

Review of compliance

Tameside Hospital NHS Foundation Trust
Tameside General Hospital

Region:	North West
Location address:	Tameside General Hospital Fountain Street Ashton under Lyne Lancashire OL6 9RW
Type of service:	NHS trust
Date the review was completed:	21 March 2011
Overview of the service:	<p>Tameside General Hospital is an acute general hospital which is eight miles to the east of Manchester and serves a population of approximately 250,000.</p> <p>The hospital has 549 beds of which 71 are for day cases. It provides a number of services: accident and emergency, medicine, surgery, paediatrics, maternity, intensive care, high dependency and critical care.</p>

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

What we found overall

We found that Tameside General Hospital was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review

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

How we carried out this review

We reviewed all the information we hold about this provider, surveyed people who use services, carried out a visit on 9th March 2011, observed how people were being cared for, talked to people who use services, talked to staff, checked the provider's records, and looked at records of people who use services.

What people told us

Generally people we spoke to were very happy with the care that they were receiving at the hospital. They told us that they were well looked after and that they didn't have to wait for staff to help them when they called.

Comments included, 'It's brilliant', 'Staff very nice – good to get along with', 'Superb' One person said that her relative had been in the hospital 12 months ago. She said that, at that time, she was extremely unhappy with the way care and treatment was given to her relative. However, for this admission she said, "Much, much improved now – I'm very impressed with the way things are run now".

Another person said "They've all done their best for me". They said that care had been very good on every admission. She said she felt involved in her care and that staff listened to her.

One negative comment was received about care received a month ago.

There were two negative comments relating to the time that people had to wait for a bed: one in the medical admission and assessment unit (MAAU) and one who had been waiting for surgery.

People we spoke to were happy with the time taken to see a doctor following admission to the hospital.

What we found about the standards we reviewed and how well Tameside General 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

The people who use services that we spoke to on our visit commented very positively about the care they received. They felt that they had enough information about their illness and felt able to approach staff if they wanted to know more.

People said that staff were happy to talk to their families, with their permission, about the care and treatment they were receiving.

People said that the staff listened to them. They knew when the doctor would see them.

We saw people being treated with respect on our visit. Measures were taken to preserve privacy and dignity.

There was information available throughout the hospital which told people how to raise concerns.

On the children's service we saw evidence of how the views of people who use services had been used to develop the design and delivery of the service.

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

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

We reviewed the information we held on the trust for this outcome and no concerns were identified.

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

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

People we spoke to during our visit were generally happy with the care they were receiving.

Care plans were usually reviewed. We saw one instance where a care plan had not been reviewed.

Risk assessments were generally in place but not consistently completed and were not always accurate. The trust had identified that falls risk assessments were not always being completed thoroughly. An audit from August 2010, based on data collected between 1 April 2009 and 31 March 2010, showed that 31 of 49 patients had not received a falls risk assessment in accordance with the trust policy. When we visited we reviewed falls risk assessments in patient's records. These were not

consistently completed and were not always accurate. Two of the records of people being looked at in the medical assessment unit did not have a falls risk assessment. It was not clear how the trust consistently shared learning from incidents across the organisation. In the incident we reviewed it was not clear that the actions reflected all the recommendations of the report.

- Overall, we found that improvements are needed for this essential standard.

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

We saw that people who required support with eating were clearly and consistently identified. We saw that staff helped people when the food arrived and that people did not have to wait.

Records were kept of what people had eaten and drunk where it was necessary. People were being weighed regularly and this was being recorded.

Nutritional assessments were usually completed.

On one ward we found that a nutritional assessment had not been completed for one patient. They had a nutritional care plan and monitoring and support was in place. In one case we found that the nutritional screening tool had been completed inaccurately.

In two cases we saw that there were delays between assessment and referral to the dietician. In one case it was not clear that the person had seen the dietician.

The trust does not employ a dedicated nutrition support nurse. National Institute for Health and Clinical Excellence (NICE) guidance for nutrition support says that an acute trust should employ a specialist nutrition nurse.

- Overall, we found that improvements are needed for this essential standard.

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

We reviewed all the evidence we hold on the trust for this outcome and no concerns were identified.

The report from the overview and scrutiny committee for health showed that there had been improvements in the management of care because of better working relationships between the trust and the primary care trust.

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

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

We reviewed all the evidence we hold on the trust for this outcome and no concerns were identified.

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

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

We saw evidence that there were effective processes in place to maintain infection prevention and control.

The hospital was clean and tidy on our visit.

We saw staff wash their hands and use gel appropriately.

Personal protective equipment such as gloves and aprons were available and used by staff.

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

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

We reviewed all the information we hold on the trust and no concerns were identified.

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

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

We reviewed the evidence we hold about the trust and no concerns were identified.

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

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

We reviewed the evidence we hold about the trust and no concerns were identified.

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

Outcome 12: People should be cared for by staff that is properly qualified and able to do their job

We saw evidence that the trust identifies when staff may have caused harm or risk of harm to people who use services.

The trust has a policy in place for ensuring that where they have to use locum doctors, that a consultant reviews and approves the suitability of the person for the post.

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

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

The people we spoke to on our visit said that they did not have to wait when they called for staff assistance. No complaints were made to us about the time people had to wait for assistance. No one complained about the lack of continuity in their care.

People knew when they would see their doctor.

Staff told us that they moved between wards far less often than they did last winter. Staff said that this consistency had helped them to provide better care.

The trust has undertaken a nursing staff benchmark exercise which identified that there is a shortfall of 16.43 qualified staff in adult medicine.

Ward manager supernumerary status is inconsistent. The ward manager is supernumerary 67% of the time on the adult medicine wards. The ability to maintain this is affected by sickness and leave.

The figures supplied by the trust show that the number of unfilled shifts decreased during the year but rose in December and January. The number of movements of staff in adult medicine increased over the winter months to 43 in January. These rises were attributed to staff sickness.

- Overall, we found that Tameside General Hospital was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

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

There is a system in place which monitors attendance at training and appraisals.

Staff spoken to could clearly identify lines of accountability and who they could raise concerns with. The staff we spoke to had attended training and received appraisals.

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

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

There is a culture of risk management and quality improvement, but there are inconsistencies in the documentation and management of action plans.

We reviewed the risk register which identified 53 corporate risks. Only 14 of the corporate risks identified had key dates and actions recorded against them

Information about outcomes and the experiences of people who use services is gathered and monitored by the trust.

We saw that documentation in reports and action plans was not always clear. This made it difficult to track that all actions had been completed.

There are some inconsistencies with the systems in place to ensure practices are reviewed and the risk of future lapses is minimised. Some actions with completion dates for July and August 2010 were not recorded as completed.

We reviewed how the trust followed up identified risk. We found that information did not consistently track through the clinical and corporate governance minutes and on to the organisational risk register.

- Overall, we found that improvements are needed for this essential standard.

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

We reviewed the information we hold on the trust and no concerns were identified. We saw that information on how to complain was readily available through out the hospital.

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

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

We reviewed notes on all the wards we visited. We found that a small number of records had not been signed and dated. We found that assessments for risk of falling and nutrition screening tools had not been completed accurately in a number of cases. This is followed up in Outcomes 4 and 5.

- Overall, we found that Tameside General Hospital was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Action we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

What we found
for each essential standard of quality
and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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

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

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

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

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 1: Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

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

What we found

Our judgement

The provider is compliant with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We visited eight wards in the hospital and spoke to patients and carers. A patient on Ward 2 said that although staff were busy they always felt listened to.
On the Medical Assessment and Admissions Unit (MAAU), a patient told us that he had been informed of what treatment will follow on from his initial admission. He was happy that he and his wife had relevant information given to them and staff were available to discuss any issues/concerns. Another patient said that his family had been kept informed with his permission. He felt that his privacy and dignity had been respected.
The Tameside Local Involvement Network (LINK) has been working closely with the trust. They are included in a number of working groups at the hospital. The LINK and the trust have been working together to monitor the action plan which the trust developed after the LINK report in 2010.

Other evidence

We reviewed the information we held on the trust for this outcome and no concerns of non compliance were identified.

On our visit we reviewed the records of patients being cared for across the hospital. All the files seen included a communication sheet for relatives to record questions. Staff said that usually families approached staff directly to discuss care.

We observed care being delivered. Staff treated patients with care and respect. Measures were taken to preserve privacy and dignity. Staff adjusted their position to make and maintain eye contact when talking to patients. Voices were lowered to maintain privacy when talking to patients. Staff were seen to adjust clothing and provide blankets and covers when people were sitting in chairs by their beds. Staff did not talk over patients. At lunchtime when people who were newly admitted had not been able to order their meal in advance, staff made every effort to provide an acceptable meal.

In Children's Services, staff told us how children had been involved in the development of the service. A local school had been involved in the consultation for the new build, along with patients and their families and carers. Staff were able to show us a number of things which had been designed as a result of the consultation. The desk in the outpatients had viewing panels with scenes in them at child height as children had said that they get bored waiting to check in at the desk. A library of 50 DVDs were available to download at any time as in the past children had to wait for others to finish watching what they wanted to.

There was a range of information on a number of health issues in the children's ward such as smoking, alcohol and self harming. Staff said that topics were changed regularly.

Our judgement

The people who use services that we spoke to on our visit commented very positively about the care they received. They felt that they had enough information about their illness and felt able to approach staff if they wanted to know more.

People said that staff were happy to talk to their families, with their permission, about the care and treatment they were receiving.

People said that the staff listened to them. They knew when the doctor would see them.

We saw people being treated with respect on our visit. Measures were taken to preserve privacy and dignity.

There was information available throughout the hospital which told people how to raise concerns.

On the children's service we saw evidence of how the views of people who use services had been used to develop the design and delivery of the service.

Outcome 2: Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:

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

What we found

Our judgement

The provider is compliant with outcome 2: Consent to care and treatment

Our findings

What people who use the service experienced and told us
The people we spoke to did not make comments on this outcome.

Other evidence
We reviewed the information we hold on the trust for this outcome and no concerns were identified. Following a visit to the trust in May 2010, the deanery identified the taking of consent as an area of notable practice across the trust.

Our judgement
We reviewed the information we held on the trust for this outcome and no concerns were identified.

Outcome 4: Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

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

What we found

Our judgement

There are minor concerns with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

We spoke to people who were in the hospital. All the people we spoke to about their care said that they were happy with the care they were receiving currently. Comments included, 'It's brilliant', 'Staff very nice – good to get along with', 'Superb' One person said that her relative had been in the hospital 12 months ago. She said that she was extremely unhappy with the way care and treatment was given to her relative then. However, for this admission she said, "Much, much improved now – I'm very impressed with the way things are run now".

Another person said "They've all done their best for me". They said that care had been very good on every admission. She said she felt involved in her care and that staff listened to her.

One negative comment was received about care received a month ago.

There were two negative comments relating to the time that people had to wait for a bed one in the MAAU and one who had been waiting for surgery. The person on the MAAU had been cared for in a chair from 14.00 until a bed was found at 23.30. The person on the surgical ward had arrived at the hospital at 10.30 and no bed had been found at 14.45. The patient and their family had found that the delay in getting a bed had increased their anxiety. This was fed back to the director of nursing at the time of the visit who said that the hospital would look at how the process of

admission for day surgery worked.

People we spoke to were happy with the time taken to see a doctor following admission to the hospital.

Other evidence

Since registration the trust has been supplying monthly Hospital Standardised Mortality Ratio (HSMR) figures to the Care Quality Commission. This figure is an indicator of healthcare quality that measures whether the death rate at a hospital is what you would expect. The trust's final figure for overall HSMR for 2009/2010 is 103.52, which is within expected limits. The Dr Foster report for 2009/2010 shows that the trust is within expected limits for all premature causes of death monitored by Dr Foster.

The trust provided evidence that they review care planning and risk assessments. Audits were supplied and showed increasing compliance across the period checked. The audit for October 2010 showed that there was 100% compliance in the medical division for care plans based on full nursing assessment, evidence of review and evaluation of care plans and evidence that relevant risk assessment and screening processes had been undertaken.

The care plans we saw were usually reviewed. In one case, one care plan had not been reviewed. The notes showed that the person was receiving care in line with the care plan.

The trust supplied minutes of the LINK action plan oversight group which showed that the trust had identified concerns with how the risk of falls was being screened for. It was identified that there was poor compliance with screening, the use of the Canard screening tool, electronic recordkeeping at ward level and general screening. The falls audit from August 2010, based on data collected between 1 April 2009 and 31 March 2010, showed that 31 of the 49 patients who were included in the audit did not receive an initial falls assessment when they were admitted to hospital. The trust has developed an action plan in response to the audit which identifies a number of measures which are being undertaken.

We also reviewed the records of patients when we visited the hospital. We found inconsistencies in the assessment of risks. Three people did not have their risk for falls assessed. Two of these people were being cared for in the MAU. In two other cases, the falls risk assessment had been completed but not accurately which had resulted in an incorrect risk rating. In one case the care the patient was receiving was appropriate to their actual risk. A second patient had been assessed as requiring a falls integrated care pathway. This had not been completed. However, the care this patient was receiving was in line with the identified risk and no falls had occurred.

We observed care being delivered at the hospital. All the nurses and support workers we observed engaged kindly and considerately with the patients while caring for them and involved them as much as possible.

We looked at how the trust shared learning from incidents. We tracked an incident that the trust had sent us information about. The time taken for the completion of the investigation was nine months. It was not clear whether all people involved in the incident had been involved in the investigation. The recommendations did not make clear what further action was to be taken. It was written in minutes of a meeting in September 2010 that the deanery was to be notified of concerns about the practice

of a healthcare professional. It was not clear on the day of the visit when talking to staff whether this had happened.

In the children's service we saw evidence of best practice. The children's service manager used incidents taken from nursing fitness to practice panels with staff to help them reflect on their practice. Staff spoken to could clearly describe how learning from incidents that happened in the unit was shared.

It was not clear how the trust consistently shared learning from incidents across the organisation. (see outcome 16)

We looked at how the trust provided same sex accommodation. On the MAAU, one bay had men and women on it. Staff said that this was due to two people waiting for surgical beds. Staff said that instances of care being provided in mixed sex accommodation were reported as incidents.

One member of staff on the ear nose and throat (ENT) and short stay orthopaedic ward said that there had been an increase in the number of medical patients having to be cared for on the ward. On the orthopaedic ward there were two medical patients being cared for on the day of our visit. Staff there said it was not uncommon for this to happen. Another nurse also identified discharges from this ward as sometimes being slow due to the amount of care having to be put in place at home.

The trust provided evidence that they monitored the use of the Patient at Risk Score (PARS) which is a system for monitoring people's level of illness. The audit demonstrated a high level of compliance with the recording of the PARS. We saw that this was being done in the notes we reviewed on our visit.

The trust provided evidence that they had implemented the plan to manage beds and discharge plans. The capacity management plan was in place. Discharge plans were seen in patient records but these were not always completed. The trust audit showed that 22% of patients did not have a completed discharge plan.

On MAAU, there were 39 beds and 41 patients. Two people were being cared for on stretchers.

Our judgement

People we spoke to during our visit were generally happy with the care they were receiving.

Care plans were usually reviewed. We saw one instance where a care plan had not been reviewed.

Risk assessments were generally in place but not consistently completed and were not always accurate. The trust had identified that falls risk assessments were not always being completed thoroughly. An audit from August 2010, based on data collected between 1 April 2009 and 31 March 2010, showed that 31 of 49 patients had not received a falls risk assessment in accordance with the trust policy. When we visited we reviewed falls risk assessments in patient's records. These were not consistently completed and were not always accurate. Two of the records of people being looked at in the medical assessment unit did not have a falls risk assessment.

It was not clear how the trust consistently shared learning from incidents across the organisation. In the incident we reviewed it was not clear that the actions reflected all the recommendations of the report.

Outcome 5: Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:

- Are supported to have adequate nutrition and hydration.

What we found

Our judgement

There are minor concerns with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
We spoke to people using the service on our visit. They generally said that they were happy with the food in the hospital. The only area where we visited that some people were not happy with the food was the MAAU. People in one bay on this ward told us that the food was warm and not hot and that often there was not a choice. Staff told us that meals were delivered to this bay of the ward last.

Other evidence
There is a nutrition steering committee in the trust. Minutes of the committee showed that it had reviewed the trust against the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) 'A Mixed Bag report'. The committee had identified that it was non compliant with the report as the trust did not employ a nurse specialist in nutrition, a dedicated nutrition team or provide a formal total parenteral nutrition (TPN) service.
The trust provided an annual nutrition action plan which detailed what plans the trust has in place to implement the actions it has identified.
The National Institute for Health and Clinical Excellence (NICE) guidelines for nutrition support in adults states that all acute trusts should employ at least one specialist nutrition support nurse.
The minutes identified actions to commence a weekly TPN ward round which would include a dietician, a consultant and a pharmacist.

Nutrition training is included in mandatory training.

We visited three adult medicine wards at lunch time to see how people were supported to eat and drink. There was a red jug system in operation which identified people who needed support to eat. Staff were seen to assist those who needed help quickly while the food was still hot. People were helped to get into a comfortable position to eat. Food and drinks were placed in reach of people. On one ward a volunteer was helping with drinks for people. A variety of aids were seen to help people eat and drink independently. Accurate records of how much people ate and drank were kept.

We looked at records of people who had been identified as needing support. In two cases there was a delay in referring to the dietician. In one case it was not clear if the person had been seen by the dietician following referral. In this case, a nutrition risk assessment had been completed inaccurately and this had led to the person being identified as a low risk rather than a medium risk. The person had been put on a red tray and their intake had been monitored and recorded. A referral to the dietician had taken place when they had begun to lose weight. According to the assessment tool this should have been done within three days: because the risk had been incorrectly identified as low this had not happened. In a second case, a nutritional risk assessment had not been completed on admission but some time after.

Weights and body mass indexes (BMI) were being recorded and updated. There were two charts for recording weight and BMIs: on one ward the weight and BMI were not always being transferred to the nutrition screening tool.

Our judgement

We saw that people who required support with eating were clearly and consistently identified. We saw that staff helped people when the food arrived and that people did not have to wait.

Records were kept of what people had eaten and drunk where it was necessary. People were being weighed regularly and this was being recorded.

Nutritional assessments were usually completed.

On one ward we found that a nutritional assessment had not been completed for one patient. They had a nutritional care plan and monitoring and support was in place. In one case we found that the nutritional screening tool had been completed inaccurately.

In two cases we saw that there were delays between assessment and referral to the dietician. In one case it was not clear that the person had seen the dietician.

The trust does not employ a dedicated nutrition support nurse. NICE guidance for nutrition support says that an acute trust should employ a specialist nutrition nurse.

Outcome 6: Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:

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

What we found

Our judgement

The provider is compliant with outcome 6: Cooperating with other providers

Our findings

What people who use the service experienced and told us
The people we spoke to did not comment on this outcome. The overview and scrutiny committee provided us with a report of their work in the health economy. They found that emergency admissions and intermediate care services had been improved by closer partnership working between the hospital and the primary care trust. A new quality committee had been set up which included staff from the entire health economy.

Other evidence
We reviewed the information we hold on the trust for this outcome. No concerns were identified. Evidence that the trust provided as part of the ongoing monitoring of compliance shows that they work with partner organisations to provide ongoing care.

Our judgement
We reviewed all the evidence we held on the trust for this outcome and no concerns were identified.
The report from the overview and scrutiny committee for health showed that there had been improvements in the management of care because of better working relationships between the trust and the primary care trust.

Outcome 7: Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:

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

What we found

Our judgement

The provider is compliant with outcome 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
The people we spoke to did not make any comments on this outcome.

Other evidence
We reviewed the information that we hold on the trust and no concerns were identified.
On our visit we saw that information about safeguarding was available in the wards we visited.
As part of our ongoing monitoring of compliance we review notifications that the trust make to the National Patient Safety Agency (NPSA). These show that the trust identify safeguarding issues and act upon concerns.
On our visit we saw that there was information clearly displayed for staff about safeguarding.

Our judgement
We reviewed all the evidence we hold on the trust for this outcome and no concerns were identified.

Outcome 8: Cleanliness and infection control

What the outcome says

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

What we found

Our judgement

The provider is compliant with outcome 8: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
People we spoke to said they thought the hospital was clean.

Other evidence
We visited eight wards at the hospital. They all looked clean and tidy.
Cleaning schedules were seen throughout the hospital.
Staff were seen to wash their hands and use hand gel. Hand gel was available through out the hospital and staff told us that they check that it is always available.
Personal protective equipment such as gloves and aprons were available and used by staff.
On one ward we saw that people who had been identified as having an infection were receiving the appropriate treatment and care to reduce the risk of passing on the infection to other people.
Staff spoken to had received training in infection control.

Our judgement
We saw evidence that there were effective processes in place to maintain infection prevention and control.
The hospital was clean and tidy on our visit.
We saw staff wash their hands and use gel appropriately.

Personal protective equipment such as gloves and aprons were available and used by staff.

Outcome 9: Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:

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

What we found

Our judgement

The provider is compliant with outcome 9: Management of medicines

Our findings

What people who use the service experienced and told us
The people we spoke to did not make any comments about this outcome.

Other evidence
The trust was rated as compliant at registration. The deanery identified the support and feedback on safe prescribing given by the trust’s pharmacists as notable practice when they visited.
The trust promotes a no blame culture for error reporting. The children’s service uses a medication error proforma which staff complete following any errors. A recent example was viewed which showed that staff had used the form following the error. The form showed that immediate action had been taken to assess staff competency before they were allowed to administer medicines again.
Medicines were seen to be stored appropriately during our visit.

Our judgement
We reviewed all the information we hold on the trust and no concerns were identified.

Outcome 10: Safety and suitability of premises

What the outcome says

This is what people should expect.

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

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

What we found

Our judgement

The provider is compliant with outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
The people we spoke to did not make any comments about this outcome.

Other evidence
We reviewed the evidence we hold about the trust and no concerns were identified.

Our judgement
We reviewed the evidence we hold about the trust and no concerns were identified.

Outcome 11: Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

- People who use services and people who work in or visit the premises:
- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
 - Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement
The provider is compliant with outcome 11: Safety, availability and suitability of equipment

Our findings
What people who use the service experienced and told us The people we spoke to did not make any comments about this outcome.
Other evidence We reviewed the evidence we hold about the trust and no concerns were identified.
Our judgement We reviewed the evidence we hold about the trust and no concerns were identified.

Outcome 12: Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

The provider is compliant with outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
The people we spoke to did not make any comments about this outcome.

Other evidence
The trust has a policy in place for ensuring that where they have to use locum doctors, that a consultant reviews and approves the suitability of the person for the post.
We reviewed a report into an incident that had occurred. It identified that there was a concern with the performance of a healthcare professional involved. Minutes of a clinical governance meeting held nine months after the incident said that the trust were to write to the deanery who employed the staff member to share the concerns. Following the visit the trust confirmed that the deanery had been contacted three months following the incident. The action had not been identified in the serious untoward incident review. This is followed up in Outcome 16.
The medical director confirmed that the trust worked closely with the deanery to raise any concerns. We were told that the trust had referred four doctors to the GMC following investigations into incidents.

Our judgement

We saw evidence that the trust identifies when staff may have caused harm or risk of harm to people who use services.

The trust has a policy in place for ensuring that where they have to use locum doctors, that a consultant reviews and approves the suitability of the person for the post.

Outcome 13: Staffing

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are minor concerns with outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We spoke to people in nine wards when we visited the trust. We were told that the staff were very helpful and came quickly when they were called.
People were able to tell us which staff were looking after them. Nobody complained to us about a lack of continuity in their care.

Other evidence
The trust provided a report showing the number of shifts where there were less nurses on duty than were rostered. In April 2010, 8% of shifts had less staff than the number on the roster to work. This had reduced over the year following the trust's recruitment of staff with figures as follows: September 4.5%: October 4.4% and November 4.1%. The figures for December and January rose with 7.3% of shifts below roster in December and 6.2% in January.
Staff movements which had been decreasing rose in January 2011 with 67 staff moves. This figure is twice as high as for the previous seven months and was the same as May 2010. The report attributes the increase to staff sickness. The figures for adult medicine show a growth month on month in staff movements from a low of 8 in September. The figures are
October 10 moves

November 18 moves

December 26 moves

January 43 moves

The trust has undertaken a nurse staffing benchmark in collaboration with the Audit Commission, which involves comparing the trust's nurse staffing levels with an average ward, derived from all participating trusts. The report from October 2010 examined nurse staffing numbers in each division. This report showed that for orthopaedics and critical care there was a slight shortfall in overall numbers of staff with 2.1 less staff than predicted in orthopaedics and 0.4 less in critical care. For adult medicine, it was reported that the numbers of staff were adequate: however the mix of qualified and non qualified staff needed adjustment as there was a shortfall of 16.43 qualified staff. In orthopaedics there was shortfall of 2.1 in whole time equivalent posts. On this unit, there were 2.24 more qualified staff than predicted and 4.22 less unqualified staff. The ear nose and throat (ENT) and orthopaedic short stay there were 0.7 fewer qualified staff and 1.4 more unqualified staff.

Information provided by the trust showed that ward manager supernumerary status is inconsistent. The ward manager is supernumerary 67% of the time on the adult medicine unit. The ability to maintain this is affected by sickness and leave. The trust said that they are looking at different models of working where managers are supernumerary on a designated number of shifts a week.

The trust provided evidence that showed that the use of agency staff had decreased over the time period.

Our judgement

The people we spoke to on our visit said that they did not have to wait when they called for staff assistance. No complaints were made to us about the time people had to wait for assistance. No-one complained about the lack of continuity in their care.

People knew when they would see their doctor.

Staff told us that they moved far less often than they did last winter. Staff said that this consistency had helped them to provide better care.

The trust has undertaken a nursing staff benchmark exercise which identifies that there is a shortfall of 16.43 qualified staff in adult medicine. The trust is currently undertaking a further review of nursing requirements.

Ward manager supernumerary status is inconsistent. The ward manager is supernumerary 67% of the time on the adult medicine wards. The ability to maintain this is affected by sickness and leave.

The figures supplied by the trust show that the number of unfilled shifts decreased during the year but rose in December and January. The number of movements of staff in adult medicine increased over the winter months to 43 in January. These rises were attributed to staff sickness.

Outcome 14: Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
People told us that they were very happy with the care that they received. No complaints were raised about the staff that were looking after them.

Other evidence
Staff we spoke to had received appraisals. The trust provided figures which showed that 96% doctors had received appraisals by the end of February.
All the staff spoken to on our visit were able to tell us how they could raise concerns. The trust provided evidence that it supports staff to access learning and development.
The trust provides induction training for staff new to the trust. Staff we spoke to said this had been very thorough. There is also mandatory training which staff have to attend every twelve months. There is a system in place for monitoring attendance at training and quarterly reports are produced. The quarter 3 report for 2010/11 shows 68% of staff have attended the mandatory training.
We saw examples in children's services where support was put in place to help staff returning to work following a period of sickness. Staff can identify what training they require and local training sessions are provided.

Our judgement
There is a system in place which monitors attendance at training and appraisals.

Staff spoken to could clearly identify lines of accountability and who they could raise concerns with. The staff we spoke to had attended training and received appraisals.

Outcome 16: Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:

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

What we found

Our judgement

There are moderate concerns with outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us

People we spoke to did not make a comment about this outcome.

Other evidence

The trust has an incident, complaints and claims policy in place that was reviewed and updated in July 2010. Decision making and accountability structures are in place which are communicated and understood by staff.

The trust has a manual incident reporting system in place. We spoke to staff who said they understood the system and could describe the types of incident that should be reported and the process for raising concerns.

There were inconsistencies with how information from patient surveys, incidents and complaints was prioritised and actioned. The 2009 patient survey identified issues relating to discharge management. Further incidents also identified shortfalls in discharge management but no review of the trust discharge policy has been carried out at the time of this review.

Risk and incident outcomes are recorded by the trust but action plans are not always effectively developed and monitored to ensure that improvements are made throughout the organisation.

We saw that documentation in reports and action plans was not always clear. This made it difficult to track that all actions had been completed.

The trust has an annual audit programme in place, which has been developed using a range of internal and external information sources. It was not evident that action was always taken to use the finding from audits to drive improvements and protect patients. Documentation of the audit programme and outcomes was not consistently thorough. Start dates for audits were documented but 50% of the audits had no anticipated completion dates recorded. Falls audits were included with a brief primary reason documented e.g. (National Health Service Litigation Authority) NHSLA but no secondary reasons such as high level of incidents and the vacant falls coordinator post were included.

We reviewed how the trust controls risk by looking at a number of documents and talking to staff.

We reviewed the risk register which identified 53 corporate risks. Only 14 of the corporate risks identified had key dates and actions recorded against them. The last review of the risk register was carried out by the trust in January 2011. Actions which were due to be completed in July and August 2010 were identified as not completed on the register.

We found that the documentation of risk controls was poor. The trust failing to achieve best practice e.g. NICE guidance, National Service Framework (NSF) was included in the register as a moderate risk in March 2007. The risk register had identified that reviews would control the risk. Action dates for when reviews would be carried out had not been completed. This entry on the risk register had not been updated since July 2010. When we looked at Outcome 5 we found that the trust does not have a nutrition support nurse in line with NICE guidance.

We looked at other documents relating to risk and found that the trust had identified falls management as a key risk issue. We could not track this through the risk management process. Serious untoward incident (SUI) reports identified that slips/trips and falls were consistently one of the highest occurring incidents at the trust and that a falls co-ordinator was a key post requirement. This information did not track through the clinical and corporate governance minutes and on to the organisational risk register.

Some completed audits showed a lack of rigour. The audit of completion of the Nutrition Screening Tool in patients' notes was completed on case files referred to dietetics only and not all files. This selection of the files that had already been referred to dietetics means that any issues with those not referred would not be identified by the audit.

A review of the management of alerts showed that these were collated and reviewed by the trusts Risk Management Committee. Documentation of progress and action was poor. Risk assessments were closed without assessment reference or timeline being included.

We reviewed how the trust had implemented an alert from the National Patient Safety Agency (NPSA): NPSA/2007/20 Promoting safer use of injectable medicines. This alert was issued on 28th March 2007 and had an action date set by the NPSA

for March 2008. It was not scheduled for sign off by the trust until January 2011. Prior to sign off an audit of injectable medicines practice was due to take place. The audit programme does not show include this audit.

Our judgement

There is a culture of risk management and quality improvement, but there are inconsistencies in the documentation and management of action plans.

We reviewed the risk register which identified 53 corporate risks. Only 14 of the corporate risks identified had key dates and actions recorded against them.

Information about outcomes and the experiences of people who use services is gathered and monitored by the trust.

We saw that documentation in reports and action plans was not always clear. This made it difficult to track that all actions had been completed.

There are some inconsistencies with the systems in place to ensure practices are reviewed and the risk of future lapses is minimised. Some actions with completion dates for July and August 2010 were not recorded as completed.

We reviewed how the trust followed up identified risk. We found that information did not consistently track through the clinical and corporate governance minutes and on to the organisational risk register.

Outcome 17: Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:

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

What we found

Our judgement

The provider is compliant with outcome 17: Complaints

Our findings

What people who use the service experienced and told us
The people we spoke to did not make any comments about this outcome.

Other evidence
We reviewed the information that we hold on the trust and no concerns were identified. When we visited we reviewed the complaints file and saw evidence that the trust responded to complaints within the time limits. Where it was not possible to resolve the complaint within the time limit, letters were sent to explain this. We saw that the information on how to complain was available throughout the hospital.

Our judgement
We reviewed the information we hold on the trust and no concerns were identified. We saw that information on how to complain was readily available through out the hospital.

Outcome 21: Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:

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

What we found

Our judgement

There are minor concerns with outcome 21: Records

Our findings

What people who use the service experienced and told us
The people we spoke to did not comment on this outcome.

Other evidence
We reviewed notes on all the wards we visited. We found that a small number of records had not been signed and dated. We found that assessments for risk of falling and nutrition screening tools had not been completed accurately in a number of cases. This is followed up in Outcomes 4 and 5.

Our judgement
We reviewed notes on all the wards we visited. We found that a small number of records had not been signed and dated. We found that assessments for risk of falling and nutrition screening tools had not been completed accurately in a number of cases. This is followed up in Outcomes 4 and 5.

Action we have asked the provider to take

Improvement actions

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

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures	22	13 Staffing
	<p>Why we have concerns:</p> <p>How the regulation is not being met:</p> <p>The people we spoke to on our visit said that they did not have to wait when they called for staff assistance. No complaints were made to us about the time people had to wait for assistance. No-one complained about the lack of continuity in their care.</p> <p>People knew when they would see their doctor.</p> <p>Staff told us that they moved far less often than they did to last winter. Staff said that this consistency had helped them to provide better care.</p> <p>The trust has undertaken a nursing staff benchmark exercise which identifies that there is a shortfall of 16.43 qualified staff in adult medicine.</p> <p>Ward manager supernumerary status is inconsistent. The ward manager is supernumerary 67% of the time on the adult medicine wards. The ability to maintain this is affected by sickness and leave.</p> <p>The figures supplied by the trust show that the number of unfilled shifts decreased during the year but rose in December and January. The number of movements of staff in adult medicine increased over the winter months to 43 in January. These rises were attributed to staff sickness.</p>	
Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures	20	21 Records
	<p>Why we have concerns:</p> <p>We reviewed notes on all the wards we visited. We found that a small number of records had not been signed and dated. We found that assessments for risk of falling and nutrition screening tools had not been</p>	

	completed accurately in a number of cases. This is followed up in Outcomes 4 and 5.
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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.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures	9	4
	<p>How the regulation is not being met:</p> <p>People we spoke to during our visit were generally happy with the care they were receiving.</p> <p>Care plans were usually reviewed. We saw one instance where a care plan had not been reviewed.</p> <p>Risk assessments were generally in place but not consistently completed and were not always accurate. The trust had identified that falls risk assessments were not always being completed thoroughly. An audit from August 2010, based on data collected between 1 April 2009 and 31 March 2010, showed that 31 of 49 patients had not received a falls risk assessment in accordance with the trust policy. When we visited we reviewed falls risk assessments in patient's records. These were not consistently completed and were not always accurate. Two of the records of people being looked at in the medical assessment unit did not have a falls risk assessment.</p> <p>It was not clear how the trust consistently shared learning from incidents across the organisation. In the incident we reviewed it was not clear that the actions reflected all the recommendations of the report.</p>	
Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures	14	5
	<p>How the regulation is not being met:</p> <p>On one ward we found that a nutritional assessment had not been completed for one patient. They had a nutritional care plan and monitoring and support was in place. In one case we found that the nutritional screening tool had been completed inaccurately.</p> <p>In two cases we saw that there were delays between assessment and referral to the dietician. In one case it was not clear that the person had seen the</p>	

	<p>dietician.</p> <p>The trust does not employ a dedicated nutrition support nurse. NICE guidance for nutrition support says that an acute trust should employ a specialist nutrition nurse.</p>	
<p>Treatment of disease, disorder or injury</p> <p>Surgical procedures</p> <p>Diagnostic and screening procedures</p> <p>Maternity and midwifery services</p> <p>Termination of pregnancies</p> <p>Family planning services</p>	10	16
	<p>How the regulation is not being met:</p> <p>There is a culture of risk management and quality improvement, but there are inconsistencies in the documentation and management of action plans. We reviewed the risk register which identified 53 corporate risks. Only 14 of the corporate risks identified had key dates and actions recorded against them.</p> <p>Information about outcomes and the experiences of people who use services is gathered and monitored by the trust.</p> <p>We saw that documentation in reports and action plans was not always clear. This made it difficult to track that all actions had been completed.</p> <p>There are some inconsistencies with the systems in place to ensure practices are reviewed and the risk of future lapses is minimised. Some actions with completion dates for July and August 2010 were not recorded as completed.</p> <p>We reviewed how the trust followed up identified risk. We found that information did not consistently track through the clinical and corporate governance minutes and on to the organisational risk register.</p>	

The provider must send CQC a report that says what action they are going to take to achieve 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 to us within 28 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance 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.

Information for the reader

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