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

Hinchingbrooke Hospital

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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
- Cleanliness and infection control: Met this standard
- Staffing: Met this standard
- Supporting workers: Met this standard
- Assessing and monitoring the quality of service provision: Met this standard
- Complaints: Met this standard
### Overview of the service

Hinchingbrooke Health Care NHS Trust is a district general hospital, providing health care for the people of Huntingdonshire and surrounding areas.

The trust has two registered locations; these are Hinchingbrooke Hospital and the Yaxley Group Practice. The trust is registered to provide the following regulated activities; Assessment or medical treatment for persons detained under the Mental Health Act 1983, Diagnostic and screening procedures, Family planning, Maternity and midwifery services, Surgical procedures, Termination of Pregnancies and Treatment of disease, disorder or injury.

### Type of services

- Acute services with overnight beds
- Diagnostic and/or screening service
- Hospital services for people with mental health needs, learning disabilities and problems with substance misuse

### Regulated activities

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- 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 2 November 2013 and 4 November 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and were accompanied by a specialist advisor.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

On 02 and 04 November 2013 we carried out an inspection of two wards at Hinchingbrooke Hospital. This included the dedicated stroke ward and a medical ward which also cared for patients who had undergone orthopaedic surgery.

During the inspection we spoke with 23 patients, 11 visitors and 37 members of staff. Staff we spoke with included registered and un-registered nurses, ward matrons, members of the risk management and human resources team, infection control nurses, specialist nurses and a consultant, managers who supported patients and staff and senior members of the trust's management team.

We found that patients had been given good information about their care and treatment and that, on the whole, there was good interaction between staff and patients on the two wards. We found that patients were fully involved in their rehabilitation which was carried out by members of the therapy team on the stroke ward. Patients told us: "I have been here two weeks now, it's busy but the staff are great and have looked after me well". Another told us: “Everything is ok. The physio tells me everything I need to know. They are great”.

We saw that patients were cared for in a safe and caring environment. Staff were aware of patient's care needs and this ensured continuity of care. We saw that patients had care plans and risk assessments in place and that these had been updated regularly to ensure that patients' current needs were recorded correctly. We were told by patients, relatives and staff that patients received a "...five day rehabilitation service" as there were no therapists available at the weekends. We were told that this issue was being addressed by the trust and that further communication would happen with key stakeholders who worked
in this area.

We spoke with patients and visitors during our inspection and they told us that they were satisfied with the level of cleanliness on their ward. We saw that staff followed infection prevention control procedures and wore personal protective equipment when required. We found that the trust had policies and procedures in place which protected patients and staff from the risk of infection. Regular reviews of practice had taken place and outcomes were monitored. We identified some shortfalls during our inspection concerning the care of patients' cannulas and noted that documentation had not been completed. The trust told us that they were addressing this by carrying out staff training and auditing the practice to identify any themes or trends.

During our inspection we observed staffing levels on the two wards. We found that the wards were adequately staffed and were supported by the use of bank and agency nurses. We saw that recent recruitment days had been successful and that new staff had been secured for these wards. We also found that the trust had contingency plans in place to address any staff shortages.

Staff told us that they were supported in their work. They attended mandatory training which ensured that they had the skills to carry out their job. Staff told us that appraisals of their performance took place, however, some told us that these were overdue. Staff told us that they felt supported by their team members and we saw that the trust had introduced new channels of communication which they hoped would improve staff engagement. We also noted that a new shift pattern had been introduced and we were told that a review would be taking place to evaluate the effect on staff and patient care.

The trust had appropriate quality assurance processes in place to monitor and improve the services that they provided. Patients, relatives and staff were asked for their opinion on how services were delivered and appropriate action was taken to address any concerns raised. Staff told us, and we saw evidence, that patient safety was a priority. We found that there was a culture of learning from unsafe events in the trust and saw that clinical care was assessed and monitored via a robust audit system.

We found that there were systems in place should a patient or their representative wish to raise a concern or make a complaint. The majority of patients we spoke with were aware of how to raise a complaint and we found that staff were able to tell us how they would escalate concerns or complaints. We found that there was a culture of learning from complaints and reviewing practice following any investigations that had taken place.

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

More information about the provider

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

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

During our inspection we spoke with 23 patients and 11 relatives on two wards in the hospital. One ward we visited (Apple Tree) cared for patients who had suffered a stroke and were undergoing rehabilitation to prepare them for discharge. The other (Spruce) was a mixed speciality ward which cared for patients with medical conditions and for patients who had undergone orthopaedic surgery.

We spoke with two patients on Apple Tree ward who told us that they felt that therapy staff took their time to discuss and explain their diagnosis and treatment but they felt that nursing staff and, in particular, the medical staff were less informative.

Both patients we spoke with told us told us that they were given clear updates about their medical condition by the stroke specialist nurse so that they understood what doctors and nurses would be doing and then they could make choices about the treatment they received.

Patients on both wards we visited told us, so far as was possible, that they were aware of when and why they had been admitted. They also confirmed that they had felt involved in, or at least aware of, decisions made about their treatment.

We looked at five patients’ care records on Apple Tree ward and found that their active consent to their treatment had been documented throughout their care plan. We noted on Spruce that it was documented when patients had been informed that they had to move wards. We also saw that documents were available for staff when a patient had been admitted from a care home which informed staff of their likes and dislikes. Patient notes we saw on Apple Tree ward were person centred and included records of discussions held with patient and relatives throughout.

Patients and visitors that we spoke with on Apple Tree ward told us that they felt they had been involved with their care plan, however, some patients and families told us that they
required more information about dates for expected discharge and access to after-care.

We spoke with members of staff who described their responsibility to provide information to patients so that they could make informed decisions about their treatment. One member of staff told us: "If a patient does not wish to do something, I would try and encourage them as it would be in their best interest. If they refused, I would respect their decision as long as they were safe".

Staff we spoke with told us that patients' privacy and dignity was an important issue on the wards. They gave us examples of how they respected patients' privacy and promoted their dignity which included dressing people in their own clothes, using the curtains for privacy, and asking/knocking before they entered a room or went behind curtains in a bay. We observed that patients on Apple Tree were dressed appropriately and that they were encouraged to dress in their day clothes by staff if able to do so.

We saw that people's privacy and dignity were respected. We saw that curtains were drawn around bed spaces when care and treatment was being provided to people to ensure their privacy. People were attended to promptly by staff when they required assistance and call bells were answered promptly on both wards.

We noted during our inspection that patient notes were held outside each bay. The provider may wish to note that this highlighted concerns in regards to the security and confidentiality of patients' personal information. Detailed multi-disciplinary team notes which included diagnosis, care plans and current patient notes were all held in one file. This was easily accessible to the public and could breach patient confidentiality. These notes were not secured in a safe place. However, patients’ medical notes were in a room with a closed door which prevented any risk to breaches in information governance and therefore demonstrated good practice.

We spoke with patients on both wards about the food and what choices were available to them. Patients told us: "The food is usually really good and I have been here three weeks, today is the first day I thought it's not as good today", another told us: "The food is not bad. I moved from another ward where it was cold most days, but it's better here, perhaps we are closer to the kitchen" and another said: "One does not expect 5-star service in a hospital. It's good food and I like it".

We observed meal times on both wards that we visited. We found that on one ward, staff were well prepared prior to the lunch trolley arriving and that the process was very smooth. Patients were given the opportunity to clean their hands with a hand wipe prior to eating their lunch. We also observed that patients were given assistance where required to eat their food and staff were deployed appropriately to assist them.

The provider may wish to note that the meal time delivery on Apple Tree ward was less structured. There was a lack of staff organisation to ensure that appropriate support was offered to patients especially if they had been highlighted as requiring some level of support to eat their meal.
Care and welfare of people who use services  Met this standard

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

Our judgement

The provider was meeting this standard. Care and treatment was planned and delivered in a way that was intended to ensure people’s safety and welfare.

Reasons for our judgement

We spoke with patients and relatives during our inspection and they told us that overall they were happy with the care and treatment they had received during their admission. Comments included; "Staff treat people kindly and have cared for me well", "I have no complaints, they have looked after me well", "(Relative) has been ok here, staff seem switched on".

We looked at five patients’ care plans on Apple Tree ward and four on Spruce ward. The provider may wish to note that we found the folders where patient information was kept disorganised and it was difficult at times to find the information we required.

We found that overall patients’ needs were assessed and care and treatment was planned and delivered in line with their care plan. We saw that care plans and risk assessments were up to date and had been regularly updated. Assessments included falls, nutritional needs, moving and handling, risk assessment of pressure sores and catheter care. This showed that patients’ care and treatment was planned and monitored.

We spoke with two members of staff who told us that any ‘Do Not Attempt to Resuscitate’ (DNAR) decisions had been discussed with the patient, their relatives and the doctors, and passed on to nursing staff during handover. The DNAR was written on the nursing handover sheet but the care notes were very muddled and the DNAR form was not placed in the same place in each file. The provider may wish to note that only three of five sets of people’s care notes had a clear DNAR in place.

There was good access to pressure relieving equipment which prevented the development of pressure ulcers for patients identified as at risk. Staff told us that this was readily available and no delays had occurred. Three members of staff who we spoke with demonstrated a good knowledge on the process of obtaining equipment and when they would use it.

We saw that patients had been referred to and assessed by other professional staff which included physiotherapists, occupational therapists and dieticians which would support the patients’ recovery and ensure that patients were safe when they returned home. We also
saw from records we looked at that appropriate and timely referrals had been made to the speech and language (SALT) team and the tissue viability nurse.

We looked at records on Apple Tree ward and found comprehensive documentation from these therapists and the stroke nurse specialist. There were clear goals set by the therapists from the daily multi-disciplinary meetings and their notes were very detailed and gave clear plans for patient care. We saw that during Monday to Friday patients received an appropriate level of rehabilitation.

The provider may wish to note that when we spoke with patients, relatives and staff we were told that the rehabilitation service on Apple Tree ward was: "…….a five day service, nothing happens at the weekend". Patients told us: "… the nurses don’t carry out any therapy based tasks, I can stay in bed all day if I like!" Three relatives we spoke with told us:" ……there is nothing at the weekends other than sitting in the chair or walking to the toilet" and raised concerns about the lack of service provision at the weekend. We raised these concerns with the stroke specialist nurse and the consultant physician who agreed that there was a lack of provision of rehabilitation services over the weekend period.

We spoke with the divisional lead nurse and the matron for Apple Tree ward. They told us that there were plans to address the current provision of rehabilitation services out of hours and that the service level agreement was under review to see if seven day working could be incorporated into the current rehabilitation service.

We saw that there were arrangements in place to deal with foreseeable medical emergencies. We saw that the resuscitation equipment had been maintained and was ready for use by the ward teams. We looked at records and saw that routine checks had been completed on this equipment. Staff we spoke with told us they were in no doubt that safety was the 'number one priority 'at the hospital. This meant that people who required urgent medical intervention would receive care safely.
Cleanliness and infection control

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

Our judgement

The provider was meeting this standard.
People were cared for in a clean, hygienic environment.

Reasons for our judgement

We spoke with patients and visitors during our inspection and asked them if they had any concerns about the cleanliness on the wards. They told us that they had no concerns and had seen a cleaner on a daily basis.
General comments included: "I watch the cleaner every day, she cleans everywhere- even the top of curtain rail", "The toilets are clean, much better than Sainsbury's, and we like Sainsbury's!", and "The cleaners come every day, they're excellent".

The trust had robust systems in place to monitor cleanliness and infection control. Staff confirmed and we saw that each month an audit had been undertaken by the matrons in relation to infection prevention and control procedures and the general levels of cleanliness in the ward. We spoke with the infection control specialist nurse who told us how the matrons had been trained to use this audit tool by their team. This meant that all audits were conducted in a similar way. Additional audits had been undertaken to check staff's compliance with the trust's hand hygiene protocols and staff we spoke with confirmed this and told us how they were involved in the monitoring.

Staff told us that they had received training in infection prevention and control procedures and training records we saw confirmed this. Staff told us when they would use personal, protective equipment (PPE) which included gloves and aprons and when they would use alcohol gel and wash their hands. They were also able to tell us about the trust policy for isolating patients if they were thought to have an infection. They told us that the infection control team were easily accessible and always responded to their calls.

We noted that staff on duty had adhered to the 'bare below the elbow' policy (this meant people had bare arms below the elbow) and were wearing clean uniforms and no inappropriate jewellery.

We observed staff during our visit to the two wards and saw that they washed their hands and removed their PPE when they had taken a commode to the sluice room. We also observed that they had cleaned the commode following its use and attached a tag which stated the date and time it had been cleaned. This meant that other staff knew that this piece of equipment was clean and ready to use. We also observed other members of the trust team (a porter) enter the ward and use the alcohol gel on entering and leaving the
Overall, patients were cared for in a clean and hygienic environment. The two wards were tidy and did not have any clutter in the main corridor. The bays on the wards were busy as patients were being assisted with personal care and curtains were round the beds. However, we noted that staff had linen trollies outside each bay and therefore did not need to carry dirty linen around the ward.

The provider may wish to note that one cleaner on a ward was still cleaning a bay when the protected mealtime period had started and had to be asked to leave by staff.

The sluice rooms were well organised, with posters reminding staff of good practice and policies and procedures. All the commodes were stored in this area and we saw that they were visibly clean and had an update to date cleaning tag in place. We checked toilets and en-suite facilities on the wards and found that there were visibly clean and observed a cleaner in an en-suite cleaning the toilet, the floor and emptying clinical waste bins.

Each ward contained a good range of PPE for staff to use and dispensers which contained antibacterial hand gel were available for staff and also for people entering and leaving the ward. There were posters by the main entrance to the wards reminding people to use the gel before they left.

We checked the equipment in the clinical room on one ward and found that sterile single use items such as sterile dressings and syringes were within the date for use and that their packaging was intact. This area was visibly clean, well-organised and sharps bins were correctly assembled and labelled.

The provider may wish to note that we checked three care records for patients who had a cannula in place. The records had not been completed and did not tell us why the cannula had been inserted and there were no checks undertaken by staff to check for any signs of infection. We spoke with the infection control team who told us that work was in progress to address this. Regular spot checks and staff training had been undertaken and an audit was being undertaken of the cannula care records to identify any themes or trends.

We noted good practice on Apple Tree ward where the Visual Intravenous Peripheral (VIP) chart had been attached to the medication chart. This meant that each time a registered nurse gave a medicine via a cannula they would check the VIP score and document it. This meant that staff were checking to see if any infection was present prior to using the cannula and preventing harm to the patient. We fed this back to the infection control team.

We were aware that the trust had exceeded its permitted level of Clostridium Difficile (Cdif) (an infectious bacterium) cases in 2012/2013. The trust had requested an independent review of the 13 cases and had introduced changes to clinical practices following the results of the review. A new ‘tool kit’ was now available for staff on each computer on the wards which assisted them when assessing and caring for patients with diarrhoea. At the time of the inspection the trust were below their permitted level of cases for Cdif and had not had a case for the two previous months.
Staffing

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

Met this standard

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We spoke with patients about staffing levels on the wards we visited and we received mixed reviews. One patient told us: "They're very good, there are just not enough of them." Another told us: "They're all brilliant, but there's no slack in the organisation."

Relatives we spoke with told us: "I have always found the staff really friendly and they always smile but they are so busy and they need more to do the work". Another told us: "The staff are always very busy because there are too few on duty during the day".

During our inspection of the two wards we observed that there were sufficient numbers of staff to meet the needs of the patients.

However, the provider may wish to note that when we spoke with the stroke specialist nurse and the consultant physician for the ward they told us that at times they felt the numbers of staff were not adequate to deliver the care that patients who had suffered a stroke required. They both felt that the opening of an additional five beds on the ward had added to the staffing pressure on the ward.

Staff we spoke with told us that when they required extra staff, bank and agency staff were requested to supplement the number on a shift. We noted on the day that we inspected that an agency nurse had not arrived and therefore the ward was one nurse short. This had been escalated to the site manager but the shift was not filled.

We spoke with the divisional lead nurse and matron for the ward who told us that they had staff who were on long term sick leave and that this had added to staffing pressures. They did 'back fill' these posts with bank and agency nurses and had just undertaken a successful recruitment drive which had secured additional registered and un-registered staff which would greatly improve the current staffing levels on the ward.

They also told us that they had concerns about the number of senior registered staff on the wards. Currently, the two wards were visited only had one band 6 nurse (deputy sister/charge nurse) employed. This then meant that if the matron and band 6 staff were not available to work that a band 5 staff nurse would be left in charge of the ward.
We addressed all of the concerns raised with the Director of Nursing, Midwifery and Quality who confirmed that they were aware of these issues and the trust was in the process of addressing them. Recent recruitment days had been very successful and the trust had taken the decision to over recruit un-registered and registered nurses and that they had a rolling advert on a national recruitment website. They also told us that a review of the skill mix of the registered nursing workforce would take place.

We were also told by the Director of Nursing that the trust had secured the services of an agency which created a "virtual ward with 20 WTE (Whole Time Equivalent) registered nurses". This would then assist the trust in ensuring that staff were available at short notice when escalation beds were opened. These staff were additional to the number which had recently been recruited.

We spoke with all staff about a new shift pattern which had been introduced. There was a mixed response from staff. Full time staff told us that they liked working the 'long days' as it meant that patients received continuity in care however, they told us that the shifts were tiring. Part time staff we spoke with told us that they had noticed on rotas that the majority of the hours they worked could sometimes be compressed into the first two weeks of the rota and that this they found tiring. They told us that they had raised this with their manager.

The Director of Nursing also told us that a review would be undertaken of the new shift pattern to evaluate how it was functioning and the impact this had on staff and patient care.
Supporting workers  
Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

We spoke with 10 members of staff who told us that they felt supported in their work. The staff we spoke were positive about the teams they worked in and the support they received from their colleagues. One member of staff told us: “It's all about the team and working together and supporting each other, we have a good team on here and we pull together”.

Most of the staff we spoke with told us that they were confident to raise any concerns with their manager and that their manager would take them seriously. The provider may wish to note that several staff on one ward told us that they felt that senior nurses on the ward were, “……always attending meetings and doing paperwork in the office ”, and that meant that they could not support them with clinical work on the ward when required.

We asked staff if they had received an annual appraisal of their performance. The provider may wish to note that we received a mixed response from staff. Some staff told us that they could not remember when their last appraisal had been and could not tell us if one was planned. One member of staff told us that their planned appraisal had been cancelled due to clinical pressures.

We spoke with the divisional lead nurse and matrons for the wards we visited, who told us that all staff appraisals were booked and would be completed by the end of November 2013. We fed back that some staff were not aware that appraisals were booked and they told us that they would ensure that all staff were made aware of the date of their appraisal.

We saw that mandatory training was completed and that adequate time was allotted for staff to complete this. Following a review of how mandatory training was delivered, a new process had been introduced. Staff now attended a one day multi professional mandatory update which included areas such as risk management, safeguarding training, fire safety awareness, infection control, basic life support training and moving and handling. A second day was also available which was practical and included areas such as moving and handling, basic life support training and a blood transfusion assessment.

Staff we spoke with told us that they preferred this method of training and most of them confirmed that they had attended training or had it booked and this was confirmed by the
training records we saw. Staff we spoke with told us that they could request extra training and two members of staff told us how they had expressed their interest in taking part in the trust’s Leadership Academy.

We spoke with the learning manager who showed us up to date records about the trust’s performance. We noted from the records we looked at that more staff had now undertaken their mandatory training and that trust had improved on previous figures.

Staff told us that they received good training which equipped them for their role. Two members of staff told us how they had recently updated their stroke knowledge with the stroke specialist nurse. We spoke with the stroke specialist nurse who explained that there was a stroke awareness training programme in place which linked to competency packs which staff completed. These sessions were offered to un-registered and registered staff and they told us how 14 of the 25 staff on the ward had attended already. Other staff were booked in to attend.
**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

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**Our judgement**

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

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**Reasons for our judgement**

Patients who used the services and their representatives were asked for their views about their care and treatment as the trust used local and national quality questionnaires to collect feedback. This questionnaire was designed to gather the views of patients and their family about their experience in hospital.

We saw that there were designated post boxes on the wards where patients or relatives could put their questionnaires when completed. There were signs on the wards reminding patients to 'have their say' and signs reminding staff to give patients a questionnaire on discharge. We saw that both wards had 'Performance Boards' which had information which included the most recent friends and family score for the ward. This meant that patients, relatives and staff were made aware of how a ward was performing.

We reviewed the minutes of the trust's quality and governance meetings which demonstrated that information received from patients and their families was regularly reviewed and that there were clear, identified responsibilities for the local clinical units. It was their responsibility to review the information and identify actions and improvements for their areas and then feedback to these meetings and we saw that this had taken place. This demonstrated that the hospital was listening to what patients told them and taking action to address concerns raised.

We were told by staff and records confirmed that the patient experience was used to help inform the trust board of what patients thought of their care and treatment. We heard from board members that the patient stories had helped to demonstrate clearly areas that worked well and areas that needed improvement.

We met with the head of staff engagement who told us that the trust were working to improve staff engagement. Results from the 2012 NHS Staff Survey had noted a lower score in relation to staff engagement in comparison to other district general hospitals of the same size.

The trust had recognised that staff needed to be involved in the development of the trust
and to feel listened to at all levels. As a result they had appointed a head of staff engagement who had overall responsibility to ensure that staff engagement levels improved. Initiatives included a new staff newsletter, information events for staff where they were informed of the trusts plans for the future and it's five year strategy and new social campaigns which encouraged staff to join in and give their views. There had also been more executive and senior staff presence on wards and members of the executive team walking around the trust and meeting staff and patients.

Most staff we spoke with told us that more information had been made available to them either by the form of newsletters, face to face events or via the trusts intranet system. They were all aware of a new social campaign that the trust had launched recently and we saw that screen savers were used on computers on the wards to promote these.

Staff we spoke with confirmed that members of the executive team were more visible and that there were now more ways for them to communicate back to management. This showed that the trust were working on ways to engage with staff and include their views in any improvement of the service.

We spoke with members of the risk management team and reviewed evidence about incidents and serious incidents that had been reported to and by the trust. We found that there were systems in place to ensure that learning from incidents took place in the interest of patient safety. We found that there was an effective system in place to monitor the higher impact incidents.

All staff we spoke with were aware of the 'Stop the Line' initiative which had been introduced to improve patient safety and two of them had used it. This initiative was introduced to the trust in June 2012 and the system had improved how the trust managed patient safety incidents. It assisted staff by helping them to focus on a rapid response to an incident and had improved the learning and culture safety of the trust. We spoke with the head of risk management who told us of incidents where 'Stop the Line' calls had been made and the positive effect this had on patient care.

We saw evidence that clinical audits had been carried out in different clinical areas to improve service provision and protect people. The records we looked at demonstrated how the trust collected reviewed and shared data on these areas which included the number of pressure ulcers, the number of falls, the number of patients who developed an infection whilst they had a catheter in place.

This demonstrated that the trust had taken appropriate action to use the complied data to assist them in reducing harm to patients. We were told by members of the infection control team and matrons how monthly audits took place in relation to infection prevention and control. We saw evidence from these audits and where areas had been identified for improvement, that action had been taken.
Complaints

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available and comments and complaints people made were responded to appropriately.

Reasons for our judgement

We spoke with patients and relatives on the wards and asked them if they knew how to raise a concern or make a complaint, and if they had seen any literature on the wards which informed them how they could do this. The majority of patients and relatives we spoke with were aware of how to raise a concern or complaint however, there were some who told us that they were not.

Comments we received from patients included: "I would speak to the sister if I had a problem", "Yes I know what to do but I have no complaints", "No, I wouldn't really know how to go about it other than speak with the ward sister". One patient we spoke with told us that they had raised concerns with the nurse in charge of the ward and it had been dealt with. Another patient and relative told us that should there be any concerns, they would raise them at ward level and they had confidence that they would be looked into.

During our inspection we spoke with staff on the two wards we visited and they told us how they would make every effort to try and address any concerns or complaints raised by patients or their relatives straight away. Staff told us that if they were unable to resolve the situation themselves that they would inform the nurse in charge of the shift or the matron for the ward. They told us that outside of normal working hours they would contact the site manager for advice. Staff told us about the role of PALS (Patient Advice and Liaison Service) and how they would sign post patients or relatives to that team if they thought it appropriate. One member of staff told us: "I would always try and listen and see if I could help with the problem, but if I couldn't then I would speak with the ward matron or tell them to use the PALS team". Another member of staff told us: "I will always try and sit down and chat about the problem, mostly it's about communication so sitting and talking can sometimes sort it out".

We spoke with the complaints and PALS manager who told us how they carried out informal meetings with teams across the trust where they explained their roles. They used these meetings to talk with staff about how to deal with concerns and complaints when they were raised. They also told us how they gave feedback to staff if they had been involved in the concern or complaint. This then ensured that staff were aware of how it had been dealt with, the outcome of any investigation and how practice had been reviewed following the investigation. Any further feedback was then the responsibility of the ward
matron and they would disseminate the information to the team via the ward meeting.

Two members of staff we spoke with told us how they had been informed of the outcome of the complaints that they had been involved in and how they had seen action plans which had been used as learning events. It was evident that staff we spoke with had an understanding of the complaints procedure, PALS and the complaints department.

We noted that one of the wards we visited had an information booklet available for patients and relatives which told them how to raise a concern or complaint. Contact details for the PALS and complaints manager were detailed in the booklet. Patients who we spoke with on that ward were able to confirm that they were aware of these and had been given information when they were admitted to the ward.

We saw evidence in the documentation we received prior to the inspection that supported what the complaints manager had told us. The hospital management had started discussions at the trust board meeting about how they learnt lessons from individual complaints and how this would be implemented at clinical unit level. The executive team had recognised that they needed to monitor these complaints more closely.

We also noted that patient stories were now embedded in trust board meetings. Patients who had raised concerns or complaints were now given the opportunity to come and talk with the trust board about their experience and discuss what the trust had learnt from recommendations following internal investigations.

We looked at the trust's Quality and Governance reports which demonstrated how they reviewed all formal complaints and noted the top ten categories of complaints. These figures were compared quarter on quarter and the same method had been adopted for PALS concerns. We looked at evidence that the trust had collated via the patient satisfaction 'Friends and Family' test. Trend comments had been noted and included concerns about the discharge process taking too long and a delay in staff answering patients' call bells. These had been addressed by the trust. For example, work had been carried out around the discharge process and the speed at which doctors completed the discharge letters. A project had been implemented and had seen a drop of 4% in the negative responses about discharge. Also, an audit had been completed which showed no significant delay in answering people's bells.

We looked at the last six complaints for the wards we visited. We saw evidence that the trust's policy for managing and handling complaints had been followed. Patients and their representatives had received a response to the concerns that they had raised from the trust within the recommended timescale as stated in their complaints policy. We saw that patients and their representatives had been given the opportunity to attend meetings and that following these they felt that the trust had initiated some positive changes.

There was also information available on the trust's web site about its PALS and complaints services. We also noted that patients and relatives had used the hospital's website to register their complaints. A service called 'Tell Mike' was available where people could leave information for the trust chairperson.
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 other services less often. 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.

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.

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Judgement</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>✅</td>
<td>Met this standard</td>
<td>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.</td>
</tr>
<tr>
<td>❌</td>
<td>Action needed</td>
<td>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.</td>
</tr>
<tr>
<td>❌</td>
<td>Enforcement action taken</td>
<td>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.</td>
</tr>
</tbody>
</table>
Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Regulation</th>
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<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>Regulation 17</td>
</tr>
<tr>
<td>Consent to care and treatment</td>
<td>Regulation 18</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>Regulation 9</td>
</tr>
<tr>
<td>Meeting Nutritional Needs</td>
<td>Regulation 14</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>Regulation 24</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>Regulation 11</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>Regulation 12</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>Regulation 13</td>
</tr>
<tr>
<td>Safety and suitability of premises</td>
<td>Regulation 15</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment</td>
<td>Regulation 16</td>
</tr>
<tr>
<td>Requirements relating to workers</td>
<td>Regulation 21</td>
</tr>
<tr>
<td>Staffing</td>
<td>Regulation 22</td>
</tr>
<tr>
<td>Supporting Staff</td>
<td>Regulation 23</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>Regulation 10</td>
</tr>
<tr>
<td>Complaints</td>
<td>Regulation 19</td>
</tr>
<tr>
<td>Records</td>
<td>Regulation 20</td>
</tr>
</tbody>
</table>

**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.
Contact us

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