Norfolk and Norwich University Hospitals NHS Foundation Trust

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| Location address:    | Colney Lane  
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                       | Norwich  
                       | Norfolk  
                       | NR4 7UY |
| Type of service:     | Acute services with overnight beds |
| Date of Publication: | February 2012 |

| Overview of the service: | The Norfolk and Norwich University Hospital NHS Foundation Trust, which includes Cromer Hospital, is the largest of three trusts covering a population in Norfolk of 839,190. The Norfolk and Norwich Hospital has 1010 beds and employs 6,245 staff. |
Our current overall judgement

Norfolk and Norwich University Hospitals NHS Foundation Trust 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 to check whether Norfolk and Norwich University Hospitals NHS Foundation Trust had made improvements in relation to:

- Outcome 01 - Respecting and involving people who use services
- Outcome 04 - Care and welfare of people who use services
- Outcome 05 - Meeting nutritional needs
- Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 19 January 2012, checked the provider's records, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

During this visit we only spoke with people admitted to the wards about their care plan records and how they were involved in completing their records. The people we spoke with told us they had been asked about the amount of food and drink they had consumed and that staff had explained to them why it was important to keep accurate records of what they had consumed.

We did not ask direct questions about other records during this visit.

What we found about the standards we reviewed and how well Norfolk and Norwich University Hospitals NHS Foundation Trust 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

The trust is compliant with this outcome area. However the ongoing improvements written in the action plan must continue to be monitored and action taken if shortfalls are found during the auditing process.
Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The trust is compliant with this outcome area. However the ongoing improvements written in the action plan must continue to be monitored and action taken if shortfalls are found during the auditing process.

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

The trust is compliant with this outcome area. However the ongoing improvements written in the action plan must continue to be monitored and action taken if shortfalls are found during the auditing process.

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

The trust is compliant with this outcome area, but should continue to implement their action plan to ensure at all times records are accurate and up to date.

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
We did not speak with people directly about respecting and involving them.

Other evidence
Following our review of October 2011 the hospital was asked to provide an action plan to show how they were going to improve the outcomes for people with regards to respecting and involving them. We received a comprehensive action plan showing how the improvements were to be achieved.

A number of areas requiring improvements had been included in the action plan. For example, how people were going to be encouraged to bring in their own nightwear rather than wear the hospital clothes, and how notice boards used to support people's dietary needs would be discreetly placed and worded appropriately. During our walk around the wards on the day of this visit we did not see too many people wearing the hospital nightwear, nor did we see inappropriate notices about individual people’s dietary requirements. Another improvement had been the need to place the call bell system within reach for all people. When looking at the new ‘check sheet’ introduced as part of this action plan we noted the clear instruction that would prompt staff to check the placement of the call bell.
Discussions held during this visit, with the management and nursing team, told us that the hospital had systems up and running that should ensure the actions they had required of staff were being followed.

At the time of our visit some of the actions were ongoing. We were told they were to be monitored and reviewed by the hospital as part of their ongoing, regular audit process. The plan also told us that as part of that ongoing monitoring the hospital will include external people to assist with the monitoring, from partners such as Age UK, LINKs (Local Involvement Networks) and the PCT (Primary Care Trust). At the time of our visit the involvement of people from these partners as well as other patient representative groups had commenced.

Our judgement
The trust is compliant with this outcome area. However the ongoing improvements written in the action plan must continue to be monitored and action taken if shortfalls are found during the auditing process.
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

Our judgement
The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We did not speak with people directly about the care and welfare of people using the service.

Other evidence
Following our review of October 2011 the hospital was asked to provide an action plan to show how they were going to improve the outcomes for people with regards to care and welfare of people who use the services. We received a comprehensive action plan showing how the improvements were to be achieved.

The improvements listed on the action plan include the use of a book called 'This is me'. The hospital has started to use this book to assist the staff with the care of people who may have problems related to their memory. We saw two examples of how information had been written that was clearly about that person and how that information would help the staff with caring for that person.

We also noted how the nurse responsible was now ensuring that all records were dated and signed within the care plan at the end of each shift. These documents, we were told, were also being checked as part of the audit process. Both nurses and management said that they understood why these records were important and were fully committed to the improvement actions required.

At the time of our visit some of these actions were ongoing with all the actions being monitored and reviewed by the hospital as an ongoing process. As part of this
monitoring the hospital had and will continue to include external people to assist with this monitoring from partners such as Age UK, LINKs (Local Involvement Networks) and the PCT (Primary Care Trust).

As part of this visit we looked at the time taken for people arriving by ambulance at the (A&E) accident and emergency department to their care being transferred to staff in the department.

During the afternoon of our visit on 19 January 2012 we spent time in the A&E department. We were shown around by two senior staff members. Nursing staff were seen directing people to cubicles and two people were receiving support in the resuscitation area. There were two families waiting in the children's A&E area.

While in this department we asked for an explanation about the time delays recorded in the past few weeks; why the times for the ambulance service to hand over the care of the person arriving to the hospital staff had shown delays. The two staff members told us they were both fully aware of the concerns related to response times within the department and that a lot of work had taken place to improve these.

We were told that the paramedics arrived with the person by ambulance. The assigned/front line nurse would then book the person in on the computer system. The issue around turnaround times, according to the staff team, had been which professional had taken responsibility for pressing the submit button on the computer. We were told this button is only pressed when the A&E nursing/medical staff, physically take over from the paramedics who were then free to go. They said that this concern had been addressed with the staffing team in A&E and that the action required had now improved with a designated staff member ensuring the button was pressed straight away.

They also stated that the nursing team had regular meetings with ambulance staff in order to ensure that these response times were accurate and the system was as effective as it could be. However it had been recognised by the A&E staff team that at times even if the submit button is pressed as soon as possible, targets could not always be met due to the high demands on A&E staff at certain times of the year.

We spent some time with the trust management talking about these concerns and how the methods that had been introduced had started to improve the problem. We were told about how more staff were now on duty at times of day that they had found to be busier than others and how senior staff in the department were closely monitoring and auditing the processes.

We were shown a report for the week ending 01 January 2012 which showed the two previous weeks figures of where the times for the transfer of care had been a concern and how the hospital were looking at ways to improve their systems in place. We noted on the report that out of 15 acute hospitals served by the East of England Ambulance Service the Norfolk and Norwich Hospital received the most people arriving by ambulance. The trust was aware of this and was working on ways to improve this area of the service to meet the greater numbers of people in the community requiring a visit to A&E by ambulance.

Our judgement
The trust is compliant with this outcome area. However the ongoing improvements written in the action plan must continue to be monitored and action taken if shortfalls are found during the auditing process.
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
We did not speak with people directly about how the hospital was meeting their nutritional needs however a number of people did tell us they knew why they were being asked about their dietary intake and that the staff were now recording what they were eating and drinking.

Other evidence
Following our review of October 2011 the hospital was asked to provide an action plan to show how they were going to improve the outcomes for people with regards to nutrition. We received a comprehensive action plan showing how the improvements were to be achieved.

Improvements found on the day of this visit were the way staff were now recording the risks that may be associated with poor eating and drinking, the regular recording of people's weight and the action taken when risks were identified. Fully completed food charts were seen and supplement foods recorded to support people with poor diets.

At the time of our visit some of these actions on the action plan were ongoing. All the actions were being monitored and reviewed by the hospital as an ongoing process. As part of that ongoing monitoring the hospital have and will continue to include external people to assist with this monitoring from partners such as Age UK, LINKs (Local Involvement Networks) and the PCT (Primary Care Trust).

Our judgement
The trust is compliant with this outcome area. However the ongoing improvements
written in the action plan must continue to be monitored and action taken if shortfalls are found during the auditing process.
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
The provider is compliant with Outcome 21: Records

Our findings

What people who use the service experienced and told us
Although we did not talk directly with people on the wards about their records we did ask questions that would help us identify that the written information was correct. For example we were told by one person how they received checks from staff on the food and liquid they had consumed. Another person told us that staff said how important it was to keep a record of food and fluid intake and how they were asked at regular intervals what they had eaten and drunk.

Other evidence
The main reason for this visit on 19 January 2012 was to carry out a follow up visit where a moderate concern had been identified following an inspection carried out in October 2011. The aim of this visit was to check the hospital was keeping accurate records for each person receiving care and treatment.

During our visit to this hospital we looked at records held on four wards. These wards are where people may stay for a period of time and require a lot of input from nurses who are used to supporting people who are older members of the community.

We observed staff completing records and noted the regular recordings of people who had been assessed as being at a high risk of concerns.

We noted that all the records for the eight people picked at random from four wards had
all received an assessment around nutrition using a malnutrition universal screen tool (MUST). Those that showed no concerns once assessed and had a low score had no meal chart to be completed. Those who were assessed as at risk had records that had been completed after each meal. We also noted that those people who required extra supplements or snacks were having these recorded when records showed that little food had been eaten. People who required it were referred on for specialist support for their eating problems. These specialists had recorded the action to take to ensure people were receiving the correct nutrition/hydration in the most suitable way. The action was then reviewed to ensure the person was still receiving the correct support. We saw review dates that were weekly and comments placed in the record of the changes that had occurred.

One example was of a person who had been assessed on admission as being at risk of poor nutrition. Records were in place and as the person improved the need for recording the meal intake had been stopped due to this person now eating and drinking well and the weight of that person had increased. We saw the record of the weights and the amount of food eaten throughout the week. Another person who had been assessed as being at very high risk of malnutrition had records of how they were to be supported. Referrals to a dietician and the mental health service had been acted on. Build up drinks were recorded as required along with a note saying 'sweet foods are not liked'. This person was listed as needing support with the 'red tray' system. The use of this tray was seen happening with the support of a staff member during the lunchtime meal, as prompted in the care plan records.

The records were also in place in all eight care notes that assessed the concerns that may be raised regarding pressure care. People who were at risk had charts within their records that highlighted where the concerns were and what action to take. Records of special pressure relieving mattresses were seen and body maps within the records were marked with the areas of concern.

One record showed that a person was to be cared for in bed as there was not a pressure relieving cushion available for the armchair. Although the record was very clear why this person should not sit out, this was not in the best interest for the person as nothing was done or recorded about finding a suitable cushion. This prevented this person from getting out of bed and into their chair as recommended in the care plan. On talking to a staff member we were told there is sometimes a problem with pressure cushions for chairs.

We saw further completed records on risks assessments. For example, infection risk such as MRSA, the safety of using sides on beds and on potential falls. We noted dates the records were started and the regular dates of changes that had taken place and reviewed if changes had not been required. For example people's weights were recorded weekly. If there was no change this was reviewed again a week later. If the weight was a concern, records of what action was taken and how it was being monitored was seen in that person's record.

Records belonging to people who may have problems related to their memory did have the 'this is me' book sitting alongside their hospital records. The completion of this book did show an improvement since the last inspection visit. More information to guide staff was noted such as family history, but there is still room for further improvement. For example one book stated that this person's behaviour may challenge the staff yet there
was no plan on how to manage this or what the triggers to the behaviour might be.

In all four wards we visited we did not see any records on view to people who should not have access to these confidential records. There were no records on display at the nurse's stations with medical files seen still held in the sling style trolleys and day to day care notes held by the person's bed. Although these care notes were untidy and information stored in them were on slightly different formats, according to which ward you visited, they were completed and up to date. The hospital action plan following our last inspection states that a review of the way notes are stored, the types of folders used and the methods of storage is being reviewed to ensure confidentiality is maintained with a resolution date for the end of March 2012.

On discussion with different senior members of nursing and management staff the untidy state of the records and the different formats used had been recognised. During this visit we were shown a new version of a care plan/record that was about to be trialled throughout the hospital. We looked at each section within this model. The wording used in the sections of the folder had been thought through to ensure that the relevant information could be recorded and adapted in all wards. The adoption of this care plan folder should ensure that no matter which department a staff member worked in they should be able to pick up, work with, and complete the paperwork required. Although this is still to be tested, the layout of this document appeared an improvement on what was presently being used.

The action plan received from the hospital in November 2011 following the October inspection told us that an introduction to quality audits throughout the hospital would begin. During our visit the evidence of these audits was very clear. We were shown a large spread sheet that had recorded all wards and departments throughout the hospital that had received an audit up to the week ending 13 January 2012. The results showed that the outcome for 'records' still required some work on them to be fully compliant. We discussed these audits with managers of wards and were told how much had happened since the introduction of these checks. Not only were shortfalls of insufficient record keeping being addressed but managers were sharing good practise with the other wards they were auditing. They also told us that the audits will continue and how valuable this process was.

As part of the action plan of improvement the hospital had also introduced a pilot scheme that was seen in place for recording care rounds. Each person admitted to a ward received a chart asking questions under the headings of C A R E. 'C' communication with compassion, 'A' assess and assist, 'R' relieve pain and 'E' encourage adequate nutrition. These checks were to be carried out as a minimum of two hourly. We saw records where these had been completed and also shown one that had been completed hourly due to the high level needs of the individual person. We also noted in the staff room of one ward where this chart had been placed on the notice board with information on display as to the importance of this document. Staff spoken to on the wards did state that it was more paperwork and time consuming but understood the need to improve the record keeping.

**Our judgement**
The trust is compliant with this outcome area, but should continue to implement their action plan to ensure at all times records are accurate and up to date.
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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