Salford Royal NHS Foundation Trust
Salford Royal Hospital

Region: North West

Location address: Salford Royal Hospital, Stott Lane, Salford Manchester.

Type of service: Acute Services

Publication date: June 2011

Overview of the service:

Salford Royal Hospital is a large teaching hospital with 850 beds. It treats in the region of 400,000 patients each year. It provides acute medical services and specialist care for brain, bone, intestine and kidney conditions.

The hospital is located in Salford approximately 2 miles from Manchester city centre.
Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Salford Royal Hospital was meeting both of the essential standards of quality and safety we reviewed but to maintain this we suggested that some improvements were made.

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

Why we carried out this review

This review was part of a targeted inspection programme in acute NHS hospitals to assess how well older people are treated during their hospital stay. In particular, we focused on whether they were treated with dignity and respect and whether their nutritional needs were met.

How we carried out this review

We reviewed all the information we held about this provider, carried out a visit on 5 April 2011, observed how people were being cared for, talked with people who use services, talked with staff, checked the provider’s records, and looked at records of people who use services.

Our inspection team was joined by a practising, experienced nurse and an ‘expert by experience’ – a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective.
What people told us

We spoke with six patients, one relative and eight members of staff and observed the care given to people during our visit to the hospital. We also used information provided by patients on NHS Choices website, complaints that we have been sent, Patient Environment Action Team assessments and patient survey results.

People we spoke to were very positive about their experiences of care and treatment. Many of the people we spoke told us that they trusted the doctors and nurses to make the right decisions about their care and treatment.

Others told us that the doctors and nurses were very good at making sure people understood everything about their illness and their treatments. People said they were kept informed, were involved in making decisions about treatment options and were given enough information both written and verbally to help with this process. Most patients also said that they had their care needs met and had been treated respectfully. The people we spoke to on our visit said that they did not have to wait when they called for staff assistance and all knew how to operate the nurse call system. No complaints were made to us about the time people had to wait for assistance.

The patients told us they were also involved in making decisions about their care. One patient told us that she had been able to discuss her future needs and options about where she should be discharged to had been explained to her.

All of the people we spoke to were aware of the reason for their admission to hospital, the likely length of stay and the treatment options available to them.

Example comments included staff described as being ‘excellent’, ‘the care being very good’, ‘staff were kind and caring’.

Some people told us that they were happy with the care they received but felt at times more staff were needed to ensure that everyone received the individual care that they required. During our visit, we observed that, on one occasion, a patients’ dignity was being compromised.

Patients were very complimentary about their experiences of mealtimes. They commented that the staff made an effort to make it a pleasant experience. Patients also commented that they were well supported to eat and drink. Patients said that there was a good choice of food, including meal options that met different cultural requirements. These findings are supported by the trust’s inpatient survey (2010) results, which showed that:

- 5.4 out of 10 on how patients would rate hospital food
- 8.5 out of 10 on amount of choice of food
- 7.9 out of 10 on whether patients received enough help with eating

These results are about the same when compared to other similar trusts’.
What we found about the standards we reviewed and how well Salford Royal Hospital was meeting them

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

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

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

- Overall, we found that Salford Royal was meeting this essential standard.

Action we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.
What we found
for each essential standard of quality
and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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

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

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

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

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety.*
Outcome 1: 
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

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<td>There are minor concerns with outcome 1: Respecting and involving people who use services</td>
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<th>Our findings</th>
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<td>What people who use the service experienced and told us</td>
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All of the people we spoke to were aware of the reason for their admission to hospital, the likely length of stay and the treatment options available to them.

Example comments included staff described as being 'excellent', 'the care being very good', 'staff were kind and caring'.

Some people told us that they were happy with the care they received but felt at times more staff were needed to ensure that everyone received the individual care that they required.

However, during our visit, we observed that, on one occasion, a patients’ dignity was being seriously compromised.

Other evidence

The information we held about Salford Royal hospital prior to our visit showed that there was a very low risk that they were not meeting this standard.

Whilst we were on wards, we observed staff taking the time to involve people in everyday decisions about their care and treatment. Interactions between patients and staff were frequent and appropriate. People were asked if they would like a drink, whether they were comfortable and whether they needed any pain medication.

We spoke to one gentleman who had fractured his patella and then looked at his records. It was clear that the medical team had respected this persons wish to not have any further surgery. There was documented evidence of this decision being made with a full explanation of the implications and possible risks and benefits.

When we looked at peoples’ medical records we could see that where decisions were made that affected a persons care they were involved in planning what happened. Where they were not capable of making their own informed decisions, we saw records that demonstrated an assessment of their mental capacity had taken place. If a person was assessed as lacking capacity but required treatment or surgery a designated consent form was completed. There was evidence from these forms, from discussion with staff and from peoples’ medical records that relatives or the next of kin were involved.

When we spoke to relatives, we were told that they had been involved in making decisions about the care of their relative from the time they were admitted from the accident and emergency department and that every thing had been explained to them.

We observed that one ward was very busy and staff told us that there was, on occasions, insufficient time to spend with patients when they were distressed or needed further explanation about their treatment and care. People told us that they were happy with the care they received but felt at times more staff were needed.

During our visit, staff were observed treating patients with respect. Patients’ privacy
and dignity was mainly maintained. The trust has issued a statement on ‘Eliminating mixed Sex Accommodation’ that is displayed in some ward areas. It states that people will be accommodated in same sex bays and have access to same sex lavatory and washing facilities except where clinical need makes this impractical. We observed that eliminating mixed sex accommodation information leaflets and posters were not available on all wards. All of the ward bays we saw were single sex. Data from the trust incident reporting system showed low rates of mixed sex accommodation.

On one occasion we observed that a patient’s dignity was being compromised. A member of staff appeared to ignore the fact that a patient was in distress and not appropriately covered up. Other ward staff responded when we brought this issue to their attention and ensured that the cubicle curtains were drawn to protect the patients dignity.

We observed that staff ensured curtains were fully drawn around people when care was being given. Lavatories, bathrooms and shower rooms had locks and engaged signs on them, which were used. We observed that in some disabled toilet facilities the toilet roll holders had been located too high on the wall for wheelchair users to access. People being assisted to the bathrooms were dressed or well covered when being moved in chairs. All of the people we saw were wearing clean clothing or nightwear and looked well cared for.

The trust has a range of ways of monitoring whether people who use the services are involved and respected. This includes spot check visits by the Director of Nursing and Matrons at any time during the day or night. Staff we talked to were well informed about the need for ongoing assessment of capacity when caring for the very frail or elderly. The trust provided data from a range of audits including, dignity and liberty, mental capacity act and consent audit outcomes. Results show that a high priority is placed on these issues.

Training records showed that staff received training on implementing the concept of privacy, dignity independence and human rights.

Information provided to us by the trust evidenced that the hospital has a range of policies and procedures in place to ensure people’s needs are met. The trust’s dignity in care action plan showed that training programmes and links had been developed to improve the hospital experience for vulnerable people including people with sensory impairment.

The trust has a specific policy on patient privacy and dignity. Staff we spoke to were able to access trust policies about assessment of needs and individualised care and were aware of the content of the trust policies.

The trust uses published guidance to develop its policies and procedures. We reviewed a number of trust policies and procedures, which confirmed that research and guidance is taken into account by the trust and trust policies are updated.

There was evidence from peoples’ records that mental capacity assessments were undertaken in accordance with the trust policy and that ‘best interest’ meetings were
held when necessary.

Staff told us that patient’s wishes and preferences were discussed with them on admission and recorded in their care plan. When we looked at people’s medical records we could see that wishes and preferences had been documented.

When we looked at peoples’ records we could see that peoples’ spiritual and religious preferences were recorded as part of the assessment process. From our observations we saw that people were addressed by their preferred name. One gentleman told us that he had been asked what he preferred to be called when he had arrived on the ward and that staff had respected this choice and always used this name.

There was information available in each ward about the Patient Advisory and Liaison service (PALS), who are the trust’s first point of contact for complaints resolution.

On the wards we visited, we observed that there was a range of information displayed for patients and their relatives. There were details of local and national support services for people who had suffered strokes and numerous information leaflets people could take away.

Information supplied by the trust and discussion with ward staff provided evidence that the trust undertakes surveys of its patient population and acts on the feedback.

Complaints are monitored at board level and analysed for any trends or serious concerns so that they can be used to improve patient care. There was information available throughout the hospital, which told people how to raise concerns.

The trust provided us with evidence that they work co-operatively with the local involvement network (LINk).

Our judgement

Many patients are very positive about their experiences of care and treatment at Salford Royal Hospital. They stated that they were kept informed and were involved in making decisions about treatment options.

One of the wards we visited was found to provide a high standard of individual care. However environmental factors on one ward resulted in some patients not having their specific care needs met and in one instance a person’s dignity being compromised.

The hospital is providing a good level of training around issues of privacy, dignity and human rights.

Overall, we found that the Salford Royal Hospital was meeting this essential standard, but to maintain this we suggested that some improvements were made.
Outcome 5:  
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

What we found

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<td><strong>Compliant</strong> with outcome 5: Meeting nutritional needs</td>
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Our findings

What people who use the service told us

Patients and were very complimentary about their experiences of mealtimes. They commented that the staff made an effort to make it a pleasant experience. Patients also commented that they were well supported to eat and drink. Patients commented that there was a good choice of food, including meals that met different cultural requirements.

These findings are supported by the trust’s inpatient survey (2010) results which showed that
- 5.4 out of 10 on how patients would rate hospital food
- 8.5 out of 10 on amount of choice of food
- 7.9 out of 10 on whether patients received enough help with eating

These results are about the same when compared to other similar trusts’.

Other evidence

The information we held about Salford Royal hospital prior to our visit showed that there was a low risk that they were not meeting this standard.

The trust told us that there was a trust specialist nutrition nurse and a link nutrition nurse on each ward. A nutrition link nurse contract was reviewed and seen to document a range of responsibilities to ensure that all patients are assessed, risks identified and appropriate nutritional care was provided.
Some of the records we looked at showed that people who were at risk of developing malnutrition due to being very frail or elderly had been referred to a dietician for specialist advice. The records showed that the dieticians had visited, assessed the person and provided advice to ward staff. Nutritional plans had been regularly updated.

We visited two wards at lunch time to see how people were supported to eat and drink. Staff were seen to assist those who needed help. The trust operates a ‘Red Tray’ system for people who need additional support with eating or drinking. This means meals are served on red coloured trays. Accurate records of how much people ate and drank were mostly kept. We looked at peoples’ medical records and saw that a Malnutrition Universal Screening Tool (MUST) was completed on admission. MUST record’s are used to identify and document people who are at risk of malnutrition and to pick up any deterioration in a persons nutritional status. On one ward not all of the MUST records we saw were properly completed and appropriately updated.

The MUST tool had been used to determine what sort of additional support or assistance a person might need. All of the staff that we spoke to had received training in nutritional screening and monitoring. Training records showed that 82% of trust staff had received training on meeting patients’ nutritional requirements.

Weights and body mass indexes (BMI) were being recorded and updated. We looked at records and saw that BMI was transferred to the nutrition screening tool.

On one ward a board was kept in the kitchen detailing all patients who had been assessed as at risk of poor nutrition. Staff told us that regular checks were made to ensure documentation was complete. Records we looked at confirmed this.

On another ward we looked at peoples’ records and saw that food and drink intake was monitored but not always accurately recorded in records. One person’s records only recorded a fluid intake of 200mls, staff checked and found additional intake had not been recorded. Another person’s records had not been updated to reflect a change in their nutritional status.

We reviewed the role and activity of the trust’s nutritional steering group. Meetings of this group were attended by clinical, dietetics and catering staff. The trust had policies in place to support a range of nutritional care needs and staff we spoke to were aware of these policies.

People we spoke to told us that food was available if a meal was missed. Snack boxes were readily available or staff would make toast or jacket potatoes in the ward kitchen. One gentleman told us that he had not wanted his hot meal after having some treatment so staff provided a salad for him.

We observed that staff hand washing facilities were difficult to locate in some ward areas. Cleanliness of some kitchen areas and equipment, toasters, fridges and microwaves was poor. Domestic service level monitoring sheets had not been completed for either of the ward kitchens we visited. On one ward staff told us that, the lack of cleanliness of the kitchen equipment sometimes impacted on their ability to provide hot snacks.
From information supplied by the trust and from what staff told us, we saw that the senior staff conduct audits of nutritional screening monthly across all the trust’s wards. If any ward falls below an acceptable level for the nutritional screening of patients at any given audit, that ward becomes subject to increased audits until the senior staff are assured of improved practice.

We saw that ‘A guide to your hospital stay’ leaflets were available on each ward, which detailed information on meal times and healthy eating.

We saw that menu choices and snack boxes were available which took into account cultural needs and requirements. A variety of aids were seen to be available to help people eat and drink independently.

We were told that the trust operates an electronic ordering system. People told us that they could order their meals using the keypad a few hours before the food was delivered to the ward. One gentleman told us that meal options were very flexible using the electronic ordering system he was able to have his preferred option of his main meal at lunchtime and a snack in the evening.

People we spoke to told us the food was good, it was served hot, that they had plenty of choice and large enough portions. We saw that temperature probes to check the temperature of the food when it arrived at the ward were not available on the wards we visited.

Patient Environment Action Teams (PEAT) inspection data for Salford Royal Hospital rated the hospital as excellent for food. PEAT is an annual self assessment of inpatient healthcare sites in England that have more than 10 beds.

Our judgement

The hospital is ensuring that patients receive a full assessment of their nutritional requirements and that these are addressed and regularly reviewed. Staff are well trained to provide support for patients to eat and drink and were found to be attentive and considerate in providing this support. However, documentation of patients’ food and fluid intake is not always completed and nutritional assessments are not always updated. Some ward kitchen facilities contained equipment, used to provide snacks, which was not sufficiently cleaned and maintained.

Overall, we found that the Salford Royal Hospital was meeting this essential standard.
**Action**
we have asked the provider to take

**Improvement actions**

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

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<th>Regulation</th>
<th>Outcome</th>
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<td>Treatment of disease, disorder or injury</td>
<td>17</td>
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**Why we have concerns:**

Many patients are very positive about their experiences of care and treatment at Salford Royal Hospital. They stated that they were kept informed and were involved in making decisions about treatment options.

One of the wards we visited was found to provide a high standard of individual care. However environmental factors on one ward resulted in some patients not having their specific care needs met and in one instance a person’s dignity being compromised.

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider’s report should be sent within 28 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.
What is a review of compliance?

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

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called Guidance about compliance: Essential standards of quality and safety.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions**: These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions**: These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action**: These are actions we take using the criminal and/or civil procedures in the Health and Adult 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.
Dignity and nutrition reviews of compliance

The Secretary of State for Health proposed a review of the quality of care for older people in the NHS, to be delivered by CQC. A targeted inspection programme has been developed to take place in acute NHS hospitals, assessing how well older people are treated during their hospital stay. In particular, we focus on whether they are treated with dignity and respect and whether their nutritional needs are met. The inspection teams are led by CQC inspectors joined by a practising, experienced nurse. The inspection team also includes an ‘expert by experience’ – a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective.

This review involves the inspection of selected wards in 100 acute NHS hospitals. We have chosen the hospitals to visit partly on a risk assessment using the information we already hold on organisations. Some trusts have also been selected at random.

The inspection programme follows the existing CQC methods and systems for compliance reviews of organisations using specific interview and observation tools. These have been developed to gain an in-depth understanding of how care is delivered to patients during their hospital stay. The reviews focus on two main outcomes of the essential standards of quality and safety:

- Outcome 1 - Respecting and involving people who use the services
- Outcome 5 - Meeting nutritional needs.
Information for the reader

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<td>Author</td>
<td>Care Quality Commission</td>
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