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

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**Norfolk and Norwich University Hospitals NHS Foundation Trust**

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent to care and treatment</td>
<td>✓</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>✓</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>✓</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>✓</td>
</tr>
<tr>
<td>Staffing</td>
<td>✓</td>
</tr>
</tbody>
</table>
## Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>Norfolk and Norwich University Hospitals NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of the service</td>
<td>The Norfolk and Norwich University Hospitals NHS Foundation Trust provides a full range of acute clinical services, including some further specialist services. It has more than 6500 staff plus 600 volunteers that care for more than 700,000 people from Norfolk and neighbouring counties.</td>
</tr>
<tr>
<td>Type of service</td>
<td>Acute services with overnight beds</td>
</tr>
</tbody>
</table>
| Regulated activities | Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Family planning  
Management of supply of blood and blood derived products  
Maternity and midwifery services  
Surgical procedures  
Termination of pregnancies  
Treatment of disease, disorder or injury |
## Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

<table>
<thead>
<tr>
<th>Summary of this inspection:</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>How we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>What people told us and what we found</td>
<td>4</td>
</tr>
<tr>
<td>More information about the provider</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our judgements for each standard inspected:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent to care and treatment</td>
<td>6</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>8</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>10</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>12</td>
</tr>
<tr>
<td>Staffing</td>
<td>14</td>
</tr>
</tbody>
</table>

| About CQC Inspections | 15 |
| How we define our judgements | 16 |
| Glossary of terms we use in this report | 18 |
| Contact us | 20 |
Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 3 October 2012, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

During this inspection visit we spoke with 14 people who were able to answer our questions on the care, treatment and support provided to them during there stay in hospital. We looked at care plans that showed us individual records of consent to treatment signed by the person and care plans that were personalised for the individuals. These records included assessed potential risks and the action required to minimise those risks.

Those people we spoke with who used the service and visitors said they were very impressed with the cleanliness and hygiene standards they had witnessed. People said staff always cleaned their hands before and after they attended to anyone.

The areas we saw had been cleaned regularly, and a cleaning schedule was available at the entrance to the ward which demonstrated to visitors the frequency and type of cleaning.

We were told staff were quick to answer call bells so that people were attended to when required. The only time there may be a delay was when an emergency arose.

People who were attending the hospital through the accident and emergency department (A&E) and were kept waiting were supported by staff who regularly attended and assessed those waiting, ensuring people with high level needs were prioritised.

During mealtimes, staff were allocated to serving and assisting with meals. This ensured that there were sufficient staff to provide people who required assistance with a relaxed and comfortable mealtime.

You can see our judgements on the front page of this report.
More information about the provider

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

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
### Consent to care and treatment

**Met this standard**

**Before people are given any examination, care, treatment or support, they should be asked if they agree to it**

### Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. The provider acted in accordance with legal requirements where people did not have the capacity to consent.

### Reasons for our judgement

14 people and three relatives, visiting at the time of this inspection, spoke with us and said they had been fully involved and could make decisions regarding their treatment. Those people who had planned admissions to the hospital were given a full explanation of the process of their treatment and the outcome aimed for at a pre assessment appointment.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. People who were on the wards for an operation told us that the risks involved with their treatment was made clear to them and that they had been enabled to make the decision as to whether or not they went ahead with the surgery. People felt that the explanations were worded suitably so that they could understand. They told us that they "Felt confident about what was being done after the explanation." One person told us that the medical staff had explained the risks involved in the procedure they were about to have and made sure that they understood this before they signed the consent form.

Another person we spoke with told us how medical staff had explained what would happen after the procedure. "The doctor said I will be playing my cello again within a few days." This showed that the doctor had read the person's file and taken note of one of their hobbies. The relative of this person told us that nursing staff had explained to them what was happening, the expected recovery time and how to contact them for an update on their relative's condition after the procedure had been done.

People who were admitted to the hospital and identified as lacking the capacity to understand were supported by the hospital staff team who understood the procedures that should be followed to ensure that any decision was made in the persons best interests. The nursing staff we spoke with told us they had attended training, understood the Mental Capacity Act and knew the way people who lacked capacity should be supported, including making best interest decisions. Two people, we noted, did not have the capacity to consent but, in both of these instances, we saw evidence that the provider had acted in
accordance with legal requirements. However, the provider may find it useful to note that one person had a 'Do Not Resuscitate' form in the front of their care plan folder, which had been signed by the doctor. The ward sister assured us that a 'best interests' meeting would have been held before the decision was made but there was no clear evidence in the care records to support this.

Although we did not speak with anyone who could not speak English the nursing staff told us that an interpreter could be requested to enable people to fully understand their treatment if one was required.

We looked at the care records for seven of the people we spoke with. These contained a signed consent form which showed that consent had been given before the procedure detailed was carried out.

The results of the internal quality audits that were carried out throughout the hospital by staff and a team of independent external patient representatives were shared with us. The conclusion of the audits on the 2nd October 2012 indicated that the provider found themselves to be compliant with the 'consent to care and treatment' standard across the 42 clinical areas which included all wards and the accident and emergency department.
Care and welfare of people who use services

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

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

People we spoke with during this inspection told us about the care and treatment they had received since they had been admitted. Three of the people told us they had been admitted through the accident and emergency department. They told us that although the department was very busy and they had a long wait, staff were, "Very calm and reassuring."

Another person told us that they had "Waited around for a long time" in the accident and emergency department. They also told us that they were "not sure what would happen." They told us that the nursing team were very helpful and "Treated them with respect."

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. During this inspection visit we looked at 11 plans of care for people on five different wards. The information found was clear, centred around the people the care plan belonged to and risks had been identified and acted upon to lessen the risk. For example, we saw clear pathways written where a person had been identified as at risk of insufficient or incorrect nutritional intake. We noted the trigger to refer the person on to a specialist within the hospital was documented. We saw the report from that specialist and then the action taken by the staff to follow the advice. This advice had then been regularly reviewed and recorded. To track the information within the care plan notes the hospital had introduced a coloured sticker for each specialist who had taken any action with the person. For example, a yellow sticker for nursing notes and a blue sticker for physiotherapy notes. This made it much easier and quicker to look back through the care plan folder to see what advice had been given by the different experts to meet that person's need.

We also noted that regular checks were made on each person to ensure they were seen regularly and offered support, if and when required. We observed staff as they carried out their day to day tasks. We noted staff were confident and supportive and assisted at regular intervals for any tasks required. These regular checks were logged in the persons care notes by the side of their beds. The nursing staff told us that handovers at the beginning of shifts, where all information was discussed, was attended by all staff. In certain wards specialist staff also attended. For example we spoke with staff on the stroke ward who told us the physiotherapists and swallowing experts attended. This showed us
that all staff were made aware and involved in the treatment and care required to meet individual needs.

We arrived on one ward just prior to lunch being served. We noted that people were encouraged to use the toilet if they wished prior to the food trolley arriving, allowing the meal time to be relaxed and less likely to be interrupted. Throughout the observation of the meal time process we noted the correct support offered to those people who required it. Suitable meals were delivered, choices were offered and staff sat with people to encourage and support them. The comments received after the meal were very positive. We were told how much the meals had improved and the choices were good. One person told us, "The staff are very good at knowing who needs help and who just needs a little encouragement."

We observed one person who was being supported and was trying to eat unaided for the first time since a stroke, which had left them blind. The staff member sat at their level, guided and supported them as they ate their meal and gave praise and encouragement. Another person was observed having an assessment carried out on their ability to swallow. The specialist carrying out this assessment was giving the person time, communicating with them at every stage of the assessment and ensuring they wished to carry on with the process. A further person had slipped into an awkward position in bed. The nurse supporting that person asked for assistance, closed the curtains and made the person comfortable. Later that person was noted to be enjoying their meal and sitting in a more upright position making it easier to eat. This showed that staff understood the needs of the people they were supporting.

We discussed the lunchtime routine with the sister in charge of one ward. They told us they operated a traffic light system, and all people who used the service were coded red, amber or green to signify the level of assistance they required to eat their meal. Individual cards above their bed showed whether the person in that bed was nil by mouth, needed pureed food, food cut small or a normal diet. The notice also showed requirements for drink and medication.

The recent internal audit carried out by the hospital on the quality on the 'care and welfare of people who used the service' carried out in October 2012 demonstrated improvements had been made.
Cooperating with other providers

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

During the inspection we spoke with three paramedics who were waiting for vacant bays in the (A&E) accident and emergency department. They told us that they often waited for some time for a bay to become vacant, and had to stay with the person they had brought into hospital until they were in the bay.

We observed the three people who were waiting for a vacant bay, and saw that on the day of the inspection paramedics were waiting for about an hour.

Staff in this department explained to both the person waiting and the attending paramedic the reasons for the delay. In the department we spoke with the operations manager who was constantly on the telephone working with all areas of the hospital and external professionals to release people from the department as and when appropriate. They told us that 44 people had attended the emergency department during the night prior to this inspection. The paramedics we spoke with all said that the staff in the A&E department were doing the best they could with the size of the department they had.

The Trust was experiencing significant emergency demand at the time of the inspection and had escalated to the highest level of operational pressure. The trolley bay in the Accident and emergency department has 15 cubicles and the resuscitation area has 6 (4 generic, 1 paediatric and 1 cardiac). There is further escalation capacity just off the main entrance to the department for 7 people on trolleys waiting for a trolley bay.

One ward we visited specialised in the care of certain medial conditions. We were told by the sister in charge of the ward about work undertaken to ensure information was shared through a multi-disciplinary meeting and of the positive results this yielded. We were told that a daily handover meeting took place which involved medical, nursing, occupational therapy, speech and language and physiotherapy staff.

On another ward one person said that they felt there was a lack of clear communication between certain departments in respect of their discharge. The person told us that they lived on their own and, following their operation, would have mobility issues for a while. Some staff had told them that they were "ready to go home" and were preparing for their
discharge, while others had said that they still had a "little way to go yet". However another person told us that everything had gone very smoothly from when their GP had first referred them to the hospital and that they were preparing to be discharged. This person told us that there had been good involvement with the physiotherapist before and after their operation and that they were confident that there would be a good hand over of their information for 'after-care', once they were discharged.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others. One person told us that they had come into hospital for a day procedure but that the doctor had wanted them to remain in overnight for observation. This person told us that they had been kept fully informed before and during their procedure and that they had already been given the information they needed and that this information had been sent regarding their 'after-care' to their GP and district nurses.

We spoke with the ward sister on one ward, who confirmed that the hospital had a Dementia Lead and Learning Disability Lead. We saw evidence in the care records that these 'Leads' had been involved in assessing and planning the care and treatment for two of the people we observed. The information was relevant and gave us a good picture of how the 'Leads' and ward staff worked well together.

Senior management told us of the various ways the hospital was working with community based services, such as drug and alcohol related services, to improve and possibly provide services that may be more suitable and meet individual people's needs.
Cleanliness and infection control

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

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed and were cared for in a clean, hygienic environment.

Reasons for our judgement

People we spoke with said they were very impressed with the cleanliness and hygiene in the hospital. One person commented that they had been a bit concerned when one of the cleaners had mopped the floor but left it wet in their ward during the daytime. They said it made things very difficult for people using walking frames, crutches or walking sticks because it was quite slippery.

The areas we saw were cleaned regularly, and a cleaning schedule was available at entrance to the ward which demonstrated to visitors the frequency and type of cleaning undertaken.

One staff member who was responsible for cleaning the ward told us of the cleaning audits used and how they were checked regularly. This told us that good infection control procedures were followed and that checks were in place to maintain appropriate standards of cleanliness.

On our walk around the hospital we noted the equipment used for various monitoring processes had a label attached which stated when they were last cleaned. Commodes taken to patient's bedside were covered with a strip of paper showing when and who had last cleaned the equipment.

One person told us that all the staff constantly cleaned their hands before they attended to anyone and when they had finished. Also, they had noticed that when the cleaners hadn't been able to sweep the floor properly near someone's bed for various reasons, they came back later and cleaned the areas they had previously missed.

We saw that a number of rooms on one ward were sign-posted 'Enteric Isolation' and one of the nurses we spoke with explained that there had been a recent outbreak of Norovirus. The nurse said that this had been brought under control very quickly. We were told that if anyone showed even the slightest sign of having the virus they would be individually isolated as a precautionary measure. We observed that the staff regularly washed their hands, used the hand gels and used protective clothing such as gloves and aprons, particularly when entering these sign-posted areas.
We saw that various pieces of equipment such as hoists and stand aids were clearly labelled when they had been cleaned thoroughly.

There were sufficient hand gels, disposable gloves and aprons for use by staff and visitors and infection control signage was clearly displayed throughout each of the wards we inspected.

There were effective systems in place to reduce the risk and spread of infection. We noted that one person, who required 24 hour one-to-one support, was in a single room and that isolation procedures were being used. We saw that everybody was required to wear gloves and aprons when they entered this person’s room. The care assistant told us that this was a precautionary measure because the person had proven positive for Methicillin-Resistant Staphylococcus Aureus (MRSA) a few years ago. The results on this admission were still pending.
Staffing

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

People who used the service told us that staff were very helpful. The accident and emergency department had been very busy, but one person who had been admitted to hospital via this department told us how calm and relaxed staff were. While we were in the accident and emergency department we saw that staff took the time to explain to people who were waiting, what was happening.

All of the wards we visited were fully staffed at the time of our inspection, but we were told that the afternoon shift on accident and emergency would be short due to sickness. The senior in charge was trying at the time of the inspection to cover the shortfall.

One person we spoke with who used the service told us that there were always "Plenty of staff around." However another person said that the nurses were all "Too busy filling out paperwork."

All four people who used the service told us that the nursing and care staff always explained what was happening. One person said that although they were always busy they were all "Very pleasant."

There were enough qualified, skilled and experienced staff to meet people's needs. We were told by one person that "99% of the time" the staff were very quick in responding to their call bell and that, generally, the only times they had "a bit of a wait", was when the ward had been dealing with emergency situations. This person said that there was often a lot of bank nurses and students on duty but this had never been a problem to them.

One person said that night staff didn't seem to be able to provide answers or make decisions in the same way that day staff did. They said that there were only three staff on the ward that night, so it didn't pay to be "too urgent" if you needed anything but, they added, on the whole the staffing levels were good.

We observed people who needed assistance to eat their meals and we saw that staff were specifically allocated to these people during the lunchtime period. We noted that staff were very respectful towards them and treated them with full dignity. We noted that the curtains were drawn briefly just before one person had their lunch, in order to position them more appropriately in the bed.
We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ Met this standard  This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

✗ Action needed  This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

✗ Enforcement action taken  If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

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

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

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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

- Respecting and involving people who use services - Outcome 1 (Regulation 17)
- Consent to care and treatment - Outcome 2 (Regulation 18)
- Care and welfare of people who use services - Outcome 4 (Regulation 9)
- Meeting Nutritional Needs - Outcome 5 (Regulation 14)
- Cooperating with other providers - Outcome 6 (Regulation 24)
- Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
- Cleanliness and infection control - Outcome 8 (Regulation 12)
- Management of medicines - Outcome 9 (Regulation 13)
- Safety and suitability of premises - Outcome 10 (Regulation 15)
- Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
- Requirements relating to workers - Outcome 12 (Regulation 21)
- Staffing - Outcome 13 (Regulation 22)
- Supporting Staff - Outcome 14 (Regulation 23)
- Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
- Complaints - Outcome 17 (Regulation 19)
- Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
### Glossary of terms we use in this report (continued)

#### (Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

#### Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

#### Responsive inspection

This is carried out at any time in relation to identified concerns.

#### Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

#### Themed inspection

This is targeted to look at specific standards, sectors or types of care.