

Review of compliance

Salisbury NHS Foundation Trust

Salisbury District Hospital

Region:	South West
Location address:	Odstock Road Salisbury Wiltshire SP2 8BJ
Type of service:	Acute Services Regulated activities: Treatment of disease, disorder or injury Assessment or medical treatment of persons detained under the Mental Health Act 1983 Surgical procedures Diagnostic or screening procedures Management of supply of blood and blood derived products etc. Transport services, triage and medical advice provided remotely

	<p>Maternity and midwifery services</p> <p>Termination of pregnancies</p> <p>Family planning</p>
Publication date:	May 2011
Overview of the service:	<p>At Salisbury District Hospital, Salisbury NHS Foundation Trust provides a range of clinical care, which includes general acute and emergency services to approximately 200,000 people in Wiltshire, Dorset and Hampshire. Specialist services such as burns, plastic surgery, cleft lip and palate, genetics and rehabilitation extend to a much wider population of more than three million people. The Duke of Cornwall Spinal Treatment Centre at Salisbury District Hospital covers most of southern England with a population of approximately 11 million people. Trust staff provide outpatient clinics in community hospitals in Wiltshire, Dorset and Hampshire. Specialist staff hold outreach clinics in hospitals within the Wessex area. In total, the Trust employs over 4000 members of staff.</p>

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

What we found overall

We found that Salisbury District Hospital was meeting all 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

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 that we have about Salisbury District Hospital. We then asked the provider to tell us how they were meeting the essential standards of quality and safety.

We made an unannounced visit to Salisbury District Hospital on the 3rd May 2011. We returned to conclude our visit on the 4th May 2011. The visits were undertaken by a team of 5 compliance inspectors and a pharmacist.

During our time at Salisbury District Hospital, we talked to people using the service, members of staff and visitors. We observed the care people received and looked at some care and treatment records. We observed the standard of cleanliness within the hospital and looked at the management of people's medicines.

What people told us

People told us that they were very happy with the care and treatment they received. They said they were fully informed of their diagnosis and their treatment plan. They were able to ask questions and felt involved in any decisions made. People told us that their rights to privacy, dignity and respect were fully promoted.

People were very positive about the staff. They said they were competent, well trained, professional and good at their job. We saw that staff were motivated and

enthusiastic about their role. They were supportive, attentive and respectful in their interactions with people.

People generally felt there were sufficient staff on duty at all times to support them with their health and personal care needs. However, a number of people on specific wards commented that the staff were very busy. They said there were delays in staff responding to them when they used their call bell. We observed that when people rang their call bell within one ward, they were kept waiting for longer than they should have been. We saw that staffing levels also impacted upon the support some people had, to have a drink. Due to their swallowing difficulties, some people needed fluids 'little and often' yet this was difficult to sustain, with the existing staffing levels and other staff pressures.

People told us that they liked the food although there were comments that if you were in hospital for a long time, the food was somewhat repetitive. A wide choice of food was available, which took into account people's religious and cultural needs. In addition, there were vegetarian, healthy eating and allergy aware meals. People told us that the food was fresh, hot, well cooked and served according to their individual appetite. We saw that staff were attentive in ensuring all food packaging was removed and the meal was within the person's reach. People were assisted to eat in a sensitive manner, at their own pace, if required. People told us that they had regular drinks throughout the day and at night.

People told us they were happy with the standard of cleanliness within the hospital. They said the cleaning staff were thorough and cleaned all areas every day. They said bed linen was also regularly changed. We saw that staff regularly washed their hands and used hand gel, which was readily available.

People told us that they would inform a member of staff if they had concerns about the service they received. There were also other systems such as the Customer Care Department whereby they could raise a concern. People felt they would be listened to and their concern would be satisfactorily resolved. Some people felt that information about the formal complaint procedure was not always readily available. They were therefore not clear about how to make a formal complaint.

What we found about the standards we reviewed and how well Salisbury District 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

People were fully involved in discussions about their care and treatment. People were able to ask questions and received answers in a way they could understand. People felt they were treated with respect and their rights to privacy and dignity were fully promoted.

- Overall, we found that Salisbury District 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

People are fully supported to give their consent in relation to their care and treatment. Staff ensure that people receive sufficient information, in a way that meets their needs, to enable them to make informed decisions. Staff have a clear awareness of the different ways of enabling consent to be given and the systems to follow, if people do not have the capacity to give consent.

- Overall, we found that Salisbury District Hospital was meeting this essential standard.

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

People receive a good standard of care and treatment, which meets their needs. However, incidents of people with pressure ulceration, has required the Trust to look at its measures in place, in order to ensure reduction. People are involved in decisions about their care and are happy with the service they receive. Whilst people are generally satisfied with the way they spend their day, activities to occupy the time for some, are limited.

- Overall, we found that Salisbury District 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

People can choose from a comprehensive range of food which takes into account their health, cultural and religious needs. People benefit from food which is fresh, hot and well cooked although for those, who have been in hospital a long while, find the food somewhat repetitive. People are supported to eat their meals in a sensitive manner and their nutritional risk is monitored and addressed accordingly.

- Overall, we found that Salisbury District Hospital was meeting this essential standard.

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

People receive care and treatment from a range of services in a safe, coordinated way. People are able to access specialist expertise according to their needs in a timely manner. Clear systems are in place for staff to liaise with other professionals whilst putting the person at the centre of all discussions.

- Overall, we found that Salisbury District Hospital was meeting this essential standard.

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

People feel safe within the hospital and their safety is protected through the clear safeguarding systems in place. People benefit from a staff team who are readily able to recognise and address any sign of abuse in accordance with local reporting procedures.

- Overall, we found that Salisbury District Hospital was meeting this essential standard.

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

People benefit from an environment that is very clean and well maintained although public areas were not to the same standard. Systems to minimise the risk of infection are thorough and regularly audited to ensure they are working well. However, the management of soiled laundry in ward areas, with overflowing laundry trolleys, conflicts with good practice guidelines and poses a risk of cross contamination.

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

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

Clear, organised systems are in place to ensure people have their medicines safely and as prescribed. People are able to manage their own medicines if they are assessed, as safe to do so. Lockable storage for medicines is in place although the transportation of some medicines is not secure and presents a risk that the medicines may be misused.

- Overall, we found that Salisbury District Hospital was meeting this essential standard.

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

People benefit from an environment that is continually being developed to meet people's needs. All areas are safe, well maintained and fit for purpose. Systems are in place to regularly monitor the standard of the environment to ensure it is well maintained. The current signage however, is not clear and therefore people are unable to easily find their way around the hospital.

- Overall, we found that Salisbury District Hospital was meeting this essential standard.

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

People have the equipment they need to support them in their care and treatment. The equipment is clean, well maintained and regularly serviced to ensure it remains

in good working order. Staff are trained in the use of the equipment so are competent and do not put people at risk of error. The use of bed rails, however, with the lack of protectors and insufficient checks to ensure they are fitted correctly, place some people at risk of harm.

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

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

People are supported by staff who have been robustly recruited to ensure they have the skills, expertise and integrity required. People can be assured that all staff have been comprehensively vetted thus ensuring they are suitable to work with vulnerable people.

- Overall, we found that Salisbury District 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

Staffing levels within some areas of the hospital were satisfactory and enabled people to be well supported. However, within other areas, people did not receive timely support when using their call bell and were not fully assisted with aspects such as having a drink. This impacted upon people's safety and compromised staffs ability to meet people's needs effectively.

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

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

People benefit from well trained, motivated and committed staff at all levels. Whilst formal staff supervision is not consistently taking place within all areas, all staff feel well supported and can readily give their views or ask about any issue they are not sure of. Due to shared learning and the staff appraisal process, people benefit from a range of expertise, which is used in a targeted way.

- Overall, we found that Salisbury District 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

Clear, organised systems are in place to monitor and evaluate the range of services provided within the hospital. People are encouraged to give their views in a variety of ways and these are valued by senior management and taken into account, as appropriate. The Trust is able to recognise and identify where there may be shortfalls in provision and has clear action plans in place, in order to continually improve services.

- Overall, we found that Salisbury District Hospital was meeting this essential standard.

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

People feel confident in raising a concern if they are not happy with an element of the service they have received. People feel listened to and are confident that any issue will be satisfactorily resolved. Complaints procedures are in place, however, some people were not fully aware of the formal processes they should follow and in some areas the procedure was not available in a written form.

- Overall, we found that Salisbury District Hospital was meeting this essential standard.

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

People had access to their records and were aware of what was written in them. Records were stored securely and those required on a regular basis were easily accessible. Whilst clearly written, not all records were consistently completed. The records did not fully demonstrate the care people received and how their needs were to be met. The format of some records was not conducive to enabling all checks of equipment to be undertaken. This had the potential of impacting upon some people's safety.

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

Action we have asked the service to take

We have asked the provider to send us a report within 10 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

People told us that they were fully involved in discussions about their care and treatment. They said they could ask questions and felt they were answered in a way they could understand. One person in the Burns unit told us ‘I saw the doctors, as soon as I was admitted to discuss what they were going to do. I saw them again this morning to review what was happening and make plans with them.’ A person within Accident and Emergency department said ‘I can’t fault it. From the doctors to the nurses, they have explained things to me’. Within the maternity unit, one person told us they had been admitted with their birthing plan and knew exactly what to expect.

People told us that staff repeated information if they had difficulty remembering. One person within the Burns unit told us that they had not digested all information given to them on their admission due to a high level of pain relief. They said that staff kept on telling them what had happened and what was happening until they had all the information they needed. We saw a staff member recognise that an older person had not fully understood what had been said to them by a doctor. They spent time with the person, breaking issues down into small areas, ensuring the person

understood before moving on to the next point. The staff member gave lots of eye contact and encouragement to support the person.

People's privacy, dignity and independence were respected. One person within the maternity unit told us 'they are respectful, most are dedicated especially the senior staff. They always explain what they are doing.' Some people's privacy was significantly enhanced through having a single room. We saw staff knock on the doors before entering. They then closed the doors behind them to ensure privacy was maintained. Within the bays of the wards, staff always pulled the curtains around a person, when a procedure was taking place. One person said 'they always make sure the curtains are pulled around you, if you're having a wash. They are very good like that.' Within a rehabilitation ward for older people, a staff member quietly explained to a person that they were to have an X ray. The staff member pulled the curtains around the person's bed space, so they could be assisted onto their bed in private. Some people chose to have their curtains around their bed space, throughout the day. This particularly applied to people within the maternity unit.

Staff were respectful to people when interacting with them. They promoted people's privacy and dignity when carrying out their duties. We saw that staff immediately noted that a person had left the door wide open when going to the toilet. The staff member checked that the person was alright and asked their permission to close the door. We saw that people were encouraged to be involved in making decisions about their personal care routines. For example, we saw staff ask people, how they wanted to be assisted with washing and dressing. We also saw one staff member ask a person if their mouth care had been sufficient or if they felt they needed more.

Other evidence

In 2010, within the hospital's Real Time Feed Back (RTF) auditing system, it was identified that 91.25% of people said they were treated with dignity and respect. 98.2% of people said they had not the same toilet, shower or bathroom as the opposite sex. The Trust told us that focused work on structural changes to sleeping areas and toilets of all of wards had been undertaken in order to move away from the mixed sharing of accommodation.

Our judgement

People were fully involved in discussions about their care and treatment. People were able to ask questions and received answers in a way they could understand. People felt they were treated with respect and their rights to privacy and dignity were fully promoted.

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

People were fully involved in discussions about their care and treatment. They told us that they were able to make decisions and give their consent. One person within the Burns unit told us that they had been given an opportunity to have their operation earlier than expected. They said they had signed forms and agreed to everything, as they were pleased they could be fitted in so quickly. A person within the maternity unit also confirmed that she had signed a consent form before her surgery. She said the consultant and anaesthetist had explained everything to her.

Some people told us about their care and treatment plans, which demonstrated they had been given sufficient information by the hospital staff. One person described how their illness had been managed and how they had been involved in the plans. They said their preferences about a discharge date had been listened to. Another person told us that they were on 'bed rest.' They knew the reasons for this. We saw a staff member talking to a person about their particular condition. The staff member fully described the proposed treatment plan and the reasons for it.

Other evidence

Staff were confident when talking to us about consent. A staff member within the oncology and haematology ward told us that people signed a consent form, for example, before receiving chemotherapy. They said a person would be offered an interpreter if their first language was not English. The staff member said that discussions might also be held with the person's family. This was to ensure people fully understood what was being said and were able to give informed consent based on their knowledge. Staff told us that if people refused treatment or changed their minds about consent, their options were discussed with them. The therapy team within the orthopaedic wards told us that they spent a lot of time 'checking things out with people'. They said that if a person did not have the capacity to make decisions, their family might be involved with the person's permission. Alternatively a 'best interests' meeting might be held whereby the person, their family and all involved health care professionals would discuss the options available. Within the maternity unit, we asked staff about the way in which emergency decisions were made if a person lacked capacity. They said that if there were no family members to consult with, the decision would be made by two consultants.

Two staff members within the rehabilitation ward for older people told us that they found that older people generally showed consent, rather than it being formally agreed. One staff member gave an example whereby a person outstretched their arm in response to being asked if their blood pressure could be checked. The staff felt it was essential that people were given clear information in order to make informed decisions. Within the children's unit, staff described the lengths they went to, to confirm parental responsibility in order to establish people's rights to give consent to treatment. They gave examples of contacting parents at long distance to verify what guardians had told them.

Within information sent to us before our visit, the Trust told us that there was a range of guidance, produced by the Department of Health, which staff followed in relation to consent. They said that staff undertook training in consent and associated issues both within their induction and on an 'on going' basis. The Trust told us that an annual audit of consent practices using patient's case notes was undertaken. In 2010, the audit showed 100% compliance had been achieved in staff documenting the planned procedure and the person signing the consent form. Within an inpatient survey in 2010, only 3.3% of people did not feel that they had the risks and benefits of treatment explained to them sufficiently before their surgery. Only 1.5% of people said that staff had not answered their questions in a way that they could understand.

Our judgement

People are fully supported to give their consent in relation to their care and treatment. Staff ensure that people receive sufficient information, in a way that meets their needs, to enable them to make informed decisions. Staff have a clear awareness of the different ways of enabling consent to be given and the systems to follow, if people do not have the capacity to give consent.

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

People were happy with the care and treatment they received. Specific comments included ‘professionals liaise well, things happen when they should’, ‘I’ve always gone private before but this is far, far better’ and ‘the ward is genuinely patient-led. They encourage you to ask questions and be in control, they emphasise I’m still the same person as before my accident.’ One person told us that staff recognised and engaged with emotional issues. Another person told us they were pleased that they had not waited long in A&E before they were admitted.

Within the spinal injury unit, people told us that they participated in goal-orientated rehabilitation planning, which worked well. People showed us examples of goal planning forms and how progress or setbacks were monitored and used to alter the goals agreed. People knew when their next review meeting would be. Within the Stroke unit, we saw a staff member take the time to find out more about the person’s social history. This enabled them to recognise the person’s identity when supporting them in their rehabilitation package.

Within the hospice, a person told us staff ‘go out of their way to make sure you’re comfortable. You can choose whether you want a wash or a shower and they will help you. They’re all wonderful.’ We saw that the person looked comfortable. They had well manicured, clean nails, freshly washed hair and clean clothing.’ However,

within a rehabilitation ward for older people, two people commented that they didn't have their hair washed enough and their finger nails needed cutting. We saw that their nails were long and uneven in their shape. Within the Stroke unit we saw that people who were 'nil by mouth' had clean mouths. This indicated that they were receiving regular mouth care to keep them comfortable. A person with a nasal cannulae had been given protection to their skin at relevant points, so they did not become sore.

Staff were friendly, attentive and considerate to people's needs. We saw a staff member apologising to a person if the intervention they were doing gave them discomfort. They encouraged the person to tell them at once if they wanted them to stop or change how they did things. Within the Stroke unit, we saw a staff member help a person walk to the toilet. They gave verbal instructions and advice throughout in order to support the person's growing independence. We also saw other staff supporting a person and verbally advising them what to do, so that they were safe.

People's experience of the way in which they passed the time during the day varied. Within the Burns unit, a person told us that they had enough to do. They said they had a newspaper every day and they had a radio and television available by their bed. A parent said the children's unit provided plenty to occupy children of different ages to distract from boredom or discomfort. However, within the Stroke unit, a person told us, that they did very little. They were bored and just sat and waited for something to happen. Another person said there was little to do apart from watch the television and watch the world going by. Similar comments were received from people within the rehabilitation unit for older people. One person said 'I just sleep and sleep some more.' Another person said 'there's not much we can do, is there? I'm just waiting to go home.' Within the Stroke unit and the rehabilitation ward for older people, other than general staff activity, there was very little taking place to stimulate and occupy people's time. Staff confirmed this was sometimes so, as people's nursing needs and other pressures, often dominated their time.

Other evidence

There were many positive comments from visitors about the flexibility of staff and the care that they gave. They told us of being able to visit 'outside of visiting hours' and being able to support their relative with personal care and feeding. One visitor told us that they had worked with the physiotherapists and did the exercises they'd set with their relative. Another visitor told us how the ward staff had planned their relative's discharge with them. Parents of two children seen at the children's unit both said they were given good information about further observation and management of their children's conditions after they were back home. They were fully confident in the child care provided by the staff.

One of the consultants within the accident and emergency department told us that the triage process was very detailed so that people could receive the right treatment, as quickly as possible. There were various assessments and check lists of indicators for people's risk of developing pressure ulcers and their nutritional status. There were special indicators for children. Staff told us that awareness of and attention to pressure area monitoring and care were central in care plans in the

Spinal unit. People had high levels of understanding of pressure area care and the risks and management of associated routines. People told us that they were weighed regularly. They saw how changes in their weight, were responded to. This included adjustments to the settings of pressure relieving equipment. Within the orthopaedic wards, when people were identified as being at risk of pressure ulceration, a sign was displayed above their bed. This acted as a reminder for staff to ensure the person's position was changed at the agreed intervals. People told us that their risk of pressure ulceration had been explained to them. We saw within the Stroke unit that people with a high risk of developing pressure ulcers were having their positions changed to prevent pressure ulcers. A staff member told us that no patient had developed pressure ulcers on the ward 'for a long, long time.'

During 2010, we received four notifications in relation to people developing significant pressure damage. Within information gathered before our visit, we noted that the Trust had recognised that the number of people with a pressure sore had gone up. The Trust were committed to reducing this level and an initial focused piece of work, which encompassed how people were assessed for their risk of pressure damage on admission, was being undertaken. The work would also target education for clinical staff including the links between nutrition and pressure ulceration. We saw that nutritionally dense meals were available on the menu. The Trust stated that any incident of pressure damage would be fully investigated and any issues would be addressed accordingly.

We saw an alert form, which the Spinal unit used, as an alert form to assess whether people were at high risk of psychological difficulty. If so, they were referred to the unit's own psychologist. Refusals to accept referral were accepted, as were requests for referral raised by people themselves. The Burns unit also provided people with information about the clinical psychology service and how to access it if needed, because of the psychological effect of burns. One staff member within the stroke unit told us that communication between staff of all shifts was a key area to make sure peoples' needs were met and nothing was missed out. Many staff told us about the coordination of care via daily 'whiteboard' meetings. All staff, including therapists commented on how useful these meetings were in planning care for individual people. One therapist described the importance of whiteboard meetings when planning discharges. They said this ensured that everything relevant for the person was discussed and considered.

Within information gathered before our visit, we saw that the Trust was successful in relation to treating Venous Thromboembolism (types of blood clots) and was a national exemplar site for this. They also ensured that the Liverpool Care Pathway, which related to 'end of life' care was in place across 94% of the organisation. This was within the top quartile of the country.

Our judgement

People receive a good standard of care and treatment, which meets their needs. However, incidents of people with pressure ulceration, has required the Trust to look at its measures in place, in order to ensure reduction. People are involved in decisions about their care and are happy with the service they receive. Whilst

people are generally satisfied with the way they spend their day, activities to occupy the time for some, are limited.

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

The provider is compliant with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us

People we spoke with within all areas of the hospital told us that the quality of the food was good. However, within the Spinal unit, there were comments that the menu was monotonous and too repetitive. They said they missed sausage and bacon, which were never offered. Within other areas of the hospital, there were positive comments about the amount of choice available, the standard of cooking and the timeliness of meals. Specific comments included 'the food quality is excellent,' 'the menu is well laid out' and 'the meals are always on time.' One person told us 'I couldn't sleep last night and was very hungry. They gave me three lots of sandwiches and two lots of toast and tea during the night.'

The lunch time meal was delivered to all wards in large heated trolleys. The food looked like it had just been placed in the heated containers, as it looked fresh, appetising and hot. We saw that staff served the food from the trolley according to people's individual choices and preferences. Other staff members then promptly delivered the meals to people on trays. This process was well managed and efficient although on the rehabilitation ward for older people, some food items were missing from the trolley. This caused some delay and frustration, as staff said this was not an unusual occurrence. Within the Spinal unit, we saw that staff were meticulous in asking people exactly how they wanted their meal served. This included the quantity, where to place the food on the plate, where to place the cutlery, napkins and drinks and how strong to make up the squash.

Staff were attentive to people's needs during the mealtime. Within the rehabilitation ward for older people, staff ensured that people could reach their food and their over-bed table was at the correct height. They removed any food packaging if people found this difficult to do independently. We saw that staff assisted some people to eat. They did this attentively and at the person's own pace. We noted similar good practice of helping people to eat, throughout the hospital.

Staff ensured all mealtimes were a pleasurable experience rather than just a means to eat. Within the Spinal unit, staff told us that the 'protected mealtime' policy was strongly implemented. This ensured that no non-emergency activity took place during lunch and teatime, so that people could eat and not be interrupted. Within an orthopaedic ward, people were asked if they wanted background music on, whilst they ate. This created a pleasant, relaxing atmosphere. We saw that people could eat where they wanted to. Within an orthopaedic ward, five people chose to eat their meal in a communal area, which looked onto the surrounding countryside. People told us within the Spinal unit that a voucher for the hospital restaurant could be requested. This enabled people to eat in a different environment with their visitors.

Staff told us that when admitted to the accident and emergency department, people had their nutritional risk assessed. This showed if people required additional nutrition or support with their eating. Within the hospital's clinical standards audit in 2010, it showed that 80% of people had been nutritionally assessed. Within the accident and emergency unit and the Acute Medical ward, people were given refreshments at different times of the day and when they asked for them. There was a range of food available including eight different sandwiches, packet soups, food supplements and cereals. Baby food could also be requested.

A person within the orthopaedic ward showed us a menu and explained the symbols. The menu stipulated key issues such as whether the food was vegetarian or a healthy option. Staff told us within the rehabilitation ward for older people that people's cultural and religious dietary needs were well catered for. We saw that one person there had a gluten free meal.

People told us that they had regular drinks delivered throughout the day. They could also ask for more, if they wanted anything. Within the Acute Medical ward, we saw that a family were given a jug of water immediately they asked for it. They were also offered tea or coffee. People within the wards had a jug and a glass of water or squash at their bedside. We saw that volunteers also served tea or coffee throughout the day. Within the hospice, we saw that one person had some ginger ale. They said that staff always asked them what they wanted to drink and never presumed their preference.

Other evidence

People's nutritional intake was monitored and food charts were maintained and kept at the bottom of people's beds, for easy access. Staff told us that if a person continually refused their food, senior staff would be informed and a dietician would become involved. They said an occupational therapy assessment would be

requested if they noted a person would benefit from adapted cutlery.

Whilst people's comments about the food were positive, staff within the Stroke unit and the rehabilitation unit for older people, told us that there was little flexibility to enable people to change their minds about the food they had previously ordered. This was because the kitchen sent specific amounts of food to the wards, according to what was ordered. Staff said that the kitchen staff did not understand and were not always accommodating, when asked for additional food items. They said that there was also an expectation that the trolley would be returned to the kitchen within half an hour. This created additional pressure for staff in order to ensure that people were not rushed at mealtimes.

From information gathered before our visit, we saw that the hospital had a high number of working groups and audits, to monitor the standard of food provided. We saw that comments from the Food and Nutrition group, had led to more vulnerable people receiving more staff assistance when eating their meals. Nutrition training for staff had also been an outcome of the group. We saw that the hospital received an award from the Hospital Caterers Association of Catering Team of the Year 2010. This focused on the implementation of a wide choice of bespoke menus such as Vegan, Allergy Aware and Halal menus. The award also acknowledged seasonal menus using locally sourced foods and vegetables. The observational ward audits and a kitchen inspection attended by the Board of Governors during 2010 showed there had been an improvement in ward preparation and the delivery of meals. The audits raised some issues of the food arriving late and of it being cold. However, from what we saw during our visit, these issues had been addressed.

Our judgement

People can choose from a comprehensive range of food which takes into account their health, cultural and religious needs. People benefit from food which is fresh, hot and well cooked although for those, who have been in hospital a long while, find the food somewhat repetitive. People are supported to eat their meals in a sensitive manner and their nutritional risk is monitored and addressed accordingly.

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

People told us about their experiences of when they had been admitted from other hospitals or had been transferred from other wards. People also spoke to us about their discharge plans, which were in the process of being arranged. People's comments were generally positive and showed a range of other services had been consulted with. One person told us how the ward was working with social services and a future care home, so that they could be moved closer to their home town. Another person told us that they were receiving help from the physiotherapist before being able to be discharged. Within Downton ward, a person told us that they found individual wards very efficient and good at what they did. However, they criticised communication between wards, particularly Downton ward and the Stroke unit. They said they were kept waiting for transfers between wards, with no updating information. Within the Burns unit, two people told us that they had been transferred from other hospitals. They both said that the transitions went well, without any problems.

One person told us that they saw good communication between the various professionals and grades of nursing staff on the unit. They said that staff always sought more experienced staff, if uncertain about anything. The person told us that they had not experienced any problems, when liaison with other parts of the hospital had become necessary. One person within the hospice told us that being attached to the hospital, albeit at a distance, was positive as they received treatment and test

results quickly.

Other evidence

Staff told us that strong links had been established with specialised services within the hospital and other services within the community. A staff member within an orthopaedic ward told us that each ward of the hospital had a link person related to key areas such as diabetes, pain relief, tissue viability and safeguarding people. This enabled staff to access specific expertise in a timely manner, as required. Within the Stroke unit, a staff member told us how they had coordinated with the tissue viability nurse to support a person with pressure ulcers. Within the Burns unit, a staff member told us that there was 'lots of support' from Social Services when a person was ready for discharge. They said an occupational therapist would undertake a visit to the person's own home if relevant, to ensure all arrangements were satisfactory. Within the accident and emergency department, a staff member told us that a co-ordinator and support staff were available to support relatives at difficult times. The police provided family liaison officers and the department accessed the paediatric social worker based on site, when needed.

Within an orthopaedic ward, the therapy team told us that they helped people prepare for discharge by offering formal presentations, DVD's and information booklets. They said that when people were discharged, emergency contact numbers were given. Any follow up action was provided by the local community services and/or out patient appointments. Within a medical ward, a staff member told us that they had introduced a policy of no discharges of older people after 4:30pm unless they lived very near. This was because late discharges were distressing to people and could be a cause of re-admission in some cases. They told us about the importance of liaison with the person's carers both family, neighbours and a domiciliary care agency if appropriate, to ensure that they were available when the person returned home.

Before our visit to the hospital, we looked at the 2010 Board of Governor's report. The report identified a number of initiatives involving other services. This included a Clinical Nurse Specialist in Palliative Care formally linking to Nursing and Residential Care Homes. Also, more formal links with the Older People's Mental Health team, to support people in the later stages of dementia. We saw that LINKS gave positive feedback that the hospital was working closely with NHS Wiltshire in order to achieve seamless multidisciplinary care, in the hospital and in the community. This was confirmed within a Quality Task Group, whereby closer work with social work teams was being undertaken to minimise the length of people's stay in hospital. In order to share expertise and learning and development, staff within the Children's unit told us about the work they were involved in with other paediatric units in the region. Staff within the Spinal unit also described strong links with other regional spinal injury units.

Our judgement

People receive care and treatment from a range of services in a safe, coordinated way. People are able to access specialist expertise according to their needs in a timely manner. Clear systems are in place for staff to liaise with other professionals

whilst putting the person at the centre of all discussions.

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

People told us that they felt safe within the hospital. Within the hospice and the rehabilitation ward for older people, people told us that they had not experienced any form of poor practice from a member of staff or any aggression from other people. One person told us ‘the staff are gentle, patient and caring. I couldn’t imagine anything abusive happening. If there was a problem, people would need to say so they could deal with it quickly.’

We saw that people consistently had easy access to their call bell. This enabled them to call for staff assistance at any time. We saw that a staff member quickly noticed when a patient fell asleep and dropped their call bell. They picked it up and replaced it by the person’s hand.

Particular areas such as the maternity unit and the children’s ward had secured access. All visitors to these areas required staff authorisation to enter and to leave. This minimised any risk of unauthorised visitors and gave people greater security. Staff told us that within the maternity unit, all babies had a security tag placed on their leg. This would be activated if the baby were taken outside of a particular zone. One person told us that they had tried to visit their relative at night and had only been able to access the building through one entrance, as all the doors were locked.

Other evidence

Staff demonstrated that they were confident in recognising any signs of abuse. They were aware of their responsibilities to report any suspicion or allegation of abuse. Staff told us about the local safeguarding procedures. Within the children's ward, staff told us about the hospital's flow chart and processes for making child protection referrals. One consultant within the accident and emergency department told us that there was a system for tracking how many times a child came into the unit. They said child protection was alerted to any concerns. The consultant told us there were criteria for identifying, recording and reporting any concerns about a child who could be at risk of harm. This was confirmed within the Children's ward whereby a staff member told us about the hospital's information technology systems. They said the system automatically flagged known issues, in relation to people who had previously been known to the hospital. A staff member within the Burns unit told us that they had experience of instigating both the adult and child protection procedures. They described both procedures to us in detail.

Staff told us that they had undertaken training in safeguarding adults and children. One staff member within the accident and emergency department told us that they had visited the domestic violence unit and refuge, as part of their training. They said that safeguarding training formed part of the mandatory staff training plan. Within discussion, we saw that a volunteer was aware of basic safeguarding, which was appropriate to their level within the organisation. A domestic worker also told us that they would report any concerns on 'at once.'

The Trust has clear systems in place including policies, codes of conduct, staff training and designated staff leads, to ensure people are safeguarded from abuse. The Trust told us that the Customer Care Department would forward any initial concerns that may involve Safeguarding, to the Named Lead Nurses for safeguarding. Within information sent to before our visit, the Trust told us of safeguarding alerts and investigations they had been involved in. Two alerts had involved pressure area care. A third had involved a poor assessment which led to injury. The Trust told us that they raised 46 Adult Safeguarding Alerts in 2010. 22 of these progressed to Safeguarding investigations. They said four safeguarding alerts were raised in the community about the hospital. In December 2010, we received one notification, which identified an agency staff being verbally abusive to an older person. Safeguarding procedures were appropriately instigated. The Trust has reported two 'Never Events' in 2010/11. One involved wrong site surgery (finger incision). The other was a retained swab. Both people made a full recovery.

Our judgement

People feel safe within the hospital and their safety is protected through the clear safeguarding systems in place. People benefit from a staff team who are readily able to recognise and address any sign of abuse in accordance with local reporting procedures.

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

There are minor concerns with outcome 8: Cleanliness and infection control

Our findings

What people who use the service experienced and told us

People told us that they were happy with the cleanliness of the hospital. A person on the Spinal unit told us that they saw cleaning in progress every day. They said they liked the reassurance of seeing labels to signify cleaned equipment. A person on a surgical ward told us they had seen ‘clear improvement in cleaning standards’ since their previous admission a year earlier. They said they had no concerns in this area. Parents on the children’s unit told us that they appreciated that all the toys available were very clean and obviously well looked after. Within an orthopaedic ward, a person said ‘you cannot fault the cleanliness here. They mop and clean every day.’

We saw that all areas of the wards including bays, cubicles, sluice rooms, kitchens, play areas, shower rooms, offices and nurse stations were very clean and odour free. However, the public toilets used in non-ward areas although superficially clean, contained a build up of dust in harder-to-reach areas. This included window sills, pipe work, light switches and the tops of notices. There were dried drip marks by the sinks and on the walls of the cubicles and one underside of a toilet seat was very dirty, in contrast to the rest of the room and fittings. There was no information within the public toilets to show when they were last cleaned. Within a Patient Environment Action Team (PEAT) audit, publicly displaying contact details of who to contact in the event that facilities (including fixtures and fittings) were dirty, was worse than expected.

We saw staff being very thorough and careful when cleaning. They did not miss areas and they checked back on themselves, to ensure they had cleaned all areas correctly. We saw that the pull cords of the call bells within lounges, bathrooms and toilets were clean and had plastic covers to enable them to be wiped over easily. We saw that the lights automatically came on when staff entered the sluice rooms. This enabled staff not to touch anything like a light switch or pull cord therefore reducing the risks of contamination.

Within the wards, we saw that linen trolleys were clean, organised and covered when not in use. However, within a medical ward, we saw that a used linen container had been overfilled and at 12:30, the linen had spilled over, on to the floor. There was also an overfilled red linen bag, which contained infected linen. We saw that used bed linen, although not potentially infected, had been left on the weighing scales within a corridor.

There were hand gel dispensers and posters about minimising the spread of infection throughout the hospital. Within the corridor leading to the rehabilitation unit for older people, a hand gel dispenser was empty yet this was quickly refilled. We saw that staff regularly washed their hands and used the hand gel available. A nurse on the children's unit considered the 'clean hands campaign' had been very successful. They thought the message was now 'ingrained' in staff. There were a range of disposable gloves and aprons available to staff within all wards. We saw that staff used these when supporting people with their personal care routines and when serving food. Within the Stroke unit, we saw three doctors going to the room of a person who was being barrier nursed. All three doctors tucked their ties into their shirts. They then washed their hands and put on gloves and aprons before they went into the person's room. They correctly disposed of items and washed their hands afterwards. They gave us the impression that this was usual practice as it was very clearly automatic for them. We saw two phlebotomists taking blood from a number of people. They did this safely and used the correct procedures.

Other evidence

Staff told us they had undertaken training in infection control. Within discussions, it was apparent that they were aware of their responsibilities in promoting infection control. Within the Burns unit, a staff member told us that wound dressings were undertaken in the morning. This was because the ward was quieter and there was less movement, which reduced the risk of contaminates to people. A member of staff within the oncology and haematology department told us that only nursing staff who had been specifically trained could deal with blood spillages that may contain infection. Within the spinal unit, a staff member told us that if a person had an infectious condition such as MRSA, their clothes would be washed daily and separately by staff. Within the maternity unit, staff explained that all nursing and theatre staff wore 'scrubs' which were blue, tunic style tops and trousers. They said they were laundered every day and if worn outside of the hospital, the staff member would be subject to disciplinary proceedings.

There were clear systems in place to ensure that all equipment was clean and safe

to use. Staff told us that monthly audits were made to ensure the systems were being followed and they were working effectively. Within the rehabilitation unit for older people, a staff member told us that due to the audits, the standard of cleanliness related to commodes had significantly increased. Within the spinal unit, it was a staff responsibility to ensure shower rooms and equipment used were cleaned after each use. A labelling system was used to show that items of equipment had been cleaned. Staff told us that they were instructed to use only equipment that had been labelled as clean, within the previous 24 hours. Within the oncology and haematology department, a nurse told us that equipment such as air mattresses would be processed in the decontamination unit on site. The equipment would be returned with a record to show the dates of decontamination and that it was safe to use. They told us that some equipment had single use attachments, which were disposed of after use. Within the children's unit, staff told us that the hospital had an established audit process for mattresses. They said this resulted in frequent provision of new mattresses. We saw that the cutlery for lunch was delivered in individual settings in individual plastic wrappers in order to reduce the risk of contamination.

Within a Board of Governors report, it was stated that the trust was working to improve and maintain rates of infection, partially on feedback from patients on staff undertaking hand hygiene. The report stated that the numbers of hospital acquired infections had continued to fall in 2010. There were 5 cases of MRSA bacteraemia and 0.45 cases of Clostridium difficile per 1000 bed days. The national average was 1.6. All cases of MRSA bacteraemia were non trust apportioned. There were no trust apportioned bacteraemias in 2010/11) The PEAT assessment which took place in 2010 awarded an excellent rating across each heading of Environment, Food, Privacy and Dignity. Salisbury Hospital was one of 40 sites out of 1240 to achieve this rating and the only Acute Trust (in England) out of 4 hospitals to have achieved the highest possible score each year for cleanliness. Within Real Time Feedback, 87.44% of patients said the ward was very clean. 94% of patients said staff always washed their hands between treating patients.

Our judgement

People benefit from an environment that is very clean and well maintained although public areas were not to the same standard. Systems to minimise the risk of infection are thorough and regularly audited to ensure they are working well. However, the management of soiled laundry in ward areas, with overflowing laundry trolleys, conflicts with good practice guidelines and poses a risk of cross contamination.

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

People told us that they were happy with how their medicines were looked after and that they were given them at the correct times. Some people brought in their own medicines from home and were being given them by staff whilst in hospital. Three people told us they had chosen to look after one of their own medicines. One person told us that sometimes their night time medicines were given late and staff had to wake them up, to take them. A staff member confirmed that sometimes, night time medicines were given later than 10:00pm. One person told us that they had not been given one of their prescribed medicines. The person's record sheet showed that the medicine had been unavailable for four days, mainly over the bank holiday period. Another person said that staff had told them to take their medicines home, as their medicines would be arranged by the pharmacy. They said they missed three doses of one medicine and were then asked to bring their medicine back to the hospital. This was because the hospital did not have any stock. People told us that staff explained the reasons for any changes in their medicines.

We saw that medicines were given in a respectful way with time to talk to the individual person. People had lockable cupboards by their bedside where their own prescribed medicines were kept. A small number of medicines were given from the

ward stock. We saw that the way in which these medicines were transported, meant there could be potential for someone other than the nurse who was administering them, to access them. Staff told us that this method of transport was practical and also used on other wards. Whilst acknowledging this, we identified that the medicines were not secure and potentially open to misuse.

Other evidence

A pharmacist told us that they checked that medicines people brought into hospital with them were correct. This included checking information with the person's own doctor. The majority of medicines were given to people by nursing staff. Staff told us that there were policies in place for people to manage their own medicines. They said people were assessed to ensure that they were able to do this safely. Staff told us that they talked to people about their medicines before they went home. They said they ensured people were clear about how their medicines were to be taken.

We looked at approximately 20 people's medicines administration record sheets. We saw that generally the record sheets had been fully completed. Codes were used to explain the reason why any medicines prescribed regularly had not been given. Staff told us that people's medicine records were checked within staff handover. This ensured that there were no gaps in the signing of medicine administration. Within one administration record, the instruction for one medicine had not been completed fully. It was therefore not clear that the person had been given this medicine, as it had been prescribed. Staff told us that they had taken action to clarify the prescription.

Secure storage for medicines was available on the wards we visited. However, we saw that on a rehabilitation ward for older people, the medicine room and cupboard doors had been left unlocked. This enabled the medicines to be accessed by anyone walking by. Arrangements were in place to ensure that controlled drugs, which needed additional security, were kept appropriately. We saw that adequate records were kept in relation to the controlled drugs. Staff made regular checks of these medicines to make sure they were looked after safely. We saw that emergency and resuscitation medicines and equipment were available and regularly checked to ensure they were fit for use.

Our judgement

Clear, organised systems are in place to ensure people have their medicines safely and as prescribed. People are able to manage their own medicines if they are assessed as safe to do so. Lockable storage for medicines is in place although the transportation of some medicines is not secure and presents a risk that the medicines may be misused.

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 environment was well maintained, safe and tidy. Paintwork was intact and furnishings were of a good standard. There were various building works and refurbishment programmes taking place. This included the development of a new children’s centre, the refurbishment of the discharge centre and the lounge/dining room in the hospice and the development of single sex accommodation and facilities throughout the hospital. The accident and emergency department had recently been redesigned and refurbished. A staff member told us that the new layout of the department meant that people could be seen and treated in a more logical and systematic way depending on their needs. They told us ‘everything flows much better.’

A large number of people told us that finding their way around the hospital was difficult. They said the signage was not always clear and the maps at various locations around the building were not easily interpreted. Specific comments were ‘you get awfully lost here,’ ‘I’m looking for Farley ward. I think it’s this way’ and ‘if I had any complaint, it would be about the signage at night. I found it difficult to gain access and I was under pressure to get to the ward quickly.’ Throughout our visit, we frequently observed members of the public, stopping others to ask for directions in both the old and new parts of the hospital. Within the main entrance area of the hospital, volunteers were available to direct people to where they wanted to go. This was not the case within other parts of the hospital although we saw that hospital

staff were very helpful in giving people directions. Within a Board of Governor's report, we saw that the Signage Policy had been updated and a capital bid had been submitted to update and/or replace the internal and external signage within the hospital.

Consideration had been given to the layout of the environment. For example, the Burns unit had peoples' rooms on the outside with support rooms on the internal walls. This meant that all rooms were light and airy with views over the countryside. However, this was not so on Farley ward. Due to being on the lower ground floor, most of the windows in the bays looked out onto enclosed areas and/or walls. The Spinal unit had a kitchen that could be accessed by a number of wheelchair users at one time. The kitchen had lowered work surfaces to enable people easier use of the area. Most of the ward accommodation on the children's unit was in cubicles. The cubicles were large enough to accommodate family members and had doors to promote privacy. Staff told us that the new children's unit had 'drop-down' beds to enable parents to stay with their child. This would replace the current use of camp beds. Particular areas such as the maternity unit and the hospice had communal rooms where people could meet their visitors. There were selections of toys for visiting children to play with. We saw that the day/dining room within the Stroke unit was empty most of the time and gave the appearance of being used as an equipment store. Staff told us that this was being addressed. We saw that there were signs on all doors to show what the rooms were used for. Within the newer parts of the building, the signs contained Braille to assist people with a visual impairment.

Other evidence

A staff member within the major injuries ward told us that maintenance and repair of the building was carried out quickly by the estates department. They said that some parts of the hospital were leased and therefore maintenance and repairs were dealt with by the owners of that building. Within oncology, staff told us that due to this, issues often took a little longer to address, than if dealt with through the hospital estates service. This was also confirmed within the rehabilitation unit for older people.

Before our visit, we spoke with the Fire and Rescue Service about fire safety within the hospital. They said there were no current outstanding issues and risk management systems were clear, organised and well managed. Problems when encountered were minor in nature and dealt with quickly by the hospital. Within the Burns unit we saw that a kitchen door, which was labelled 'Fire door keep shut,' was wedged open. There was also a period of time, within the rehabilitation unit for older people, whereby space in the corridor was restricted due to the serving of meals. This could have been problematic, if an emergency situation had occurred.

Within the hospital's most recent Environmental Health Inspection, the kitchen was awarded '5 stars.' This meant that there was total compliance with statutory obligations. Specific comments included 'Excellent structural standards and very high confidence in standards.'

Within the 2010 Board of Governors report, it was identified that Mini PEAT auditing ensured that the premises and grounds were properly maintained. They said that there had been fewer requests to the maintenance department, as a result.

Our judgement

People benefit from an environment that is continually being developed to meet people's needs. All areas are safe, well maintained and fit for purpose. Systems are in place to regularly monitor the standard of the environment to ensure it is well maintained. The current signage however, is not clear and therefore people are unable to easily find their way around the hospital.

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

There are minor concerns with outcome 11: Safety, availability and suitability of equipment

Our findings

What people who use the service experienced and told us

Throughout the wards, specialist equipment was available to help people with their personal care needs. There were different types of hoists, height adjusting baths, wheeled commodes, pressure relieving mattresses and raised toilet seats. One person within the hospice told us that they liked the ‘spa facility’ on the bath, as it helped them to ‘unwind’ and relax. There were also other forms of equipment, which were used in relation to people’s treatment. This included two birthing pools in the labour wards and comfortable reclining chairs. Within the spinal unit, there were mobile hoists to use in the event of overhead tracking failures. Within the major injuries ward, one of the bays had been fitted with equipment to treat children. The equipment and supplies were colour coded to easily differentiate between their use for adults or children. The storage cupboards within the wards had photographs of the equipment and supplies inside, for easy identification. We saw that some wards had well equipped therapy rooms for people to gain support in regaining their daily living skills.

People within the rehabilitation ward for older people and within the maternity unit told us that the equipment staff used such as blood pressure machines were clean and in good working order. They said they were confident that staff had a sound

underpinning knowledge of how to use the equipment.

People had their call bells within easy reach and were aware of how to use them. People could therefore summon help, as required although response times to call bell varied across wards (see outcome 13: Staffing.) The call alarm system in the oncology and haematology ward was linked to the other two wards nearby. This meant that the bell sounded throughout the ward when activated from one of the other wards, day or night. Staff told us that this was soon to be rectified.

We saw that one person who was at high risk of developing a pressure sore on Farley ward, had an air mattress on their bed. However, they did not have a pressure relieving cushion on their chair, where they spent much of their time. Another person had a pressure relieving mattress but it was not on the right setting for their weight. We saw that none of the bed rails had protectors on them, although some people had very thin skin. One person was at risk of bruising. We talked to staff about the risks to people of not having bed rail protectors. By the end of our visit, this area was being addressed. We saw that some of the bed rails were loose in their fixings and if the head of the beds were lowered, some rails could show an unsafe gap between the end of the rail and the bed-head. We saw that none of the beds were adjustable to be lowered to the floor. One staff member told us that due to this, more bed rails needed to be used.

Other evidence

Within the rehabilitation ward for older people, staff told us that they had the equipment they required to meet people's needs. This was confirmed within the Spinal unit, whereby a staff member told us 'we are well off for equipment.' They said that staff were not able to work with any item of equipment until they had received documented training for it. This included supervised use of the equipment before being assessed as competent. Staff told us that competency included the ability to train and supervise others.

Effective systems were in place to keep equipment maintained and in good working order. A staff member within major injuries told us that equipment and services were audited each day to ensure it was available and in good working order. Within the maternity unit, staff told us that some equipment would 'alarm,' when it was due to be serviced. A staff member on the children's unit had delegated responsibility for equipment issues on the ward. This included maintaining records of servicing and replacement and ensuring the status of staff training in the use of equipment. Within the intensive care unit (ICU) staff told us that the equipment was being overhauled. Ten new bedside monitors had been provided. Staff told us that they had been involved in decisions about which monitors to purchase. They said that the unit, employed technicians who were trained in the maintenance and servicing of the complex equipment needed. The technicians were on call 24 hours a day, to be able to maintain equipment needed in an emergency. Within the hospital's website, we saw that main contractors and suppliers used by the hospital were displayed.

Our judgement

People have the equipment they need to support them in their care and treatment. The equipment is clean, well maintained and regularly serviced to ensure it remains in good working order. Staff are trained in the use of the equipment so are competent and do not put people at risk of error. The use of bed rails, however, with the lack of protectors and insufficient checks to ensure they are fitted correctly, place some people at risk of harm.

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

People did not raise any concerns with the fitness and competency of the staff who supported them. One person told us that staff of all grades displayed excellent motivation and skills.

Other evidence

Two staff within the rehabilitation unit for older people told us that they had a thorough recruitment process before being offered a job at the hospital. They said they had completed an application form and had declared their physical and mental fitness. They had also declared that they had not had any criminal convictions or cautions. The staff members told us that they had provided the hospital with two referees, who could be contacted for information about them. They gave evidence of their professional qualifications and completed a Criminal Record Bureau (CRB) disclosure. This ensured they were suitable to work in a role with vulnerable people. The staff members told us that they had attended an interview. They said they were told they had been successful in their application although this was subject to satisfactory references and a clear CRB. The staff told us that they had a full induction to enable them to do their job effectively. Another staff member told us that they had completed a three day induction to the ward. They were supernumerary and therefore not counted, as part of the ward's staffing allocation. Another member

of staff told us that new members of staff were 'buddied' or shadowed for varying amounts of time depending on their experience. They said this was generally between a period of two to five weeks. The staff member described how the staff induction pack for the unit had recently been reviewed to ensure it remained relevant.

A senior sister told us that she interviewed all potential members of staff for her ward. She told us that she could remember when recruitment was not in the ward sister's control. She was pleased that ward staff were now fully involved in such decisions again, as she felt it was integral in recruiting the 'right' staff.' A staff member within ICU also told us that she was involved in interviewing new staff. She said this was critical in this speciality.

We looked at four personnel records of newly appointed staff. The records were clear, organised and the content demonstrated robust recruitment procedures. Each record had information as described by the above staff members. This included an application form, a health and criminal record declaration, evidence of identity and qualifications, two written references and a CRB disclosure.

Within information sent to us before our visit, the Trust confirmed that the recruitment of staff was controlled through a central recruitment administration team. The Trust stated that the team was fully trained and there were policies and procedures in place to ensure that all staff started work only, after all checks and a corporate induction had been undertaken. Staff then received a local induction on the ward or within their area of their work.

Our judgement

People are supported by staff who have been robustly recruited to ensure they have the skills, expertise and integrity required. People can be assured that all staff have been comprehensively vetted thus ensuring they are suitable to work with vulnerable people.

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

People’s experiences of the number of staff available to meet their needs varied across different wards. Some comments were positive ‘they’re always very quick, when you ring the bell,’ ‘there are ample staff around’ and ‘if I call, they come as soon as they can, or they say they’ll come back, and they do.’ A parent at the children’s unit said there appeared to be enough staff and it had been easy, as a parent to work alongside staff and share responsibilities. All people spoken to on the spinal wards thought there were always enough staff available, although three described response times to call bells, as ‘reasonable.’ One person said response times were ‘not too bad.’ Within an orthopaedic ward, we saw one person had spilt their tea on their bed linen. Staff assisted the person quickly and changed their bedding straight away. We saw that several people came into the accident and emergency unit with the ambulance service. Staff told us that there were target times, which stated that each person should be assessed within 15 minutes of their arrival. During our visit, we saw that people did not have to wait more than a couple of minutes to be seen.

Other people’s experiences of staff member’s availability were not so good. Specific comments were ‘staff are good “75%” of the time at coming when you ring the bell,’ ‘it is well run here but they could do with more staff’ and ‘they are not always swift but they are so busy, at least everyone is willing.’ One person on a surgical ward

told us that staff availability was poor during the change over times of staff. A person within the Medical Assessment Unit said they thought the nurses were 'run off their feet' but despite this, they were very good at coming back and checking blood pressure frequently. Within the rehabilitation ward for older people, people told us that staff took a long time to answer their call bells. We saw that one person had to wait ten minutes for a response from staff when they rang their bell. They said this was not unusual. Within this ward, other than at lunch time, the call bells were sounding continually.

Within Farley ward, we saw a person's drink had thickening agent, which had thickened it to a custard consistency. The person's records showed that their fluids should be of a jelly consistency. There was no record to show that the person had been given a drink all morning. This may have indicated that the drink had thickened through being left to stand. Staff were aware that when someone was starting to drink again, best practice was to ensure that they had fluids, 'little and often.' Staff told us they had not been able to do this, that morning. They said they often did not have the time, especially in the mornings. Staff were clearly aware of this omission and felt guilty that they were not able to meet all of peoples' needs, as they wanted to.

Other evidence

Staff member's experiences of staffing levels varied in different areas of the hospital. Within the Spinal unit, staff said they had sufficient time to give people one-to-one emotional support. Our observations confirmed this, as staff appeared unhurried and spent significant time with people. Within the children's ward, staff told us that they felt staffing levels to be appropriate, as the majority of children were accompanied most of the time by their parents or others. However, when busy with a maximum number of children, staff felt that non-priority children and their parents had too little face-to-face contact. Staff told us that they offset this by using a volunteer to do a drinks round and combine this with conversation.

Within the rehabilitation ward for older people, staff told us that there were often occasions when they could not respond to call bells as quickly as they wanted to. Staff told us that they were aware that social stimulation and involvement were sometimes limited on the ward. They said the level of people's needs and existing staffing levels did not enable this to be addressed. Staff explained a similar situation on Farley ward although this was being addressed through the reliance of volunteer contribution, rather than a member of the staff team. A therapist talked to us about communication between the different roles of staff. They said they believed that if their instructions were not carried out, it would be to do with staffing levels, not staff motivation.

Within the Burns unit, the ward sister was answering the telephones, as there was no ward clerk. This did not use the staff member's expertise and they were also unable to do their own job. A staff member told us that if a risk was identified through staff shortage, this would always be escalated to their manager. They said they were always supported if they did this. A staff member within the Spinal unit told us that staffing needs on each ward were reviewed daily.

Within an inpatient survey, we saw that the proportion of respondents, who stated that after they used the call button they never got help, was worse than expected. During 2010, we received a notification regarding an injury to a person due to a fall. One of the contributory factors, as well as the person being at risk of falling was that the ward was very busy and staff were 'unable to closely supervise all patients continually.' Within another notification, additional staff were requested, as staff had assessed the ward, as being 'unable to manage safely.' This was because people were unsettled and at risk of falling. Within a survey on Patient Safety Culture in January 2010, 63% of staff felt that there were not enough staff to handle the work. 35% agreed that they often worked in crisis mode.

Within information sent to us before our visit, the Trust told us that the national maternity survey did show that staffing availability was an issue, resulting in less than ideal response times. However, this was being monitored. The Trust had agreed that the national cost cutting exercises in relation to reducing staffing levels were not sustainable. The Trust told us that in the period between April 2009 and January 2011, there were a total of 1982 complaints and concerns raised. Of these 7 concerns and complaints were about being short staffed, but only 4 were substantiated.

Our judgement

Staffing levels within some areas of the hospital were satisfactory and enabled people to be well supported. However, within other areas, people did not receive timely support when using their call bell and were not fully assisted with aspects such as having a drink. This impacted upon people's safety and compromised staffs ability to meet people's needs effectively.

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 were very positive in their comments when talking to us about the staff. They said they were competent, well trained, professional and good at their job. A person on the Spinal unit said ‘they seem happy among themselves and that makes such a difference.’ Another person said ‘everyone is brilliant. No-one could do more for you.’

We saw that staff were attentive and interacted well with people. They were friendly, confident, professional and highly motivated in their role. They were open and approachable and wanted to do their best for the people they were supporting.

Other evidence

Some staff such as those within the Spinal wards, the Burns unit and the rehabilitation ward for older people told us that they always worked on the same ward. They did not complete other shifts elsewhere in the hospital. Due to this, there was very low staff turnover and a high level of expertise had been developed. We saw that staff’s expertise was well utilised and shared within the wider teams. For example, registered nurses within the Burns unit told us they completed people’s dressings in the Intensive Care Unit. A psychologist attended ward meetings to advise on the management of behaviour issues, some people presented.

All staff spoken with told us that they felt very well supported. They said they could request any training they felt they required and could also discuss any matters arising with the senior nurse on duty. One registered nurse within the Burns unit told us that even though they had worked in the unit for over two years, they felt they could still go and ask for support with a complex area they'd not come across before. A junior member of staff told us that they felt able to contribute at 'whiteboard' (handover) meetings. They said they were confident that they would be listened to by medical and therapy staff. Within the accident and emergency department, staff told us that the team gave each other particularly good support. Some staff on the Maternity unit described how they had taken on additional roles and how they had been supported to learn new skills. One staff member told us that they now worked in the hospital theatres. Another staff member had become a maternity assistant, which involved working in the community. A member of staff in the accident and emergency department told us that the local police were very supportive to staff, if people became angry or aggressive. They said the police would remove people from the building if they were causing a disruption. There was also an on site security service to ensure staff remained safe at all times.

Staff told us that the training opportunities within the hospital were very good. One staff member described the training as 'excellent.' They said the hospital wanted them to 'expand and develop.' All staff told us that they had access to a range of mandatory training and other training in relation to their specific area of work. They said mandatory training included basic life support, equality and diversity, pain management, manual handling and safeguarding. Other topics included end of life care, pressure ulcer prevention, swallowing difficulties, dementia care and minor injuries. Staff told us that their competencies within ICU were regularly checked to ensure they were maintaining their skill level. They said they had a specific training team, with a lead education nurse. Staff told us that there was a programme in the hospital for enabling nursing assistants to qualify to NVQ (National Vocational Qualification) level 3. Staff told us that senior nurses often arranged training for more junior members of staff. We saw a ward sister on the Burns unit being very supportive to a student nurse. They were fully aware of the training outcomes for the student nurse and what support they needed. One registered nurse within the Burns unit told us that the most recent training session they had undertaken was pain relief in children. Staff told us that there was information available as to how to support people who have a learning disability.

Staff member's experiences of formal one to one supervision and appraisal varied across the hospital. Some staff said they did not receive regular supervision and appraisals although other staff described the systems as positive. One staff member told us that as a result of a recent appraisal, she was commencing a degree in nursing. A staff member within the children's ward told us that they felt there was no need for individual supervision. They preferred the sharing of experience and learning through their ward meetings. They said that they found appraisals meaningful. They considered support to staff to be very strong and increased, when needed. A staff member within the Spinal unit told us that there was no provision for one-to-one supervision of staff although they felt greatly supported by the teamwork ethos of the unit.

Within information sent to us before our visit, the Trust told us that following

induction, staff were appraised on at least an annual basis. Each staff member had a personal development plan for the year. The Trust stated that further improving the number of staff with an appraisal was a priority, which would be addressed through various initiatives. The Trust told us about many training initiatives for staff. They were proud of the resources to run training such as video conferencing, theatre links and a lecture theatre.

Our judgement

People benefit from well trained, motivated and committed staff at all levels. Whilst formal staff supervision is not consistently taking place within all areas, all staff feel well supported and can readily give their views or ask about any issue they are not sure of. Due to shared learning and the staff appraisal process, people benefit from a range of expertise, which is used in a targeted way.

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

The provider is compliant with outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us

People told us that they were very happy with the standard of care and treatment they received. Some people compared their experiences to other hospitals they had stayed in. One person said the service they received at Salisbury Hospital ‘far outweighed’ any other. Another person said ‘I’ve been in some hospitals but this one is definitely the best.’

We saw that people were encouraged to give their views about the service they received. Within the Maternity unit, one person showed us a quality feedback form, staff had given them to complete. Another person who was about to go home, showed us the feedback form they had completed. It stated ‘received a very good service overall.’ Within the hospice, one person told us ‘they regularly ask us if we are happy and if we can think of any improvements, which could be made. They are very open to suggestions.’

On notice-boards within the main corridors, there were displays showing information which analysed areas such as falls, concerns and medicine errors. This enabled people to openly see any analysis of adverse events, which had taken place in the hospital.

Other evidence

A staff member within the children's unit told us that they saw hospital management, visiting the ward every week in connection with monitoring in one form or another. They said the audits helped staff to be aware of what they were doing well and where improvements might be indicated. They said the audit processes in the hospital were transparent and they always felt involved. Within the rehabilitation unit for older people, staff confirmed that a range of audits regularly took place. One staff member said 'we never know when someone might turn up to check the commodes for example, so it's become standard practice that everything is 'up together.'" A staff member within the Spinal unit said they valued the interest of higher management in directly monitoring the quality of patient experiences and the environment. They said they also valued higher management sharing outcomes with the whole staff group. Another staff member within the unit told us that all staff were emailed with the outcomes of the audits on the ward. They had weekly team meetings where the emphasis was on improving performance. They appreciated that the process consistently valued what they did well, as well as helping identify where there were shortfalls to make up. The audit process was supported by delegation of responsibilities within the unit. For example, one staff member had specific responsibility for hand hygiene. Within a medical ward, one staff member showed us an action plan, which they had devised in response to some improvements they wanted to make. The plan was detailed and clearly evidenced that outcomes for people would be enhanced, as a result.

Within the children's unit, a staff member said they used Real Time Patient feedback and adverse incident reports, as learning tools within their monthly ward staff meetings. They said it was 'important to get patients' and parents' views, good or bad, to learn from and keep improving.' A staff member within the hospice confirmed this. They said it was essential in the development of the unit to gain real feedback about people's direct experiences. They said 'we can think about improvements we could make but we need to check out whether they are the improvements people feel they need.' They said people had been involved in choosing colour schemes and flooring for the unit. Discussion groups on pain relief, holiday insurance and alternative therapies had also been arranged in response to requests of people. Within a surgical ward, a staff member told us that through Real Time Patient feedback, an issue of night-time noise on the ward was identified. The source was traced to early hours activities in the hospital laundry situated near the ward. This was shared with the Facilities Department and a change in laundry practices was undertaken. Within the Spinal unit, staff told us that the hospital's 'patient feedback' system had identified that some people wanted improvements in how goal planning meetings were conducted. This led to a focus group involving people and delegated staff to explore possible ways of improvement.

Within information sent to us before our visit, the Trust demonstrated that there were many auditing systems in place to assess and continually develop the service people received. They stated that RTF (Real Time Feedback) was a valuable system, which was undertaken by the governors and volunteers on a daily basis and collated monthly. There was a Customer Care Department, which collated concerns, compliments and complaints from people and their relatives. This department was

clearly advertised within the hospital's website.

Before our visit to the hospital, information indicated that the Trust had higher than expected mortality rates in large intestinal disorders and alcohol related liver disease. In such instances, the Trust has shown that they are quick to respond to such information and will identify and implement any action required.

Our judgement

Clear, organised systems are in place to monitor and evaluate the range of services provided within the hospital. People are encouraged to give their views in a variety of ways and these are valued by senior management and taken into account, as appropriate. The Trust is able to recognise and identify where there may be shortfalls in provision and has clear action plans in place, in order to continually improve services.

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

People told us that they had not found it necessary to raise any concerns or to make a formal complaint. They said they would report any problems to a member of staff or to a supervisor. Within the orthopaedic wards, people were able to tell us who they would contact if they needed to. People had been provided with information about PAL's (Patient Advisory Liaison Service.) One person within the children's ward said that they had not specifically been told about how to make a complaint, nor had they seen any leaflets available. They had noted there was a suggestion box on the unit. In response to this, staff told us that literature was being developed in preparation for when the new children's unit was opened. In the Spinal unit, people told us they were given an information book. They said this was comprehensive and included clear details on how to make a complaint.

Other evidence

A visitor told that they had made a complaint about a previous ward that their relative had been on. They told us they had been able to talk to senior managers 'face to face' to explain their difficulties. They said they knew they would receive an action plan when all matters had been addressed. The visitor felt that senior managers were approachable, unbiased and genuinely wanted to improve things.

Staff told us that they would immediately try to resolve any concern a person raised. They said that if this was not possible, they would inform a senior member of staff or refer them to the hospital's Customer Care department. A consultant said that they were responsible for dealing with any complaints about their department. This included carrying out the investigation, interviewing staff and writing a response to the complainant. This would be sent out by the chief executive. They said an apology would be made and complainants would be offered a meeting to discuss their concerns.

Staff told us that previous 'patient feedback' had identified that some people were unsure, as to how to make a complaint. Within the Spinal unit, there was an action plan, which showed an achievement of improving how information was given. This included better provision of complaints leaflets within communal areas of unit.

Our judgement

People feel confident in raising a concern if they are not happy with an element of the service they have received. People feel listened to and are confident that any issue will be satisfactorily resolved. Complaints procedures are in place, however, some people were not fully aware of the formal processes they should follow and in some areas the procedure was not available in a written form.

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

People were aware that records were maintained about their care and treatment. One person within the Maternity unit explained ‘anything written about you has been explained to you.’ A person within the Stroke unit told us about written records and verbal information. They said ‘everything is made understandable.’ A person within the rehabilitation ward for older people pointed to a file at the bottom of their bed, when we asked them about their records. They told us ‘I haven’t looked at them, as I’m not really interested.’ We saw that the records showed details of the person’s temperature, blood pressure, medicines, bodily functions and food consumption. We noted that the food charts had not been consistently completed. A person within the Acute Medical ward was aware that staff measured and documented their fluid input and output in order to monitor their condition.

Other evidence

We saw that there were instructions about correct record-keeping on the notice-boards in the wards. We looked at six people’s records and saw that the quality of the documentation varied. For example, whilst we observed mouth care being

given, people who were 'nil by mouth' had sparse records relating to their mouth care. We saw that one person needed support to drink. They had a fluid chart in place yet no records were completed on the day we visited. We met with a person who had oxygen being administered via nasal canulae. Records did not show if the cannulae had been changed or if staff had checked various areas for soreness.

We saw a person who had been assessed as being at high risk of developing pressure ulcers. There was no written evidence that their position had changed during our visit. When we looked at the person's records for the day before, there were two records of pressure area care, no more. The records of another person at similar risk, demonstrated that they had only been supported to change their position once during the day. The records showed that they were for 'regular' turning yet there was no precision, as to how often. We saw that the person had continence needs yet there was not a continence assessment in place. The records showed that a continence aid was used yet there was no detail as to its type, size or who applied it. There was a section in the records to identify if the person was a vulnerable adult. The record was not completed. The person had food charts, which were completed in detail. There were also completed assessments in relation to nutrition, manual handling and pressure ulceration. We looked at three other records and saw that there was a similar pattern. Records regarding changing a person's position, fluids given and mouth care were not well completed. Staff told us that they felt the care was taking place but it was not always written down.

We saw that within the standard bed rail assessment, there was no assessment for the risk of tissue damage and the need for bed rail protectors. This meant that people, who may have needed them, to prevent bruising, were not properly assessed. In addition, the standard bed rail assessment did not have a space for staff to check if the bedrails were safe. This particularly included fixings and whether people were at risk of entrapment within the gaps of the rails. Similarly, we saw that documentation regarding pressure area care did not include a box for the staff member to check that the air mattress was on the correct setting for the person's weight.

More positively, we saw that records for people with swallowing difficulties from the speech and language therapist were clear and precise. The records detailed the outcome needed for each person. All these directives were dated and signed. One person had clear records of their blood glucose levels. The records showed good detail about the actions to be taken if the levels were outside of the person's usual parameters. One person had a detailed wound dressing plan.

Other records such as staff personnel records were ordered and well maintained. A computer system, in addition to paper records demonstrated a clear, recruitment procedure. There were checklists, which reminded staff to verify each stage of the process. This ensured that references for example, were received before a candidate was formally offered a job and started work at the hospital. Medicine administration records were also well maintained and fully completed.

Staff told us that people's daily observational notes were kept with the person at the end of their bed. Other records, which included the person's history, any

assessments and treatment plans for example, were stored securely within the nurse's office. We saw that there was a computer system, which tracked people through the accident and emergency department. There was a colour coded system to show priority of need and the times of treatment. A staff member on ICU was very aware of the importance of confidentiality. They explained that there were times when relatives did not understand all that was said to them, due to the emotional upheaval they were experiencing. Due to this, the staff member felt documentation was particularly important.

Our judgement

People had access to their records and were aware of what was written in them. Records were stored securely and those required on a regular basis were easily accessible. Whilst clearly written, not all records were consistently completed. The records did not fully demonstrate the care people received and how their needs were to be met. The format of some records was not conducive to enabling all checks of equipment to be undertaken. This had the potential of impacting upon some people's safety.

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
<p>Treatment of disease, disorder or injury</p> <p>Assessment or medical treatment of persons detained under the Mental Health Act 1983</p> <p>Surgical procedures</p> <p>Diagnostic or screening procedures</p> <p>Management of supply of blood and blood derived products etc.</p> <p>Transport services, triage and medical advice provided remotely</p> <p>Maternity and midwifery services</p> <p>Termination of pregnancies</p> <p>Family planning</p>	<p style="text-align: center;">9</p> <p>Why we have concerns:</p> <p>People receive a good standard of care and treatment, which meets their needs. However, incidents of people with pressure ulceration, has required the Trust to look at its measures in place, in order to ensure reduction. People are involved in decisions about their care and are happy with the service they receive. Whilst people are generally satisfied with the way they spend their day, activities to occupy the time for some, are limited.</p>	<p>Outcome 4: Care and welfare of people who use services</p>
<p>Treatment of disease, disorder or injury</p> <p>Assessment or medical treatment of persons detained under the Mental Health Act 1983</p> <p>Surgical procedures</p> <p>Diagnostic or screening procedures</p> <p>Management of supply of blood and blood derived products etc.</p> <p>Transport services, triage and medical advice provided remotely</p> <p>Maternity and midwifery services</p> <p>Termination of pregnancies</p>	<p style="text-align: center;">12</p> <p>Why we have concerns:</p> <p>People benefit from an environment that is very clean and well maintained although public areas were not to the same standard. Systems to minimise the risk of infection are thorough and regularly audited to ensure they are working well. However, the management of soiled laundry in ward areas, with overflowing laundry trolleys, conflicts with good practice guidelines and poses a risk of cross contamination.</p>	<p>Outcome 8: Cleanliness and infection control</p>

Family planning		
Treatment of disease, disorder or injury Assessment or medical treatment of persons detained under the Mental Health Act 1983 Surgical procedures Diagnostic or screening procedures Management of supply of blood and blood derived products etc. Transport services, triage and medical advice provided remotely Maternity and midwifery services Termination of pregnancies Family planning	16	Outcome 11: Safety, availability and suitability of equipment
	<p>Why we have concerns:</p> <p>People have the equipment they need to support them in their care and treatment. The equipment is clean, well maintained and regularly serviced to ensure it remains in good working order. Staff are trained in the use of the equipment so are competent and do not put people at risk of error. The use of bed rails, however, with the lack of protectors and insufficient checks to ensure they are fitted correctly, place some people at risk of harm.</p>	
Treatment of disease, disorder or injury Assessment or medical treatment of persons detained under the Mental Health Act 1983 Surgical procedures Diagnostic or screening procedures Management of supply of blood and blood derived products etc. Transport services, triage and medical advice provided remotely Maternity and midwifery services Termination of pregnancies Family planning	22	Outcome 13: Staffing
	<p>Why we have concerns:</p> <p>Staffing levels within some areas of the hospital were satisfactory and enabled people to be well supported. However, within other areas, people did not receive timely support when using their call bell and were not fully assisted with aspects such as having a drink. This impacted upon people's safety and compromised staffs ability to meet people's needs effectively.</p>	
Treatment of disease,	20	Outcome 21: Records

<p>disorder or injury</p> <p>Assessment or medical treatment of persons detained under the Mental Health Act 1983</p> <p>Surgical procedures</p> <p>Diagnostic or screening procedures</p> <p>Management of supply of blood and blood derived products etc.</p> <p>Transport services, triage and medical advice provided remotely</p> <p>Maternity and midwifery services</p> <p>Termination of pregnancies</p> <p>Family planning</p>	<p>Why we have concerns:</p> <p>People had access to their records and were aware of what was written in them. Records were stored securely and those required on a regular basis were easily accessible. Whilst clearly written, not all records were consistently completed. The records did not fully demonstrate the care people received and how their needs were to be met. The format of some records was not conducive to enabling all checks of equipment to be undertaken. This had the potential of impacting upon some people's safety.</p>
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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 10 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 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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