City Hospitals Sunderland NHS Foundation Trust
Sunderland Royal Hospital

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<th>Region:</th>
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<td>Location address:</td>
<td>Sunderland Royal Hospital</td>
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<td>Type of service:</td>
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Overview of the service:
City Hospitals Sunderland provides acute hospital services to the Sunderland area as well as some specialist services for the wider geographical area. This includes acute services for elective and emergency care including in-patient, outpatient, and
| day care. The Trust also supports patients with palliative and continuing care needs, care for people with physical or mental health problems and day care, community and intermediate care services i.e. physiotherapy, dietetics and community support. |
Our current overall judgement

Sunderland Royal Hospital was meeting all the essential standards of quality and safety.

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

Why we carried out this review

We carried out this review 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 a visit on 7 November 2011, carried out a visit on 8 November 2011, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

We were supported on this review by an expert-by-experience who has personal experience of using or caring for someone who uses this type of care service.

What people told us

As part of the review of City Hospitals Sunderland NHS Foundation Trust we carried out a visit to Sunderland Royal Hospital. The visit was carried out by four compliance inspectors, a regional intelligence and evidence officer and an expert by experience. An expert by experience has personal experience of using or caring for someone who uses a health, mental health and/or social care service. Experts by experience come from varied backgrounds.

We spent time on the out-patient departments, the medical admissions unit, and surgical and medical wards. We spoke with patients and their visitors about their experiences of the hospital and the service they had received. We also spoke with staff and observed how patients were cared for and how staff undertook their day to day duties.

Comments from patients' about their care and treatment included "I'd give the nurses 10/10, they work hard and I'm well cared for" and "they've looked after me properly"; they also told us "the nurses will do anything you ask", that they "felt safe on the ward" and that, "everyone is lovely, very nice". People also told us, "it's been alright, fine" and one person said that it was, "better than I expected" One person said "I couldn't fault the care" and when asked about how they were treated, one person said that staff were "really nice and helpful" and another person said they were "very good."

The majority told us that they enjoyed the food although one said that she had not liked all
of the food available but "generally there was always something to choose". A person told us "It's very good, nobody can complain about the food"; another said "They try to give me what I like. I have to drink a lot, the staff remind me. The food is nice".

We did receive some negative comments including one person who told us that they did not like being on the ward and that although some staff were "okay" she said, "I wish some staff were more friendly, they always seem too busy". One person's relatives raised concern about trying to find out about their relatives care "no one seemed able to tell us" and that they had been unable to speak to any one from the ward on the telephone which they said was very distressing. These comments were passed on to the hospital and action was taken to address peoples' individual concerns.

We asked people about the length of time they had to wait after using the buzzer to attract staff attention. One person said, "They seem to take a long time to answer" but another person said they waited, "a normal time, it depends which ones on duty but it's never very long". Another person said, "They don't come immediately but they do answer quickly."

**What we found about the standards we reviewed and how well Sunderland Royal Hospital was meeting them**

**Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run**

Overall, we found that Sunderland Royal Hospital was meeting this essential standard.

People were supported in a way that maintained their privacy and dignity taking into account their diversity and they were encouraged where possible to make decisions about how they received their care.

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

Overall, we found that Sunderland Royal Hospital was meeting this essential standard.

We found that an individualised approach was taken towards the planned care for patients using this service.

**Outcome 05: Food and drink should meet people's individual dietary needs**

Overall, we found that Sunderland Royal Hospital was meeting this essential standard.

The patients were being supported to maintain an adequate food and hydration intake to maintain their wellbeing or to maximise their potential for recovery.

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

Overall, we found that Sunderland Royal Hospital was meeting this essential standard.

We found that people who use the services received their care, treatment and support
from competent, trained and supervised staff.

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

Overall, we found that Sunderland Royal Hospital was meeting this essential standard.

The quality of the service offered was regularly monitored and processes were in place that identified, assessed and managed risks relating to the health, welfare and safety of patients and staff.

**Other information**

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*
Outcome 01: Respecting and involving people who use services

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
During the visit we spoke with patients on wards, out patients departments and other clinical areas. The majority of the of the views of patients and their relatives about the service they had received were very positive and the few negative comments were dealt with at the time of the visit.

We spoke with persons who were using the service about how they felt they were treated by the staff on the ward. One person told us, “they are lovely with me, they are to everyone”. Another person said it was, “not bad, could be better”. She also told us that, "the doctors are fairly good at explaining any care". This person told us that she liked to know why her medication was necessary and she said, "sometimes they tell you, sometimes they don't". One person we spoke with had received a bed bath earlier that day and was happy that her privacy and dignity were respected as curtains were drawn around her bed whilst she was bathed.

We observed a healthcare assistant helping someone to the toilet and saw the above detailed process in operation. We noted that appropriate care and patience was shown by staff during this time. We saw a porter on the ward who informed an elderly patient that he was there to take her for a scan after she had had her injection. He also explained that he would bring her back in time for lunch and she appeared very
reassured by this.

We asked patients how well staff passed on information to them and to each other about the care they received. One person told us, "I've been kept up to date but they usually speak to my daughter".

One person told us, "it could be a bit more private than what it was, when you come to talk to the doctor". He told us he felt "embarrassed" that the man in the next bed knew he had tried to harm himself as he had overheard the conversation he was having with the doctor. He further explained that this conversation took place at his bedside and that the curtains had been drawn around his bed, but the person in the next bed was still able to hear the conversation. We discussed this with the manager of the ward and it was agreed that action could be taken to minimise the risk of this occurring in the future where very sensitive information was being discussed.

A person suffering with cancer told us that he felt the doctors did not always listen to everything he wanted to tell them about his medical condition and history. The doctor told him that he would discuss it with him later, but this never happened. This person told us that if he had been able to give the doctor a fuller medical history he would have felt better and it may have helped to give him a better understanding and explanation of the symptoms he was suffering from.

We spoke with another person who told us that she was happy that her privacy was being maintained. However a person in the same bay was prone to frequent bouts of using offensive language and the person we spoke with said, "The language is terrible but I'm okay about it, she can't help it. I wouldn't put up with it at home". She told us that staff had not discussed this matter with her and that she would rather be in a different bay, hence unable to hear the swearing. This was discussed with the managers and they informed us that the individual had very challenging needs including those around the inappropriate language they used. Action had been taken later that day to transfer the individual to a more suitable ward.

We spoke with a family member of a person who had been admitted the previous day, and was in a side room. The relative told us that this reassured both the patient and the family that dignity was being maintained. The family were also happy with the amount of information being given to them and their relative and the manner in which it was being delivered. They were very happy with their relative's named nurse but were less happy with a junior sister who had spoken to the named nurse about the patient, in their presence, as if he wasn't there.

People waiting in the ear, nose and throat outpatient department were alerted to their appointment by staff calling their name. Seating arrangements meant some people were faced away from staff and were unable to see the person calling. Twice a name was called and when no response was received no further steps were taken. No alternative display or system for alerting people was available and this left people uncertain that they were being missed.

A patient within outpatients explained that they had recently been discharged from the hospital and were visiting for a follow-up appointment. When asked, they said that the discharge from hospital went very smoothly and they had a letter that explained all about their further treatment. When they were an in-patient they told us they had a side
room to themselves with an en-suite which made them feel like their privacy was being respected.

Three people told us that they had an appointment that had been cancelled but that this was done by letter and not at short notice. They were given a new appointment. One lady had experienced some difficulties when trying to change an appointment it had taken her sometime for the hospital to answer the telephone which she had found a little distressing.

Other evidence
We looked at the information we held about the trust from external surveys and reports from other agencies. The majority of the information we had regarding incidents, concerns and untoward events that had occurred in the service were at the same level as other similar services. We did have some information from a survey we undertook of adult inpatients, outpatients and maternity patients where people had raised issues. These included post operative information, privacy, and appointment choice. These issues were looked at as part of this inspection.

The wards we visited provided single sex accommodation and toilet facilities. Staff told us that the use of commodes was discouraged in shared accommodation to ensure patient dignity. Call bells were within easy reach and were answered promptly. Staff talked at a discreet volume and used curtain screening around beds to attempt to maintain patient’s privacy and dignity. They introduced themselves by name and job title and spoke to patients in a respectful manner. One person told us the privacy available was “more or less what I expected.”

We observed many instances when staff involved patients and their relatives and reassured them about their anxieties, though on occasion staff missed opportunities to acknowledge patients. An older lady expressed confusion at her surroundings and asked questions that the nurse present did not respond to. A health care assistant then entered the bay and spent time talking with the patient and explained where she was and why. A staff member delivered medication for a patient who was being discharged. She did not attempt to speak to the patient or inform her about what she was doing.

We saw that a day room on a longer stay ward was being further developed to encourage social interaction. A wide screen television had been purchased and the ward sister told us there were plans to provide social activities. The room also had dining facilities to encourage patients to take their meals together.

A high volume of patients were assessed and treated on the shorter stay unit we visited. Their stays were usually between 24 - 48 hours before being transferred to other wards or discharged home. We were told that continuity of care was managed through good staff retention, use of the same bank staff and designating staff to allocated areas of the unit. The staff here said they asked patients what they could and could not do for themselves to maintain their independent skills. They told us they were instructed to keep patients and their relatives well informed and to explain what they doing before and during provision of care and treatment.

Staff demonstrated values of treating people as individuals with diverse needs and rights. They had good knowledge of patient’s preferences, though these were rarely documented into patient records. There was some evidence within assessments that
patients and relatives had been consulted and given explanations about medical conditions and treatments.

Staff described how they ensured patient privacy when they assisted older people with toileting needs. They said they helped them to the toilet and left after explaining how to use the buzzer to alert staff when they were finished. They also said they made sure the person was clean and had washed their hands before they were assisted back to the bay.

A nurse explained to us that she would involve patients in their care in a number of ways such as asking their preferences, making sure she understood their wishes and level of awareness and by discussing matters with their next of kin where appropriate.

Staff on this ward also told us that they maintained patient's privacy and dignity by ensuring curtains were drawn around beds when they carried out positional changes of people. They also requested that visitors remained outside of the curtain when any care had to be delivered during visiting times. When discussing medical issues with people, staff told us they lowered their voices. They told us about how when bed bathing someone they made sure that only certain parts of someone's body were uncovered at any one time. Staff said that they would always explain to the patient what was happening or about to happen and one staff member commented that this was particularly important as, "the elderly can be frightened of being in hospital anyway and it helps to reassure them".

During the ward round by a doctor, we saw that a Do not Disturb sign was pegged to the curtains when drawn around any particular bed.

Some of the staff we spoke with told us how patient's views had influenced changes to practice. An example of this was feedback on lack of information about medication. This had lead to patient's routinely having individual discussion with a pharmacist prior to discharge and provision of clearer records about the purpose of each prescribed medication.

One male staff told us there was clear information in patient's records if they had requested, when asked, not to have help with personal care from males. Patients confirmed that they had been asked this question.

There was evidence within two records that when necessary an assessment of mental capacity was carried out to establish the patient's ability to give consent and make particular decisions about their care and treatment. The trust has provided training in the Deprivations of Liberty Act so that staff would be aware of their legal responsibilities in ensuring that patient freedom is respected at all times.

All staff interviewed in the outpatient areas and on the head and neck ward were able to provide examples of treating patients with dignity and respect. Examples included treating people as they themselves would like to be treated and recognising a patient's right to refuse. They gave us examples of different religious and cultural needs and beliefs and how they made reasonable adjustment to the department to accommodate them.

Within outpatients there was a suggestion box visible with a sign above it saying 'How
‘Can We Do Better?’ This provided patients and relatives an opportunity to provide quick feedback without speaking to a member of staff or using the internet.

The hospital had a Patient Advice and Liaison Service (PALS) that provided support; advice and information to assist patients make decisions about their treatment options and understand their personal circumstances. The service had identified through its’ own quality assurance process that the PALS did not have a high enough profile in the hospital, as a high number of patients were not aware of this facility. The office used by this service is therefore to be has been moved in early 2012 to a more prominent position in the hospital near to the entrance. Information about the service had also been made more available on the wards and out patients departments.

A range of leaflets were provided for patient and visitor information on one of the wards we visited. These included information on how to give compliments and suggestions and raise concerns or complaints; health care associated infections; and preparing to leave hospital. Posters were displayed to inform people of the ward sister’s round and her availability to spend time with relatives and patients to discuss their care and treatment. Results of a patient satisfaction survey carried out in 2010 were also displayed. These showed that 99% of patients on the ward said their privacy and dignity was respected.

To check into the outpatients people had a choice between using the electronic terminals or going to the desk. The information was available in large print and in different languages and a member of staff was positioned next to the terminals to assist. Once checked in a member of staff was available to tell them which waiting area to go to. All of the people we spoke to said it was easy to check in and that staff showed them where to go.

**Our judgement**

Overall, we found that Sunderland Royal Hospital was meeting this essential standard.

People were supported in a way that maintained their privacy and dignity taking into account their diversity and they were encouraged where possible to make decisions about how they received their care.
Outcome 04: Care and welfare of people who use services

What the outcome says
This is what people who use services should expect.

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

What we found

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<th>Our judgement</th>
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<td>The provider is compliant with Outcome 04: Care and welfare of people who use services</td>
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<th>Our findings</th>
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<td><strong>What people who use the service experienced and told us</strong></td>
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<td>We spoke with patients on wards, out patients departments and other clinical areas.</td>
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We asked the patients in the out patients department how they felt they were being looked after. One person said, "I couldn't fault the care" and when asked about how they were treated, one person said that staff were "really nice and helpful" and another person said they were "very good."

One person told us that on his first visit he had been concerned about the practice of the nurse who replaced his dressing. He raised these issues with the nurse on the second visit and was "very impressed" with the reaction. He had been asked for further information about the concerns and both the nursing sister and the consultant discussed the action they would take to respond. He was also approached on a subsequent visit to ensure that he continued to be satisfied with the care and to give him the progress on how they had dealt with his concerns.

Comments from patients included, "I'd give the nurses 10/10, they work hard and I'm well cared for"; "They've looked after me properly"; and "The nurses will do anything you ask".

We saw in all of the patient areas that staff responded promptly when patients requested pain relief. Some patients told us they wanted to know more about changes to their medication, however others told us that they were satisfied with the information they had been given.
We asked people about the length of time they had to wait after using the buzzer to attract staff attention. One person said, "They seem to take a long time to answer" but another person said they waited, "a normal time, it depends which ones on duty but it's never very long". Another person said, "They don't come immediately but they do answer quickly."

Another person told us that the care had been, "quite good, quite pleasant, but you always get one or two who are not as good as others". He went on to explain that on the evening he was admitted he had been cared for by a nurse who was "really pleasant" and that she was always smiling, which made a big difference to him and to what it felt like to be on the ward. Staff had taken the time to assist him to the toilet and this made him feel very safe. He had also been awake during the night therefore he was aware that night staff had been coming into the bay to check that everyone was okay and this reassured him. Upon realising that he was awake, the night staff had checked to see whether or not he wanted a drink.

We observed an elderly person who was confused being moved to another ward. We heard staff updating the patient's relative about the move and saw that staff were very caring in the way they dealt with the patient. We saw staff checked to make sure the patient was wearing their dentures as they were not in the denture box and we noted that when the patient was assisted into a wheelchair, that footrests were used appropriately.

Despite the fact that the older persons ward was busy, particularly at visiting times, we observed that the staff never appeared too busy to speak with people and they were friendly and showed a respectful manner. People told us that staff were very helpful, polite and supportive. They said, "They provide a very good service", and, "I would give them 11/10 every time".

One person told us that they did not like being on the ward and that although some staff were "okay" she said, "I wish some staff were more friendly, they always seem too busy". One person's relatives raised concern about trying to find out about their relatives care. The daughter told us that, "no one seemed able to tell us". She also said that she had tried to telephone the ward several times but had not been able to get through which she said was very distressing.

**Other evidence**

We looked at the information we held from external surveys and reports from other agencies. The majority of information we held about incidents, concerns or from patient surveys was the same as, or better than, other similar trusts. Where we had individual negative comments we looked at the issues as part of this inspection.

We spent time on the ward that accommodated people with head and neck problems. The atmosphere was very calm and staff were friendly and respectful towards people.

Staff were assigned to certain bays within the wards to ensure continuity of care for patients. One nurse told us that this enabled her to get to know patients well, as they can, "sometimes be here for a long time so it's important to make them feel settled".

The staff we spoke with were knowledgeable about the patients needs and they confirmed they were kept up to date about patients' welfare through handovers at each
shift change, and developed and reflected on their practice at meetings and clinical supervision. We were told that identified staff took the lead on initiatives, such as the Trust's 'dementia strategy' that was currently being piloted, and following this training would be rolled out and cascaded to other staff.

Patient’s records showed that a range of assessments were regularly updated including risk of falls, handling, nutrition, skin integrity and infection control. A warning system was in place that could trigger the need for further assessment. Computerised care plans were used in a format that enabled standardised interventions to be pre-populated using the ‘activities of daily living’ model. We found that options to specify patients’ needs within care plans were not always used. However, daily evaluations in patients' notes demonstrated improved ongoing records of the care and treatment that staff provided.

Additional information was provided following the visit of the planned changes to the patient records. This included the changes in relation to the nursing and personal care provided. This focused on making them more individualised and detailed in peoples preferences and specific needs.

On a longer stay ward we saw that 'comfort charts' had been introduced to monitor patients' needs. These prompted staff to offer drinks; ask patients whether they needed to go to the toilet; check call bells and walking aids were within reach; check correct footwear; make sure the patient area was clutter free; and to ask if they could help the patient in any way. The charts were completed hourly or two hourly and we were told they were in use on all wards where care was provided to older people.

We saw that a variety of methods were used to organise additional assessments, secure aids/equipment and care at home provision to enable patients to be safely discharged. This included liaison with community based professionals to make sure up to date information was passed on about the patient's care and treatment.

Nutritionists, ward staff, and the head and neck co-ordinator all met to discuss patients currently undergoing treatment. This had been put into place to co-ordinate the approach to treatment for patients.

We attended a short, focused meeting where a ward manager, occupational therapist and a social worker discussed individual patients' needs with a view to planned discharge. They reviewed current physical and mental health, including capacity issues; progress on assessments; the patient's home situation; level of support needed; and patients' and relatives' wishes about future care arrangements.

The staff we spoke with had a clear understanding of protecting vulnerable people and of how to raise concerns about their safety and welfare. We were told about a potential safeguarding incident that had been recently reported. This followed concerns on admission that a person may have been neglected at home. Ward staff said they had prompt access to mental health professionals who provided support including assessment of patients' capacity to give consent to treatment, best interest decisions and deprivation of liberty safeguards.

Patients were provided with jugs of water and glasses at their bedside. On one of the wards we visited red lidded jugs were used to identify patients who required support
with drinking and monitoring of fluid intake. We were told that this system had been adopted in other wards. Staff asked patients their choices of tea, coffee or milk before meals and if they preferred cups or spouted beakers.

We saw notices on the doors to the bays specifying that the ward sister or senior nurse would carry out a 'ward round' at 2pm each day, the start of visiting time. The purpose of this was to be available to speak to relatives and patients and we saw the junior sister undertaking this round in the afternoon.

**Our judgement**
Overall, we found that Sunderland Royal Hospital was meeting this essential standard.

We found that an individualised approach was taken towards the planned care for patients using this service.
Outcome 05: 
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
The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
On a longer stay ward we saw that patients were assisted to get into comfortable sitting positions before food and drinks were served. Choice of drinks was offered even though staff were clearly familiar with individual's usual preferences. Patients were asked which of the options of main meal they wanted and their preferred portion size. The food was served from a hot trolley by the ward sister. We were told that a qualified staff member always took responsibility for serving the main meal here.

The mealtime was well organised and all staff were actively involved. Red napkins were used to identify patients who required assistance. We saw that staff provided sensitive support to patients who could not manage their meals independently. However, some staff stood over patients in bed whilst assisting them with their meals and this did not appear comfortable for either party. The patients we spoke with told us they were always given choice of meals and said they enjoyed the food.

We saw that people were offered hand wipes to clean their hands prior to eating and staff told us that people were also offered an option to wash their hands at a basin where possible and appropriate. Hot drinks were served prior to the food and people were offered the choice of a cup or a beaker to drink from.

We saw that a patient who remained in bed during the lunch being served had the end of his bed raised and when he asked why the staff were doing that, he was informed that it was to prevent him choking. However we saw that on another bay, a person was having difficulty sitting up high enough in bed to eat their food.
Staff were observed making sure that people who were receiving medical or nursing care whilst the drinks were being served were offered them following the treatment.

People on one of the other wards were being supported to make the choices from the menu; they were offered any mixture of the options. They all told us that they enjoyed the food although one said that she had not liked all of the food available but "generally there was always something to choose".

People were positive about the food being served examples of their comments were "It's very good, nobody can complain about the food", "They try to give me what I like. I have to drink a lot, the staff remind me. The food is nice", "It's alright by me, more than enough to eat".

Staff told us that trained members of staff would always assist people with eating when necessary and we observed the junior sister doing this. She gently woke a patient to offer her lunch. She sat next to the patient whilst assisting her to eat and gently encouraged her with the main course of which she did eat a small amount. Afterwards the staff member encouraged her to have a drink and also assisted her with this.

Other evidence
We looked at the information we hold from external surveys and reports from other agencies. The majority of information we held about incidents, concerns or from patient surveys was the similar to other hospitals. Where we had individual negative comments or information we looked at the issues as part of this inspection.

On the ward for older people we were told that there was a rota system in operation which ensured that food was served first to different bays on different days.

Prior to the meal being served we heard staff discussing special dietary needs of the patients. In particular we heard conversations between staff confirming which patients were diabetic and we also heard them discussing which patients would need assistance to eat.

Patients were provided with jugs of water and glasses at their bedside. On one of the wards we visited red lidded jugs were used to identify patients who required support with drinking and monitoring of fluid intake. We were told that this system had been adopted in other wards. Staff asked patients' their choices of tea, coffee or milk before meals and if they preferred cups or spouted beakers.

Leaflets titled 'Don't go hungry in hospital' were displayed on one of the wards we visited. These informed patients about sharing information with staff about weight, appetite and dietary needs; asking for help; and how to give feedback on positive experiences and any concerns. Guidance was also displayed on good practice at meal times. This set out a six step checklist regarding positioning of patients to eat; hand washing; oral hygiene; preparing the area; offering help; and making sure everyone had eaten. Results of a patient satisfaction survey carried out in 2010 showed that 97% of patients on the ward said they received enough help with their meals.

Patients' records showed that nutritional needs and weights were assessed and monitored. Care plans did not always specify individual's special diets though there was evidence that these were recorded in daily evaluations. Food and fluid intake charts
were completed in specific detail.

We saw that a dietician visited a patient who was being discharged. They discussed their diet and provided them with information leaflets on diabetes.

Ward staff told us that the catering department provided a good, prompt service. They said they could get anything they needed for patients, including alternatives to the menu and snack boxes between meals. Staff on a longer stay ward told us they had found the serving of the main meal in the evening did not suit patient's preferences and routines. They had trialled and subsequently adopted having the main meal served at lunch time. They also said that probiotic yoghurt drinks were provided as standard to patient's who were prescribed antibiotics. Records for this were in place.

Ward nursing staff had identified a Link Nurse to undertake additional education in relation to nutrition and provide a cascade of this information at local level to colleagues. A programme of meetings had been established and was well attended from staff across the Trust.

Water coolers were situated at various points within outpatients and were available for patients and their families who were waiting for appointments.

We were given information from the trust about the Real Time Patient Feedback survey undertaken in November 2011. This gave an outcome of over 95% when people were asked if they were given enough help from staff to eat their meals.

There was a two week rotational menu in place with identified food suitable for patients' with specific dietary needs. We were told that further work was ongoing to look at the food provided to the wards and label food to assist staff provide the correct type for patients with special dietary requirements such as coeliac disease or diabetic diets.

**Our judgement**

Overall, we found that Sunderland Royal Hospital was meeting this essential standard.

The patients were being supported to maintain an adequate food and hydration intake to maintain their wellbeing or to maximise their potential for recovery.
Outcome 14: Supporting staff

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We spoke with patients on wards, out patients departments and other clinical areas.

When asked one person said a nurse had been "really pleasant" and that they were always smiling, which made a big difference to him and to what it felt like to be on the ward. Staff had taken the time to assist him to the toilet and this made him feel very safe. He had also been awake during the night therefore he was aware that night staff had been coming into the bay to check that everyone was okay. This reassured him. Upon realising that he was awake, the night staff had checked to see whether or not he wanted a drink.

When asked about the care and the way the staff supported them one person in the out patient department told us about the way the staff had helped them on the first visit and that they had been "kind and helpful". Another said his care had been "really good". We also spoke with families of the patients who were attending their appointments with them, one said "the staff are professional" and another said "I thought that my relative would be worried about the visit but the nurses have put him at ease."

Other evidence
Staff told us they received guidance to keep them safe and were trained in how to de-escalate aggressive or violent situations. They said there was Closed Circuit Television monitoring and ready access to security staff and, where necessary to the police. Incident forms were completed and monitored and follow up support was provided to staff involved in untoward incidents.
Staff said they received a range of training, including courses that could be completed through e-learning. They told us they had undertaken mandatory training such as moving and handling and fire safety and training on safeguarding vulnerable adults, child protection, mental capacity and deprivation of liberty safeguards. All the staff we spoke with said they received annual appraisal and were well supported by their employer.

On one of the wards we spoke with two members of staff about their training, supervision and appraisals. Both were aware that appraisals were carried out annually. Neither staff member felt that this was an area of concern and both felt very well supported by both their colleagues and managers on a day to day basis.

A nurse practitioner showed us the records of their monthly peer supervisions. These contained relevant topics of discussion around the clinical area and development of the service to improve the experience for the patients.

We were shown evidence that regular appraisals were completed by senior ward staff and that staff received regular training in all mandatory areas. At the time of the visit all mandatory training was within date.

A senior manager told us that there was a system for group supervision which identified specific clinical issues in the specialist areas which staff explore within their own team and with the senior staff.

A junior nurse who had recently qualified told us that the previous day, a patient who she had treated had died unexpectedly. She had been very upset and said she had received a lot of support from her colleagues and the ward sister had taken her into a quiet room and talked to her. The nurse told us that she felt very supported by this and that it helped to make her feel better about the situation.

This nurse had recently undergone an induction at the trust which lasted for one week and four days. During this time she had undertaken mandatory annual training such as moving and handling, learning disability awareness and infection control. She told us how she became aware of wider issues affecting the trust by reading bulletins on the intranet. She said that the ward sister also updated staff following any meetings she had attended, such as those held to discuss clinical governance.

We spoke with a healthcare assistant on the ward who had been there almost two years. We asked her about any training she had undertaken recently and she told us that she was due to have a fire lecture and health and safety training later that week. She told us how she was informed when her mandatory training was due to be renewed through an e-mail and a letter. Training was arranged for her by a colleague whose specific role it was to organise staff training.

Staff on a ward told us they enjoyed their work and felt part of a team. They said they felt supported at work and were able to explain what they would do if they felt threatened or vulnerable. All staff interviewed showed knowledge of safeguarding procedures and highlighted that there was a trust policy available.

An annual review was undertaken of staff training needs and staff then updated skills and knowledge in a range of topics depending upon their needs and the area they
worked in. Records of the training programme were held on both the wards and clinical areas as well as in the personnel department. The records on the ward were up to date.

The trust provided us with information about training being planned and provided these included, electronic learning packages adapted to reflect nutritional support for patients, Acute and Critical Care Awareness Training, the Critical Care Skill Programme, Three programmes delivered by Northumbria University, Medical Patient's Acute Care and Treatment (IMPACT), Care of the Critically Ill Surgical Patient (CCGSP) and Acute and Life Threatening Events Recognition and Treatment (ALERT).

Additional training was provided for Health Care Assistants through the Health Care Assistant Development programme.

All staff received a copy of the Executive Briefing; this is sent to their home if they are on sickness absence. Staff are required to sign that they have read the briefing, which is distributed on a monthly basis. Staff told us that the briefing included information from the Executive Board about financial savings targets, clinical targets and other information relevant to all members of the Trust.

For newly qualified doctors and those who were employed as Trust doctors there was an induction process and all new foundation trainees undertook a week of shadowing before starting their work with the Trust.

**Our judgement**

Overall, we found that Sunderland Royal Hospital was meeting this essential standard.

We found that people who use the services received their care, treatment and support from competent, trained and supervised 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

<table>
<thead>
<tr>
<th>Our judgement</th>
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<tr>
<td>The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision</td>
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</tbody>
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<th>Our findings</th>
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<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
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<tr>
<td>We observed that staff undertook complex nursing tasks; they followed good practice procedures and consulted other staff as necessary when they needed assistance. Senior staff provided good leadership to the more junior staff in a way that encouraged them and supported them to carry out their roles effectively.</td>
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<td><strong>Other evidence</strong></td>
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<td>Outside one of the wards we visited 'thank you' cards were displayed that praised staff for the care and attention provided to former patients. Quality monitoring information from 2010 was also displayed on the ward. This included results of a patient satisfaction survey and other details relating to patient care and safety.</td>
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<td>Posters advertised opportunities for patients to be assisted by trained volunteers to give 'real time feedback' through completing short questionnaires. The trust told us that monthly real time patient feedback identified that some improvements could be made with the meals. As a result individual wards has started to request the views of patients directly following the meal to try to identify changes that could be made.</td>
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<td>Notices were placed on the doors to the bays that advised patients how to give feedback about their hospital stay.</td>
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<td>Matrons told us that they undertook daily quality assurance patient walkarounds, and asked specific questions about the quality of meals patients’ received. We were told that the catering department worked with ward teams to assist with the provision and</td>
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presentation of food. This took place on the ward at meal times and across the food service period by members of the catering team.

We were told that regular checks were made on ward compliance with the provision of protected mealtimes. Where compliance was not always possible, for example on the admission wards, staff were mindful of the aim to have protected mealtimes and keep disruption to patients to a minimum.

We were told that as a result of patient feedback a new beverage trolley was being introduced across the trust. This was to facilitate fresh, hot tea/coffee and snacks, as patients required them and to supplement main meals.

Senior ward staff said they received outcomes of feedback, quality assurance audits and statistics on health care associated infection on a monthly basis. They agreed that this information should be updated at ward level to inform patients and visitors.

Staff expressed pride in their work and told us about arrangements to develop their practice. They openly shared details of how working practices had been changed as a direct result of patient feedback and complaints. They said further training on complaints and customer care had been provided and communication systems with patients’ relatives had improved. Matrons attended quarterly meetings with the senior nurse responsible for quality and complaints to review common themes and develop preventative measures.

We were told that information analysis and capture was a corporate priority, and the Governance Committee and various governance groups, which include representation from the Director of Nursing, Medical Director and Director of Assurance provided feedback directly to the board. Documents provided showed that internal clinical issues were brought to the board and monitored to make sure that action had been taken.

The trust had a Clinical Governance steering group, which is supported by a number of sub-groups including Safeguarding, Clinical Governance and Infection Control. Information was collected at ward level and then either considered and monitored with any action needed taken or escalated to director level. These groups also looked at directorate level concerns and themes and, if necessary, passed these down to ward level. The trust provided several examples of when this information 'loop' process had resulted in local level concerns being given a corporate lead. These included new systems being implemented or training provided to improve outcomes in the hospital. The governance groups periodically completed themed reports that drill down to individual ward level. The most recent themed report was an Ophthalmology Review. This included lessons learned, complaints analysis and training provided to address staff concerns.

Documents provided by the trust showed how trends and themes of concern were monitored and acted upon by the clinical governance sub groups. The groups looked at a variety of risks and concerns by using directorate risk registers and complaints to target areas of significant concern. An additional risk manager has been appointed and there were weekly high risk (red incident) group meetings.

Staff members we interviewed during the visit were aware of how to raise concerns, and they received updates on the clinical governance findings and corporate priorities.
electronically by e-mails and verbally through ward meetings.

The directorates carried out a root cause analysis when any serious untoward incidents were reported and a complaints report was completed every three months. Complaint reports were broken down by each directorate with major trends and themes identified and examined. Each directorate had an internal complaint response time target, and the report contained a lessons learned section. The trust was able to demonstrate how complaints were followed up and if the follow ups resulted in improvements or changes in working practices.

The trust had recently appointed an Assurance Manager whose job was to check compliance against regulatory outcomes and ensure that any complaints or improvements were correctly followed up, with action taken as necessary. This process ensured that the management team were reassured that any improvements made were effective and reduced the risk to people using the service. For example, the Assurance Manager had recently identified that improvements could be made to the Patient Advice and Liaison Service (PALS) service. This was to re-house and, rename it 'patient services', to advertise it and make it more visible to people using the service.

**Our judgement**

Overall, we found that Sunderland Royal Hospital was meeting this essential standard.

The quality of the service offered was regularly monitored and processes were in place that identified, assessed and managed risks relating to the health, welfare and safety of patients and staff.
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

<table>
<thead>
<tr>
<th><strong>Document purpose</strong></th>
<th>Review of compliance report</th>
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<tbody>
<tr>
<td><strong>Author</strong></td>
<td>Care Quality Commission</td>
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