and departments. The trust told us that they reviewed the skill mix of permanent, bank and temporary agency staff on a daily basis. The trust told us this had resulted in staff frequently changing their shifts and days off at short notice and had also required them to work on different wards to address any shortfalls. The trust management spoke highly and praised their staff for their support during what had been a very difficult time and their commitment to patient care.

During this inspection we asked staff about staffing difficulties within the trust and checked if or what impact they identified on people's care.

We spoke to a total of 44 clinical staff which included nurses both trained and untrained, doctors and a volunteer. Staff we spoke with agreed that the recent weeks had been difficult; covering shifts and providing care to people with different needs than their wards usually treated, such as medical rather than surgical patients. Several staff told us about their commitment to patients' care as well as challenges for the future. Several staff told us: "We always put patients first". One staff nurse said: "Yes the patients have different needs but we are all nurses and here to ensure they are well looked after".
In the accident and emergency department we spoke with six members of nursing staff, two healthcare support workers and three doctors. We were told by the matron and senior nurses in the accident and emergency department that there was still a high vacancy rate amongst nurses. Some nursing staff told us about their dissatisfaction with working arrangements and shift patterns, although they told us this was being reviewed. We were told that these vacancies were covered by nurses from an agency. In order to maintain stability within the workforce the senior nursing team told us that they used the same agency nurses regularly. We were told that this reduced the risk associated with staff being unaware of the department's policies and procedures.

We were told that the accident and emergency department had recently been supported by staff from the University Hospital of North Staffordshire (UHNS) and was currently being managed by a consultant employed by UHNS. The consultant was positive about forthcoming changes which would enable greater joint working of staff between both hospitals which would enhance people's care on both hospital sites. The vast majority of staff felt satisfied with their working environment and all told us that the standard of care they were able to provide was improving as a result of the changes made throughout the organisation.

As we spoke with staff in different wards and departments we found that not all areas had the same difficulties in recruiting and retaining staff. The matron for critical care told us that they had recently successfully recruited having a choice of "strong candidates". The matron told us that they never used agency staff and they had a committed team who when needed covered any absences between them. The matron told us that they believed this was due to: "Excellent training opportunities they provided". The ward managers for the paediatric unit and surgical day case unit also told us that their departments were fully staffed. Three nurses that we spoke with in the critical care and paediatric departments told us that they had come to work at the hospital within the last year. The nurses told us that they had made a positive choice to work in the department; felt supported and had excellent training opportunities. One nurse said: "My children were both on the ward and I knew I wanted to work here".

The trust had told us that a response to their requests for experienced nursing staff from other hospitals had been successful. Senior management told us that during the week of our inspection 22 experienced nurses had come to work or had agreed to work at the hospital from other trusts. We spoke with some of these nurses. Nurses we spoke with told us that they had been made to feel welcome by the trust and its staff. The Chief Executive of the trust told us that even with the additional nurses staffing difficulties would continue to worsen and this could only be addressed with a clear decision and direction of all specialisms to their receiving trusts.

People we spoke with during this inspection spoke favourably about the staff. One person told us: "Staff have been kind and considerate. The nurses are really busy but stop and talk to me if I have any concerns". Another person said: "The staff in this hospital are gentle and caring nothing like what people say happens in here that's just bad rumours".
Assessing and monitoring the quality of service provision

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

Our judgement

The provider was meeting this standard.

Systems were in place to monitor and assess all aspects of care and service delivered.

Reasons for our judgement

As part of our inspection we reviewed how the trust's system to monitor and check the quality of the service it provided. The trust used a system of 'dashboards' (a dashboard is a visual display which demonstrates the results of monitoring several aspects of people's care or safety such as the incidence of falls, pressure ulcers and infections). We also reviewed how the trust had responded to incidents and complaints. The trust had a five point quality vision which was shared widely in the main thoroughfares throughout the hospital.

Two of these quality initiatives were: "To see zero harm as our target by keeping patients safe", and "Listening, responding and acting on what our patients and community are telling us".

The trust had suitable systems to manage its clinical audits and planned to meet national and commissioner requirements through this process. We could see what progress the trust had made and what action they were taking to ensure that they audited key areas in a timely manner. The trust undertook monthly infection control monitoring and identified issues where it needed to work in partnership with the wider healthcare community. It also developed plans to address issues it had identified internally and we saw evidence that these areas were monitored and reviewed. For example the actions taken to reduce the incidence of clostridium difficile were refreshed following a recent episode. A dedicated plan was put in place to address and minimise the risk of further infection. This meant that the hospital had taken suitable steps to protect people within the hospital and wider community from the risks associated with infection. We saw that there was a nursing quality, safety and patient experience dashboard for all areas excepting the operating theatres. This dashboard was supported with suitable action plans to manage actions required on a monthly basis. Matrons and ward managers were aware of this dashboard and knew what actions they were required to implement for their specific areas. This meant that there were systems in place to regularly review and when needed take appropriate actions to ensure that quality care was provided.

The trust may like to consider that operating theatres are a high risk area and that including this area in quality monitoring would support their quality initiatives. We asked...
the Deputy Director of Nursing about monitoring in theatres. We were told that the only indicator at the moment is the World Health Organisation (WHO) check. WHO checks are mandatory checks undertaken to confirm the safety of people requiring a surgical operation. From an internal audit carried out within the current financial year; WHO checks were carried out appropriately. This was corroborated as we observed suitably completed WHO checks within patients’ notes on surgical wards. The organisation may wish to review the frequency of this audit for quality monitoring purposes. This would support their quality initiative to support people’s safety.

We saw evidence that the trust now had all medically trained consultants involved in a review process following the death of any patient. Although the reviews identified all areas which required improvement, we found inconsistencies in the way these improvements were recorded. For example several reviews identified note keeping required improvement, however some reviews only made the comment; whilst others included this as an action required. We saw that ‘cause of death’ and being specific about this had been reviewed with clear learning outcomes for consultants and their teams. We saw evidence that the Medical Director continued to take suitable steps to monitor this effectively. We saw that there were plans to further improve the process and where lessons to be learnt were recorded. We were told that the trust had not yet developed a dedicated template for these reviews.

We saw that the organisation had a clear accountability and reporting structure. Staff we spoke with knew how to report incidents and concerns. Permanent staff had access to the electronic systems for reporting concerns or incidents. Temporary staff had to ask a member of permanent staff to do this for them. We found that staff did not always record when they were reporting for another member of staff on the system. This meant that there was not a clear auditable time line of events.

We saw that the time the incident/or concern took place was recorded however; there was no auditable track of how and when an event was reviewed. This meant that if further information required the incident or concern to be re-graded as more serious that it was not possible to follow when this had happened or who carried out the review. We discussed these problems with the executive team at the end of the inspection. The Chief Executive and Medical Director told us they would look at how they could improve this.

We reviewed 12 complaints which were either still in progress or completed. We found that the trust offered translation services to meet the needs of people whose first language was not English during the resolution of the complaint. We also saw that audio recordings were offered to people who required them. This meant that the Trust had taken suitable steps to support the equality and diversity of people who used the service and supported peoples' human rights. We followed one complaint in which the complainant had taken the opportunity to say that they were unhappy with the first response. We saw that the trust responded appropriately to the person’s concerns and that they took suitable steps to ensure that they had resolved the complaint to the complainant's satisfaction. The Trust had taken steps to improve their response time to complaints. The process and timescales were explained in a leaflet sent out to people with an acknowledgment of their complaint.

We saw that PALS (Patient Advice and Liaison Services) was situated in the main reception area of the hospital. However, there were no prompts within the thoroughfares and communal areas of the hospital about how to raise a concern or complaint. We saw that there was a board for capturing people’s views in the main corridor outside reception. We found that this board was no longer updated and were told by a member of the patient
experience team that this was no longer in use. We discussed this with the executive team at the end of the inspection. The Chief Executive told us that they would do whatever was required to ensure people could see what actions the trust had taken as a result of their comments.

Within the clinical areas there were blue wall mounted ‘comment’ boxes. Although there were comments cards provided these were not always readily available for people to fill in. It was not made clear on either the comment card or the patient experience leaflet that either of these could be filled in as a complaints form. We looked for but could not find a complaints form. This meant that people were not given enough information about how to complain should they have a complaint. The Chief Executive told us that this was already being addressed and that improved information about how to make complaints or raise concerns was being made available.

We also spoke with the Chief Executive of Health Watch Staffordshire. The chief executive told us that they had been asked by the hospital management to look at people’s satisfaction with the hospital and the care provided. Health Watch had found that the hospital’s management to be open and had responded positively to concerns and complaints raised. The chief executive said they were continuing to monitor complaints received against the hospital but the number of complaints had not increased in recent months whilst there was increased staff shortage. This meant that people’s views about their care were listened to and considered with respect.

We had concerns about the way in which complaints that were about serious incidents were managed. We looked for but could not find an auditable process which showed how a complaint would be reviewed and regarded as a serious incident. We could not find evidence that the trust always knew about an incident before a complaint was made.

We reviewed 50 incidents which included serious incidents and never events (a never event is an incident which should never occur if all suitable safety checks are in place). We found that we could not follow an audit trail for the change in grade or status of an event (which would be expected as a result of further information becoming available). A member of the incident management team demonstrated to us how the system should work. It was unclear how a final risk rating for each incident had been calculated as some final ratings were not commensurate with the event. This meant that there was a risk that a serious incident could be viewed as less serious. This could prevent effective lessons being learned and shared in order to reduce the risk of a repeat event.

We found that the trust followed best practice guidelines for the root cause analysis (RCA) for each incident. The Trust reviewed patient records and established a timeline of events. However, there were a number of statements within these root cause analyses which identified that a root cause had not been found. This meant that the Trust had not used additional RCA tools to further determine the causes. This could lead to a recurrence of the event or the prevention of trust’s wider learning from a serious incident. We discussed this with the executive team at the end of the inspection and they told us they were committed to making further improvements to this important aspect of their safety culture. We will continue to monitor incidents and those that are presented to the trust as complaints at future inspections.

Staff we spoke with in clinical areas confirmed that they knew about incidents elsewhere in the hospital and that lessons learnt were shared widely. This meant that the hospital was taking steps to keep patients safe. We saw that the trust had systems and policies in place
to be open with people who had suffered any degree of harm. This included meeting with people and sharing the findings of investigations in an open and inclusive manner. This meant that when things had gone wrong the trust had told people what had happened and why as well as what they would do to put things right.
Records

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

Our judgement

The provider was not meeting this standard.

People were not adequately protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

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

The essential standards of quality and safety require that people’s records including medical records are accurate, fit for purpose, held securely and remain confidential. Other records required to be kept to protect people's safety and wellbeing are maintained and held securely where required.

We found that people's medical records were kept securely in locked trolleys or cupboards when not in use. Staff explained that people's main medical records were available on the ward or in the department for them to refer to when needed and also separate medical records for their current hospital admission. We were told the reason why the medical notes were separate was that previously medical notes were untidy and sometimes incomplete. We were told that when the person was discharged all records were filed in the main file to ensure their availability in the future. Nursing staff we spoke with assured us that they had all required information available about people and their medical history. One doctor whom we spoke with said that a review of the availability and completion of medical records was being undertaken to ensure they were appropriate and fit for purpose. This is important because the availability of accurate information protects people against the risk or receiving unsafe or inappropriate care.

We saw that records of the nursing care provided were kept at the bottom of the person's bed. These records included an assessment of the care the person needed and confirmation of the care provided. We saw that these records were not consistently completed throughout the hospital and sometimes information was missing from the records we looked at. We saw that there were records of when a person had their position changed. However this was not undertaken consistently. We saw that records of when a person’s position was changed were recorded on a 'turn' / 'change of position' chart or on a 'comfort check' chart. It was also sometimes difficult to see the frequency the person should have their position changed. This meant that records in place did not protect people from receiving unsafe or inappropriate care or support.

We saw that staff recorded what people's intake such as what they had to eat and drink...
and any output. We were able to see that staff checked with people what they had eaten and accurate records were maintained. We saw that when records indicated a person's intake or output were of concern appropriate medical or nursing actions were taken in response to these concerns.

One person whose care records we looked at showed that they had received 'mouth care' or 'oral care'. The ward sister explained actions that staff were taking to ensure that the person's mouth was clean and their health was maintained. We did not see any record of instructions to direct staff about the frequency that the person should have care to ensure their mouth was clean and that they also required protective petroleum jelly to be applied to their lips. The availability of this information would provide greater assurance that staff were aware of the person's needs to maintain their health and wellbeing.

The Health and Safety Executive had visited the hospital in November 2013 and required that improvements were made to the completion and review of people's records. The Health and Safety Executive had also required that improvement was made to communicate information about people's care needs and any risks to their health and welfare.

Staff told us that they always had verbal handover about people before they were transferred to the ward or department. Staff told us that the handover sometimes took place over the phone or at the time of the person's transfer to their ward or department. It is important that the person's new ward or department is fully informed about their needs, previous history and any risks to their welfare such as a risk of falls. We saw that in addition to the verbal handover there was usually a record of the handover given. Handover records were inconsistently used throughout the hospital. We saw examples of when no information was received about a person on the handover records and other examples when this information was incomplete. One handover record we saw only had the person's name recorded. Senior management staff told us that they were piloting the use of one handover sheet. The use of one handover record which was accurately completed would provide greater assurance that people would be protected against the risk of unsafe or inappropriate care when they moved to a new ward or department.
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.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td></td>
<td>Records</td>
</tr>
<tr>
<td></td>
<td><strong>How the regulation was not being met:</strong></td>
</tr>
<tr>
<td></td>
<td>The registered provider had not ensured that people were protected against the risks or unsafe or inappropriate care and treatment because accurate records about them and the care they needed and had received were not available (Regulation 20(1)(a)).</td>
</tr>
</tbody>
</table>

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 2014.

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.
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:

<table>
<thead>
<tr>
<th>Essential Standard</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>17</td>
</tr>
<tr>
<td>Consent to care and treatment</td>
<td>18</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>9</td>
</tr>
<tr>
<td>Meeting Nutritional Needs</td>
<td>14</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>24</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>11</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>12</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>13</td>
</tr>
<tr>
<td>Safety and suitability of premises</td>
<td>15</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment</td>
<td>16</td>
</tr>
<tr>
<td>Requirements relating to workers</td>
<td>21</td>
</tr>
<tr>
<td>Staffing</td>
<td>22</td>
</tr>
<tr>
<td>Supporting Staff</td>
<td>23</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>10</td>
</tr>
<tr>
<td>Complaints</td>
<td>19</td>
</tr>
<tr>
<td>Records</td>
<td>20</td>
</tr>
</tbody>
</table>

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.
<table>
<thead>
<tr>
<th>Phone:</th>
<th>03000 616161</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email:</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
</tr>
<tr>
<td>Write to us at:</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td></td>
<td>Citygate</td>
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<td>Gallowgate</td>
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<td>Newcastle upon Tyne</td>
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<td>NE1 4PA</td>
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<tr>
<td>Website:</td>
<td><a href="http://www.cqc.org.uk">www.cqc.org.uk</a></td>
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</table>

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