# Review of compliance

| Sherwood Forest Hospitals NHS Foundation Trust<br>Newark Hospital | |
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| **Region:** | East Midlands |
| **Location address:** | Boundary Road, Newark, Nottinghamshire, NG24 4DE |
| **Type of service:** | Acute Services |
| **Publication date:** | June 2011 |
| **Overview of the service:** | Newark Hospital has 77 beds, plus day case facilities. The hospital provides consultant led outpatient services, planned inpatient treatments, daycase procedures, diagnostic and therapy services, an out of hours GP service and a minor injuries unit. Prenatal care is provided in the purpose-built Sherwood Women's Centre. |

# Summary of our findings
for the essential standards of quality and safety

## What we found overall

**We found that Newark Hospital was meeting all the essential standards of quality and safety we reviewed but, to maintain this, we suggested that some improvements were made.**

The summary below describes why we carried out the review, what we found and any action required.

## Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

## How we carried out this review

We reviewed all the information we hold about this provider, carried out visits on 15 March 2011 and 13 April 2011, observed how people were being cared for, talked with people who use services, talked with staff, checked the provider's records, and looked at records of people who use services. The visit on 15 March was part of a targeted dignity and nutrition inspection programme in acute NHS hospitals to assess how well older people are treated during their hospital stay. On this occasion we were joined by a practising, experienced nurse. The inspection team also included an "expert by experience," a person who has experience of using services, and who can provide the patient perspective.

## What people told us

We visited a number of wards and departments where we spoke with patients and their visitors. They told us they had been well informed about their treatment through written and verbal information. One patient described how he was presented with three options for treatment, and "…it was all made very clear." Another told us they chose the hospital because their relative had received good care. "The hospital's excellent, I heard it was good and I'm not disappointed."

Overall, their experience of the arrangements before admission and up to the point of discharge was very good. One patient told us: "I've been so impressed with the quality of the service, and I've had excellent treatment…. everyone is professional and helpful."

Patients and relatives told us they would raise concerns in a number of ways, and not all knew about the complaints process. But they were all confident the hospital would take any concerns seriously, and they were not worried about being treated differently if they made a complaint.

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

### Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People who use services usually have their dignity, privacy and independence respected, and are involved in making decisions about their care and treatment.

- Overall, we found that Newark Hospital was meeting this essential standard.

### Outcome 2: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

People who use services usually give valid consent to the examination, care and treatment they receive, but procedures to gain consent from adults without the capacity to give consent are not always followed.

- Overall, we found that Newark Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

### Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

People who use services receive effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

- Overall, we found that Newark Hospital was meeting this essential standard.

### Outcome 5: Food and drink should meet people's individual dietary needs

People who use services are usually well supported to have adequate nutrition and hydration. However, care plans do not always identify how risks of poor nutrition and hydration are managed and there may be a delay in obtaining specialist advice and techniques when needed, which mean that personalised care is not always provided.

- Overall, we found that Newark Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

### Outcome 6: People should get safe and coordinated care when they move between different services

People who use services receive safe and coordinated care, treatment and support where more than one provider is involved or they are moved between services.

- Overall, we found that Newark Hospital was meeting this essential standard.

### Outcome 7: People should be protected from abuse and staff should respect their human rights

People who use services are protected from abuse or the risk of abuse and their human rights are respected and upheld.

- Overall, we found that Newark Hospital was meeting this essential standard.

**Outcome 8: People should be cared for in a clean environment and protected from the risk of infection**

People who use services are usually protected from identifiable risks of acquiring an infection by effective infection prevention and control measures.

- Overall, we found that Newark Hospital was meeting this essential standard.

**Outcome 9: People should be given the medicines they need when they need them, and in a safe way**

People who use services have personalised care through the effective use of medicines

- Overall, we found that Newark Hospital was meeting this essential standard.

**Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare**

People who use services receive care and treatment in safe and accessible surroundings.

- Overall, we found that Newark Hospital was meeting this essential standard.

**Outcome 11: People should be safe from harm from unsafe or unsuitable equipment**

People who use services are not at risk of harm from unsafe or unsuitable equipment and benefit from equipment that meets their needs

- Overall, we found that Newark Hospital was meeting this essential standard.

**Outcome 12: People should be cared for by staff who are properly qualified and able to do their job**

People who use services are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and able to do their job.

- Overall, we found that Newark Hospital was meeting this essential standard.

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

People who use services are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

- Overall, we found that Newark Hospital was meeting this essential standard.

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

People who use services are safe and have their health and welfare needs met by competent staff.

- Overall, we found that Newark Hospital was meeting this essential standard.

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

People who use services benefit from care and treatment that is monitored to ensure it is safe and of high quality.

- Overall, we found that Newark Hospital was meeting this essential standard.

**Outcome 17: People should have their complaints listened to and acted on properly**

People who use services cannot be sure their comments and complaints are acted on effectively because information about making a complaint is not always accessible and the provider does not have robust systems in place to manage comments and complaints.

- Overall, we found that Newark Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

**Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential**

Although there is no evidence of inappropriate care and treatment, people who use services cannot be confident their personal records are always completed fully, held securely, and not kept longer than necessary.

- Overall, we found that Newark Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

## Action we have asked the service to take

We have asked the provider to send us a report within 28 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.

**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 1:
# Respecting and involving people who use services

## What the outcome says

This is what people who use services should expect.

People who use services:

- Understand the care, treatment and support choices available to them.
- Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
- Have their privacy, dignity and independence respected.
- Have their views and experiences taken into account in the way the service is provided and delivered.

## What we found

**Our judgement**

**The provider is compliant**

**Our findings**

These findings are largely based on the dignity and nutrition inspection carried out on 15 March 2011 and a report is available on our website.

**What people who use the service experienced and told us**

We visited two medical wards and spoke with five patients and four visitors. The patients told us they are given a chance to say how they would like to be treated and that staff listen to them. Most knew about relevant facilities such as a room where they can use a mobile phone, how to order a daily paper, the hospital shop and chapel. There were numerous displays of information about facilities, meal times, healthy eating, hospital policies and clinical conditions and procedures. However, some leaflets were difficult to reach as they were wedged in high wall racks, and some posters were difficult to read, for example blue type on a green background with text superimposed on an image.

Patients told us that staff ask before helping them with personal care and explain what they are doing when carrying out tests or procedures. They told us their needs were met quickly enough and care was given respectfully most of the time. We saw staff taking time to listen to patients and responding appropriately, using good communication skills such as keeping eye contact and listening attentively. Patients

told us procedures are generally explained to them, although staff may talk a little too fast, but if they ask questions staff will answer them. We observed relatives and carers being involved in discussions about patients' care needs, for example a pharmacist explaining a change in tablets to a patient and their daughter.

Although we observed staff behaving in a way that respects patients' dignity and privacy most of the time, we heard staff at the nurses' station discussing patient issues loud enough to be heard in the near-by patient areas. On one ward there were large whiteboards that list the patients by surname and record their nutritional needs, conditions such as dementia or diabetes, and therapeutic input such as occupational therapy. This information was in full sight of anyone visiting the ward, so that patients' privacy and confidentiality were not maintained.

**Other evidence**

Between March and December 2010, there were thirteen patient comments on the NHS Choices website relating to respect and involvement: six reported positive experiences of being treated with care and respect, and seven described negative experiences of poor communication. The National Cancer Patient Experience Programme 2010 survey found that whilst the trust scored very well for patients' confidence in staff and privacy for discussions, they were rated poorly for providing information and explanations about treatments. This was a trust-wide survey and not specific to Newark Hospital, but the findings are reflected in the trust's own survey of nearly 200 patients at Newark Hospital for the period May 2010 to March 2011. The vast majority (more than 95%) said they were involved in decisions about their care and treatment and were given enough privacy, but nearly a third (29%) did not feel they had enough information about medication side effects, nor whom to contact with any concerns after leaving hospital.

The findings from Patient Environment Action Team (PEAT) inspections (self-assessments managed by the National Patient Safety Agency that check the non-clinical aspects of patient healthcare experience) in early 2010 and March 2011 rated the hospital as excellent for facilities relating to maintaining modesty, dignity, privacy and respect. The Department of Health produces "Essence of Care Benchmarks" with which healthcare providers can assess and improve the quality of care, ensuring the fundamentals of care are at the centre of the patient experience. Recent hospital audits in line with the benchmarks for respect and dignity found the majority of in-patients felt their dignity and privacy was respected.

Due to recent changes in admissions to the hospital, on the day of our visit the wards were quiet with a quarter to a half of beds occupied, so patients could be spaced out in the bays increasing their privacy. The wards were divided into male and female "halves", so that each had single sex toilet and bathing facilities and each of the larger six-bedded bays had their own toilet. The hospital has carried out significant work over the last three years to meet the Department of Health's "same sex accommodation" requirements. We did not observe problems accessing toileting and washing facilities, although the accessible toilet on one ward was used for equipment storage (a commode chair) making it less accessible to an independent wheelchair user.

We spoke with medical, nursing, allied health and support staff, who told us it is important to communicate well with patients, asking them about their needs, without making assumptions. If patients lack capacity or are very frail staff discuss their care

needs with their families or carers. They also use non verbal means of communication such as body language and picture boards, or request help from a speech and language therapist (SALT).

Staff told us they work well as a team and do their best to meet patients' needs, making sure patients feel able to talk to them and raise concerns. We saw that patients had call bells within reach if they needed them and we always saw staff respond in a reasonable time. We heard staff explaining things to patients clearly and in a reasonably detailed way. One of the nurses described their role as being an advocate for the patients, taking part in ward rounds and making sure afterwards that the patients understood what was discussed with the doctors.

We asked staff about their training on privacy and dignity, independence and human rights. They told us they attended mandatory updates that included these topics. Most of the qualified staff told us this had been included in their basic training and that they were updated through written and online professional guidelines and codes of practice.

Staff told us they identify people's usual needs or activities of daily living (ADL) on admission and discuss with them what type of assistance they need now. They review care plans on a daily basis to ensure they are based on need. Staff told us when patients have communication difficulties they usually discuss care needs with relatives and carers, and they can gain support from a mental health liaison nurse. Patients' case notes provided only a small space for recording "Cultural/Religious Needs" and there were no entries in any of the care plans we looked at. Staff told us they always respect people's diverse cultural needs, such as language or religion. For example, there are many Polish speaking patients and interpreters are easy to access. Staff also use a multi language phrase book and approach the chaplaincy for support for patients from other faiths.

Staff told us patients' needs are discussed at shift handovers. They record information on a staff notice board and pass on information verbally. Medical and therapy staff told us they explain treatment options, as well as risks and benefits, although we did not see this documented in the patients' care notes.

Patients who are able to, keep their own medicines at their bed-side in a locked drawer, and take their tablets themselves as usual, which promotes their independence. Ward staff told us they work with the therapists to improve independence and a physiotherapist told us she asks patients when they would like her to come and see them, which helps them participate in planning their day. Patients are encouraged to go off the ward with family members, for example to the coffee shop.

We saw an admission pack given to patients, with information about facilities on the ward and in the hospital, and contains a check list of questions to ask before discharge. It also offers the opportunity to submit comments and complaints. The pack was two A4 double-sided sheets of poorly photo-copied print. Some of the text was impossible to read as it was small, faint or distorted. Most of it was extremely difficult to read and not accessible to people with a visual impairment. This is not an adequate means of providing information and requesting feedback.

Ward staff told us they relay verbal feedback from patients to the nurse in charge, and that "how to complain" is well publicised throughout the hospital; most said that if asked, they advise patients to approach a nurse, the hospital matron or the Patient Advice and Liaison Service (PALS). All patient feedback goes to the hospital

matron. Results are posted on the staff notice board and reviewed at staff meetings. Although staff told us when people are unable to give an informed view or have special communication needs they ask their relatives or carers, or use other means of communication like a picture board, it was not clear that these patients' views were routinely and deliberately sought.

**Our judgement**

People who use services usually have their dignity, privacy and independence respected, and are involved in making decisions about their care and treatment.

# Outcome 2:
# Consent to care and treatment

## What the outcome says

This is what people who use services should expect.

People who use services:

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

## What we found

**Our judgement**

**There are minor concerns**

**Our findings**

**What people who use the service experienced and told us**

We visited the outpatient department and surgical ward where we spoke with staff and patients and looked at patient information and patient records. All the patients we spoke with told us they had been very well informed about their surgery or other treatment through written and verbal information, before giving their consent. They also confirmed that they knew they could change their minds at any time.

The patient records we looked at documented that the doctor had explained the risks and benefits of a procedure during the outpatient appointment. We saw that consent forms were completed and signed. Patients told us everything was explained to them; one described how he was presented with three options for treatment, and he decided on one which involved surgery. He said, "…it was all made very clear." CQC's Survey of Adult Inpatients in the NHS (April 2011) found that across the trust, patients said that staff did not always explain or answer their questions about procedures and operations, but overall, patients were positive about being informed about their condition and getting answers they could understand.

**Other evidence**

It is a general legal and ethical principle that valid consent must be obtained before starting treatment, investigation, or personal care. For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question. The trust's Policy for Consent to Examination or Treatment is up to date and provides a framework for employees to follow when seeking consent for treatment, procedures or clinical photography relating to patient care. All the staff we spoke with knew where to find the policy, and receive emails that tell them about any changes. They also attend a formal update session each year.

Nursing staff told us they gain verbal consent from patients before providing care such as helping with hygiene or taking blood. Senior staff told us they monitor this informally by being present in the departments and observing the care their staff provide. We did not see any verbal consent recorded in nursing notes but in all the physiotherapy and occupational therapy treatment notes we looked at, patients' verbal consent to treatment was recorded. Staff told us that signed consent to an operation is usually taken by the consultant in outpatients. When the patient attends for surgery, the ward staff make sure the patient has understood the procedure, including the potential benefits and risks, and then sign the consent form to confirm the patient has given valid consent.

We asked staff about gaining consent from children and adults who do not have the capacity to consent to the procedure. They described appropriate courses of action in line with Department of Health guidance and the trust's consent policy. There is a special consent form used when adults are unable to consent, which enables recording of taking a decision in the best interests of the patient under the Mental Capacity Act (1995). The Act protects people who lack capacity to make a decision for themselves because of permanent or temporary problems such as mental illness, brain injury or learning disability. The consent form contains clear guidance on taking consent in this case and documents the decision making process including the views of the patient, their family or carers, and the health professional involved.

When we looked at patient case notes on the medical wards, we found that mental capacity was not part of the assessment on admission; none of the case notes recorded an assessment of capacity to make decisions, although some contained conflicting information about confusion. One person's case notes contained cognitive screening tools (Mini Mental State Examination and Montreal Cognitive Assessment), used to check if people have problems like dementia, but these were not completed, nor referred to in the medical notes, indicating that there had been no formal assessment of the patient's mental state.

There was nowhere in the care plans to record issues like a Power of Attorney or the need for an advocate. Nursing staff told us mental capacity was assessed by a social worker, occupational therapist (OT) or a doctor. The trust provided evidence that a range of medical, nursing, allied health and support staff had received training in the Mental Capacity Act in the last year, but not the proportion of staff still to receive training. The trust told us that further training is scheduled over the next few months and there is an e-learning resource available on the trust intranet.

We observed one patient in a deep-seated chair, often called a "fall out chair" because it prevents the person falling out; in effect it prevents them from getting out

of the chair un-aided, and is used to maintain the safety and comfort of a confused person who may wander, or someone with poor postural control. It is a form of physical restraint and its use should be assessed as in the patient's best interests. We looked at this patient's notes and saw that she had a history of falls, dementia and Parkinson's disease, and presented with confusion and inability to call for assistance. But the care plan did not mention the use of this specialised seating, or an assessment of the patient's capacity to consent to the use of the chair.

A ward manager told us that new staff receive training on consent during the trust induction programme, and she directs them to the guidance on the consent forms, which is clear and informative. She goes through the issues of verbal consent with health care assistants. As patients are admitted the ward manager reviews the care records and checks that consent has been correctly gained and confirmed. Any errors in consent would be reported through the incident reporting system.

Staff described two occasions when patients attended for surgery but could not demonstrate they understood why they had come into hospital, and so did not, at that time, have capacity to consent to the operation. In both cases the operations were cancelled and staff contacted the patients' relatives and GPs to discuss how to proceed. The nursing staff we spoke with had not had training in caring for people with a learning disability, but knew where to access advice and support from a specialist nurse. They told us people with a learning disability from care homes were usually well supported in hospital by care home staff.

Occasionally, patients have an "advance decision to refuse treatment", which means that if they lose the capacity to make a decision about their treatment, there is a record of which medical treatments they do not wish to receive, such as being resuscitated. Staff told us that all medical and care staff, including transport staff, are made aware at the beginning of each shift, and a large eye-catching sticker is attached to the front of the patient's notes.

Staff showed us a range of information leaflets they can access from a web-site and print off for patients. Each leaflet has a Plain English Campaign Crystal Mark and the company that provides them is certified under the Department of Health's Information Standard, meaning the information is accurate, impartial, balanced, evidence-based, accessible and well written. We also saw photocopied information sheets, which were not always clearly printed, as some of the text was small and distorted making it difficult to read.

The leaflets we saw described alternative options for care, the risks and benefits of the treatment, possible complications, recovery and returning to normal activities. Staff told us they could access information leaflets in different languages and formats when needed, and that they could arrange for interpreters to be present at outpatient appointments if this was requested by the referring GP. Sometimes people who do not have symptoms attend for scans as part of screening programmes to detect early cancers or measure foetal developments. The trust told us they send NHS national screening programme leaflets to people before they attend so they are fully informed.

**Our judgement**

People who use services usually give valid consent to the examination, care and treatment they receive, but procedures to gain consent from adults without the capacity to give consent are not always followed.

# Outcome 4:
# Care and welfare of people who use services

## What the outcome says

This is what people who use services should expect.

People who use services:

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

## What we found

**Our judgement**

**The provider is compliant**

**Our findings**

**What people who use the service experienced and told us**

We observed patient care in the medical and surgical wards, outpatients and the minor injuries unit. We talked with patients who told us they had been involved in planning their care and treatment. Although patients told us they felt informed about their care, it was not recorded in their care plans whether and how they had been involved in developing their plans of care.

One patient said they had opted to attend the hospital because they had been impressed by the way their relative, who had complex needs, had been cared for: “The hospital’s excellent; I heard it was good and I’m not disappointed.” Another patient, who has a long term condition requiring coordinated care and support, told us that everyone involved is informed quickly about any changes in the treatment plan. Patients who answered questions about care and treatment in CQC’s trust-wide Survey of Adult Inpatients in the NHS (April 2011) were largely positive about their experiences.

We saw staff caring for patients in a sensitive and professional way, taking time to listen and answer questions. We saw staff respond to patients’ needs in a timely way, demonstrating they were familiar with the individual person’s needs and abilities. We observed staff involving relatives and carers in explanations about care and treatment. We heard staff explaining procedures and arrangement for appointments clearly and politely.

**Other evidence**

The patient records showed that patients' individual needs were established on admission and reviewed regularly throughout their inpatient stay. Ward nursing staff told us the care plans are evaluated at least once per shift and some, such as surgical wound care, change quite frequently.

The care plans we saw related to patients' physical, rather than mental, emotional or social, needs. The patient records included risk assessments appropriate to each patient, including the risk of falls, pressure sores, malnutrition, moving and handling and discharge; these were reviewed and updated at regular intervals appropriate to the person's needs. The risk assessments we saw were usually personalised to take into account the patient's choice but this was not always apparent.

On the medical wards we saw evidence of swift referrals to appropriate services such as physiotherapy, occupational therapy, and speech and language therapy. The patient notes also recorded conversations with relatives and community services. Staff told us there was good communication within staff teams and between different professions, such as the community tissue viability nurse specialist who advises on care to help prevent or manage pressure sores. Some told us it could be difficult to access specialists such as dietitians and speech and language therapists who were based at King's Mill hospital, which could mean delays in assessment and treatment, to the detriment of the patient.

Staff told us they report adverse events, incidents, errors and near misses through the trust's online patient safety reporting system. They told us the system is easy to access and use, and they receive good feedback quickly and can implement changes to practice as a result. We saw two patients recently admitted from another healthcare provider with significant pressure sores. Staff had submitted incident reports, and the reference numbers were recorded in the patient notes. The trust shared with us their reporting of incidents related to problems with notes or records at the hospital for the year April 2010 to March 2011. This shows an appropriate process of investigation and lessons learned, including communication with individual staff or managers as required.

All the nursing staff we spoke with were aware of National Patient Safety Agency (NPSA) alerts, medical devices alerts from the Medicines and Healthcare products Regulatory Agency (MHRA), and alerts about medication that are received through pharmacy bulletins. The hospital manager passes on national patient safety alerts to clinical governance leads and ward managers who inform their staff through meetings and memos. The ward managers complete a record of actions taken at ward level that they return to the clinical governance department. If the alerts are not relevant, the information goes back to the hospital manager who informs the trust's patient safety manager, so that monitoring can take place. The trust has responded positively to incidents of over exposure to diagnostic and therapeutic ionising radiation, such as X-rays, especially with regard to patient identification errors which are significantly lower than average.

We saw an example of a safety alert from the NPSA concerning complications after a type of surgery. The alert advises actions such as specifying the observations required in the immediate post operative period, and on discharge giving patients verbal and written advice about signs of deterioration and when to seek medical advice. The ward leader copied the relevant information to staff and asked them to

sign a record sheet when they had read it. We spoke with a number of senior staff and although they introduce changes in practice where necessary as a result of the safety alerts they did not formally check that staff were putting changes into practice and continuing to do so.

**Our judgement**

People who use services receive effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

# Outcome 5:
# Meeting nutritional needs

## What the outcome says

This is what people who use services should expect.

People who use services:

- Are supported to have adequate nutrition and hydration.

## What we found

**Our judgement**

**There are minor concerns**

**Our findings**

These findings are largely based on the dignity and nutrition inspection carried out on 15 March 2011. We have already suggested the hospital makes improvement to maintain compliance, as reported in the dignity and nutrition inspection report published on our website.

**What people who use the service experienced and told us**

Patients and relatives told us the food was usually good with plenty of choice and help with eating when needed. Some patients did not realise snacks were also available between meals, but they told us if they have to miss a meal due to tests or treatment, staff check if they would like something before the next meal.

At lunch time, food was heated up on the ward and carried on individual trays to patients by their beds, so that it was served hot. Staff told us patients have the option to eat in the dining rooms, but this only happens occasionally when relatives visit. Most patients were sitting in chairs by their beds and were offered napkins to protect their clothing. Adapted cutlery was available; some patients had plate guards, non-slip mats, or cups with lids and drinking spouts to prevent food and drink spillage. The food portions appeared appropriate and most patients seemed to enjoy their meal and ate well. People were offered alternatives if they did not like part of the meal or had little appetite.

The main course was served first and then dessert options were taken round on a trolley. We saw staff supporting people to eat and drink when needed. We observed a health care assistant feeding a patient sensitively and patiently. She used

appropriate verbal and non-verbal communication, and involved the patient as much as possible. Staff were attentive to people's needs and asked if they would like help moving into a more comfortable sitting position, or placing a napkin on their lap. We saw drinks being topped up on request. There were plenty of staff to help, for example one ward had seven staff assisting nine patients. We saw staff checking patients had eaten enough and had finished. After the meal, patients were made comfortable and helped to wipe their hands with sanitising wipes. Health care assistants checked everyone had finished and the food and fluid charts had been completed, before wiping down the tables.

**Other evidence**

The wards had several strategies in place to ensure patients' nutritional needs were met. Coloured stars above patients' beds and on wall charts identify different nutritional needs such as whether a food intake needs recording (pink star) or if the patient has diabetes (yellow star). Meals were served on red trays to patients who require assistance with feeding or who are at nutritional risk. This is a way of alerting care staff to ensure support is given and/or a food and fluid chart is completed after every meal. There were "protected meal times" at lunch and tea, which means that patients are not disturbed during their meals by unnecessary clinical and non-clinical interruptions. Care staff did not take breaks during this time and were on duty to support patients with eating and drinking, in a quiet environment. Only visitors who are assisting a relative with their meal were able to go on the ward for this purpose. We observed lunch time on two wards and saw the protected meal time and red tray policies being adhered to.

Patients were assessed on admission using the Malnutrition Universal Screening Tool (MUST). This helps identify patients who are malnourished, at risk of malnutrition or obese, and includes management guidelines that can be used to develop a care plan. It was introduced at the end of 2010 and staff told us they find it very beneficial. Doctors may also take blood tests, for example to identify dehydration or nutritional problems. A patient's weight is recorded weekly or more frequently if requested by their doctor. Staff told us they add notes on nutritional needs to the handover sheet so that patients' care needs are highlighted at shift handovers.

Each ward has an occupational therapist (OT) who may assist with feeding support. A physiotherapist told us she liaises with staff when a patient's joint or balance problems, such as from arthritis or a stroke, might affect eating and drinking. Patients may be referred to Speech and Language Therapy (SALT) for swallowing assessments or Dietetics for specialist advice, both based at King's Mill Hospital in Sutton-in-Ashfield. Several staff told us there can be unacceptable delays in accessing these services, from several days to more than a week.

The ward staff reported various training in nutrition, with link nurses and the housekeeper playing key roles in attending trust meetings and cascading information to the rest of the ward staff. The housekeeper on one ward told us she has attended training on MUST, swallowing and stroke awareness, and accesses information on the trust intranet. She has tasted all the food and supplements so that she can discuss them with patients. Trust records show that training in MUST was provided last year for five staff nurses but we do not know where in the hospital these nurses work. The trust also supplied us with information that five staff nurses

received training in nasogastric feeding (in which a thin tube is passed down the nose into the stomach so that patients can be given nutritional support) during 2010. Most of the ward staff told us they had not had further training in nutritional care since induction and some felt they were not adequately trained to meet patients' needs, especially when patients may have to wait several days for SALT or dietetics assessment and intervention.

The hospital achieved high scores in Patient Environment Action Team inspections of nutritional services in early 2010 and March 2011. Each ward has a nutrition link nurse who carries out audits of nutritional care. Recent ward audits in line with the Department of Health's Essence of Care benchmarks for food and nutrition found appealing food, good availability of food, and nutritional screening usually in place. There were lower scores for an acceptable eating environment, planning and implementing nutritional care, and encouraging patients in healthy eating.

We looked at six patients' case notes and found that some did not link clinical findings to the risk of malnutrition or dehydration, and adequate nutritional support. One patient's notes recorded low and decreasing levels of blood protein but this was not recognised in the care plan or the nutritional assessment. Risk assessments relating to falls, tissue viability (pressure sores) and nutrition did not relate to each other as they should. For example, one patient was assessed using MUST and found not to need nutritional support, but they were overweight, had probable diabetes and a persistent wound, which would indicate the need for a therapeutic diet. Another patient's nutritional intake charts recorded low intake, but no strategies were identified for dealing with this.

One patient was believed to have a stomach ulcer but there was no link with a nutritional plan. Their MUST assessment stated "no food sensitivities or allergies" whilst the patient's admission notes stated they were allergic to citrus fruit. An assessment of nutritional health was carried out as part of a stroke assessment; on the same date the care plan recorded "no needs" and "no assistance needed," the patient was referred to SALT for problems with swallowing (dysphagia). Interventions were identified through this assessment but none were recorded as taking place.

In one patient's notes we saw that a strict fluid record was requested on the previous day, and this had been well maintained. The patient told us nursing staff were encouraging them to drink and completed the chart regularly. The food and fluid charts we saw were completed thoroughly, noting the amounts offered and proportion consumed, throughout the day.

On one ward, patients told us they had discussed food preferences with staff and completed a form about what they do not like. Staff told us they use picture boards to help them discuss food choices with people who have communication difficulties. Patients selected meals from the menu for the following day, but were not always sure they received what they had requested. On the other ward, the housekeeper asks patients each morning what they would like to eat for lunch and tea that day, checks their preferences and appetite, and liaises with nursing staff about clinical needs, before placing the orders with the kitchen. Staff told us the housekeeper supports people in making choices about their meals, discusses with family if they need help and liaises with kitchen and other staff such as the OT and dietician. The housekeeper requests additional meals, snacks or supplements as required. The housekeeper works Monday to Friday until 3pm, and delegates to other staff for

when she is off duty. Nursing staff told us the support provided by the housekeeper is invaluable, although they encounter more problems at times when the housekeeper is not there and the ward is busy.

There was a poster explaining protected meal times outside the entrance to one ward and near the nurses' station in the other. The admission pack also gives brief information about these arrangements. Most patients told us the food, choice and support provided were good. Most staff thought the meals were quite good but the choice could be limited, especially for those with restricted (e.g. gluten free or vegan) diets. They told us they receive very few negative comments from patients about the food.

**Our judgement**

People who use services are usually well supported to have adequate nutrition and hydration. However, care plans do not always identify how risks of poor nutrition and hydration are managed and there may be a delay in obtaining specialist advice and techniques when needed, which mean that personalised care is not always provided.

# Outcome 6:
# Cooperating with other providers

## What the outcome says

This is what people who use services should expect.

People who use services:

- Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

## What we found

**Our judgement**

**The provider is compliant**

**Our findings**

**What people who use the service experienced and told us**

We spoke with five patients and two of their relatives in the surgical and medical wards and the outpatients department. They all told us they had been given good information and explanations before discharge, about their treatments and follow-up care and support. One patient told us he was very pleased how follow-up care was explained to him and that staff had explained everything to his relative when he had asked them to, so they were both clear about what to expect. The findings of CQC's trust-wide Survey of Adult Inpatients in the NHS (April 2011) support this, with mainly very positive responses from patients asked about the arrangements for leaving hospital.

People we spoke with were positive about the tests they had before surgery and the information they received to confirm the operation could go ahead. One person said they had hoped to be admitted earlier than they were but they were kept informed of the reason for the delay and were satisfied with this. They were then offered an earlier appointment due to a cancellation. Overall, their experience of the arrangements before admission and up to the point of discharge was very good. They told us:

> "I've been so impressed with the quality of the service, and I've had excellent treatment…. everyone is professional and helpful….I've been given the information I needed and I know what's going to happen when I leave."

We spoke with a patient who has a long term condition requiring coordinated care

and support, and their relative. They said they were given the information needed to understand the condition and how best to manage the symptoms, and that everyone involved in their care was informed quickly about any changes in the treatment plan.

The Patient Advice and Liaison Service (PALS) shared with us the results of patient surveys between January and March 2011. Only about half of patients admitted for emergency care said staff had told them who to contact if they were worried about their condition or treatment after leaving hospital. About 80% of patients in hospital for planned medical care said they had this information and the figures showed an improvement over the three month period. In February and March, nearly all (95%) of outpatients said they knew who to contact if they were worried about their condition or treatment when they get home.

**Other evidence**

All the staff we spoke with told us there was good communication between different professional groups and we saw effective referrals and communication between specialities in patients' records.

The local primary care trust (PCT) told us the trust and community health care staff work well together. The trust cooperates with other providers for safeguarding referrals and investigations, and engages with health community serious incident investigations. The PCT told us about ongoing concerns from local GPs about unsatisfactory discharges from the trust, and has arranged to meet with the trust to work on this.

The hospital's discharge liaison nurse coordinates discharges and described the arrangements in place to meet the Community Care (Delayed Discharges etc.) Act (2003). This involves working with local social and health care services to put in place support to enable an individual to live in their own home, or in a care home, so they can be safely discharged from hospital. The discharge liaison nurse uses the hospital's computerised records of in-patients and their planned date of discharge to identify any issues that might prevent or delay someone's planned discharge. Some people are supported through a "fast track" system if they have end of life care needs and the wishes of the patient and their relatives are taken into account when deciding about arrangements for discharge.

The discharge liaison nurse told us she ensures good communication with providers of learning disability services to ensure there is a properly coordinated discharge plan. She also has links with the community learning disability teams who provide guidance and support. We asked staff about supporting people with a learning disability in the hospital. Outpatient staff gave us an example of someone who became distressed when asked to give a blood sample. The staff found a quiet area on a ward, away from the busy outpatient department, where he could sit quietly with his carers in private, and he then consented to giving the blood sample.

Patients showed us examples of discharge information that included a summary of the reason for being treated at the hospital, the name of the health care professional responsible for their assessment and treatment, medication on discharge including special instructions, dose and why it was prescribed. The discharge summary contained a description of the follow-up care they should expect and the date, for example when the district nurse would visit them at home. The form also confirmed that the same information was sent to the GP.

We spoke with two qualified nurses and one health care assistant who told us about the coordination of outpatient and day patient care: The consultant dictates letters recommending specific treatments and discharge planning, and these are transcribed and posted by medical secretaries. This makes sure that patient information is transferred securely. Patients remain under the care of the consultant whilst specialist services are accessed. Staff said: “The process works well because this is a small hospital and liaison is good.”

**Our judgement**

People who use services receive safe and coordinated care, treatment and support where more than one provider is involved or they are moved between services.

# Outcome 7:
# Safeguarding people who use services from abuse

## What the outcome says

This is what people who use services should expect.

People who use services:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

## What we found

**Our judgement**

**The provider is compliant**

**Our findings**

**What people who use the service experienced and told us**

We spoke with three patients on a medical ward and they told us they felt safe and protected. They said that staff were respectful when supporting them and maintained their dignity, and we observed this when staff provided personal and medical care. Patients told us staff listened to them and acted on any concerns they expressed.

**Other evidence**

The hospital matron visits each ward and department daily to discuss any concerns staff may have regarding vulnerable adults. There is also a paediatric safeguarding lead who meets with minor injuries staff regarding issues such as non accidental injury. The local primary care trust (PCT) told us the trust works constructively with them on safeguarding issues and the appointment of safeguarding leads has been beneficial in working with the PCT and other providers, providing a focus for staff training, education and support.

We spoke with four staff who told us they received training in safeguarding adults and children, with mandatory updates. They all said the training helped them recognise signs of abuse and they understood what to do if they suspected it. They told us how they consider people's behaviour and try to reduce the negative effects some patients' behaviour may have on others. The trust's Safeguarding Adults Policy (Jan 2010) sets out staff responsibilities in preventing and minimising the risk

of abuse to vulnerable adults; the staff we spoke with showed commitment to maximising people's choice and control, and protecting their rights.

The trust produces a newsletter reminding staff of the importance of safeguarding and their duty of care to report any concerns they may have regarding vulnerable adults. We also saw up to date policies and procedures on safeguarding for staff to follow.

The Mental Capacity Act (2005) (MCA) provides guidance for when a decision is made in the best interests of a person lacking capacity. Deprivation of Liberty Safeguards (DoLS) are intended to protect people from being deprived of their liberty unless it is in their best interests to protect them from harm and there is no other less restrictive alternative. Hospitals need to obtain authorisation to deprive someone of their liberty, lawfully. We looked at the records of one person who had fluctuating capacity to make choices regarding their care. Staff had referred the patient to the social worker for an urgent best interest assessment under the MCA and subsequent application for DoLS. The hospital matron showed us records of comprehensive communication with all parties involved including the person's relatives. In this case, a person was deprived of their liberty only after a "best interests" assessment and the involvement of relevant member of the multidisciplinary team.

We saw staff liaising with families and the mental health liaison nurse, and in patient care plans we saw records of face to face and telephone conversations with relatives about people's care. Staff also provided easy read guidance on the MCA and DoLS, which provides information in a format that is accessible to people with a learning disability. The local PCT told us the hospital has robust systems in place to manage DoLS, producing detailed records and supporting staff well.

The trust has a multidisciplinary Safeguarding Adults Board that meets monthly and leads on all safeguarding issues including policy implementation and training. They held an awareness day last November and are arranging future training in safeguarding for all staff. A laminated poster "Safeguarding Adults Quick Reference Guide" is displayed in wards and departments, and provides staff with a checklist of what to do if they have safeguarding concerns. Staff also have a small "quick reference" card that attaches to their name badge and contains all relevant urgent contacts for safeguarding vulnerable people.

**Our judgement**

People who use services are protected from abuse or the risk of abuse and their human rights are respected and upheld.

# Outcome 8:
# Cleanliness and infection control

## What the outcome says

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

## What we found

**Our judgement**

**The provider is compliant**

**Our findings**

**What people who use the service experienced and told us**

We visited a medical ward, surgical ward, day case theatre and the minor injuries unit. All areas were clean, with good access to storage and hand washing facilities. Bathroom and toilet facilities were clean and in a good state of repair. There were disposable curtains at all bed areas including the minor injuries unit, and these were in good condition and appropriately labelled and dated. There was an appropriate supply of soaps and hand gels at the entrances to all areas and all patient contact areas had appropriate hand gel.

We spoke with visitors in the main hospital corridor who told us they were very happy with the cleanliness in the hospital. They thought there was plenty of information on infection control and they were aware of the need to gel their hands and they found this reassuring. They said they had never had any concerns about cleanliness when visiting the hospital. On the NHS Choices website between April 2010 and March 2011there were 11 positive comments from the public about cleanliness and only one negative comment. CQC's Survey of Adult Inpatients in the NHS (April 2011) found patients across the trust were very positive about the cleanliness and hygiene of the hospitals.

We saw that infection prevention and control (IPC) policies and procedures were being put into practice and audited. We saw staff wearing appropriate uniforms, including being bare below the elbow. We saw staff hand washing before and after each patient contact, and using hand gels in addition as they moved about the wards.

**Other evidence**

The trust's director of infection prevention and control (DIPC) prepares the annual statement, which contains information on the involvement and commitment of the board, the assurance framework in place and the monthly surveillance reports to the board on infection rates. The DIPC, supported by the Infection Prevention and Control team (IPCT), chairs the Infection Prevention and Control Committee (IPCC), responsible for providing advice and assurance to the board, which reports directly to the Clinical Governance Committee. At ward level there are link representatives, who are trained and attend study days. The hospital has local infection control meetings which report on training, implementation of policy, programme of audits and infection rates.

We spoke with seven members of staff who told us they sought advice from the IPCT and that link nurses attended meetings and carried out ward and department audits. On the minor injuries unit staff showed us examples of IPC risk assessments. A range of medical, nursing, support and administrative staff all confirmed they received IPC training as part of induction and through mandatory updates, and there is an e-learning course. Staff access policies and advice through the trust intranet. We were told that all contractors have induction training before they start work on the premises and this contained an element of IPC.

The inpatient wards have notice boards which display the results of IPC audits, such as for hand hygiene. The audits were up to date and area-specific. We saw the Tissue Viability Mattress Audit Record for one of the medical wards (24 November 2010). The audit was carried out appropriately and one mattress identified as an infection control risk had been replaced, and this was confirmed by the housekeeper.

The hospital matron is responsible for ensuring cleanliness in the hospital and regularly tours all areas including checking individual items of equipment. The ward leaders manage the ward housekeepers who told us how they kept each area clean, referring to the national cleaning standards, how cleanliness is audited and showed us cleaning schedules and check lists. We saw that the cleaning equipment was colour coded and used appropriately, including the use of micro fibre products. Staff knew which products to use to clean or decontaminate a given area or piece of equipment. The hospital matron told us there is a deep cleaning squad available 24 hours a day.

We saw appropriate segregation of domestic and clinical waste, and soiled linen collected in appropriate bags. There were lockable bins strategically located throughout the hospital, for example one outside a medical ward was hidden behind a screening curtain and locked. We saw that items such as needles and syringes (called "sharps") were disposed of in properly designated bins that were correctly labelled and dated. An external contractor ensures that the hospital premises are maintained and fit for use. All senior staff we spoke with confirmed the service for requesting maintenance and repairs is excellent. Staff confirmed there were procedures in place for the cleaning and decontamination of equipment. All equipment observed in all three areas was visually clean, with no areas of concern regarding fitness for use.

We saw that some of the hand washing basins in patient areas had traditional style (hand-operated) taps. These did not conform to the requirement for lever or sensor operated taps which reduce the risk of hand contamination. We also saw some sinks with plugs attached, which also increases the risk of infection through washing hands in contaminated water. The trust showed us a work request dated 19 August

2010 to replace all conventional taps in the clinical areas at Newark Hospital to wrist or elbow operated taps, which was approved at the end of March 2011.

There is a traceability system in place for commode cleaning, which means that once the commode is clean, a tape is put on to show that is ready for use and who last cleaned it. Staff on the medical ward told us that commodes are steam-cleaned weekly. A nurse demonstrated the cleaning of a commode and was confident with the traceability system.

Storage areas were well organised and there was a plentiful supply of linen in each area and this was appropriately stored. All single use items remained within their sealed packaging until used and staff confirmed they were disposed of once used. We saw appropriately labelled single use hoist slings and there was a plentiful stock of spares. Regular checks of the cleanliness of equipment were displayed on notice boards and the sister in charge of a medical ward showed records of checks going back many months. We examined fridges used for food storage (for both staff and patients) on one of the wards. They were clean and the food was clearly labelled. Fridge temperatures were monitored daily. The fridges where medication is stored were also clean and their temperatures were monitored.

We saw a range of information about IPC for patients and visitors on display throughout the hospital. At the main entrance there were posters with information on the hospital's screening policy and hand washing campaign. On each ward visited we saw an infection control notice board, with information on cleaning schedules, infection rates for that area, audit information and patient leaflets. There is a patient information leaflet for patients who have an infection and a discharge letter that goes with the patient when they leave hospital. We saw new hand washing posters in visitors' toilets that were clear and eye-catching. There is a wide range of infection control information on the hospital website, including some policies and procedures.

The hospital matron told us there is a screening programme for meticillin-resistant *Staphylococcus aureus* (MRSA) at admission. When a patient's history is unknown then a risk assessment is carried out and in case of doubt a patient is nursed in a side room. If an incident of infection is found then a root cause analysis (an approach to finding and correcting underlying problems) is carried out to find out how this occurred, and referred to the IPC team. The wards we visited had three side rooms and one double room, which can be used to isolate a patient with an infection, until they have three negative tests. The hospital matron told us of an incident last December when a patient was suspected of having a Norovirus infection, which spreads very easily from person to person and can survive for several days in a contaminated area. The patient was immediately isolated in a side room and barrier nursed, which means nurses wear gowns, masks and gloves, and they observe strict rules to minimise the risk of passing on infectious agents. This meant that the infection was prevented from spreading to other vulnerable patients. In all areas we visited we saw a plentiful supply of gloves, aprons and cleaning equipment. There was also a stock of signs giving information on isolation.

The DIPC annual statement (2009/10) describes the trust's commitment to the antibiotic prescribing policy and how this is impacting on the success of infection prevention and control. The hospital matron told us the pharmacist carries out audits of antibiotic prescribing in line with trust policy and the senior medical team ensure that the trust policy is applied within their teams.

The trust has had no MRSA infections in the year 2010-2011. *Clostridium difficile*

infections, which peaked in June 2010, have tailed off and no new incidents have been reported since December 2010.

**Our judgement**

People who use services are protected from identifiable risks of acquiring an infection by effective infection prevention and control measures.

# Outcome 9:
# Management of medicines

## What the outcome says

This is what people who use services should expect.

People who use services:

- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

## What we found

**Our judgement**

**The provider is compliant**

**Our findings**

**What people who use the service experienced and told us**

The patients we spoke with on a medical ward told us staff provided them with information about their medicines, including their effects and side effects. They confirmed they received their medicines when they needed them and they felt their pain was well controlled.

We spoke with one patient who told us he was well supported to self-administer his medicines; a nurse had spent half an hour discussing his medicines and his safety when administering them himself. He kept his medicines in a lockable drawer in the bed-side locker, and he described keeping the key safe. We saw the pharmacist discuss with him his supply of medicines to ensure he had sufficient to take home.

The trust shared with us the results of outpatient surveys from January to March 2011: around a third of patients who had been prescribed new medication at the hospital said they were not told about its side effects. These results were not reflected in the trust findings from CQC's Survey of Adult Inpatients in the NHS (April 2011).

**Other evidence**

We visited a medical ward and saw there were systems in place to ensure that each patient had the opportunity to discuss any issues with their medicines. The ward

pharmacist told us she spends time with each patient discussing their individual needs and support when taking medicines. She told us that people have a choice regarding their medicines and their wishes and cultural requirements are accommodated wherever possible, for example vegetarians who do not wish to have gelatine capsules, or people who fast during religious festivals. These issues are included on the medicine record sheet to ensure they are always considered when prescribing.

We looked at records that documented how staff made sure people were properly assessed for their safety with administering their own medicines. Risks were reviewed each day to ensure that any changes in a person's condition were considered. We spoke with three patients who all confirmed that nursing staff and the pharmacist had spent time with them discussing any support they needed to self administer medicines where they were able.

The pharmacist explained how she monitors medicines prescribing and provides guidance on the effect of medicines to reduce the risk of any adverse reactions. We spoke with four staff about adverse events relating to medicines and they were all able to describe how to report such events and how lessons learnt are fed back to them so that the risk of it happening again is reduced.

We saw that medicines were stored securely in lockable cabinets and trolleys. We looked at records of controlled drugs (prescription medicines that are controlled under the Misuse of Drugs legislation) and saw they provided a clear audit trail of receipt and administration, complying with the relevant legislation. We saw the pharmacist checking people's medicine supplies and discussing with them the security of the medicines. We checked the number of controlled medicines in the minor injuries unit, which demonstrated accurate recording and twice daily audits. We saw records that showed medicines which required cold storage were monitored by staff twice a day to ensure they were being stored at the correct temperature.

We looked at the arrangements in three clinical areas and saw that medicines required for resuscitation and other medical emergencies were accessible to staff and kept in tamper proof packaging that allowed them to be used as quickly as possible.

We spoke with four staff who all confirmed that they had received medicine competency training at the start of their employment. They all confirmed receiving mandatory updates in medicine administration and said they felt competent to undertake their role. We saw medicines being handled and administered properly to reduce any risk of mistakes. We looked at the medicine records of 3 people and saw that staff recorded when medicines were administered and taken by the person using the service as part of their plan of care. We saw how the pharmacist produces a printed document that people take home with them, it gave clear information on the type of medicine they were taking, how often and what it was used for.

We asked staff about access to evidence-based and good practice guidance published by appropriate professional bodies and alerts about medicines management. They told us they have electronic access to a range of guidance provided by the trust. They also receive a regular newsletter which is produced to keep staff up to date with any new guidance and changes in hospital policy. They told us the hospital lead for controlled medicines is available for advice and provides them with relevant information.

Current legislation requires every hospital to appoint an accountable officer who

takes organisational responsibility for controlled drugs, and each primary care trust (PCT) to establish a local intelligence network (LIN) comprising accountable officers from local NHS and independent healthcare organisations, along with regulatory bodies and agencies. The role of the LIN is to share information about controlled drugs. The local PCT told us the trust's chief pharmacist (accountable officer) is fully engaged with the LIN, submitting regular reports and sharing information, and there have been no concerns with the trust's management of controlled drugs.

**Our judgement**

People who use services have personalised care through the effective use of medicines.

# Outcome 10:
# Safety and suitability of premises

## What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are in safe, accessible surroundings that promote their wellbeing.

## What we found

**Our judgement**

**The provider is compliant**

**Our findings**

**What people who use the service experienced and told us**

Patients and visitors told us they thought the building was in good general repair, and well maintained given that it was an old building.

Staff told us they felt the building was safe and well maintained. They were able to contact a help desk should any repair or maintenance issues arise and the service from an outside contractor was very good. Staff were confident that all the necessary health and safety checks were being undertaken and that appropriate regulations were adhered to. All staff spoken with confirmed that they had received training in health and safety, fire safety and were aware of contingency plans should there be plant failure or emergencies.

**Other evidence**

Corridors were well lit, heated, ventilated and had good access. There was suitable signage regarding health and safety, such as fire safety and restricted access to plant equipment. We saw the fire escape routes were clear and appropriately signed. The facilities manager and the minor injuries manager told us there were regular risk assessments.

There was clear evidence of the building complying with the Health and Safety at Work Act 1974 regulations. We saw appropriate signage relating to restricted access, fire safety, evacuation points and fire procedures, appropriate waste disposal, use of personal protective clothing and equipment and controls in place

regarding particular plant equipment. The facilities manager confirmed that before any contractor was allowed to work on the premises they attended hospital induction training, which included health and safety. We saw records of this training, which are kept in case a contractor needs to return to the site at a later date.

There were no concerns raised regarding people's right to privacy, dignity, choice and autonomy. We visited two wards and saw that male and female patients were accommodated separately and screens were used around beds when needed to maintain privacy. The screens were in good condition. Some bays had en suite toilet facilities. The minor injuries unit had appropriate screening and toilet facilities and there were side rooms for individual consultation. There were family rooms available for any relative or visitor who wishes to stay overnight. In the minor injuries unit there were designated play areas for children There were facilities for breast feeding mothers in the outpatients department and also the family rooms. There was a quiet room available for breaking bad news.

An audit has taken place to ensure that the premises are accessible and comply with the Disability Discrimination Act 1995 (DDA). On touring the premises there was good level access, toilets for disabled people, vertical lifts to upper levels and designated car parking for disabled people.

The facilities manager confirmed the hospital complied with appropriate Department of Health best practice standards in planning, design and building components of healthcare facilities. Before any building work goes ahead an impact assessment and risk assessments are carried out.

Regular checks are made on machinery and equipment including the hoists, and we saw records of unsafe equipment taken out of use with adequate replacement. We saw that electrical equipment was regularly tested and inspected. The porters carry out six weekly checks of the oxygen cylinders and the full and empty cylinders are segregated. The most recent X-RAY radiation protection audit carried out in May 2010 found a high level of compliance with the relevant regulations governing the use of ionising radiation. The trust provided us with evidence that unused toilets and bathrooms were managed appropriately to decrease the risk of *Legionella* infection, which can lead to Legionnaires' Disease.

There were appropriate licences and systems in place for the handling and disposal of waste. We saw that waste was appropriately bagged and colour coded, as well as labelled. There were four locations for the bins, and these were locked and out of view. There was no evidence of any build up of waste within the hospital and staff confirmed that the porters collected waste at regular intervals and were very careful to comply with all procedures. Staff told us they felt well supported by the porters with this. We saw the contractor's current certificate of liability.

We saw that all chemicals were appropriately locked away. We spoke with two housekeepers who described appropriate use of cleaning products, managing a spillage. All staff are trained in the Control of Substances Hazardous to Health (COSHH) regulations during induction, and we saw a COSHH file with the relevant risk assessments in place.

The facilities manager and head porter confirmed that risk assessments for unauthorised access to the hospital were carried out. We saw an example of when children tried to gain access to the waste compound and the measures put in place to eliminate this risk. There were CCTV cameras on most corridors and the outside of the building. At nights the doors are all locked except for the minor injuries unit.

There is an intercom system in place at night for entrance doors and porters tour the premises regularly.

Regular estate meetings discuss maintenance issues within the building, and we saw minutes from a recent meeting that contained information on how maintenance issues were being dealt with. There was a five year programme for re-decorating the buildings. There were also contingency plans for all major failures and emergencies. Staff confirmed they knew what to do in the event of an emergency. There is a generator in case of electrical failure and regular fire alarm tests take place. We saw the record of the most recent annual fire lecture.

**Our judgement**

People who use services receive care and treatment in safe and accessible surroundings.

# Outcome 11:
# Safety, availability and suitability of equipment

## What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
- Benefit from equipment that is comfortable and meets their needs.

## What we found

**Our judgement**

**The provider is compliant**

**Our findings**

**What people who use the service experienced and told us**

We visited two wards and the minor injuries unit and spoke with four staff and three patients who told us they had the equipment they needed and there was enough equipment to meet everyone's needs. We observed a patient being supported to use equipment which promoted their independent mobility; the staff member took time to explain about the equipment and how to use it in a safe way.

**Other evidence**

We spoke with four staff who explained how patients were assessed for any risks associated with different equipment they needed to support them. The staff told us they received training to use all types of equipment and this ensured they were competent and people remained safe. They told us there were good systems in place to access further training if needed. From discussion with all four staff, including senior staff, it was clear there was a robust system in place to report any adverse events when using equipment, and this promoted an open culture of reporting incidents and improving patient safety.

We saw that equipment was suitably labelled, recording the date of servicing and maintenance. Emergency equipment was tamper proof and accessible for use as quickly as possible. We saw single-use items stored in sealed packaging and disposed of after use. In all areas we visited we saw a good supply of personal

protective equipment, such as gloves and aprons, used to protect against the transmission of infection

An X-ray radiation protection audit in May 2010 found that all items of protective clothing had been properly checked and the equipment inventory was maintained centrally. There were a few remaining people to be trained in the use of the mobile image intensifier and the trust's action plan confirmed this has since been completed, and training in "local rules" or protocols is included in the induction of relevant theatre staff.

Staff told us they were kept informed of alerts and guidance, such as Medical Device Alerts from the Medicines and Healthcare products Regulatory Agency (MHRA), which is responsible for the regulation of medicines and medical devices and equipment used in healthcare and the investigation of harmful incidents. Each ward had an appointed person responsible for the management of equipment and related training. Staff told us they never encountered any delays in accessing or having equipment repaired

**Our judgement**

People who use services are not at risk of harm from unsafe or unsuitable equipment and benefit from equipment that meets their needs

# Outcome 12:
# Requirements relating to workers

## 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 staff who are fit, appropriately qualified and are physically and mentally able to do their job.

## What we found

**Our judgement**

**The provider is compliant**

**Our findings**

**What people who use the service experienced and told us**

Not relevant to this outcome

**Other evidence**

The hospital manager told us how she has a tight control over recruitment procedures. Ward leaders identify vacancies and the requests go through a series of approvals within the trust and there is a set process to follow to short list candidates and arrange their interviews. The appointing officer and the hospital matron or hospital manager carry out the interviews. The trust's human resources department provides guidance on equality and diversity issues when conducting interviews, and all appointing officers have attended a recruitment and selection course. We saw that recruitment and selection training was raised at the hospital's inter-departmental meeting in January 2011 and that dates for forthcoming training were confirmed in the March meeting.

The hospital manager told us they carry out all pre-employment checks in line with the NHS Employment Checks Standards. Administrative staff follow set procedures for chasing references, checking qualifications and offering posts. Audits pick up any errors or omissions in the recruitment procedures. The trust's human resources department sends the hospital manager monthly update regarding staff member's professional registrations that are due for renewal (other than allied health professional registrations, which are managed by the therapy team leaders).These

are sent on to managers who check dates of registration and follow up renewals with individual members of staff and check continued membership of and registration with appropriate professional bodies; these are then confirmed with the human resources department.

**Our judgement**

People who use services are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and able to do their job.

# 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**

**The provider is compliant**

**Our findings**

**What people who use the service experienced and told us**

We visited three wards, the outpatients department and minor injuries unit. We saw people's needs being met effectively and sensitively, and we did not see people being left waiting or ignored. We observed staff speaking calmly and clearly with patients and their relatives, spending enough time with them and supporting them during a meal time. One patient told us: "The staff know what they're doing and want to help you. The hospital's small and personable."

CQC's adult inpatients survey (April 2011) found that nearly 80% of 390 people thought there were enough nurses on duty to provide patient care.

We saw in patients' care records that when ward staff referred patients to other professionals, they were usually seen within a reasonable length of time. There was a friendly and supportive atmosphere in all the clinical areas we visited. In outpatients, we saw that each clinic was well staffed with health care assistants who helped take patients through the various waiting and clinic areas, and added to the smooth running of the clinics.

**Other evidence**

We spoke with staff and patients on the wards and in outpatients who told us there were enough staff with the right skills to meet the needs of the patients. Qualified and care staff said they are well supported by domestic and administrative staff and

porters. One member of staff told us that even when the wards were busy there were always enough staff to meet patients' needs, although it was difficult to allocate staff and they could not spend as much time with patients as they would like to. Some staff told us there were delays accessing specialist staff who were based at the main King's Mill Hospital site.

The hospital manager told us there are currently a high number of vacancies as part of planned workforce transformation, as services are reconfigured to meet financial challenges. A number of staff have been employed on temporary contracts to cover the vacancies and these contracts are being extended for another two months. There is a robust procedure for workforce change and the hospital manager runs a weekly staff forum where staff can raise concerns. There is also a bi-monthly joint staff partnership forum, attended by senior managers, staff support coordinators and union representatives, where issues such as workforce review, equality and diversity and staff welfare are discussed.

The trust's Mandatory Training Policy (updated Nov 2009) defines essential training and sets out which staff groups must receive different types of training, how often and how long the training is. Mandatory training incorporates topics such as fire awareness, infection control, moving and handling, medical devices, safeguarding adults and children and basic life support. Training and development is a standing agenda item in the inter-departmental meetings. The hospital manager ensures that staff attend mandatory training through reports from human resources on staff who failed to training sessions, and this is followed up through line managers and the inter-departmental meetings. All the staff we spoke with confirmed they attend annual updates of mandatory training and access a range of learning materials on the trust intranet.

The hospital manager reviews staff absence and return to work records with team leaders on a monthly basis. She checks that appropriate actions have been taken, such as phased returns to work. We spoke with a member of staff who had been off for some months who was very happy with the support from the hospital in a phased return to work. The hospital manager formally meets staff with a poor attendance record, and supporting people to manage at work is discussed in her supervision sessions with team leaders.

**Our judgement**

People who use services are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

# Outcome 14:
# Supporting workers

## What the outcome says

This is what people who use services should expect.

People who use services:
- Are safe and their health and welfare needs are met by competent staff.

## What we found

**Our judgement**

**The provider is compliant**

**Our findings**

**What people who use the service experienced and told us**

CQC's adult inpatient survey (April 2011) found that the vast majority (nearly 90%) of patients across the trust had confidence in the nurses and doctors treating them.

**Other evidence**

The hospital manager told us that all new employees start work on a trust induction date and are allocated a mentor. All the staff we spoke with told us they had attended induction and received regular training updates, including mandatory training once a year. They told us they have an annual appraisal with their line manager when they discuss their performance and development needs. All the staff we spoke with told us this was a constructive and supportive process.

CQC's 2010 National NHS staff survey (March 2011) found that trust staff were highly engaged with their work, their team and their employer, and few experienced discrimination at work. The trust was in the highest 20% for staff receiving job-relevant training, learning or development in the last 12 months and getting support from immediate managers. The staff we spoke with agreed with this and told us that although they do not have regular supervision sessions with their line managers, they meet with them whenever they need to. They all told us their managers and senior hospital staff were approachable and supportive. Staff told us they had been on various professional development training courses, to enhance their role as housekeeper, health care assistant or link nurse. One mentioned that many courses are held at King's Mill Hospital, which is some distance away, and that discouraged

her from attending other than mandatory training.

The hospital manager told us she reports appraisals to the trust's human resources department and carries out an annual training needs analysis with input from team leaders. The requests are sent to the trust's "learning beyond registration" coordinator, and usually these requests are supported and funded. Occasionally the hospital manager uses ad hoc trust funds to pay for one off courses when funding won't be provided through normal learning and development budgets. She agreed the vast majority of training takes place at the King's Mill Hospital location, due to the logistics of numbers, staff and training facilities, but there are e-learning packages and some training can be carried out through a video link from Kings Mill Hospital.

Staff told us they feel safe at work and have been supported to raise any concerns without fear of recrimination. "It feels like a family here." They told us they are able to take regular breaks away from the ward or department. The hospital has up to date policies on bullying, harassment and grievance. The hospital manager is on the trust's staff wellbeing committee and there are two staff wellbeing days per year. The committee is looking at concerns raised by CQC's 2010 National NHS staff survey (March 2011). This found that although the trust scored well for staff experiencing little harassment, bullying or abuse, they were in the worst 20% for perceptions of effective action from employer towards violence and harassment (the trust was worse than average for experiencing physical violence from patients, relatives, the public and staff).

Two members of staff gave us examples of positive help from the occupational health services on return to work after sickness and during normal working practices. Staff told us about the effective counselling service provided by the occupational health department and there is a staff benefits coordinator who helps people with more practical concerns such as managing long term sick leave or child care.

**Our judgement**

People who use services are safe and have their health and welfare needs met by competent staff.

# Outcome 16:
# Assessing and monitoring the quality of service provision

## What the outcome says

This is what people who use services should expect.

People who use services:

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

## What we found

**Our judgement**

**The provider is compliant**

**Our findings**

**What people who use the service experienced and told us**

Some of the patients and visitors we spoke with told us they had been asked to provide comments about their care and the hospital in general. Most patients said they felt well informed and involved in decisions about their care, and were confident in the quality of treatment they received. There were eye-catching displays in the main corridors with thank you cards and letters of thanks from patients and relatives.

**Other evidence**

In August 2010, we reviewed compliance with this outcome across the trust. We found the trust had arrangements for clinical governance and audit systems across all of its services that help them deliver high standards of care and enable them to monitor improvements and progress. We published our findings in our report dated 21 September 2010.

In March 2011 the trust's patient safety manager explained how it was developing its approach to mortality outliers, which look at how many patients have died after being admitted to hospital for a particular condition or procedure. An alert is generated when the number of deaths is much higher than expected for that type of hospital. The trust has developed a reporting template so that responses to mortality outlier alerts are standardised and carried out promptly. The trust also reviews the

cases of patients who have survived so that interacting issues affecting illness as well as death can be addressed. Mortality outlier reviews must be reported to the trust clinical governance committee, and outcomes from the reviews are used to support proposals for service development. For example, improved management of the life-threatening condition “abdominal aortic aneurysm” and re-structuring wards to better manage patients with pneumonia. There is a monthly “quality scrutiny” meeting with the local primary care trust (PCT). This brings together issues from the acute hospital and the community so that better responses are developed, for example re-designing integrated plans of care for people with a given condition.

During our visit to Newark Hospital in April 2011, the hospital manager explained how various indicators of quality are used to monitor care and drive improvement. For example, the Patient Advice and Liaison Service (PALS) carries out brief patient experience surveys each month, complaints are reviewed for trends, and regular audits take place in line with the essence of care benchmarks as described previously in this report. Serious incidents and adverse events affecting patients are reported through a computerised database, and senior staff are required to investigate and respond with appropriate action that can only be confirmed as closed by the hospital manager or matron.

The hospital manager attends the trust’s clinical governance committee. Senior nursing staff receive weekly nursing bulletins from the hospital’s clinical governance adviser. We looked at the last two sets of minutes from the bi-monthly inter-departmental meetings (January and March 2011). We saw that these meetings discuss and report on cross-department issues such as strategy and improvement, training and clinical audit. Clinical governance is a regular item at meetings of ward leaders and medical staff groups. Lessons learned and changes to practice are shared and cascaded to ward staff via these meetings, and reviewed at divisional meetings. For example there was an unexpected death after routine surgery. The doctor had written “observe” but had not directed how frequently. Now there is a retrospective audit of notes to make sure terms like “observe” are clearly defined.

**Our judgement**

People who use services benefit from care and treatment that is monitored to ensure it is safe and of high quality.

# Outcome 17: Complaints

## What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:

- Are sure that their comments and complaints are listened to and acted on effectively.
- Know that they will not be discriminated against for making a complaint.

## What we found

**Our judgement**

**There are minor concerns**

**Our findings**

**What people who use the service experienced and told us**

We asked eight patients and relatives what they would do if they had a complaint or concern about the hospital. Three people said they would write to the hospital manager if they had concerns; two people did not know what the complaint process was but said they would go to the PALS office to find out. One told us they had used the PALS service before to leave a positive comment about the care they had received. They were all confident the hospital would take any concerns seriously. The patients we spoke with were not worried they might be treated differently if they made a complaint, nor that it would be detrimental to their care and treatment.

One patient told us they were given information about the feedback process on admission. Another person showed us a form they had been given to complete if they had comments or concerns to make about their stay in the hospital. Some of the forms we saw during our visits were poorly photo-copied with small, faint or distorted print, and were not adequate for requesting feedback.

**Other evidence**

There was a Patient Advisory Liaison Service (PALS) office in the hospital and we saw signs and leaflets about their services in each department we visited. Newark Hospital PALS currently has over 200 volunteers who help find out patients' experiences, through surveys, interviews and visits. PALS also informs and

discusses with patients how complaints can be made, escalated and resolved. Their information includes the support they can provide and an explanation of the two stage NHS complaints process. PALS provides feedback forms, pens and post boxes in six areas of the hospital where people can leave their complaints and comments. Feedback can be anonymous if preferred and PALS told us this does not affect the way complaints were dealt with.

Newark Hospital does not have a complaints office on site and all formal complaints are initially sent to Kings Mill Hospital with a copy given to the Newark Hospital manager. We saw a record of recent complaints about services at the hospital, with each step documented and a record of when each complaint is sent to the trust's Chief Executive Officer. The hospital implements the trust's complaints procedure, which meets the Department of Health requirements on complaints. There is a named person with responsibility to co-ordinate investigations into complaints and make judgements about whether they are upheld or not.

During the period April 2010 to March 2011, Newark Hospital received 89 formal complaints, a 45% increase on the previous year. The trust acknowledged all complaints (87% within three days) but a third of the complaints were not dealt with within the trust's own time scales. The trust told us this could be explained by significant staff sickness and absence in the complaints department last year. The trust shared with us a break down of the nature of complaints received at Newark Hospital and the outcome and learning from nine investigated complaints, but was not able to provide us with a summary of the complaints with the responses made, as required under the relevant legislation.

The NHS Litigation Authority (NHSLA) handles negligence claims and works to improve risk management practices in the NHS. The trust has achieved NHSLA level 1. This means it has an approved documented process for listening, responding and improving when people raise concerns or complaints, but not that they monitor compliance with the process.

During our visit, staff accessed the intranet to show us a copy of the complaints leaflet, which explained the complaints process and the trust's commitment to respond within pre determined timescales, but we did not see this leaflet displayed around the hospital. The leaflet says the information and guidance on complaints is available in other languages and in Braille on request, but we did not see this information made available in different languages and formats. Findings from the NHS inpatient survey (April 2011) support this as only a third of 280 patients said they saw posters or leaflets explaining how to complain, although the survey was across the whole trust not just Newark Hospital.

Each month, PALS presents information on patient and visitor feedback to senior members of the hospital team, so that managers are made aware of themes and trends, both in compliments and concerns. Staff told us they receive feedback and guidance on their team's practice from their managers if a complaint about their service has been made and upheld. One person said they may also receive individual feedback through appraisals. Three staff from different departments said that the main concern patients talked to them about was waiting times, but that people were generally satisfied when staff explained the reasons. It is not clear how patients' and visitors' informal concerns are captured and fed back to senior managers. We spoke with three staff from different hospital departments about receiving complaints and it was clear they understood the process and would take

appropriate action to support the complainant.

**Our judgement**

People who use services cannot be sure their comments and complaints are acted on effectively because information about making a complaint is not always accessible and the provider does not have robust systems in place to manage comments and complaints.

# Outcome 21:
# Records

## What the outcome says

This is what people who use services should expect.

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

## What we found

**Our judgement**

**There are minor concerns**

**Our findings**

**What people who use the service experienced and told us**

We spoke with two patients who confirmed their notes were available at the time of admission and remained with them as they moved between departments in the hospital. Two people we spoke with in outpatients told us different providers were involved in their care and letters about their consultations were sent to the others so that everyone knew what was happening, and everything worked smoothly. Another patient said there was a clear system that meant staff in different departments were confident they were treating the right person and used his notes to discuss the treatments he had received so far and explain the next stage of the treatment programme.

**Other evidence**

The hospital manager told us the hospital uses three main computerised record keeping systems to store patient information and activity. Each system is password controlled and access depends on staff grade and role. Systems track a patient's care pathway, care records as a patient moves between departments, and discharge. The opening page of one electronic system alerts users to patient records that are lost or missing. We saw there were only eight lost or missing records across the two hospital sites on the day we visited. None of them were for

patients in the departments we visited, but staff explained the process to trace the missing records.

The information on patients who attend as “day cases” is kept as paper records only. The medical records department generates an “outcome slip” that is attached to the notes and is used to record each stage of the patient’s care during the day. One member of staff in outpatients explained that at the end of each clinic, referral information is posted out by medical secretaries. In the out-patient departments, there is a secure system to ensure records are transferred between medical records and the clinic.

Staff told us a patient’s notes travel with them when they transfer from one ward to another within the hospital. There is a handover of the notes and information about the patient when they arrive on the ward. Staff were aware of the key issues of information management such as only sharing information on a need to know basis and recording only relevant information in a professional way. The hospital has a suitable protocol for the sharing of information with other providers.

There is a central admissions office at the main site (King’s Mill Hospital), available twenty fours hours a day, seven days a week. Records are transported daily between the two hospital sites using the hospital transport system, in order to maintain security.

We looked at a record of the 22 documented incidents relating to patient notes during the year April 2010 to March 2011. These included delays in obtaining healthcare records, failure to note relevant information in patients’ records, and patients incorrectly identified. Actions taken to investigate the incidents and prevent recurrence and were generally clear.

We spoke with different grades of staff about how they make sure accurate personalised records are kept and maintained. They told us staff induction includes records management training and this training is refreshed periodically. Staff check the patient’s identity so as to access the correct records, and patient identity wristbands can be printed on the wards. All types of records are updated as soon as possible and some paper records that are used frequently, such as food and fluid charts, are kept at the patient’s bedside. Other records are kept at the ward desk and staff follow the agreed filing system. Some of the individual paper records in regular use had not been secured within the file but were tucked in the front for ease of access, which increased the risk of them being misplaced.

The records we saw included information to identify the patient, entries were dated and signed and contained information that was relevant to the clinical assessment and treatment. Patient case notes did not always document special social or cultural needs; the care plan provided little space for this type of information and there were no entries in any of the ones we looked at. Care plans did not record how people were involved in decision making, and we found only minimal recording of what information had been given to patients about their care and treatment.

We saw that records not in use or waiting to be collected for archiving or transfer were not always stored in a lockable cabinet, so could have been seen by other patients, visitors or non-clinical staff. We also saw some computer monitors facing out toward public areas, which may compromise confidential information. The local primary care trust (PCT) raised similar concerns with us when they visited the hospital in January 2011.

We saw bins for confidential waste paper on the wards and staff told us these were emptied daily by authorised contractors. We spoke with two qualified nurses and a health care assistant about the management of confidential records and information. They told us this was covered during induction and annual mandatory updates. All three were confident in the key principles of good information management.

The hospital medical records manager told us they aim to comply with the Department of Health Records Management Code of Practice that provides guidance on the length of time patient records should be held, with reference to the principles of the Data Protection Act 1998. There is a rolling programme of review of the records, to assess which should be retained and which need to be destroyed, but currently the hospital is keeping records longer than necessary.

**Our judgement**

Although there is no evidence of inappropriate care and treatment, people who use services cannot be confident their personal records are always completed fully, held securely, and not kept longer than necessary.

# Action
we have asked the provider to take

## Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

| Regulated activity | Regulation | Outcome |
|---|---|---|
| Treatment of disease, disorder or injury<br>Surgical procedures<br>Diagnostic or screening procedures<br>Nursing care | 18 | 02 |
| | **Why we have concerns:**<br>People who use services usually give valid consent to the examination, care and treatment they receive, but procedures to gain consent from adults without the capacity to give consent are not always followed. | |
| Treatment of disease, disorder or injury<br>Surgical procedures<br>Diagnostic or screening procedures<br>Nursing care | 19 | 17 |
| | **Why we have concerns:**<br>People who use services cannot be sure their comments and complaints are acted on effectively because information about making a complaint is not always accessible and the provider does not have robust systems in place to manage comments and complaints. | |
| Treatment of disease, disorder or injury<br>Surgical procedures<br>Diagnostic or screening procedures<br>Nursing care | 20 | 21 |
| | **Why we have concerns:**<br>Although there is no evidence of inappropriate care and treatment, people who use services cannot be confident their personal records are always completed fully, held securely, and not kept longer than necessary. | |

The provider must send CQC a report about how they are going to maintain 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 within 28 days of this report being received.

CQC should be informed in writing when these improvement 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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