

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

Salisbury District Hospital

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Date of Inspections: 21 February 2013
20 February 2013
19 February 2013
18 February 2013

Date of Publication: March
2013

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

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Staffing	✗ Action needed
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Salisbury NHS Foundation Trust
Overview of the service	Salisbury District Hospital is the primary location for Salisbury NHS Foundation Trust. It provides a range of clinical care, which includes general, acute, and emergency services. The hospital provides both inpatient and outpatient services to people of all ages living in mainly Wiltshire, Dorset and Hampshire. The hospital also provides specialist services including being a centre for spinal injury treatment and rehabilitation. Just over 4,000 staff work for Salisbury NHS Foundation Trust.
Type of services	Acute services with overnight beds Community healthcare service Hospice services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Termination of pregnancies Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury

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Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 18 February 2013, 19 February 2013, 20 February 2013 and 21 February 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information we asked the provider to send to us. We took advice from our pharmacist, reviewed information sent to us by local groups of people in the community or voluntary sector, talked with other regulators or the Department of Health and were accompanied by a specialist advisor.

What people told us and what we found

We found Salisbury District Hospital staff open and honest in telling us their views and sharing information with us. Patients spoke well of staff and found them capable, kind and approachable. Our professional advisor found the operating theatres well organised and well run. Staff here and in other parts of the hospital were professional and friendly in their interactions with patients and colleagues and appeared fully committed to their roles and responsibilities.

One older patient told us: "no one likes staying in hospital, but the time comes when we might end up here. I've been very fortunate. It's the best conditions and food that anyone could wish for. The staff are most helpful and pleasant."

We found patients we met were treated with privacy, dignity and respect. Their care and treatment needs were assessed and being met. Patients were receiving care and attention to make sure they had enough to eat and drink. The hospital was clean and had systems to prevent or control the spread of infection. Staff understood the principles of infection control. We found the hospital had a good system of governance, although incident reporting and data about staff needed strengthening.

We were concerned the hospital did not have sufficient experienced, qualified and skilled staff to meet people's needs effectively at all times. We also found paper-based confidential patient information was not protected effectively on some wards.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 05 April 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People who need to be treated in hospital want to be respected and involved in their care. To see if this happened at Salisbury District Hospital, we visited six inpatient wards, including the specialist spinal injuries unit. We also visited day surgery, the physiotherapy and emergency (A&E) departments. Most patients we met said they were treated with respect. They confirmed staff talked in low voices to keep information private. Staff closed curtains and doors when intimate care was being provided to patients. Staff called patients by their preferred name; patients were accommodated in single-sex bays; and had time and space to see visitors.

One patient we met on the spinal injuries rehabilitation unit who was on their second visit said: "I am treated like a normal human being. I feel like an old friend." Another patient told us "I feel safe here. That's down to clear communication. If they (staff) say they are going to do something, they do it." A patient said encouraging people's independence was "central to what they (staff) do" on the spinal injuries unit. They said respecting people and treating them with dignity was "particularly important to people who have to spend life in a wheelchair." They said "staff here understand that better than anyone."

One patient told us they had been given "excellent physical care" but had concerns over some aspects of care relating to equality and diversity. The issue was progressed with senior staff during our inspection visit.

Most patients told us they understood why they were in hospital. Patients said they had enough information about proposed treatment in order for them to make informed decisions. Patients were told the risks and benefits of any procedures, including surgery. They said they felt the information was presented clearly. They had been able to ask questions about anything or wanted more information.

Staff told us some of the ways they respected patients' privacy and dignity. This included, for example, asking before they entered a patient's bed space if the curtains were closed.

We observed this happening in practice. Staff also said they made sure patients were covered up if they would otherwise be exposed to other people. We observed a nurse supporting an older patient in this way with kindness and patience. They explained they wanted to close the curtains around the bed, and asked if that was okay with the patient, before supporting them to maintain their dignity.

Our professional advisor visited the main operating theatres. They found patients treated with dignity, being properly covered at all times, including when anaesthetised. Patients were asked how they wanted to be addressed. Pre-operative checks were carried out in private. Patients kept any glasses and/or dentures with them until the last minute. Patients were able to be accompanied by a friend or relative to theatre and were given reassurance throughout.

Staff also told us they made sure patients were able to make informed choices and decisions. A consultant we talked with said they discussed the advantages and disadvantages of any proposed treatment with a patient. This included the risks and the benefits they perceived for the patient. They said as an example of patient-centred approach to care was that "all patients are different, and the risks and benefits will not be the same for everyone." The consultant said patients were able to make up their own minds about how to proceed. They said some patients did not take what clinical staff thought to be the best course of action, but this was something clinical staff accepted.

We were told doctors and nurses would ensure the patient was confident about decisions and if they wanted further time or space to consider the options. Clinical staff told us they were happy to share information with a patient's family, friends or carers as long as the patient had given permission. They said patients sometimes wanted their supporters to be able to ask questions of staff they might not have thought of.

Some patients had dementia and were somewhat confused, but we observed staff were patient and kind to them. Staff told us they implemented the provisions of the Mental Capacity Act 2005. We were given a number of different examples of how other people had been involved in decision-making. This was done in the best interests of a patient who did not have the mental capacity to make their own decision. This included involving hospital staff and the family of a patient with dementia. We saw this was documented in the patient's records. Staff said important decisions would not be taken for a person with cognitive impairment without involvement of other key people.

The provider may find it useful to note we had some concerns about staff understanding equality and diversity. When we asked three members of staff what they understood of equality and diversity they talked of people's racial origin. These staff were of the view there were not many people from ethnic minorities in the local area. They felt issues of equality and diversity did not have a significant impact on the way in which they treated people as individuals. We discussed this with senior staff and they confirmed equality and diversity training at the trust was mandatory for all staff. Senior staff also confirmed the demographics of the local population, as understood by those staff, was not accurate. Other staff we spoke with did, however, give a variety of more appropriate responses around the six strands of equality and diversity.

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

People who come to hospital need to be assessed so the planning and delivery of care safely meets their needs. At Salisbury District Hospital we looked for different ways of this being done and maintained for patients as part of their care. Most patients we met said they felt staff knew why they were there and how to progress their treatment. They said nursing staff assessed them when they arrived. This included finding out about them; asking if they were in any pain; when they had last eaten and drunk something if they had arrived in an emergency; any medications they were taking; and confirming personal details they might already have recorded. Patients said the nursing staff then commenced charts and started observations which were kept with the patient.

If a patient was being prepared for discharge they said staff had asked about support at home; had discussed and offered assistance with occupational needs; made sure the patient had independent transport or arranged transport by ambulance; and ensured the patient had any medicines they needed to take home, and information about taking them.

The provider may find it useful to note we met three patients who, for various reasons, had been waiting for over five hours to be able to go home. It was not clear how this was being managed for people who were becoming anxious.

Most patients we talked with said staff responded when they needed assistance. Some patients told us this took longer than they would like, although they felt their needs were met. There were many hundreds of good interactions between staff and patients taking place when we visited.

On one ward we heard call bells ringing for many minutes while nursing staff were occupied with paperwork. When questioned the staff immediately attended the call bell. During our visits to wards we saw staff carrying out 'intentional rounding'. This was a process where nursing staff checked each patient directly to see if their fundamental and immediate needs were being addressed. This process focussed upon patient comfort (pain and position); whether they had enough fluids; if they needed to use the toilet; if call bells were in reach; and the environment was safe.

One consultant we spoke with on the specialist spinal injuries unit said they felt the

medical cover was under-resourced. Patients were more commonly presenting with additional physical and mental health issues coupled with their spinal injury. We were told developmental work in spinal injuries was consequently often not able to flourish due to daily pressures.

The hospital had introduced a 'skin bundle': a procedure for reducing the risks to patients of the development of pressure ulcers. Staff we talked with understood the risks from development of pressure ulcers, and how they could be minimised. They told us all patients were assessed and if they were considered at risk, a 'skin bundle' procedure commenced. This included, for example, monitoring and recording fluid balance for patients; use of pressure-relieving mattresses or cushions; repositioning patients often; and regularly inspecting skin for damage. We saw these records were used in many wards of the hospital, particularly with older and/or frail patients. Those we checked were completed regularly as required by the assessed needs of the patient.

Nursing staff told us there was a thirty minute handover session arranged for staff each day between shifts. This involved on-duty staff formally updating arriving staff about each patient and what to be aware of. We observed this on two of the wards we visited. The hospital also had a 'bed meeting' twice each day. This involved senior staff across the hospital meeting to discuss a range of issues. This included, for example, matters relating to patient safety; infection control; the hospital capacity for delivering safe care; and (on Fridays) weekend planning.

The hospital had just been subject to an external peer review of its strategy for caring for people with dementia. This was the second round of reporting, and the hospital had taken part also in round one (2010/2011). The report had yet to be made public, but we found the hospital had been recorded as having made a number of improvements from round one and staff were pleased with the results.

We were accompanied on this visit by a professional advisor in operating theatre practices who visited the main theatres. They found full implementation of the World Health Organisation (WHO) surgical checklist requirements observed at all stages of the process. This process, for minimising the risks of mistakes in theatres, appeared well embedded in use, and accepted by theatre teams. Our advisor observed appropriate patient checks carried out in detail with the full surgical team before anaesthesia commenced. Other required checks were carried out when the patient was asleep, for example, anticipated blood loss and any potential problems to be aware of. There was also a recommended 'STOP' moment observed pre-incision, to ensure all checks and procedures were complete and staff were aware of their responsibilities and roles.

The hospital used standard intra operative care plans for patients in theatre. We saw in these plans, specific important information had been transferred and used. For example, a patient with a recorded latex allergy was treated in a 'latex-free' designated theatre. Any specimens taken during surgery were appropriately handled, labelled, checked by the surgeon, and dispatched according to hospital protocol. We were told aids and attachments were available to staff and used for pressure area care and risks associated with the development of venous thromboembolism (VTE).

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

People not eating and drinking well can be one of the first indicators of underlying health problems. We found Salisbury District Hospital recognised the importance of meeting nutritional needs. Patients we met mostly commented well about the food, although a number of patients on Redlynch ward said it was "rarely" and "never" hot enough. A patient on Chilmark ward said the main course was usually hot but dessert, arriving at the same time, tended to be cold once it was served. We observed one lunch served. The food was hot and appeared appetising. Patients who needed help to eat were supported with patience and dignity by staff.

The hospital had a food and nutrition steering group which met quarterly. We read the terms of reference of the steering group and its objectives included receiving, reviewing and auditing compliance in this area against national guidance and standards. The group, chaired by the deputy director of nursing and made up from a range of appropriate personnel, also reviewed patient satisfaction and feedback.

We read minutes for the last three meetings, one of which had just been held. One of the many areas discussed was the introduction of ways of supporting people, particularly those with dementia, with eating and drinking. The use of bright coloured crockery and finger food was being trialled on one ward caring for older people. Pictorial menus had also been discussed, with the patients' food forum contributing to their development. Plans were in place to trial the new menus in May 2013.

The steering group received reports from a sub group which was established in 2010 to focus upon actions around food and nutrition. It also reviewed complaints, comments, and feedback and worked on specific initiatives. We reviewed the most recent four sets of minutes and associated papers from the sub group which met six-weekly. Some of the specific initiatives the group had looked at included the improvements for people with dementia. The group had, for example, been involved in the use of the brightly coloured crockery. The sub group had also promoted the use of the pictorial menus and discussed the findings of a UK local authority study report. The reviewed research findings persuaded the group the food and liquid intake of people with dementia had improved using these relatively simple measures.

The steering group received reports from meal time observation rounds carried out by a range of staff. This had included, for example, observations by the director of nursing,

deputy director of nursing, dieticians, speech and language therapists, and members of the catering team. All the hospital wards were covered in 2012/13 across a period of around 9 months. Visits took place usually every two weeks. Where visits had been cancelled we saw they were added back into the schedule at a later date. We reviewed the reports going back to 2011. We questioned how concerns raised from mealtime observations were being used to improve practice or further analysed for development of trends. The deputy director of nursing told us these questions had recently been considered and there were plans for use of the reports and findings to be improved (the meeting minutes supported this).

Many people who have reduced or limited mobility need to have good hydration in order, among other things, to prevent the development of pressure ulcers. Pressure ulcers are the result of the deterioration of skin integrity. This can happen in only a few hours. The risk is predictable and a number of factors, such as poor nutrition and hydration strongly contribute.

We found nursing staff recognised the role nutrition and hydration contributed to reducing risk to patients from developing pressure ulcers. Patients were assessed upon their weight, appetite, and ability to eat and drink as part of pressure ulcer risk assessments. Information relating to hydration was used as part of the tool to ensure a patient's fluid balance was monitored so staff knew patients were getting enough to drink. The provider may find it useful to note two of the charts we reviewed on Avon ward had not been fully completed. Other ways in which the hospital monitored safe levels of nutrition was through recording patients' weight. Audits of how this was being done showed compliance had improved in both recording weights and nutritional assessments, although the data we saw was a year old. The trust told us all weighing devices had been updated and portable equipment for weighing bed-bound patients was in regular use.

The hospital told us stroke patients were assessed on admission for their ability to swallow food and fluids. They were then fully assessed by speech and language therapists (SLT). We saw instructions at a number of patients' bedsides in relation to nursing staff supporting them with eating and drinking. An audit by the SLT team showed 99% of patients had been reviewed within 48 hours of referral to them. The SLT department was represented on the food and nutrition groups and worked with the catering department to ensure the correct texture for soft food was understood and provided.

Complaints from patients in relation to the food had been generally low.

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Patients we talked with, without exception, told us they thought Salisbury District Hospital patient treatment and waiting areas were clean. All the inpatients we met said they had seen cleaners working. One patient commented: "there are two of them cleaning every day: right up on the top ledges as well as the floor." Another patient said: "it looks spotless to me."

On this inspection visit we were joined by a professional advisor who visited the main operating theatres. They found effective cleaning and infection control practices were being followed. Hand hygiene audits were carried out regularly by infection control lead staff and results displayed.

We saw safe storage and disposal of sharp instruments. Waste, including clinical waste, was correctly bagged and safely removed. The operating theatres and equipment were thoroughly cleaned between cases. The presentation of surgical trays and supplementaries was seen to be acceptable. Audit systems had recently identified damaged wraps on surgical trays. This had been investigated and improvements made to storage and handing methods. Checks for sterility and expiry dates on equipment were made between two practitioners before introducing to the sterile field. Any remaining 'down time' (such as lists finishing early) was used productively to extend cleaning duties.

The provider may find it useful to note we saw in the operating theatres and some treatment rooms examples of paper notices (unlaminated) and, additionally, some affixed to walls with sticky tape. This, and the damage to paintwork from the removal of notices in some treatment rooms, may have created a potential infection hazard.

During our visit we spent time observing the practice of clinical staff. We saw most of the nurses and doctors washing their hands thoroughly between patients. A number of staff said they felt this was embedded in hospital practice. Staff were also able to tell us when they used PPE and how to safely remove and dispose of it.

Some staff also said the cleaning at the hospital had changed and improved. One member of staff said: "there's been a real focus on it lately. It's a lot more visible." We observed some areas of the hospital being subject to enhanced cleaning. Where we saw

this it was in areas previously closed due to the presence of a viral infection. We saw staff, for example, carefully cleaning the wheels on a patient bed with disposable cloths.

All visitors were required to use anti-bacterial hand wash upon arriving and leaving the ward. Staff said some of the dispensers were not visible to them so they would check visitors had used it. There were also posters in the lifts and corridors about hand hygiene. Anti-bacterial gel was readily available all across the hospital. We observed some wards, ward bays, or side rooms had been closed to limit the effects of a communicable viral infection. These areas were marked with a red sign and staff were managing the arrival and departure of any visitors to the ward.

The provider may find it useful to note we saw a few areas of the hospital were not as clean as they should be. There was an area in the physiotherapy department which was hard to clean being behind a metal frame temporarily stored on the floor. This area was dusty and had not been cleaned for some time. Some floors and stairs in communal areas had not been effectively cleaned. The decontamination of hospital wheelchairs was not in an area which permitted a safe flow of work. The hospital was in the process of opening a new department for this process. The blades of a cold air fan on one of the bays which had been recently closed for the presence of a viral infection were coated with dust on the leading edge.

The director of nursing was also the director of infection prevention and control (DIPC) for the hospital trust. We read the DIPC report for the six months from April 2012. This report was written in accordance with the Health and Social Care Act 2008: code of practice, which is the basis for how the Care Quality Commission assesses hospitals against this essential standard. To further ratify the trust's processes and audit, the trust was reviewed by external auditors in quarter one 2012/13. The DIPC report stated the South Coast Audit "identified that the processes in place provide significant assurance to the trust."

To demonstrate assurance to the trust board, the hospital developed an action plan for infection prevention and control. This was monitored by a working group which reported to the infection prevention control committee (IPCC). The IPCC reported to the clinical governance committee, which in turn reported to the trust board. The hospital had an IPC team which provided a liaison and telephone service for all inpatient and outpatient services. This could be used, for example, to provide arrangements for service cover during outbreaks of Norovirus.

We saw in the report a list of recent audits carried out, resultant action plans and a section outlining what changes had been made to trust policies as a result of the audit routines.

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

Our judgement

The provider was not meeting this standard.

At the time of our visit we were not assured patients were being cared for by enough suitable skilled, qualified and experienced nursing and health care staff.

This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

When we visited Salisbury District Hospital we had mixed comments from patients and relatives about staffing levels. Some told us they felt there were not enough staff some of the time; others said it depended on the varying needs of patients; and some said staffing was generally adequate. Some patients told us either they or patients around them had to wait on occasion for what they described as "basic needs" to be met. Patients described this as waiting for someone to help them get to the toilet; asking for pain relief and waiting, as one patient said "over an hour on two occasions"; being left on a commode and "forgotten" as one relative said.

There were many hundreds of good interactions between staff and patients taking place when we visited. However, we did witness some incidents where patients were left unattended or not responded to in an acceptable time. On one ward we were unable to locate a member of the nursing staff (throughout this report we refer to 'nursing staff' meaning trained nurses and health care assistants taken collectively) to assist patients on two separate occasions as staff were engaged with other patients. An allied health professional on the ward did not respond to the request for assistance despite being asked. When the member of staff did attend, we nevertheless observed the patient treated with kindness and compassion.

We had mixed comments from staff. Most nursing staff said they could "always do with another pair of hands" or "we will always say there's never enough staff if you ask." Staff told us the hospital tried to cover most unfilled shifts as quickly as possible. However, this was mostly with agency or bank staff. We were told by one senior member of the nursing staff this sometimes "brings more problems than it solves when we have to supervise them too. Sometimes there's an unacceptable ratio of agency to regular staff too and that's hard."

A consultant we met was concerned about staffing on a ward for older patients. They told us tests and treatment were not always carried out in a timely way. They confirmed staff were supplemented by agency workers who were not experienced. We visited the ward concerned on two occasions during this visit. On our visits the ward was fully staffed. Although the ward was busy after reopening following a viral infection, patients appeared well cared for.

We reviewed around 200 comments from feedback gathered from patients by volunteers visiting wards in December 2012 and January 2013. There were many comments about the kindness and friendliness of nursing staff. However, we read 23 comments in this feedback relating directly or indirectly to insufficient staff on duty. Nine of these were from the wards where we had concerns. We also noted of the 18 set questions posed to patients, none of them directly asked if patients felt there were enough staff to provide safe care. The only question relating to this asked how long it took staff to respond to call bells. On one ward where calls bell use would be likely to be higher because of the dependency needs of the patients, we found response times had risen significantly from February 2012 onwards.

We reviewed a sample of eight adverse incident reports from the two weeks preceding our visit. Seven of the eight reports related directly to staff shortages and the effects on care delivered.

We discussed nursing staff levels and skill mix with the director of nursing and deputy director of human resources. A review of the nursing staff establishment had recently taken place in response to known pressures. This was also to address the effects of ward moves and changes to clinical specialities over the last five years. The review had been conducted and presented to the board by the director of nursing. It made a number of recommendations which had been accepted. Staffing levels were to be changed starting from April 2013 to reflect anticipated patient needs. We saw from the review the wards where we had seen staff pressures had been identified as needing additional staff. To respond to the high number of nursing vacancies, the trust had identified and was recruiting a cohort of qualified nurses from overseas who would be joining the trust.

The trust told us the hospital had faced pressures with recruiting and retaining nursing staff. Meetings had been held with concerned staff to listen and respond to issues raised. Each day meetings were held in the morning and again in the afternoon with senior nurses and departmental managers to discuss, among other things, staffing levels. If shifts were unfilled the hospital would first determine if other wards or departments were able to release staff. Bank or agency staff were then contacted to cover shifts. The hospital trust said most available shifts were covered, but, as in most organisations, this was not always possible.

We reviewed the nursing staffing levels and the hospital had covered most of the nursing shifts over the period April 2012 to January 2013 from staff being relocated from other wards, and the use of bank and agency staff. The trust told us they had used more bank and agency shifts than planned. The use amounted to around 8% of the workforce costs for the 10-month period. Available personnel for bank shifts had also dropped during this period for various reasons. This had been responded to with an increased use of agency staff. We calculated from data provided to us there had been just under 7% of shifts requested from bank or agency staff unfilled in this period.

We were concerned about how staff levels were reported and considered at trust board

level. The board was not informed of whether the hospital was meeting staffing levels, the use of agency and bank staff, or unfilled vacancies.

Assessing and monitoring the quality of service provision

✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

Reasons for our judgement

Arrangements for governance at the hospital trust were headed by the trust board. This comprised of both appointed directors and non-executive directors. As part of the trust's foundation status, the board is accountable to its council of governors. The 25 governors were drawn from patients, members of the public, and staff. As required, at least 51% of the governors were drawn from the public and patient constituencies.

The trust board received information from a number of governance committees and groups. This was led by the clinical governance committee and supported by a range of other audit committees. Beneath these committees were a number of sub committees and groups looking at more specific matters. The clinical governance committee's primary focus was to assure the trust board and chief executive about the quality of care provided. The committee met every two months for a half day session. We read a number of sets of minutes and papers from the clinical governance committee. We found the clinical governance committee discussed those subjects and matters we would expect such a group to regularly cover.

We spent one of the days at the hospital meeting with staff from different areas of the trust who contributed to governance. The head of patient and public involvement told us of the work of gathering and using patient feedback and experiences. One area in which patient experiences were captured was through the work of the 'real time feedback' group. This comprised of a group of volunteers and governors who talked with adult inpatients. The results were collated and fed back to ward leaders.

We saw the trust board were presented with a quarterly report from the customer care team. We reviewed two reports. The reports highlighted what percentage of patients treated had cause to complain (0.1% in both cases). The board were informed about the nature of complaints and what actions had been taken in response. We noted no complaints taken to the Parliamentary and Health Service Ombudsman (PHSO) in the year 2012/13 had been upheld.

We met with the head of clinical effectiveness who looked at how patient care was

delivered and how well it achieved good results. We reviewed a number of reports on clinical areas. Reports identified learning points; contributory themes; and local actions identified. The hospital also reported upon a number of reviews of different clinical measures. We saw reports picking up concerns from the report into the failings of the Mid Staffordshire NHS Foundation Trust (the 'Francis report') and University Hospitals of Morecambe Bay NHS Foundation Trust. The trust had evaluated the recommendations from these reports and highlighted shortfalls to be investigated internally. As a result of one area of partial compliance identified, the trust approved and issued a new whistleblowing policy for staff.

We were told patients were involved in the way the hospital was run. One example we were given of this was in the design of the new children's unit. The report on the development of the unit highlighted how the consultation had worked successfully with children, parents and staff. Another was a consultation on staff uniforms which had just been completed. Changes would be made as a result.

Other governance areas we reviewed included observations carried out for the Patients Association. Reports from their observations were reviewed as part of the clinical governance committee sessions.

We also met the head of risk management for the trust. The trust used a risk register of those areas to be monitored for quality and safety. This extensive document covered those areas of risk we would expect to see in an NHS acute hospital. We also reviewed the trust strategy which had been reviewed and updated and agreed by the board in October 2012. This strategy outlined objectives, responsibilities and organisational arrangements for the trust.

We found staff and the trust reporting of adverse events was open and honest. Staff said they did not hesitate to report incidents and did not feel they would be discriminated against if they did so. The system was paper-based and staff told us this made it time consuming to use. The provider may find it useful to note we were concerned some incidents were not being reported back to the trust. The head of risk management confirmed the two incidents we witnessed while on one ward in the hospital had not been reported. We felt, and senior staff agreed, these incidents should have been reported. We also knew of another incident which had been reported by a patient which had also not been fed back for attention by senior staff. This may have meant the governance committees were not always aware of adverse events. Staff may also have not engaged with the reporting system enough to be aware of when they should be reporting events.

We reviewed the workforce report for 2012 which was an extensive report provided to the trust board annually. The provider may find it useful to note there was no record of results for training, development and appraisal of staff. We were concerned about how staffing levels were reported and considered at trust board level. Although feedback from patients was fed back through clinical governance reports, the human resource key performance targets were not a standing agenda item. The board were informed, only on an annual basis, of levels of staff absence, and percentage and numbers of short and long term absence (both for the whole trust). The board was not informed of whether the hospital was meeting staffing levels, the use of agency and bank staff, or unfilled vacancies. The annual staff workforce report did not report on vacancy rates, or the hospital's achievement against staff establishment. We felt, overall, the board was not provided with enough information on key performance indicators for supporting workers.

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

Our judgement

The provider was not meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained. However, records were not always kept securely to protect patient confidential information.

This is a breach of Regulation 20 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

During our visits we noticed there were a number of occasions on wards in the hospital where we found patient records left unattended by staff. This included full sets of patient notes unattended on nurses' stations, on patient tray tables (including beside unoccupied patient beds). We saw them left outside patient bays, for example on trolleys where they were not supervised by either the patients' themselves, or the hospital staff. We also saw patient drug charts left without supervision on nurses' stations.

We found patient confidential information openly on view on a number of wards where, generally, the side room or bay was closed to visitors. This predominantly involved 'skin bundles' where people's weight, continence, and mobility needs were recorded. These charts were hung outside a patient room or bay and information was clearly visible to anyone wishing to read it.

We brought this to the attention of staff. We were concerned some staff on wards did not have alternative arrangements in place as a rule to protect patient information. We found some staff saw this as acceptable practice and did not consider how the lack of guardianship of private and personal information may impact upon a patient.

This section is primarily information for the provider

✘ Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</p> <p>Staffing</p>
	<p>How the regulation was not being met:</p> <p>At the time of our visit we found the trust had relatively high levels of vacancies for nursing staff filled by the use of agency and bank staff. Evidence we gathered told us staff were under pressure to provide prompt quality and safe care to patients at all times. On some wards this was because there were not always enough staff to meet the needs of patients with high needs.</p>
Regulated activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010</p> <p>Records</p>
	<p>How the regulation was not being met:</p> <p>On a number of occasions we found confidential patient information not supervised or protected. Private information was visible to visitors. Some drug charts were unattended where they were accessible to members of the public visiting unlocked wards. Staff told us this was common practice in the hospital and there were not always suitable arrangements for notes to be kept safely and securely.</p>

This section is primarily information for the provider

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

The provider's report should be sent to us by 05 April 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

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

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

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

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

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

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

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

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

You can tell us about your experience of this provider on our website.

How we define our judgements

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

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

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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