Review of compliance

East Kent Hospitals University NHS Foundation Trust William Harvey Hospital	
Region:	South East
Location address:	Kennington Road Willesborough Ashford Kent TN24 0LZ
Type of service:	Acute services with overnight beds Blood and Transplant service Community healthcare service
Date of Publication:	August 2012
Overview of the service:	William Harvey hospital is one of five hospital sites managed by East Kent Hospitals University NHS Foundation Trust. This is an acute hospital providing services to the general population of around 720,500 people in the South

	East Kent area. This inspection included visits to the following wards: Cambridge J, K and M1, Kings A2, C1 and D1.

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

Our current overall judgement

William Harvey Hospital was not meeting one or more essential standards. Action is needed.

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

Why we carried out this review

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

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 31 May 2012, checked the provider's records, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

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

What people told us

We spoke with eight patients on Cambridge J, five patients on Cambridge K, three patients and two visitors on Cambridge M1. On Kings A2 we talked with nine patients, on Kings C1 we talked with four patients and two relatives, and on Kings D1 we talked with four patients.

Everyone said that their privacy and dignity was protected and promoted. People said staff always pulled the curtain around their bed before any treatment. On Cambridge J a person said. 'They treat me with respect here'. On Cambridge K a person said, "They always pull the curtain around and knock on the toilet and shower doors". On Cambridge M1 a person commented, "Staff speak loudly and clearly enough. Always draw the curtains. They come quickly and they don't rush me if I need to use the commode". On Kings C1 a person said "Yes, staff always speak with kindness and care. Always pull curtains etc". On Kings A2 a person said, "Yes, curtains always drawn and they help with the toilet." On Kings D1 a person commented, "Yes staff are always respectful. They always pull curtains but often forget to pull them back again!"

People said they had been given sufficient information to make a decision and consent to their care and treatment.

Relatives of people who had dementia or confusion commented, "there is a lack of awareness of advanced dementia." They were referring to staff asking the person

questions and not being aware of when the person had capacity or not.

People spoke very positively about the care and treatment they had received. On Cambridge J a person said, 'This ward is top dog, I have no complaints at all. They don't rush me and they keep me informed, they show me my records and results'. On Cambridge K people said, 'They have been brilliant, nothing has been too much trouble'. On Kings A2 people said they were given the information they needed about their care and treatment. On Kings C1 one of the relatives said that the staff communicated with them because they were the next of kin and they had been given good information, "The risks and benefits were explained before surgery."

Some people on Cambridge M1 said that they were not given enough information about their care and treatment because staff did not have the time to speak to them. However, despite saying that the staff were busy, one person said, "The care I have always received at William Harvey Hospital is world class and I've never felt unsafe here. There have been hospitals in the UK where I have felt unsafe but not here."

On all the wards people said they were satisfied with the food provided. One person said, "The food is brilliant and I am looked after well... you can have extra if you want it." Another person said, "The food is served hot, I have no complaints about the food. There is a choice and I am given time, I am never rushed." People said that there was a good range of choices of food. One person commented, "The food is pretty good. There are three choices. The last two mornings I have had a cooked breakfast."

People said the food was good but it was not always hot. People also commented that by the time they got "…the ice-cream it had turned to liquid."

People said they were impressed with the standard of hygiene and cleanliness in the wards. They said that the wards were clean and that they saw cleaners come everyday and the care staff cleaned too. They commented "…cleaning staff come round two or three times a day cleaning." "The sheets are changed every day, the ward is very clean." There was only one negative comment and that was on Cambridge M1 and again related to there not being enough staff to carry out tasks in a timely way.

A person on Kings A2 said, "Staff are straightaway your friend when you come in. There are plenty of them too." They said staff were available to help when they needed assistance. One comment was "…yes they are, sometimes have to wait a little, they are run off their feet." One person on Cambridge J commented, "The staff are pretty good." "Sometimes they rush, but usually they are good."

People we spoke to said that their call bells were answered quickly apart from people on Cambridge M1.

On Cambridge M1 people were concerned about the lack of staff. They said this had meant that some people had to wait for assistance.

People said, "The staff are very nice, very pleasant". "The nurses are happy, I do not know how they manage it and stay happy as they are very busy".

People said they felt confident in the staff who were supporting them.

What we found about the standards we reviewed and how well William Harvey Hospital was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People's privacy, dignity and independence were respected.

The provider was meeting this standard.

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

The procedure for obtaining consent from people who lacked capacity was unclear. This meant that people were not always given the support they needed to make decisions about their care and treatment.

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

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

The provider was meeting this standard.

Outcome 05: Food and drink should meet people's individual dietary needs

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

The provider was meeting this standard.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

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

The provider was meeting this standard.

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

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

The provider was meeting this standard.

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

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

The provider was meeting this standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

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

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

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

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

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that 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.

A moderate impact means that 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.

A major impact means that 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.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
All the people we spoke to told us they were treated with dignity and respect. People said staff always pulled the curtain around their bed before any treatment. One person said "staff talk to you and treat you with respect here". "They always pull the curtain around and knock on the toilet and shower doors". Another person said, "Staff help me wash and respect that I don't want a wash every day as it is too much. When I want one they help me."

People expressed their views and said that they were involved in making decisions about their care and treatment. Most people told us they were happy with the way staff shared information with their relatives and kept them informed.

People said, "Yes everything was fully explained and leaflets were given to me regarding my future care and prognosis", "I received plenty of information by the sister, anaesthetist and surgeon." One person said "I ask questions and they get answered."

People explained that when they had been admitted as an emergency they had subsequently been given all the information they needed. This meant that when the person was unable to understand the treatment and care at the time staff made sure that people were given the information as soon as possible afterwards.

The provider may find it useful to note that the patients and visitors on Cambridge M1 did not receive the same level of information that people on other wards did. One person said "I haven't been given any information and I keep asking but no one seems to know anything." She didn't feel involved in her care. Another person said she felt anxious and was not being given information to help her from the staff.

Another person explained that the staff helped her to maintain her independence. "They have helped me mobilise. I now can do it on my own using a frame."

Other evidence
People who used the service were given appropriate information and support regarding their care or treatment.

All the wards we visited had notice boards displaying information about the ward and trust. This included details about visiting times, phone numbers, transport, protected meal times and various leaflets on specific procedures offered on the wards. On Kings C1 there was also a Dementia awareness poster - "This Is Me". The notice board on Kings D1 also displayed photos of staff, which included everyone from consultants to house keeping staff.

People's dignity and privacy was respected. People were able to use single sex facilities on all the wards, there were locks on bathrooms and toilet doors and staff made sure that curtains were pulled round when they were attending to patients.

On Cambridge J, we saw staff talking discreetly and quietly to patients. Medical notes showed choices were respected, for example, when a patient declined physiotherapy that day, the plan said to go back and try later or the next day.

On Kings A2, we observed a physiotherapist helping a patient. She spoke politely and respected her dignity by ensuring that she had her dressing gown on as the walked. There were good processes in place to support people with communication difficulties. These included communication passports and additional notes in the written plans of care.

There were systems in place to make sure people were given the information they needed about their treatment both verbally by the staff and written, in leaflets and on notice boards. People were able to make choices about their care and treatment. Staff told us they would welcome new patients to the ward, orientate them and explain the call buzzer system. They said they explained the general running of the ward, when food was served and about the medicines rounds. Staff also explained that they gave people choices in the routine of the day, for example, asking them when they want to get out of bed as some people prefer to stay in bed. Staff said "On admission we talk to the patient. Ask what help they need. What they know about their illness. We discuss all elements of care and check if a specialist is needed, for example, a dietician." "The doctors talk to the patient but we tend to have a nurse in there as well to be able to explain things to the patient after the consultant has been." We saw staff talk politely to people explaining their care and treatment.

Our judgement
People's privacy, dignity and independence were respected.

The provider was meeting this standard.

Outcome 02:
Consent to care and treatment

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is non-compliant with Outcome 02: Consent to care and treatment. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
On Cambridge J and K and Kings A2 wards, everyone spoken to said they were always asked for their consent before staff carried out treatments.

On Cambridge M1 one person said they were waiting for a colonoscopy but had no idea what it entailed, had no idea of the risks and benefits of the procedure and had not signed a consent form.

One person thought it would be helpful to have some of the information written down for them to refer to after their treatment options had been explained to them.

People said they had been given sufficient information to make a decision and consent to their care and treatment.

Relatives of people who had dementia or confusion commented, "there is a lack of awareness of advanced dementia." They were referring to staff asking the person questions and not being aware of when the person had capacity or not.

Other evidence
Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. This worked well for people who were

able to understand the options presented to them. Where people lacked capacity the procedures were not so clear. Consultants completed forms saying that a person did not have capacity and completion of mental capacity assessments was variable. Senior staff explained that best interests meetings were held but there was little information available to indicate that these were available for all patients that needed them.

Some staff were aware of the need to assess people's mental capacity to make sure they were supported to make as many decisions about their care and treatment for themselves but not all staff were aware of this. This meant that not all patients, on the wards we visited, were able to make decisions on the aspects of treatment that they may be able to understand.

The provider may find it useful to note that staff on Cambridge J, K and M1 were not familiar with the Mental Capacity Act 2005 (MCA 2005) or Deprivation of Liberty Safeguards (DoLS) and that this may have left people without the support they needed to make a decision about their care and treatment.

On Kings A2 the staff were knowledgeable about the MCA 2005. They explained that usually the consultant made the decision for treatment and held a best interests meeting with the next of kin and this meant that treatment was carried out in a timely way. Staff explained how they supported people with learning disabilities, confusion and dementia. They said that the mental capacity assessments were carried out for different aspects of care and treatment and they changed from day to day. One of the staff also explained about a best interests meeting she had been involved with and how the treatment options had been explained in a specific way to suit the person's needs. A communication passport had been developed which was a booklet using words and pictures to assist the person to understand. The person had been able to make the decision about treatment and about the support they needed after discharge. Staff said they had also received advice and support from the Practice Development Nurse for patients with learning disabilities based at the hospital.

On Kings C1 staff explained that if people came in for elective surgery they had usually had a mental capacity assessment and best interests meeting before they came into hospital.

On the subject of resuscitation, Staff on Kings D1 said that they liked to talk to all patients about resuscitation and thought it was important. They said that although consultants were sometimes reluctant to agree not to resuscitate that patients needed to be given the choice.

Staff explained, "There is a mental capacity team number on the boards and there are Link nurses if we need them." They said training was available but not all staff have had the training yet. There was also a safeguarding vulnerable adults e-learning course available.

The trust were aware that improvements were needed in understanding and implementing the Mental Capacity Act 2005 in the hospital. They had an action plan for improvement with a timescale for achieving the targets set by November 2012.

Our judgement
Before people received any care or treatment they were asked for their consent and the

provider acted in accordance with their wishes.

The procedure for obtaining consent from people who lacked capacity was unclear. This meant that people were not always given the support they needed to make decisions about their care and treatment.

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
Peoples' needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

People spoken with said they had a care plan that they had been involved in. People said they had sometimes read their end of bed notes or asked to see their main set of notes. People said staff were always writing in their notes and updating them. One person said "They come round all the time and fill in my records. I have not looked at them but I could'

People spoke very positively about the care and treatment they had received, "I could not sleep last night so I sat in the chair. They kept coming over to check I was alright'. Another person said, 'This ward is top dog, I have no complaints at all. They don't rush me and they keep me informed, they show me my records and results'. People said, "They have been brilliant, nothing has been too much trouble." "Staff are around and they came quickly when I pushed the buzzer."

People said that the staff took their time when giving them care and treatment but two people commented, "sometimes they are a little rushed".

People said they felt safe and were given equipment and support from staff to make sure they did not fall. They said staff checked them regularly to make sure they were comfortable and their skin did not get sore. People said that staff washed them and applied cream and some people also had pressure mattresses or a waterbed.

On Cambridge M1, one person said she had been well looked after and that she had had no falls since she had been in hospital despite having a history of falls. Another person said, "the care I have always received at William Harvey Hospital is world class and I've never felt unsafe here. There have been hospitals in the UK where I have felt unsafe but not here."

People said they were happy with the care and commented that this was despite the staff being so busy. One person commented, "I can't fault the care." People also said that the staff were very particular about their skin care and cleanliness. Another person commented, "…they make sure I don't get sores by creaming my skin and providing other help."

People said they were supported well. Most people said they had not had any accidents since being in hospital. Three people had fallen in hospital but they said the staff had been supportive and they did not feel that it could have been prevented. They also said that staff made sure they had the equipment they needed and the support to make sure they were comfortable and did not get sore skin.

One person on Cambridge M1 said they did not feel they had the care and treatment they needed and did not feel they had received the support from staff. They said they had previously been in another ward and that this had been very good. "...they had kept a note of my inputs and outputs…since I have been in this ward they have done nothing." The provider might like to note that staff on this ward were finding it difficult to manage the work load.

People were supported to maintain their mobility and independence. People said staff took their time when giving them care and treatment. One person commented, "Yes, the staff always give me the time when treating me. They do not rush at all." People said they had been helped to regain their mobility. One person said "They have helped me mobilise. I now can do it on my own using a frame." They were given the equipment they needed to prevent their skin getting sore, including pressure mattresses and cushions. One of the relatives said, "[person] doesn't get out of bed to walk. They are hoisted into a chair for short periods." This meant that the person was able to move to different positions periodically. The person was not able to talk to us but they did say they were comfortable.

Other evidence
Peoples' needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

Assessments were carried out for each person on admission. All staff clearly described the admission and discharge process. Nurses said that they encouraged Doctors to plan the electronic discharge from the beginning of each person's admission. They said they checked to see if social care was needed. They said they aimed to have everything ready for the day before discharge and this included the pharmacy. Staff stated that the vulnerability of the patient was taken into account and whether they had anyone to go back home to. They said that late discharges were avoided especially if the person was vulnerable.

There were two discharge coordinators who could be called if further support was needed for people who needed to be discharged with a follow up care package or

placement. We found the discharge process to be effective on the wards we visited.

People were able to receive care and treatment from a variety of specialists. Care and treatment was provided by Nurses, Doctors and other health professionals. Physiotherapists, Dieticians, Occupational therapists and Speech and Language therapists were involved with people's care. We saw the Dietician talking to people and people being supported by the Physiotherapist and Occupational therapist. Kings C1 had two Occupational Therapists dedicated to that ward. People's care records showed daily checks, reviews by Doctors and meetings with the health professionals. The notes included assessments, plans and guidelines to follow. The Occupational therapy lead was carrying out an audit of the notes completed by them.

People admitted by ambulance had records from the ambulance crew and information from accident and emergency.

Teams of specialist nurses were available in the hospital and were contacted by bleep when needed. This included the pain nurse, tissue viability nurses (for prevention of bed sores and skin problems) and falls nurses. This meant that there was additional support for people who needed it.

All staff spoken with explained clearly what would happen if someone had a fall and the measures taken to prevent further falls. Moving and handling assessments had been completed and there was involvement with physiotherapist and occupational therapist when people needed assistance, equipment and exercises to help with their mobility. The hospital falls team were contacted if there were any accidents and if advice was needed. Equipment was used to assist in prevention of falls.

There was an intensive Care Outreach Team based in the hospital. On Kings A2 people who were more poorly or had recently moved from the Intensive Care Unit were receiving additional support from the Intensive Care Outreach team. This meant that people's health and treatment were being closely monitored, and being disturbed or moved to other wards were minimised.

Staff had a daily handover, where they would find out any changes to the care of their allocated patients. Staff carried out two hourly rounds to make sure that observations and checks had been carried out and to see if people needed things like pain relief, if the buzzer was within reach, if they were comfortable or needed food or drinks. Generally these were effective at making sure people had what they needed.

On Cambridge M1 of the three notes seen, there were only a few instances where comments were made by staff. One person had no checks completed for the daily assessments in two out of three days in her care pathway. Another person who was quite distressed. We noted that in her care notes, her food chart was undated and incomplete, even though she had abdominal symptoms. This person had not had other assessments completed for her condition, including weight, nutritional risk assessment or a formal referral to a dietician, even though she had been given supplementary drinks by staff. The provider may like to note that these rounds were necessary to check that people were being given the care they needed.

On Kings C1 care plans were used for people with dementia and delirium. In Kings A2 care plans were being introduced for people with dementia and delirium and were in

place for people with learning disabilities. These records connected all the different assessments, treatments and involvement with other specialists so that it was possible to see a clear care pathway from admission to discharge. The provider may like to note that no care plans were used on Cambridge J, K, M1 and Kings D1, just risk assessments and basic pathways for various areas, including nutrition, moving and handling, falls, pressure ulcer prevention. Staff explained that there should be a care pathway for all people but that it was a time problem. This meant that there was a risk that care was disjointed.

The trust had carried out an audit of care records in May 2012 and were aware of the shortfalls in some of the record keeping. The audit showed that there had been some improvements since they had first identified the shortfalls. The trust had an action plan for what still needed to improve. Another audit was planned to be carried out in October 2012.

There was an overall risk strategy for dealing with emergencies so that if anything arose that might affect the hospital provision there were plans in place to minimise the impact on patients.

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

The provider was meeting this standard.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
People were provided with a choice of suitable and nutritious food and drink. People told us that generally they thought the food was good.

On all the wards people said they were satisfied with the food provided. One person said, "The food is brilliant and I am looked after well... you can have extra if you want it." Another person said, "The food is served hot, I have no complaints about the food. There is a choice and I am given time, I am never rushed." People said that there was a good range of choices of food. One person commented, "The food is pretty good. There are three choices. The last two mornings I have had a cooked breakfast."

The provider may like to note the only complaint was the temperature as the main meal was not always hot enough and the ice cream was melted by the time they were given it.

People told us that specialist diets were catered for along with those relating to cultural and religious needs.

People said they were given enough to drink.

People said snacks were not routinely available. They said their relatives brought additional snacks in for them. However, one person on Kings A2 said he couldn't eat that morning due to an appointment. When he came back to the ward after the test, the staff sorted him out some cheese on toast as he had missed previous meals.

There was a policy for providing people with an undisturbed lunch time as far as possible which was called 'protected mealtime'. No appointments and assessments were to be scheduled at this time. People said that generally this worked well and they were able to eat their meal in peace.

Other evidence
All the people on the wards were provided with a jug of water and this was refreshed three times a day. Staff made sure the jugs and cups were within reach. This meant that all the people on the wards had fresh drinks accessible to them.

All the meals were prepared in the main kitchen at the hospital. Meals were taken to each ward in a heated trolley. Nurses ordered the food from what people chose on the menus. Meals were served from the trolley onto the plates at the meal time. This meant that there was some flexibility for people to change their minds from what they had ordered. Meal portions were small, medium or large. Hot meals were provided at lunch time and soup and sandwiches at tea time. Tea and coffee were offered following each meal.

Staff said that they could order additional food for people who had just been admitted onto the wards or who had been fasting before surgery and had returned to the ward. They could order breakfast, dinner or if the main meal time had passed, in the evening or night they could order snack boxes which included sandwiches.

People were provided with a choice of suitable and nutritious food and drink. There were several different menus that were provided for people who had special requirements. There was a special bespoke pureed menu, soft menu and gluten free menu and a bespoke ethnic menu. All the menus were colour coded for less confusion. This meant that people's food and drink met their religious or cultural needs

Staff told us that they knew which patients had special dietary or nutritional needs as the information would be displayed on the board at the head of their bed and also on the main patient board opposite the nurse station. This included those people who were fasting before surgery.

People were supported to be able to eat and drink sufficient amounts to meet their needs. People were assessed when they were admitted to hospital. If there was a risk that they may not be able to eat or drink enough, a malnutrition universal screening tool (MUST) assessment was completed. We saw that staff were polite and patient whilst having conversations with patients over the menu choices.

There was a good system of making sure that people had enough support to eat and drink. People who needed support to eat and needed to have this monitored were given their food on a red tray. This meant that staff would know that they needed to be checked and assisted. We saw staff checking people with red trays. Relatives were encouraged to come in at meal times to help if a person had dementia because there were not always enough staff to take the time needed to assist. Charts were completed to state how much a person had eaten and drank. People were weighed weekly routinely or more frequently if needed.

People who had difficulty eating and drinking were given nutrition clinically to protect them from becoming dehydrated or malnourished. They either received a solution of

nutrients through an intravenous line or delivered into the digestive system through a tube.

People were supported to be able to eat and drink sufficient amounts to meet their needs. However, the provider may like to note that when people needed support to communicate their needs they relied more heavily on the staff checking what they had eaten and drank and these checks had sometimes been missed out.

The nutrition and hydration charts were checked as part of the two hourly rounds the staff carried out. We found on two of the wards Kings C1 and Cambridge M1 that the two hourly rounds had not taken place earlier in the day. On Kings C1 this meant that two people's notes we checked in the afternoon indicated they had not had a drink since early in the morning and one of the notes did not have any drinks recorded. Staff said this was because they were so busy and one of the rounds had been timed during their lunch break. The ward manager said she would address this straight away. On Cambridge M1 of the three notes seen, there were only a few instances where comments were made by staff. Two of the three had incomplete charts, where several hours had passed without checks being recorded.

The dietician and speech and language therapists were involved with people who needed additional support or care. We saw the dietician talking to patients and saw clear notes in the care plans showing assessments and treatment plans.

Hand cleansing gel was kept at the end of each person's bed and on some wards they were also offered cleansing wipes after each meal.

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

The provider was meeting this standard.

Outcome 08:
Cleanliness and infection control

What the outcome says

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

What we found

Our judgement

The provider is compliant with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
People were cared for in a clean, hygienic environment.

People said that the wards were clean and that they saw cleaners come everyday and the care staff cleaned too. They commented "…cleaning staff come round two or three times a day cleaning."

People said that their bedding was changed every day. They also commented, "as soon as a patient goes the bed is raised and is thoroughly cleaned before it is made up."

Everyone we spoke to said that staff cleaned up spills quickly after they had occurred. Another person commented, "Staff cleared the ward bin twice in two hours."

People commented that staff always cleaned their hands before attending to them.

Other evidence
There were effective systems in place to reduce the risk and spread of infection.

Since the trust failed to meet infection control targets in April 2011 they had put new systems in place and developed the infection control lead team role. The infection control team were on call 24/7.

All the wards we visited looked clean. All the bathrooms, showers and toilets looked clean. There were paper towels, toilet paper and soap in good supply. There were aids present to assist people, including heightened seats and rails by the toilet and all

looked clean. The cleanliness of the washing and toilet areas were checked routinely throughout the day. Staff said there was a dedicated toilet cleaning team based on each floor who attended to toilets and commodes. Patients were also encouraged to inform staff if there were any problems with the cleanliness of the ward.

There were systems in place to make sure that all parts of the wards and equipment were checked, thoroughly cleaned and replaced systematically. These were recorded in a data system so that compliance to the procedures could be checked. If there were any areas of weakness they would produce action plans. All mattresses were audited routinely and there was a label system to alert staff. All staff had received training on how to check mattresses. A survey of commodes had recently been carried out and new ones had been purchased where necessary.

All people including staff were guided by information on notice boards on the walls and in clinical areas giving instructions about infection control. There were signs reminding people to wash their hands above sinks and washing areas.

People were able to wash their hands as often as needed as there were hand gel dispensers at all ward entrances and near entrances to bays and side rooms. There was hand wash at the ends of the beds and these were filled up adequately.

Clinical waste and rubbish were disposed of appropriately. There were hazard waste bins and gloves available that were placed so that staff had easy access to them.

There were two infection control nurses based at William Harvey Hospital who carried out audits, training and offered advice and support to staff on the wards.

An infection control manual had been developed for the hospital by the infection control team, which included all aspects of cleanliness and infection control and was organised so that staff could use for reference. There was also an infection control induction training pack contained sheets with simple, key messages.

All staff completed infection control training and hand hygiene training was carried out every year.

The staff explained that all hospital staff were monitored including consultants. Consultants were challenged when they were not bare below the elbows as this was hospital policy.

The nursing team carried out a clinical review of any patient with an infection. The infection control team were informed and depending on the level of infection the patient was isolated in a side room or moved to Oxford ward. After patients had moved, a deep clean was carried out in all affected areas. This meant that the spread of infection was minimised and people were protected.

The hospital had a low incidence of hospital acquired microbiological infections including MRSA (Methicillin-resistant Staphylococcus aureus) and Cdif (Clostridium difficile).

Our judgement
People were cared for in a clean, hygienic environment and were protected from the

risk of infection because appropriate guidance had been followed.

The provider was meeting this standard.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People said the staff were good and they did not have to wait too long for staff to attend to them.

A person on Kings A2 said, "Staff are straightaway your friend when you come in. There are plenty of them too." They said staff were available to help when they needed assistance. One comment was "…yes they are, sometimes have to wait a little, they are run off their feet." One person on Cambridge J commented, "The staff are pretty good." "Sometimes they rush, but usually they are good."

People we spoke to said that their call bells were answered quickly apart from people on Cambridge M1.

On Cambridge M1 people were concerned about the lack of staff. They said this had meant that some people had to wait for assistance, one person's dinner had gone cold while waiting, another person's drip had run out and was bleeping for a long time before staff took it away and staff had not taken a used bed pan away for over an hour.

One person commented, "staff were rushed and she was so depressed and needed someone to talk to about what was happening to her… but there were no nurses available…staff were so rushed that it was taking ages for bells to be answered…"

Commenting about the staff, one person said "…sometimes you don't know who you

are speaking to". Another person said "Some staff are very good, others ignore you."

Other evidence
All of the wards we visited had staff vacancies and many of these were through unplanned absences. These were displayed on the notice boards in the ward entrances.

There was an electronic rota system that picked up some of the staff vacancies which meant that staffing numbers were organised more efficiently across all wards but it needed to be altered manually for unplanned absence. Ward managers had meetings and where there were staff shortages these could be addressed.

Ward managers were able to make some additions to the rotas. The provider may wish to note that adjustments were not always in place to make sure the rota system was effective in having the right level of staff on duty. This was because the staffing levels did not take into account the needs and dependency of the patients which varied so much.

Staff on Kings A2 were concerned that the new electronic rota only took into account the numbers of staff on duty. They said often the skill mix was wrong, for example, there was only one nurse allocated instead of two and although there were more health care assistants that day it meant that the nurse was not able to manage all her duties effectively. They also explained that they worked both day and nights and working from one to the other with only enough time to sleep in between because the electronic rota just worked out the hours. They said this affected their body clocks and they felt more tired.

Staff commented that relatives were encouraged to come in at meal times to help if a person had dementia because sometimes there were not enough staff to assist.

The call buzzers were not answered for several minutes on Cambridge M1. Staff told us that they were unhappy with the staffing levels, and it was always busy although they were discouraged from using agency staff because of the cost. Staff said they did not have time to sit and talk with patients who needed reassurance.

On Kings D1, the manager completed an action plan to increase the staffing following an assessment and also reduce the beds. Desks had been moved into bays so that staff could work closer to the patients, to prevent falls and answer questions about patient care. The nurses commented that they found this made their work more manageable, as they were able to attend to people and make observations and complete the records. Staff said they were happy with the staffing levels but it could get very rushed when they were busy.

The electronic duty rota system is fairly new and adjustments still needed to be made for it to be an effective tool but overall nurses and managers had found creative ways to manage the staffing levels. The provider may like to note that the staffing level varied across the wards and that standards of care could be compromised.

Our judgement
There were enough qualified, skilled and experienced staff to meet people's needs.

The provider was meeting this standard.

Outcome 14:
Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
People said 'the staff are very nice, very pleasant'. 'the nurses are happy, I do not know how they manage it and stay happy as they are very busy'.

People said they felt confident in the staff who were supporting them.

One person commented that there was a lack of awareness for advanced dementia. Another relative said that staff sometimes inappropriately asked questions to a person with dementia without fully understanding their capacity.

Other evidence
We observed staff to be motivated and enthusiastic in their work. Staff were smiling and talking to patients as they were working.

The Trust used the National Learning Management system and e-learning for most training. For nursing, midwifery and Allied Health Professionals there was a competency framework for procedural skills which was developed by an expert in that area. Staff said they felt confident in their roles and talked knowledgably to us.

Staff attended induction training and shadowed experienced staff when they first started working.

A training needs analysis was being compiled to review training being provided. The intranet training was going to be refreshed in July 2012 to include clearer direction for staff to know what training they needed to do and how frequently it needed updating.

The trust did not have a system of monitoring what training staff had attended overall at this time and said that this was being developed. Staff said they were supported by ward managers and that training was discussed in their annual appraisal.

The provider may like to note that most staff said that they were unable to find the time to complete their mandatory e-leaning training in work time as they had been directed to do. Some staff said that they had completed training courses in their own time.

Training was being provided for allocated staff to have increased dementia training and become the lead on each ward. Staff said that they found the training really useful and it had increased their understanding of dementia. They planned to share this training with other staff on the ward. They also had purple folders of information to assist with this but they had not had the time to carry training out. This meant that potential improvements to the support of people with dementia had not been able to happen. The provider may like to note that staff morale was affected by this, as they wanted to develop their practice further but were not being given the time to do so.

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

The provider was meeting this standard.

Action
we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Diagnostic and screening procedures	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	How the regulation is not being met: Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. The procedure for obtaining consent from people who lacked capacity was unclear. This meant that people were not always given the support they needed to make decisions about their care and treatment.	
Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	How the regulation is not being met: Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. The procedure for obtaining consent from people who lacked capacity was unclear. This meant that people were not always given the support they needed to make decisions about their care and treatment.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

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

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

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

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

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

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

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

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
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Audience	The general public
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