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

Diana Princess of Wales Hospital

Scartho Road, Grimsby, DN33 2BA
Tel: 01472874111

Date of Inspections: 14 February 2013
12 February 2013
Date of Publication: May 2013

We inspected the following standards as part of a routine inspection. This is what we found:

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### Details about this location

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<th>Registered Provider</th>
<th>Northern Lincolnshire and Goole Hospitals NHS Foundation Trust</th>
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<td>Overview of the service</td>
<td>Diana Princess of Wales Hospital is part of Northern Lincolnshire and Goole NHS Foundation Trust serving the population of North East Lincolnshire and surrounding area. The hospital has around 430 beds with an accident and emergency department. There are good transport links with Scunthorpe, Hull and Doncaster and ample car parking.</td>
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<tr>
<td>Type of services</td>
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<td>Regulated activities</td>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Nursing care Personal care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury</td>
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When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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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 12 February 2013 and 14 February 2013, 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 local groups of people in the community or voluntary sector, talked with other authorities and 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

The inspection visit focussed on how care and treatment was delivered to people who had suffered a stroke. We visited the accident and emergency department (A&E), the acute medical unit (AMU), the stroke unit and a new four-bedded stroke rehabilitation care unit.

Patients were provided with information about their care and treatment and told us they were treated with respect. Comments included, "The doctors have told me everything" and "They always treated me with dignity."

Patients we spoke with told us they were happy with the treatment they had received on the stroke unit. We found that the acute phase of treatment was managed in a timely way. However, we had concerns with some aspects of ongoing care and treatment.

We found the trust worked in cooperation with other providers to enhance patient care.

We found the trust employed sufficient staff although staff deployment and bed management affected work pressures.

Not all staff had received mandatory training. There was limited formal staff supervision and not all staff we spoke with had received appropriate development and appraisal.

We found that some elements of patient's records did not have full information in order to audit the care they had received. There were also instances when records were not held securely.
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 13 June 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

More information about the provider

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

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Inspection Report  |  Diana Princess of Wales Hospital  |  May 2013  |  www.cqc.org.uk

Our judgements for each standard inspected

Respecting and involving people who use services  ✔ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

Patient’s privacy, dignity and independence were respected. Patient’s views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

We spoke to patients on the acute medical unit (AMU), stroke unit and the stroke rehabilitation care unit. We found that patients who used the service understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.

Patients confirmed that nursing and medical staff explained treatment options to them. One patient told us they had been fearful regarding an investigation they were to have and staff tried to allay their fears. They said, “They have even sent a nurse who has had the same investigation to tell me all about it. I am still a bit frightened but now I understand more and the staff will be with me.” A patient receiving treatment in the stroke rehabilitation care unit said, “The doctors have told me everything. They have been very good. The nurses have been brilliant and I have had a good experience here.”

All patients spoken with said staff treated them with respect and they felt fully informed and involved in their care. Comments included, “The doctor has been this morning and explained the results but I’m not sure what is happening next”, “They asked how I like to be called” and “They always treated me with dignity. They keep me warm and never leave me alone in the bathroom without checking I am OK. I always feel safe.”

Patients expressed their views and were involved in making decisions about their care and treatment. They told us they were involved in their discharge plans to go home. One patient said, “I started ‘physio’ upstairs on the stroke ward and they continue it here. It’s the same with occupational therapy – I have been home and made a cup of tea. It won’t be long before I am home.” Patients were provided with information about meals and the daily menu so they could make choices.

Each patient had a bedside locker for storage of their personal belongings which included a lockable cupboard.
All patients were accommodated in single sex bays or single rooms. Data from the trust incident reporting system showed low rates of mixed sex accommodation.

The trust had a range of information leaflets available about conditions that could affect people and these were located on the wards. The stroke unit had notice boards with information about stroke, how it affected people and the treatment available. The information was bright, colourful and easy to read. There was information about the whole staff team and their roles on the unit.

During examination of records we found that patients were provided with information about treatment options. It was recorded that consent to treatment had been given at various stages. For example, prior to thrombolysis treatment (used to dissolve clots) and prior to physiotherapy. We found that discussions had taken place with relatives when important decisions were required for patients and they lacked capacity to make their own decisions.

Staff told us they made every effort to ensure that patients were involved in their care and treatment. They said they explained procedures to people and checked out their understanding of the information. We observed staff speaking to people in a friendly and professional way.
Care and welfare of people who use services  

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

Our judgement

The provider was not meeting this standard.

Patients did not consistently experience care, treatment and support that met their needs and protected their rights.

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

Reasons for our judgement

In the last four years the trust, which operates three hospital sites including this one, has had four episodes when the mortality figures for patients who experienced a stroke were higher than national figures expected. To address these concerns the trust developed a 'stroke pathway' which detailed how people who had suffered a stroke would be cared for and treated. The stroke pathway was in line with the National Institute for Health and Clinical Excellence (NICE) quality standards. This was to ensure patient's care and treatment reflected relevant research and guidance and incorporated targets and checklists for staff to adhere to.

During discussions with a broad range of trust staff we found that they were very patient focussed and wanted to provide the best care and treatment possible for patients. During a check of patient's records we found that when patients were acutely ill with a stroke they received an assessment and treatment in a timely way. In the records we checked, we found that in most cases the timescales contained in the NICE guidelines for patients to receive specific assessments and investigations were met although we found some concerns with ongoing care and treatment for some patients.

During a check of eight patient records on the stroke unit and the stroke rehabilitation care unit we found an inconsistency in recording and we were unable to note that full care had taken place for some patients. In one case we found that the patient had not had access to previously prescribed medicines and this may have impacted on a pre-existing medical condition. We also found the patient had been seen by a dietician who requested their weight be recorded, 'as soon as possible'. However, three days later the dietician noted the patient's weight had not been recorded. Nutritional intake recording was blank for most of these three days.

In some cases there was a lack of evidence that care and treatment was planned. In one patient's nursing notes, there was a care plan for personal hygiene and monitoring of pressure areas but no plans for other areas of need. For example, at one stage of their
treatment the speech and language therapist gave advice on the texture of food and fluids they should receive and later the patient received their nutrition via a nasogastric tube. There was no care plan for these nutritional needs. The recording of the patient's fluid balance was inconsistent and there was evidence that a sore area deteriorated following a lack of pressure relief. Nursing staff had recorded in the patient's notes that staff had not been made aware the patient was nil by mouth due to swallowing difficulties and had given them a meal to eat. This could have posed a serious risk to the patient's health. The therapist had written this in the multidisciplinary notes but it was unclear if this had been handed over from one shift to the next. In discussion with staff we were told a similar incident had occurred with another patient.

We were told by some staff that pressures of work had led to shortfalls in basic care and this had caused them concern. They gave examples such as correct positioning of a patient in bed and in a chair, oral hygiene, recording of care and ensuring patients ate their meals.

We found that due to a shortage of beds at specific times, patients were not always admitted to their speciality ward. For example, the stroke unit had 21 beds, 18 were for patients who had suffered a stroke. However, we were told a number of admissions were non-stroke patients. This had an impact on transfer from A&E and the CQC specialist advisor felt this posed a potential risk to the stroke pathway through priority for beds and resources. Staff told us that the amount of movement of non-stroke patients onto the stroke ward and medical patients to non medical wards meant qualified nurses were not always focussed on nursing care.

Patients with medical conditions were occasionally placed on other wards not directly related to medicine, for example surgical wards. This meant that the ward may not have been assessed as suitable to meet their needs. One consultant told us there was not always ownership regarding the medical oversight of these patients. Another consultant told us the impact of assigning beds to medical patients in this way sometimes resulted in a lack of beds to accommodate planned operations on other wards, which in turn led to them being rearranged. They told us they had concerns that nurses did not have the specific skills and training to nurse medical patients on their ward.

In the A&E department, the two bays where triage took place to determine priority of need were adjacent to the external doors. As ambulance crews were arriving and departing the doors were frequently opened and we found the area to be cold. Also paramedics told us the area outside the doors where the ambulance crews docked was exposed to the elements and when it rained patients got wet during transfer between the ambulance and A&E. We checked this area and found there was no overhead cover.

We also noted a limited supply of A&E trolleys to transfer patients onto from the ambulance trolleys. We were told new trolleys had been ordered. Ambulance crews told us they were sometimes waiting over an hour to handover their patient to A&E staff which delayed their availability to answer other calls. Triage arrangements meant that patients could be waiting long periods of time on the ambulance trolley which was designed for transporting patients and could be a potential risk for older and frail patients. Information received from East Midlands Ambulance Service regarding pre-handover and turnaround times confirmed the extended waiting times for patients between arrival at A&E and handover to A&E staff. Following the inspection the trust told us they were to complete an observational audit during March to monitor handover times.

We looked at incident records and in some cases care provided did not ensure patient's
safety and welfare. For example in one week on the AMU, two confused patients left the hospital and were found on the main road, one confused patient was found outside the ward near the lifts, a patient fell on two occasions, there was a failure to isolate a patient previously known to be MRSA positive and a patient sustained a skin tear to their arm.

Although there were concerns with ongoing care and treatment for some patients, we found that patients received assessment and treatment from a range of therapy staff such a speech and language, physiotherapists, occupational therapist and dieticians.

The stroke pathway included how ambulance crews would alert A&E and how they in turn would alert the stroke unit staff so that emergency treatment such as thrombolysis could be completed in a timely way. We spoke with ambulance crews and staff in A&E who confirmed this occurred in practice. We found that patients admitted with a suspected stroke were transferred directly from A&E onto the stroke unit when their condition had stabilised.

We found specific documentation was used to record assessment and treatment when a diagnosis of stroke was made. Patients who met the criteria for thrombolysis treatment had medical information and frequent observations recorded in their record of care. The thrombolysis service had recently been extended and could occur between the hours of 9am and 8pm Monday to Friday and plans were well advanced for the introduction of 24hour 7 day thrombolysis from April 2013.

We saw there was documentation in place to assist staff in managing patients whose health may be deteriorating. This guided staff in the frequency of observations and a scoring system highlighted any concerns. This enabled the staff to review care practices and treatment. Staff spoken to said the documentation was a new monitoring tool, recently introduced, gave them clear guidance and enabled them to provide doctors with information which assisted them to prioritise work.

Patients spoken to were positive about the care they received on the stroke unit, the stroke rehabilitation care unit and the AMU. Comments included, "The nursing staff have been very accommodating", "I am awaiting the doctor this morning. They are getting me stabilised", "The nurses are very good and help me" and "I am having a lot of professional help from people and I'm getting stronger everyday."

A relative spoken with said, "I am delighted with the care she is receiving. It is all geared up for her." They also told us they had been involved in the therapy the person received and had been shown how to continue specific care once their relative was discharged home.
Cooperating with other providers

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

Patient's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

Patient's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others such as commissioners, GPs, ambulance services, residential and nursing homes and community services.

The North East Lincolnshire Clinical Commissioning Group and Care Trust Plus (CCG/CTP) is the lead commissioner for services provided by the trust. The CCG/CTP works in partnership with associate commissioners in North Lincolnshire, Lincolnshire, East Riding, Hull and Doncaster. Commissioners involved the trust in care pathways with other providers and their role is to monitor contracts regarding key performance indicators.

The local CCG commissioned a pilot scheme whereby GPs and home care teams worked within the A&E department to promote alternative care. This was an initiative to help to reduce the number of admissions to hospital, as community support services could be arranged for people as they needed them.

The trust had a protocol with East Midlands Ambulance Service. This was to ensure handover of patients took place within agreed targets so that ambulance crews could turnaround quickly and return to an on-call status. Ambulance crews were part of the trust's stoke pathway, as they completed an initial test for stroke and alerted the A&E team so they in turn could request the stroke team to meet the patient. This helped the patient receive timely assessment and treatment. There had been delays in handover and turnaround times for ambulance crews according to recent figures provided by the trust. Meetings had been arranged with East Midlands Ambulance Service to try to address this.

We found that on admission, ward staff on the stroke unit and acute medical unit (AMU) checked any shortfalls of information with relatives or care staff from residential and nursing homes. One care file we checked had an assessment and care plan from a nursing home, which enabled ward staff to see how the patient's health and welfare was on a day to day basis prior to admission.
The care records we checked on the stroke unit evidenced a multi-disciplinary approach to care and treatment. Review meetings were held to discuss a patient's progress and plan treatment, which enabled a range of professionals to express their views about options for treatment.

We found the hospital pharmacy team completed a medicines reconciliation exercise with patients' GPs to ensure they had correct information about medicines prescribed prior to admission. However, we were told by commissioners that this could be completed in a more timely way.

We found there were early supported discharge arrangements in place for stroke patients. Records of reviews showed that discharge planning took place with the involvement of the patient, relatives and other professionals. Medical staff told us they aimed to provide detailed discharge summaries that included input from therapy staff. We were told that patient's GPs received a discharge summary electronically and the patient received their own copy. The provider may find it useful to note that although the electronic version of discharge summary meant GPs received information quickly we were told by commissioners and a GP that the content was an area to be addressed.

There were discharge liaison nurses responsible for coordinating complex transfers or discharges of patients from hospital to home or to other trusts. There was also a continuing care coordinator to liaise with NHS commissioners when patients required fully funded health care on discharge. We observed social workers on the stroke wards assessing patients and liaising with staff about discharge arrangements. We also observed there was a fast track discharge pathway for patients who were entering an end of life phase and who had alternative preferred place of care than the hospital.

There had been instances when discharge planning had not gone as well as expected which had resulted in complaints made by families or care staff at residential and nursing homes. These had been investigated using the trust's complaints procedures. A discharge action plan to look at issues was part of governance monitoring.

The trust worked in partnership to provide services to people in the community, such as diagnostics, dementia care and rehabilitation therapy. There were different models of rehabilitation used, dependent on location. For example, there were four stroke rehabilitation care beds in the community hospital in Goole, Diana Princess of Wales Hospital (DPOW) had a four-bedded stroke rehabilitation care unit and therapy staff from Scunthorpe General Hospital and DPOW could visit people at home or in residential/nursing homes. We were told the patients on the stroke rehabilitation care unit at DPOW, although treated as inpatients and had medical cover for emergencies, had officially been discharged. It was unclear what this status meant for them in relation to consultant oversight and possible readmission if needed. The trust-wide discharge and transfer of care policy did not make reference to this.
**Staffing**

Met this standard

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

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**Our judgement**

The provider was meeting this standard.

There were sufficient staff employed by the trust to meet patient's needs. However, staff deployment and bed management had at times affected work pressures.

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**Reasons for our judgement**

We found the trust employed sufficient staff to meet patient's needs. The trust told us staffing on the stroke unit was fully established according to stroke accreditation guidance. The trust had recognised that patients admitted to wards were increasingly more acutely ill, which had led to an assessment of service needs and an increase in the numbers of nurses in ratio to healthcare assistants (HCAs).

The hospital had an electronic system where people in charge of shifts could input information about nursing staff shortfalls. This was centralised so attempts could be made to cover gaps with bank staff or movement of staff from other wards. Nursing staff rota gaps were sent in a block to the bank to fill a month in advance so there was an audit trail. A night coordinator completed a bulletin for matrons so they were aware of staffing issues throughout the hospital.

The provider may find it useful to note that although we found there was sufficient staff employed by the trust, the way beds were managed, the skill mix of staff and the way staff were deployed had caused an impact on pressures of work in some areas.

Staff told us the situation of moving non-stroke patients onto the stroke unit and medical patients to stay on non medical wards had an impact on patients, staff and general workload. Apart from the issue of patient/relative/staff relationship that had built up, staff said they spent a lot of their time completing non-nursing duties. Staff told us that patients were moved onto the ward to prevent a breach in A&E waiting times or to keep the flow of patients out of short stay assessment wards. Comments from staff included, "Staff work hard and are under pressure to manage beds – it eats into breaks." A consultant told us, "It is not good for patients, physicians or surgeons and we really need to sort it out."

Staff on the acute medical unit (AMU) told us they had staffing vacancies at present and relied on bank staff to fill the gaps. Staff told us the levels were safe but patients would benefit from being checked more often and offered drinks more frequently. They told us there was not always sufficient staff to sit with patients at the end of their life if relatives were not available.

The recently created four bedded, stroke rehabilitation care unit, was staffed by health
care assistants. However, nursing staff from the stroke unit administer medicines to these patients. They told us this took trained staff away from the stroke unit for half an hour, four times a day.

Staff told us the amount of newly qualified staff affected the skill mix on the ward and had the potential to impact on work pressures. For example, on weekdays during the day and up until 5pm, a specialist stroke nurse responded to emergencies in A&E. However, this was different after 5pm and at weekends. Staff said because of the skill mix of nurses, sometimes there was only one nurse on the ward qualified to administer medicines or attend A&E in an emergency. If this occurred the stroke unit could be left with inexperienced staff. During the inspection 16 of the 21 patients on the stroke unit required all aspects of care to be delivered to them and two staff to move them. One comment from staff was, "It is absolutely exhausting work and I wonder if it is sustainable. If there are impacts on staffing such as a patient requiring thrombolysis or staff going to A&E, they try to get an extra carer but I have never seen this happen." We were told staff could be off the ward in A&E for up to three hours. Another staff said, "Staff are very resilient on the ward and care is given regardless. I am very proud of the unit."

On the stroke unit one staff said, "It is difficult to cover sickness. We use the rapid response team which comprises of health care assistants and this can give some back up to get through the basics for a few hours. In theory it works but practically it doesn't work very well as they are always busy".

Although we found some concerns about staff deployment, patients gave us mostly positive comments about the care they received from staff. Comments included, "They brought me a phone so I could let my relative know what was happening", "They all seem very kind although it is busy" and "The doctors are very nice as well. One said they would be with me all the way." Patients on the stroke rehabilitation care unit told us they felt well supported by staff and said the unit was giving them the extra confidence they needed to cope independently.

However, some patients commented negatively on the time it took for the nurse call bell to be answered. Comments included, "It takes far too long. It could be up to half an hour for someone to see you when you buzz", "Sometimes you have to wait for the buzzer to be answered but there are worse off than me" and "It would be a big improvement if they could answer the buzzer quickly. I was worried I may have an accident at times as they took so long."
Supporting workers

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<td>Staff should be properly trained and supervised, and have the chance to develop and improve their skills</td>
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Our judgement

The provider was not meeting this standard.

Patients were cared for by staff who were not consistently supported to deliver care and treatment safely and to an appropriate standard.

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

Reasons for our judgement

The trust had a range of policies, procedures and systems in place to support staff. These included induction, clinical supervision, appraisal and a training programme. However, we found that not all staff we spoke with had received clinical supervision and appropriate professional development to enable them to be skilled and confident to carry out their role.

We requested trust-wide information regarding the training completed by staff. This showed significant gaps in training the trust considered to be mandatory. For example in moving and handling training, safeguarding of adults and children, resuscitation, infection control, fire safety and the Mental Capacity Act 2005. One member of staff told us they had not had any moving and handling training for six years. Staff told us teaching sessions were arranged during quiet times on A&E but not all staff could attend due to the staff rota or the needs of patients. Staff told us not all A&E nursing staff had completed training in triage, which was important when assessing patient's health risks and prioritising the need for treatment. We discussed this with the trust who told us they had a triage training programme in place and would ensure those staff who had not yet completed this training received it as a priority.

We found that staff on the stroke unit had access to stroke training and development and a stroke training day was arranged last July. The ward manager told us there were minimum training requirements for new staff to enable them to attend A&E when a patient was admitted with a stroke emergency. Nursing staff also had specific training with therapy staff which covered swallowing assessments and moving and handling techniques for patients who have had a stroke. Some staff told us training met their needs but could be delayed due to staffing levels and the impact this had on more experienced staff being able to demonstrate skills or observe practice. Support staff spoken with told us they had not had an induction for their role other than working alongside other staff.

Junior doctors told us they completed a corporate and local induction process and said they felt supported by staff on the wards and by their line managers. Junior doctors had a separate appraisal system which was a requirement of the post graduate deanship.
Staff were able, from time to time, to obtain further relevant qualifications. Therapy staff told us they received some formal in-service training but made alternative arrangements for most post qualifying training.

We were told that ward managers could not access team training records on the current information system (oracle learning management), but only their own personal records. They had to request training information from the training department. This made it difficult for them to audit and keep track of staff training requirements. We noted on the mandatory training action plan that monthly mandatory training reports were to be accessible to managers by the end of February 2013, which they felt would resolve this issue.

Some staff told us they felt the system of admitting medical patients to non-medical wards or specific wards such as the stroke unit meant staff lacked the clinical expertise to care for them. Comments from staff included, "I don't feel like I'm doing my job properly because of a lack of resources, training and support." Staff also told us staffing levels affected the uptake of training. Comments from staff gained via discussions and correspondence included, "I have not undertaken mandatory training for 2 or 3 years. I book myself onto it but it gets cancelled by management due to staffing shortages", "We work hard and miss breaks and morale is low" and "I should have been training today but there are two new nurses on duty."

The trust acknowledged the shortfalls in training and had already begun to take steps to address them. The trust had recently undertaken a training needs analysis and developed a training matrix which set out the statutory and mandatory training requirements for all groups of staff employed. The analysis identified 12 mandatory training topics staff must maintain compliance with and a further eight topics for clinical staff. It highlighted the frequency of renewal and level of training required. However, it was recognised that staff had difficulty in accessing information regarding training requirements which led to a poor uptake of training events and eLearning. To this end an electronic mandatory training information system (MTIS) had been developed to enable staff to see what training was required for their role. This response was at an early stage and the trust will monitor it to see how it improves the take up of mandatory training for staff.

The trust had a clinical supervision strategy which identified that one to one or group supervision sessions could be undertaken at a time and frequency agreed between the supervisee and supervisor. The strategy quoted a definition of clinical supervision by the National Health Service Litigation Authority (NHSLA) as: -

"A key mechanism supporting clinical governance; it contributes significantly to reduce emotional exhaustion among clinical staff. Supervision gives a means to develop professional skills, judgement, and a commitment to achieving professional growth in order to improve the standard of the service."

Nursing staff we spoke with told us formal clinical supervision could be arranged after incidents as part of debrief but they did not receive clinical supervision to explore professional practice in a structured and proactive way. This meant that staff viewed clinical supervision in a negative way. Comments included, "I have never had clinical supervision", "There really isn't enough support to newly qualified nurses" and "It's not formal and we don't record it." One matron told us they met with the ward manager weekly but they did not record any discussion.

We found that in certain circumstances management had arranged formal supervision sessions when required to address areas of poor practice and these were documented.
Another matron told us they wrote to staff to praise people's contribution and performance.

Following the inspection the trust confirmed that clinical supervision was not currently mandatory. However, we were told this was to be addressed and would be monitored and recorded in future.

The trust had an appraisal system for staff called 'annual development review' (ADR). This included documentation to record self assessment, discussion with line management, training analysis and a plan to set objectives for the next year.

We found there were differences between staff regarding ADR. For example, some groups of staff were receiving ADR and a six monthly review whilst others had not received it at all or on an annual basis.

Comments from staff on the stroke unit, the AMU and the A&E department included, "I have not had any annual development for seven years", "I've not had any supervision for two years and my last ADR was 2010", "There is no planning for career goals and I feel undervalued" and "I've had one (ADR) about five or six years ago."

The trust provided figures from a staff survey that showed 64% of staff had received an appraisal in the last 12 months, which was below the national 2012 average of 84% for acute trusts. The figure dropped by two thirds to only 21% when members of staff were asked if the appraisal was well structured.

The trust acknowledged during the inspection that further work was required in respect of staff appraisal. They shared details of some actions that were underway.
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.

Patients were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not consistently maintained. Records were not always kept secure.

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

Reasons for our judgement

We found that people's personal records including medical records were not consistently accurate and not all records were kept securely.

The trust had a records policy and procedure and staff had access to Information Governance (IG) training. Figures showed that nearly 76% of staff had completed IG training. The trust printed a quarterly newsletter for staff that provided information governance news, reminded staff on the necessity to keep information secure and identified training dates. We were told that part of induction included staff signing a declaration of confidentiality, which was kept in their employment file.

The trust had invested in electronic equipment in order to reduce the amount of paper in patient's care files. This system called Web V clinical portal, was being tried out on different wards at present. It enabled staff to collect patient data at the bedside on portable hand pieces which was then relayed to a ward monitor. The system provided an overview of the patient's treatment and pathway through the hospital and flagged up when observations were required. The system also meant that investigations and tests could be requested electronically and results accessed quickly.

Multidisciplinary records called 'stroke inpatient management' were completed by medical staff, therapies and nursing staff. These detailed initial assessment by each discipline such as doctors, physiotherapists, speech and language therapists and occupational therapists. Nursing staff recorded their interventions in the inpatient stroke management document. We found these records were recorded in line with patient care and treatment. One care file we checked had recorded palliative care provided to the patient and end of life decisions.

However, other documentation on the stroke unit had shortfalls in recording. For example, one patient's records showed that the dose of medicine had not been documented. This resulted in the pharmacist not being able to dispense the medicine, which led to the patient...
not receiving it for six days. Food and fluid monitoring charts were not consistently kept up to date, not all assessed needs had plans of care and there were some shortfalls in documentation regarding pressure relief. This meant that staff may not have accurate and up to date information about patients to ensure the correct nursing care and treatment.

We found that the acute medical unit (AMU) had the names of patients at the entrance to each bay. We found the names on the board had not been updated and recorded correctly and did not correspond with the patients. For example, one bay according to the names had five male patients and one female patient. In reality the bay had three female and three male patients. This could cause confusion when staff carried out clinical interventions.

The trust’s stroke pathway indicated that an assessment tool should be used in A&E to assist in confirmation of a stroke diagnosis and that this should be attached to medical records. We noted that the documentation for this test was not always completed.

We observed on the stroke unit that medical records were placed on shelves at one end of the ward. Administration staff sat at the desks in this area during the day but they were frequently called away leaving the medical records unattended. We also observed that a trolley containing medical records was left unattended on the ward for a significant period of time.

On other wards there was a system of medical records placed on the counter at reception awaiting staff to deal with them. The notes were facing outwards so names and personal information were visible. We noted that these were easily accessible to patients and relatives who attended the reception.

We were told that all records were kept in medical notes and stored in the records department when not in daily use. They were then stored off-site at a licensed storage facility. Records could be accessed on site at anytime and off-site with 24hours. Ward clerks assisted staff to access records.

We observed that a trolley outside an office had medical records in it and was left unattended. There was no facility to lock the trolley. We waited for several minutes but staff did not appear. Staff had to collect medical records for the wards or outpatients department and told us they were not allowed to take the trolley into the office as it was too bulky. We were told this was common practice and meant that personal medical records were at risk of being accessed by people walking by. We also noted that a door to a medical records store was usually locked using a key pad system. We found that the door was unlocked and personal medical records could be accessed.

Following the inspection we were advised staff had received an email reminding them of the trusts policy on information governance. This showed us the trust took our findings regarding information security seriously and took steps quickly to start to address it.
**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 activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td><strong>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</strong></td>
</tr>
<tr>
<td>Nursing care</td>
<td><strong>Care and welfare of people who use services</strong></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td><strong>How the regulation was not being met:</strong></td>
</tr>
<tr>
<td></td>
<td>The provider had not taken proper steps to ensure that each patient was protected against the risk of receiving care or treatment that was inappropriate or unsafe. The assessment, planning and delivery of some aspects of care and treatment, for example nutrition and catheter care, were not in line with their individual needs. Regulation 9 (1) (a) (b)</td>
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</table>

<table>
<thead>
<tr>
<th>Regulated activities</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td><strong>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010</strong></td>
</tr>
<tr>
<td>Nursing care</td>
<td><strong>Supporting workers</strong></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td><strong>How the regulation was not being met:</strong></td>
</tr>
<tr>
<td></td>
<td>The provider did not have suitable arrangements in place in order to ensure staff received appropriate training, professional development, supervision and appraisal. Regulation 23 (1) (a)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td><strong>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Records</strong></td>
</tr>
<tr>
<td>Nursing care</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>The provider had not ensured that there was an accurate record in respect of each patient, which included appropriate information in relation to the care and treatment provided. Records were not kept securely. Regulation 20 (1)(a) 2(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 13 June 2013.

CQC should be informed when compliance actions are complete.

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

<table>
<thead>
<tr>
<th>✓ Met this standard</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗ Action needed</td>
<td>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.</td>
</tr>
<tr>
<td>✗ Enforcement action taken</td>
<td>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.</td>
</tr>
</tbody>
</table>
How we define our judgements (continued)

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

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

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

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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
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>Regulation 17</th>
<th>Regulation 18</th>
<th>Regulation 9</th>
<th>Regulation 14</th>
<th>Regulation 24</th>
<th>Regulation 11</th>
<th>Regulation 12</th>
<th>Regulation 13</th>
<th>Regulation 15</th>
<th>Regulation 16</th>
<th>Regulation 21</th>
<th>Regulation 22</th>
<th>Regulation 23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services - Outcome 1</td>
<td>Consent to care and treatment - Outcome 2</td>
<td>Care and welfare of people who use services - Outcome 4</td>
<td>Meeting Nutritional Needs - Outcome 5</td>
<td>Cooperating with other providers - Outcome 6</td>
<td>Safeguarding people who use services from abuse - Outcome 7</td>
<td>Cleanliness and infection control - Outcome 8</td>
<td>Management of medicines - Outcome 9</td>
<td>Safety and suitability of premises - Outcome 10</td>
<td>Safety, availability and suitability of equipment - Outcome 11</td>
<td>Requirements relating to workers - Outcome 12</td>
<td>Staffing - Outcome 13</td>
<td>Supporting Staff - Outcome 14</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.