Mid Staffordshire NHS Foundation Trust  
Stafford Hospital

| Region: | West Midlands |
| Location address: | Weston Road  
Stafford  
Staffordshire  
ST16 3SA |
| Type of service: | Acute services with overnight beds |
| Date of Publication: | November 2011 |

**Overview of the service:**
Mid Staffordshire NHS Foundation Trust is the main provider of acute emergency & planned general hospital services, community midwifery and paediatric services in and around South Staffordshire. The trust operates from two main hospital sites. Stafford Hospital has 360 in patient beds and the main accident and emergency department for the area. Cannock Chase Hospital has 98 inpatient beds.
and a minor injuries unit which is open from 8am to 12 midnight.
Our current overall judgement

Stafford Hospital 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 to check whether Stafford Hospital had made improvements in relation to:

Outcome 13 - Staffing

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 12 October 2011, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

We visited the accident and emergency department (A & E) in September 2011. At that inspection we identified a shortage of nurses and in particular we were concerned about the trust’s contingency arrangements when staff were absent in an emergency. We were also concerned that some of the nurses working in the department didn’t have the skills and experience needed to work in A & E. As a result of our concerns we had given the trust until 4 October 2011 to address our concerns and as such become compliant with the regulations.

We re-visited the A & E department on three occasions for this review, 17, 18 and 19 October 2011 to see what action had been taken and to make sure that the trust was now compliant.

We involve people who use services and family carers to help us improve the way we inspect and write our inspection reports. Because of their unique knowledge and experience of using health and care services, we have called them experts by experience. Our experts by experience are people of all ages, from diverse cultural backgrounds who have used a range of health and/or social care services.

An expert by experience took part in this inspection and talked to the people who used the service and their relatives. They looked at what happened in the A & E waiting room and what it was like to be a patient. They took some notes and wrote a report about what they found and details were included in this report.
To help us to understand the experiences people have we used our SOFI (Short Observational Framework for Inspection) tool at this review. The SOFI tool allows us to spend time watching what is going on in a service and helps us to record the type of care they get and whether they have positive experiences. Some people using the service were able to tell us about their experiences in A & E and this is included in the report.

We were supported at this review by the CQC nurse advisor who interviewed patients and staff and reviewed relevant information and documents.

Several patients and their relatives told us that their visit to A & E had been a good experience. They told us, "The staff have been very attentive and kind. We haven't had to wait very long to be seen and we have been told the plan of care." One person we spoke with was very anxious about their relative and unhappy about the care they had received. The senior staff in the department dealt with the situation, reassuring them and resolving the issue immediately.

One patient told us that they had been in the hospital a few times and each time felt that the care was very good. They told us, "Even though the staff are very busy, they have told me what is happening, asked if I am in pain and got me a drink. They all seem very professional."

All of the staff spoken with told us of the improvements made by the trust since our last visit. They now know that they can use agency staff to cover shifts and the bank of staff has been expanded. Work is being undertaken to ensure that the staff have the skills and competencies to work in the A & E department. The trust is looking to implement permanent systems which will provide long-term solutions. This includes new ways of working and addressing staff absenteeism at its root cause.

What we found about the standards we reviewed and how well Stafford Hospital was meeting them

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

Improvements have been made and must be continued to ensure that people’s health and welfare needs are met by sufficient numbers of staff with the right knowledge, experience and skills.

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 found that improvements were needed for the following essential standards:

- Outcome 09: People should be given the medicines they need when they need them, and in a safe way

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

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 13: Staffing

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 sufficient numbers of appropriate staff.

What we found

Our judgement
There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People in the waiting room told the expert by experience (ex by ex) that they had received good attention from the staff since booking into the Accident and Emergency Department (A & E). The ex by ex spoke to eleven people in the waiting room.
One person told us they were very happy with the attitude and professionalism of staff and assured us that if they had any questions they would see the receptionist.
The relative of a patient brought in by ambulance was full of praise for the staff and doctors. They told us "This hospital has been wonderful to me for the past year." They went on to tell us that when they had asked for any assistance in whatever way they had found staff to be professional, attentive and polite to them both.

It was felt by some patients that the A&E process could be explained to each individual. All the patients that we spoke with had an understanding of why the posted waiting time was two hours and not one person had any complaints about the staff or the A&E process.
One person had waited twenty minutes to see the nurse and whilst the process had not been explained, they were quite happy with the service and assured us that they felt able to speak with the receptionist if they wanted further information.

Several patients and their relatives spoke positively about their experience in the emergency department. One person told us, "The staff have been wonderful, I can not fault them. They are busy but they have looked after me." A patient's relative said, "It's good here, you can't fault them."
We saw staff talking to patients and explaining their treatment to them. One patient said, "The doctors and nurses told me what is happening and why I needed to stay in overnight. They have arranged for me to go into a home for a few days, I am not happy about it but I understand why."

As part of this inspection we completed a short observational framework inspection (SOFI). This helps us understand the experiences of people who are unable to tell us themselves and who are most likely to have the greatest care needs. It allows us to get an insight into the general state of well-being of individuals and staff interaction with people who use the service during the observation. During the SOFI in the observation unit one member of staff was seen relaying messages from telephone calls to the patients, offering drinks and asking for preferences and permission to carry out nursing tasks. Some staff were heard explaining to a patient what would happen when they went up to ward. A porter talked to a patient whilst waiting for a second person's assistance; he explained where they were going and made sure the patient was comfortable and at ease.

We saw staff sit next to a patient gently telling the person what they needed to do and giving reassurance. One family did have to ask for a commode three times before one was given to the patient who had arrived in an ambulance. We saw a call button being placed in a patient's hand before the staff left their side and the curtains closed. We saw the curtains being closed when the patients were attended to and staff waiting to enter when entering them.

Other evidence
We visited the A & E department in September 2011. At that inspection we had identified a shortage of nurses on shift and in particular we were concerned about the trust's contingency arrangements when staff were absent in an emergency. We were also concerned that some of the nurses working in the department didn't have the skills and experience needed to work in A & E. As a result of our concerns we had given the trust until 4 October 2011 to address our concerns and as such become compliant with the regulations.

We re-visited the A & E department on three occasions for this review, to see what action had been taken and to make sure that the trust was now compliant.

All of the staff that we spoke with, of varying roles and grades were able to tell us of the improvements made by the trust since we had last visited. We were told that they now knew that they could use agency staff if they needed to cover sickness and that this had happened. We were also told that the trust had increased its bank of staff, by encouraging the permanent staff to become a member of the bank. We saw rotas, which confirmed this.

Some staff told us they felt they had enough nursing staff working in the department while others felt the staffing levels were not adequate. All of the staff we talked to knew there was going to be a change in shift patterns so that staffing levels across the shifts would be increased. Some staff told us they welcomed the changes which would mean that all nursing staff would start and end their shift at the same time. One person said, "It makes sense for us all to start together." Staff were fully aware of the intended changes to the department and discussions with senior managers and human resources staff were being undertaken. The trust provided us with a copy of their...
workforce development plan for the department.

We evidenced that not all patients received care and treatment quickly during the evening shift but as the night staff came on duty the department started to gradually settle down. By the early hours of the morning the patients in the observation unit had settled down to sleep. There was only one qualified nurse for this area which meant the five patients could not all be observed. Staff raised some concern about the staffing levels in the observation unit and one person said, "It is hard to cover this unit when it is full if you are on your own. I can get help if I need it but I have to leave the patients to go and find someone to come and help me." We saw there was also a healthcare assistant available to the observation unit but they were also working in other areas. Staff told us it was unusually busy; "It's very busy tonight; it's not normally this bad."

A doctor told us there was a consultant on call and said they could call the consultant in if it was getting too busy. Despite the shift being very busy, they had not needed to call the consultant into the department. We saw the Director of Quality & Patient Experience, a qualified nurse working in the department, in recognition of the shift being very busy. This person said, "I try to support the staff as much as I can and they needed my help here tonight." We were told that there were escalation plans in place to inform executive directors when the department was very busy, however the staff were not clear who instigated the plan and how it was managed.

During our day time visit to the department it appeared to be well organised and staff knew what was happening with the patients they were looking after. We talked to one patient who said, "I didn't wait long to be seen, as soon as I arrived they sorted me out."

We were told that work had commenced to identify and eliminate the causes of staff absenteeism. A new absenteeism policy had been introduced and cascaded to managers and staff. It was hoped that this would get down to the root cause and create a permanent solution.

The occupational health team had worked closely with the emergency department's manager to offer support to staff that were not at work. We were told that the occupational health team had offered to run support sessions for the emergency department staff but these had not been required.

We were told and saw evidence of a newly implemented training programme for nursing
staff within the department. The trust's practice development team were now working in the department observing staff practices and checking their competency. Nurses were being trained and shown how to do tasks needed in an A & E department. On the last day of our inspection manual handling training was to be delivered to the last seven staff needing it. Nurses and health care assistants welcomed the new training initiative. They told us they thought it was a good programme and were pleased it had commenced. Further training was planned in weekly sessions, which would be ongoing and ensure the appropriate competency of staff be achieved and then maintained within the department.

Doctors told us they could usually attend their weekly planned training sessions. One doctor said; "By and large I feel supported here." Some doctors told us they felt some of the skills of the nurses varied. One doctor said, "Not all of the nurses have the right level of skill for an emergency department, but we are addressing this and it's getting better." Doctors and nurses told us they felt the department was safe for patients.

We talked to doctors working in the department and they told us they got their breaks. A consultant in the department said the doctors always received a break but recognised this was harder during night shifts. Nursing staff told us they did not always get a break but we were also told that some staff preferred to go without a break so they could finish their shift earlier. We spoke with three staff during one of our visits who had not received a break during their shift. One member of staff told us, "No one has mentioned when I can have a break, I would like one but I don't think I will get one as we are too busy." We did not see evidence of the nurse in charge of the shift coordinating breaks for the nursing staff. We discussed this with the trust during our feedback.

The trust was monitoring the patient experience in the A & E department. A senior clinical nurse manager had been into the department to observe for an hour; they looked at ten sets of records and talked to staff and the manager. The main aim of the visit was to look at the essence of care, dignity and the support of people with dementia. They also observed how staff addressed people, used single sex bays, privacy issues and the use of dignity screens. They told us they had spoken to patients and received positive feedback and only identified one concern. This was to ensure that staff should promote confidentiality by finding an appropriate place for the handover of patients.

When we visited at night time we found it to be very busy. A total of sixty patients had attended the department between the hours of 4 to 11pm. Staff told us it was unusually busy and far above their predicted number of patients. We looked at the records of one patient who arrived in the department and we were concerned about their care and treatment since being admitted. We raised this concern with a senior member of staff and this was addressed immediately. We followed up this patient's care the following day and found that they had received appropriate care and assistance overnight. Another patient's records did not show what fluids or food had been given to them whilst in the department and when this was highlighted to the nurse looking after this group of patients, again this was addressed immediately. We discussed these incidents with the trust at our feedback.

The trust had made significant improvements in a relatively short period of time towards
full compliance of this regulation. We were assured that the systems introduced once embedded should provide permanent solutions and improvement to the sufficiency and quality of nursing staff employed in the A & E department. As such we have lowered our level of concern, although a compliance action is issued, which requires the trust to continue the work they have commenced to meet full compliance.

**Our judgement**
Improvements have been made and must be continued to ensure that people’s health and welfare needs are met by sufficient numbers of staff with the right knowledge, experience and skills.
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.

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<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
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**How the regulation is not being met:**
Improvements have been made and must be continued to ensure that people's health and welfare needs are met by sufficient numbers of staff with the right knowledge, experience and skills.

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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