## Manchester Royal Infirmary

Oxford Road, Manchester, M13 9WL

Tel: 01612761234

Date of Inspections: 20 December 2013
19 December 2013
18 December 2013
17 December 2013
16 December 2013

Date of Publication: April 2014

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

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Details about this location

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<th>Registered Provider</th>
<th>Central Manchester University Hospitals NHS Foundation Trust</th>
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<tr>
<td>Overview of the service</td>
<td>Manchester Royal Infirmary (MRI) and the Royal Manchester Children's Hospital are two of several hospitals that come under the governance of the Central Manchester University Hospitals NHS Foundation Trust (CMFT). The Trust headquarters are based at the Oxford Road site which includes two other acute hospitals St Mary's Hospital and the Manchester Royal Eye Hospital. The four hospitals are teaching hospitals for Manchester University’s Medical School. The MRI is a specialist regional centre for kidney and pancreas transplants, haematology and sickle cell disease. The MRI, together with the Royal Manchester Children's Hospital are the only hospitals in the region which undertake kidney transplantation. The Heart Centre is a major provider of cardiac services in the region, specialising in cardiothoracic surgery and cardiology. The Accident &amp; Emergency department sees around 145,000 patients each year. The new buildings have good access. Parking is available at different pay as you go car parks near the hospital and there is disabled parking on site. The hospital is situated on one of Manchester's major bus-routes.</td>
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<tr>
<td>Type of services</td>
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<td>Regulated activities</td>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Management of supply of blood and blood derived products Maternity and midwifery services Nursing care</td>
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Surgical procedures
Termination of pregnancies
Treatment of disease, disorder or injury
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 16 December 2013, 17 December 2013, 18 December 2013, 19 December 2013 and 20 December 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff, reviewed information given to us by the provider and reviewed information sent to us by commissioners of services. We reviewed information sent to us by other regulators or the Department of Health, reviewed information sent to us by local groups of people in the community or voluntary sector 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

Due to the complexity and scope of the location we visited the Manchester Royal Infirmary (MRI) and the Royal Manchester Children's Hospital (RMCH) with an inspection team. The team was made up of:- a specialist in hospital infection control; a specialist advisor in governance (quality assurance) for children's hospitals; and a specialist advisor in governance (quality assurance) for adult hospitals.

We were also supported on this inspection by Experts by Experience (Ex-by-EX). An Ex-by-Ex is a person who has personal experience of using or caring for someone who uses this type of care service. During this inspection we had two Ex-by-Ex's, one for speaking with adults at the MRI and another who talked with children and their parents at the children's hospital. In addition to this a total of five Care Quality Commission inspectors spent time on the wards at both hospitals.

Patients said they were given appropriate opportunities to consent to their care and treatment. We were told: "I'm very happy with care, consent is always obtained."

Where people did not have the capacity to consent to treatment, the Trust acted in accordance with legal requirements.

Most patients we spoke with were positive about the overall care they received at the MRI and children's hospital. One adult patient told us: "Now I am nearly ready to go home."
Thanks to them."

A young patient said: "My consultant has been excellent."

We found care needs were assessed and treatment plans were put in place. There was evidence that an effective level of care and individual support was provided.

Patients at the children's hospital were not protected against the risks associated with poor quality and choice of food. When asked about suggested improvements the overall comment was: "I would make the food better…"

We found evidence that patients at the children's hospital continually told the Trust that food was of poor quality, we saw that menus were not varied and the meals offered did not provide sufficient healthy options. The Trust had not taken sufficient steps to ensure patients had information about all the food available and so their choices had also been limited unnecessarily. We have asked for improvements in this outcome area.

The Trust was effective in preventing cross infection and the wards were clean and tidy. Patients also confirmed there was a good standard of cleanliness on the wards.

The Trust had systems in place to provide well-trained and skilled doctors, nurses, health care assistants and allied health care professionals. These were available in sufficient numbers on the wards we visited most of the time.

We saw that the Trust had comprehensive quality assurance systems in place. The Board were keen to introduce initiatives and schemes to investigate how best to make improvements to care and treatment. There was an open culture. We fed-back observations about putting the data they collected to practical use on the wards. We fed-back observations about target dates for completing the rollout of pilot schemes to the rest of the hospital as appropriate.

We found that the Trust needed to take more action to ensure the records made by staff promoted the wellbeing and safety of patients because many records were incomplete and difficult to read. We have asked for improvements in this outcome area.

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

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**What we have told the provider to do**

We have asked the provider to send us a report by 09 May 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

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

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

<table>
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<th>Consent to care and treatment</th>
<th>Met this standard</th>
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<tr>
<td>Before people are given any examination, care, treatment or support, they should be asked if they agree to it</td>
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Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We found that the Trust had systems in place to ensure that people's right to give consent was promoted and their decisions were respected.

We spoke with a number of patients and their representatives on wards at the Manchester Royal Infirmary (MRI) and the Royal Manchester Children's Hospital (RMCH). The interviews were conducted in some depth. Patients told us about their experience of consent to care and treatment. The vast majority of patients, their parents or representatives told us that they had been involved in planning their care and treatment. Patients felt they had been given as much information as possible, and provided with opportunities to give or withdraw consent. Parents reported that the level of information given was good and was provided in a way that was easy to understand.

Patients at the MRI told us:
"They did go through the risks and benefits so I knew what to expect. I refused a daily injection for blood clotting. Staff always ask me but I refuse, they respect that."
"Everything has been explained."
"I'm here to get better so I'm not going to say 'no', I'm willing to do anything."
And: "When I came in first of all, I more or less understood everything that was said to me. The doctor tells me each day what is happening and how near I am to going home. My family also talk to the nurses and doctor, about my care and I am happy with that."

Patients and parents at the RMCH told us:
"They tell me everything."
"Ten out of ten for information."
"There is nothing we have not understood."
"I was sent a leaflet about treatment before we came in, so I knew what to expect. I ask a lot of questions and they are always answered."
"My treatment was explained fully and they always answer any questions I have."
"My doctor rang me to arrange the admission and told me everything I needed to know"
over the phone and also answered all my questions, I preferred this personal touch."
And: "My doctor always explains things to me, as well as my mum and dad, he uses short
sentences not long words."

We were told by staff:
"Doctors do take the time to obtain consent properly."
And: "I always make sure I ask them if they are ok and understand."

We looked at a sample of nursing and medical records on each of the wards we visited.
We saw that patients had signed to consent for surgical and other procedures as required.
We saw that there were different consent policies and guidelines for different parts of the
Trust. We saw that different types of consent such as verbal, implicit through cooperation
with a procedure and formal, such as written, were explained. We noted that consent
forms provided detailed information about the reason, benefits and risk for the planned
procedure. Ward managers were able to explain the different forms used depending on if
the patient had capacity to give consent.

These findings meant that systems were in place for staff to follow to ensure that the
patient’s right to give consent was understood and obtained.

We observed nurses and doctors' interacting with patients and saw that permission was
sought before support was given and clear explanations provided about procedures and
treatment. We saw patients being asked permission for routine daily interventions and
tasks such as staff taking basic observations. These findings meant that staff conduct in
relation to consent to care and treatment was in keeping with good practice. We saw that
hospital staff delayed an examination in the case of a child until consent could be
arranged. Staff also highlighted in the medical records when consent had not been gained
and the risk that this could result in the delay of a procedure. This showed that medical
staff followed good practice guidance.

We saw from medical and nursing records that discussions took place with patients and
their relatives in relation to whether the patient was a good candidate for emergency
resuscitation. Issues discussed included individual medical diagnosis and continued
quality of life. We saw that forms were completed by two senior doctors and outcome of
the conversations with the patient and / or relatives were also recorded in medical notes.
This meant that doctors ensured the wishes of the patient, relating to all aspects of their
care was known to medical and nursing staff.

We noted however one area of consent that required clarification. This related to the
concept of 'limitation of treatment'. Discussion with nurses and doctors indicated that this
concept was used in different scenarios relating to the choices patients made. For
example 'limitation of treatment' was mentioned in conversation when we discussed the
continued care of a patient if they did not want to be resuscitated and also in relation to a
patient who wanted to continue with ordinary meals when it had been assessed that they
should have a soft diet. We found that the Trust used a 'Limitation of Treatment'
agreement form and looked at a completed agreement for one person. We saw that
although this requested signatures and information from all the health professionals who
had been involved in drawing up the agreement, the document we looked at had been
signed by one doctor and there was no information on the form to confirm that a
multidisciplinary discussion had taken place. Neither did the form we looked at confirm that
the patient had been involved with drawing up the agreement. We saw, however, that the
doctor stated in the medical records that the limitation of treatment agreement was initiated
following a medical ward round and discussion with the patient. The medical records showed that the discussion had included 'quality of life' concerns raised by the patient. This meant that the patient's right to refuse treatment was respected.

We noted that the limitation of treatment document did not have a space for patients to sign in agreement to the plan. Neither was there space for relatives to confirm that they had been given the opportunity to discuss the concept of limitation of treatment with reference to the continued care and treatment for their relative. The Trust should consider making sure that patients have the opportunity to give written consent to this agreement so that the document provides standalone evidence that the Human Rights of the patient has been protected in relation to the level of care and treatment that is offered and accepted.
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.

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

Reasons for our judgement

We found that systems were in place to meet the care and welfare needs of patients were met at Manchester Royal Infirmary (MRI) and Royal Manchester Children's Hospital (RMCH).

We spoke with a number of patients and their representatives on five wards at the Manchester Royal Infirmary (MRI) and children and parents on six wards or departments at the Royal Manchester Children's Hospital (RMCH). The interviews were conducted in some depth. Patients told us about their experience of care and welfare. The vast majority of patients and parents at the children's hospital were satisfied with the care and treatment. They described the steps taken to make sure that all aspects of the hospital admission and treatment was correct and met their needs. We found that parents trusted the hospital enough to travel some distance to the RMCH if their child was ill.

Parents told us: "The play specialist phoned me this morning to see what sort of things my daughter liked and disliked, I said to her that we would be better in a cubicle as she can become distressed especially in the hospital environment, when we were admitted we got a cubicle."

"My consultant has been excellent."

"It's good that my son comes back to the same ward as he is partially sighted and he knows his way round."

Patients at the MRI were generally satisfied with the nursing care and medical treatment. We were told: "I always get medicines on time, staff point out dangers when I'm walking. The doctor comes to the ward regularly but it varies who he sees."

"I used to be a nurse, many years ago, so I am quite capable of having an input into my nursing care. They keep me up to date with what is happening. I have a mobility scooter here, and I go to M&S for shopping and pick up things for other people."

"When I arrived 7 weeks ago, I was put on a life support machine. I have received very
good attention and the staff including doctors appear to be continually looking for ways to ease my situation."

"When I arrived, I was in a bad way requiring urgent treatment. It was only the next day that I realised to what extent the staff had gone to in dealing with me. Apparently, the consultant had kept a team of people waiting until he had the results of my blood tests, to make the decision whether I had an operation or not. In the end I did not require an operation, but I feel very humble at the lengths they went to for me. I am kept informed all the time."

"I was told yesterday that someone was coming to take me home just to assess my needs before the final discharge, but no-one has been as yet. The care and nursing has been excellent…"

Relatives told us: "My relative has been in hospital for two and a half weeks and has been on this ward for one and a half weeks. The main doctor is brilliant and is working to transferring my relative back to London. Staff are generally flexible. Their (partner) has been given accommodation to stay. We are well supported by staff and can visit at any time."

Another relative said: "One female doctor is excellent and always listens. Lots of lovely staff. Care is good on the whole."

Although satisfied with the care some patients also said that they had experienced delays in changes to their treatment, for example one person told us: "The nursing care is good, however, I have been waiting the two weeks for a specialist doctor to come and see me. Nothing is happening."

And another patient said:
"Nurses produce good to excellent work; it depends on their personal practices. This does not only refer to me but to the patient across from me who needs more nursing attention. There appears to be a lack of communication. My arm requires redressing regularly. The nurse here said she would find some better dressings that would not stick to my arm. She came back and said there were none left on the ward, so she made two phone calls which had the same results in that she was told they had the dressing available and each time she got there, there were none. This makes every small chore a large chore."

Although the majority of relatives we talked with were satisfied with medical care and treatment a minority felt that nurses needed to pay more attention to detail in respect of the care and support provided. This was particularly true on the medical wards where patients needed support to maintain a good level of personal hygiene, assistance in getting to the toilet and other personal care tasks.

One person felt their relative's recovery was being hampered because of continual room changes. We were told: "My relative has been in the hospital for one week and this is their fourth room." This person said they were due discuss their relatives care with nursing staff.

Relatives on two of the wards we visited at the MRI raised specific concerns, one relative told us that they were unhappy with the level of personal care provided and another felt that the 'older' doctors did not listen to what they said. Both of these concerns were brought to the attention of the nurse in charge of the respective wards.
We looked at a sample of nursing and medical records on each of the wards we visited. This was to check whether patient's needs had been fully assessed and whether care plans and treatment pathways were in keeping with best practice in relation to the reason for admission.

We saw that all patients had their health and medical needs assessed when they were admitted to the hospital. We saw that different assessment tools were used according the reason for admission. Initial assessment tools were appropriate to the immediate need of the patient and additional assessments were completed as more information was provided. This was through clinical observation and monitoring, test results and information from the person themselves or relatives. This meant that a patient's condition could be stabilised and prevented from deteriorating because the most immediate needs were identified and met.

We saw that specialist risk assessments were completed to identify people who were susceptible to avoidable harm. These risk assessments included nutrition and hydration, developing pressure sores, risk of developing a deep vein thrombosis. We saw that care plans were put in place to promote safety and well-being in these areas if required. This meant that systems were in place to monitor needs and ensure the correct treatment and care was provided as necessary.

We noted that specific early warning score (EWS) observation charts were used to monitor the condition of patients. Early warning scores are sets of observations specific to a particular diagnosis and the results alert nurses and doctors to a possible deterioration in the patient's condition. This meant that prompt action could be taken to prevent further illness or complications. We saw from completed observation charts, nursing and medical records that nurses and doctors usually responded quickly to the results of observations. This meant patients received on-going care and treatment to deal with their condition and promote healing.

We found that patients had access to the most appropriately qualified health professionals in relation to assessing specialist needs and treatment. For example we saw that patients were visited by physiotherapist, dieticians and occupation therapists. Patients were referred for diagnostic tests and doctors took account of the results before initiating treatment. Nurses confirmed that access to allied health professionals was through a simple referral process. This meant the patients wellbeing and safety was promoted because treatment plans were in keeping with the appropriate expert advice and up to date guidelines.

We saw that progress was monitored because assessments were continually reviewed, updated and changed to reflect the care needed to keep a patient safe and comfortable. The specialist assessments and care plans available were numerous and covered all the areas and disciplines of medical and surgical diagnosis and treatment. The wards we visited were general medical and surgical wards and so examples we saw included pressure area care assessments, care plans and records, pain management assessments and records and wound management assessments and records. This showed that the Trust had the infrastructure and expertise to provide effective care and treatment for the health conditions with which patients presented.

In the main we found that the needs of the patients were effectively communicated between the nursing and medical teams. On each ward we visited we saw that there was a handover of information about patient care at each change-over of shift. The Trust was in
the process of transferring to a ‘paper free’ system and we saw that a computer programme was in use which updated patient’s records and detailed the care and treatment they needed. This information could be viewed on a screen by all staff. The system was not embedded on all the wards we visited. We found that staff also printed a copy of the plan so that this could be referred at any time.

We listened to a handover of information between shifts. We found that the information discussed was detailed and person centred, and described medical and nursing needs in detail. The discussion at handover also included plans for discharge. We looked at the information on the printed handover sheets and compared this to information in the nursing notes and found that the printouts were comprehensive and provided clear instructions about the care and treatment required. This meant that patient’s wellbeing was promoted because nurses had the information required to provide effective nursing care and treatment to hand. The provider may wish to note that at times the information on the printed handover sheets was more detailed than the written treatment plans.

We observed care and treatment on the wards we visited. We found that on three of the five wards we visited at the MRI that patients always received care and treatment in a considerate, dignified and caring manner. We saw that at all times privacy curtains were used during personal care or medical procedures, staff took time to find out what was required and were caring and kind in their approach. We saw that staff talked with patients in a natural manner and took time to get to know them. Staff also made sure that patients could summon assistance by ensuring that call bells were placed within easy reach. This meant that the emotional wellbeing of patients was protected.

On the two remaining wards we noted that although privacy and physical safety was maintained and in the main people were treated with kindness, there were instances where staff response to general needs was delayed when assistance was requested. We also saw that on occasion tasks were completed with very little warmth or friendliness for example when drinks were handed round or assistance given to get up or go to the toilet. The provider may wish to look at ways in which to monitor the response time to call bells and find ways to encourage all staff to always relate to patients in a positive and kindly manner.

We looked at communication with reference to planned discharges from the MRI. Staff told us that discharge plans were sent to the community based teams by sending a fax. We found that no check was made to confirm that the referral had been received and the work allocated. The provider may wish to introduce a means of ensuring that discharge plans have been received and activated this will make sure that the correct support is provided to patients as soon as they return home.

We looked at the care provided to people who had said that they did not want emergency medical intervention if their condition were to deteriorate. We saw that these patients looked comfortable. We noted that medication including treatment for pain and discomfort was being prescribed and administered as prescribed. We saw that patients were provided with nutrition and hydration to keep them as well as possible. Daily records, charts and readings confirmed that personal care was provided to promote good wellbeing for as long as possible. This meant that people at or near the end of their life were treated with dignity and kept as comfortable and free from stress as possible.

We talked with staff about dealing with emergencies. Staff we talked with told us they had completed Basic Life Support training and all managers and senior nurses were also
Paediatric Life Support trained. Staff stated that the training included emergency response scenarios and practical training included the use of adult, children and baby sized manikins.

We saw that resuscitation equipment was situated on each ward and completed record books showed that equipment was checked as ‘complete and ready to use’ at least once every 24 hours. We saw that the number for the rapid response team was on each ward. Nurses we talked with had memorised the number. The children's hospital is a major trauma centre and regular simulations were undertaken. We were informed that the last simulation was held in November 2013 four weeks before this inspection visit.

These findings meant that patients were protected from avoidable harm because systems were in place to effectively deal with medical emergencies.
Meeting nutritional needs

Food and drink should meet people's individual dietary needs

Our judgement

The provider was not meeting this standard.

The patients were not adequately protected from the risk of poor nutrition because a proportion of the hospitals population were not provided with a choice of wholesome food and drink.

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

Reasons for our judgement

We found that only a minority of patients liked the food at the MRI. Three patients made completely positive comments about the quality of the food. They told us: "The food is surprisingly nice, it's edible and there are different choices every day."

"Always liked the food, no problems with food."

And: "Food is very nice."

All other patients we talked with at the Manchester Royal infirmary and the Royal Manchester Children's Hospital were dissatisfied with the meals or different aspects of food and nutrition.

Patients at the MRI told us: "The food is ok, but not always good."

"There's not much choice in food, and it is never hot enough for me, but can't grumble."

"The food is not good."

"The food is not so good and it's always cold, but it has to come a long way from the kitchen."

And: "Food could be improved, some days it's just stodge, other days it's nice."

A relative told us: "There has been little time for staff to get used to my relatives eating habits. She is actually not eating, and I am hoping that a dietician will see her today."

We talked with approximately twenty patients or their parents at the RMCH and we also interviewed staff. Patients, parents and staff at the RMCH all said they felt the children's menu needed to be improved.

Children told us: "I don't like it at all...It's all kiddy food, and it's the same over and over."

"I have pizza or sausage every day. Want more choices it's always the same menu,
sometimes I get a bit bored with it."

Other children also commented on the temperature and choice of food and said:
"Food is the same every day."

"There's no variety and it's not very hot."

"Menus are boring."

Comments about food from parents included:
"You get the same menu for 12 days."

"He's had cottage pie four times this week."

"He orders from the adult menu but a lot of the time it doesn't come up so he has to make do with what's left."

And: "There is no healthy food."

We saw that the Trust consulted with patients about the quality of care and treatment including nutrition on each ward we visited at the MRI and RMCH. We saw that the rating for each ward included food and nutrition. The result of the ratings was displayed outside each ward. The results about patient satisfaction with food for the wards we visited at the Manchester Royal Infirmary scored at around 75% satisfaction in October 2013, while at the RMCH one result in October 2013 was as low as 34.8% satisfaction. The Trust also produced a monthly analysis of patient overall satisfaction at the MRI. This report showed that although 80-86% of respondents were happy with the presentation and choice of food, only 70-75% were satisfied with the quality of food.

We discussed these results with members of the Trust management team. We also talked with the estates manager responsible for overseeing catering which is provided by a private contractor. We were told that a pilot scheme to improve meals had been started. The provider may wish to prioritise addressing the quality of food provided by the contracted company so that improvements are made which will promote the emotional and physical wellbeing of patients.

We looked at nursing records and assessments for sample of patients on each ward we visited. We saw that nutritional assessments were completed as a part of the initial admission process. These assessments included recording weight, food allergies, general appetite, special medical dietary needs, religious preferences and lifestyle choices. The initial assessments also highlighted when a more detailed nutritional assessment was required. In-depth nutritional risk assessments such as the malnutrition universal screening tool (MUST) were used. We saw that special dietary care plans were in place for when it was essential to adhere to a particular diet such as a renal diet. We saw that blood tests were taken to ensure that patients were sufficiently hydrated. Patients with dementia had been referred to the speech and language therapist for swallowing and chewing assessments, this was to make sure food and drink offered was at the correct consistency to prevent other complications such pneumonia caused by food going into the lungs, discomfort from choking and coughing and loss of appetite.

Although we saw evidence that when MUST assessments were completed the appropriate risk reduction plans were put in place, we also saw numerous occasions when MUST
assessments had been placed on files but were only partially filled in. This meant that the welfare and wellbeing of some patients were not protected because their risk of malnutrition may not have been identified. The provider needs to ensure that MUST assessments are completed in full so that all patients are fully protected from nutritional risk.

Nursing and medical records showed that when needs were identified patients had good access to dieticians and patients spoke highly of this service. We were told: “The dietician has been excellent, really good, she has explained everything to me. I was really scared but now I think I'll be able to cope, it's still a shock but the dietician has helped me to feel better about it.” These findings meant that appropriate allied health professionals were available when nutritional needs were assessed.

We looked at the menus on offer at the MRI and the RMCH. We saw that at the MRI there was a different menu for each day of the week. Meals for adult patients were varied and included a choice at each mealtime. Dishes included breakfast cereals and porridge, meat or poultry stews, roasted meat and cooked fish. We saw that vegetables and salads were also offered. A choice of carbohydrate was also offered such as potatoes, rice or bread. We saw that when ordered soft and pureed diets were provided. These meals were presented in an appetising way.

We observed on all the wards we visited that additional drinks were offered between meals and water was provided to each patient. We saw there was more flexibility with regards to meal choices on the wards where staff plated up the food because it was usually possible for patients to have an alternative to what they had originally chosen. This also meant portion sizes could be tailored to the individual. We saw that additional menus were available for patients with allergies and to meet cultural or religious needs. The culture specific menu included Asian and afro-Caribbean meals. These findings meant that a choice of food was available to meet the needs of patients at the MRI and cultural and religious backgrounds were taken into account.

We found that the menu at the RMCH was less varied. We saw that the menu choice which was in itself limited remained the same everyday throughout the year. We noted that the lunch menu was very similar to the menu for supper. The hot meals offered relied heavily on processed foods such as pizza, fish-fingers and other breaded fish, sausages, and items made with minced meat such as cottage pie and burgers. The only options for fresh fruit or vegetables were salad or mixed vegetable and an apple, orange or banana as a dessert. Sandwiches were on the menu but there was no option on the menu to choose wholemeal bread. This menu made it difficult for children to choose a varied diet that would meet standard nutritional guidance such as a minimum of five portions of fruit or vegetables each day. The lack of choice meant children would become bored if they had a prolonged stay in hospital and those with poor appetites might not be tempted to eat.

Staff on the children wards also stated there was a lack of flexibility with regards to obtaining specialist diets such as the Cystic Fibrosis snack boxes. We were told that these were not provided as stock and there was a delay in children getting the extra food they needed. This was seen as a particular problem on the day ward. The provider may wish to find a way of ensuring all wards have ready access to all specialist diets at the time they are needed.

We saw one specific example of a concerted effort made to ensure children at the hospital had the varied and nutritional diet they required. This was because we interviewed one
housekeeper who was especially enthusiastic about food and nutrition on their ward. We were told: “My role is to make sure people get what they need to eat, are happy and to put a smile on their face.” This member of staff also commented that the “normal menu was the same for every day.” On this ward we saw that extra fruit and drinks were offered during the day and some wards kept a stock of fruit yoghurt, jelly, biscuits and ice creams. We also saw that a range of baby foods and milk were available. This included halal baby meals so that cultural and religious preferences could be met.

We discussed the lack of variety and the quality of the food offered at the RMCH with the senior management team. We were told that an additional menu called the 'fatigue menu' was available at the RMCH. We found however, that neither nursing staff nor housekeeping staff were aware of this menu. Parents were also unaware of this menu despite their dissatisfaction with the main menu. We collected a copy of the menus available from one of the children’s ward and this menu was not amongst them. We would like the provider to take note that the quality of the food choices at the children hospital was inadequate because the options available were not varied or wholesome. We found that improvements were needed in respect of diet and nutrition.

We observed the management of mealtimes and the way drinks were provided on the wards we visited. This was to check whether patients were provided with the support they needed to eat and drink in sufficient quantity. We found that some wards operated a 'protected mealtime'. This meant that visitors were limited to relatives who would assist with meals or for patients who were unwell. Medical examinations would not take place and there was as little disruption as possible on the wards. This meant that good nutrition was encouraged because patients could concentrate on eating their meal and staff would not be distracted when serving and assisting with meals.

The Trust had introduced the 'Red Tray' system. This was used at the MRI. Patients who were assessed as needing additional support with their meals were placed on this system. We discussed how this should operate on the wards with a senior nurse. We were told that patients on the red tray system would be supported to prepare for their meal such as being sat out of bed or sat up in bed to make eating easier. These patients would also be allocated a health care assistant or nurse to provide one to one support and encouragement when meals and drinks were served. The amount consumed would then be recorded on a food and drink intake chart. This meant nutritional intake could be monitored and changes made as necessary. We saw that information about dietary needs including thickened fluids to prevent choking, pureed diet or if 'nil by mouth' was displayed above the bed of each patient. This was to inform housekeeping staff who served drinks and snacks and remind to nursing staff and visitors so that patients were not accidently put at risk. This meant that a system was in place to communicate dietary need so that health and wellbeing was promoted.

We observed mealtimes and noted that the red tray system worked particularly well on one ward and patients were prepared for their meals, which were provided quickly. No one had to wait for assistance and so meals were at a good temperature. The atmosphere on this ward was reported as ‘calm’. On the majority of wards we saw that people were provided with the meals to meet their assessed dietary needs and staff usually took time to sit with people to make sure they ate their meal. Where we found exceptions to this it was raised with the senior nurse on the day of the inspection.

We noted however that more management input was needed to ensure that the red tray guidance was followed for all patients on all wards. This is because at times we saw that
the environment was not conducive to a pleasant dining experience or patients were not properly prepared for their meal. For example on one ward we saw that a patient was seated on a commode behind a curtain while others in the same bay were served their lunch. We also found that sometimes people were not sat out of bed before their meals arrived and when this was suggested staff said it was too late because of the equipment and manpower needed. A procedure called 'rounding' was carried out on each ward. The aim was to ensure that every patient had their comfort checked by a nurse at a regular interval. The provider may wish to consider providing a protocol for the 'rounding' before main meals as this could make sure everyone was comfortable and prepared before meals are served.

The provider was not meeting this standard because food provided at the children’s hospital lacked variety and was not wholesome. We consider non-compliance as appropriate because nearly every parent and child we talked with complained about the quality and choice of food; because most of the meals were processed children and young people were at risk of poor nutrition if they had to stay in hospital for a long period and could only choose foods from the menu provided. Furthermore the hospital is the major service provider of children’s medical and surgical treatment in the Greater Manchester area and also cares for children from outside of this area, therefore a significant number of children were at risk of experiencing poor quality food and a lack of choice.
Inspection Report | Manchester Royal Infirmary | April 2014

Safeguarding people who use services from abuse  ✔  Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

We looked at safeguarding and child protection at the Royal Manchester Children's Hospital. Patient and parents said they felt safe and that steps were taken to keep the ward secure. Parents said that security was good and that they always had to buzz to gain access. We were told: "I feel safe if I have to leave my daughter on the ward."

"Security guards at night will always ask where we are going and who we are seeing."

"I have heard the nurses telling parents not to hold doors open for other people."

We saw that babies were treated at the hospital but these were not tagged which meant that they could be taken from the ward unnoticed. Although it is not a requirement it might be a precaution the Trust may consider.

We found instances when we entered the ward and staff did not approach us to confirm our identity. This showed that unknown people could gain access unchallenged and so children could be at risk. The provider may wish to look again at security with regards to accessing the children's wards. This is so that they can be certain that the level of security is as robust as it can be. We discussed these observations with the management team at the time of the inspection visit.

We saw that celebrities visited, and filming took place on the hospital wards. Ward staff we talked with did not really know much about the safeguarding checks made or how the visits were risk assessed and organised. The Trust staff we talked with said this was managed by the publicity department. The provider may wish to consider involving ward staff in developing risk assessments for when celebrities visit the different wards. This would ensure plans were tailor made and staff would know what extra precautions were needed during those times.

We saw from the minutes of the Safeguarding Effectiveness Committee that a working group called 'access to vulnerable people' had been setup in response to the Savile Investigation looking into allegations of child abuse. This working group had commissioned
a team to focus on and review the Trusts human resource processes and check compliance with existing policies. This meant that the Trust intended to learn from events and make changes as required. The Trust may wish to make checking compliance at the publicity department a priority.

With regards to child protection in relation to ill-treatment by adults known to a child, a member of the medical team said: "We always have safeguarding in the back of our minds. If we have any suspicions we would consult with the safeguarding team for guidance."

We discussed safeguarding matters further with the Trust wide lead for safeguarding and the matron for child safeguarding. The safeguarding lead told us that she was a member of an effective child protection team working at the RMCH. She said the team were able to attend training and specialist conferences concerned with child protection. We were also told that because the children who used the hospital came from all over the North West, good links had been forged with the Safeguarding Children Board at the different Local Authorities. This meant strategies and plans developed at the Trust would be influenced by the latest research and discussion with other practitioners and specialists in the subject.

We saw from the training log that the majority of staff had completed level three safeguarding training. Staff also confirmed that they had received safeguarding training as a part of their degree and also updated training at different levels since joining the Trust.

We asked staff what they would do if they suspected a colleague of abuse. We saw that nurses found it difficult to comprehend that a colleague would be a cause for concern, but they were clear about the protocol and would report concerns to senior staff. During safeguarding training and updates the Trust may wish to reiterate the potential risks posed by Trust employees. Reference to historical cases may be useful.

We asked staff to describe the possible signs and symptoms of an abused child. All the staff were able to describe behaviours and symptoms that would need further investigation and possible referral to the safeguarding lead nurse. Staff were aware that the full safeguarding protocols were available on the Trust intranet. This meant that staff understood their responsibilities, knew how to recognise abuse and would respond appropriately to protect children from further harm.

We discussed the care of children whose parents did not stay with them or who had to leave them for long periods of time. We were told that if a child was alone they were placed in a room near the nurse’s station and a verbal handover was given to that effect. We also saw that it was expected that nurses pay attention to the lone child during the process called ‘rounding’. This meant that steps were taken to safeguard lone children. The Trust may wish to consider introducing a specific risk assessment and plan for lone children to make sure their safeguarding needs are fully identified and met.

We looked at medical records for a number of children and saw evidence that the hospital received information regarding safeguarding from different sources including schools. Records showed that this matter was always taken seriously and dealt with at multidisciplinary meetings with senior safeguarding nurses and social workers involved. We saw that intervention plans were clear and detailed. We saw that communication between different statutory services including schools and the GP was effective. We found that additional input was provided to parents to make sure they were given every opportunity to care for their child properly. We saw that the progression of a safeguarding
concern was tracked. These findings meant systems were in place to endeavour to identify abuse, take action if it is suspected and protect children from continued harm.

We saw that the records for one child did not indicate what action had been taken in response to a concern raised by a school. We discussed this with the Nurse Safeguarding Lead on the ward. We were told that she had investigated the concern by contacting the school. The school had informed her that a consultant paediatrician had already dealt with the matter and contributed to a meeting called to discuss the concern. We found that the consultant had not recorded their actions. We were told that an update from the school would be added to the patient's notes to confirm the matter had been resolved. The conclusion had been that the child was not at risk. The safeguarding nurse had dealt with the matter on the day of the inspection and updated the records at that time. This meant that there was communication between partnership agencies and the Trust responded when concerns were raised.
Cleanliness and infection control  
Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Patients and visitors on the wards visited felt the staff were well presented and the wards were clean. Comments included: 

"(I) think the hospital is lovely and clean all the time."

"They come in every day and clean the bathroom."

We looked at infection control on eight wards in total between the MRI and the children's hospital and found a consistently high standard of infection control. We found that nurses and staff we talked with were committed to protecting patients and the wider community from the risk of infection. We saw that on the majority of wards there was full adherence to infection control policies.

We looked at the admission records for patients and saw evidence that each had been screened for the Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteria. This was so that people who were found to have the bacteria could be treated and nursed in a side ward until their tests results were clear. This meant the Trust took active steps to protect patients from harm because the risk of cross contamination to those who did not have the bacteria was reduced.

We saw that information about patients with infections was communicated to staff at the change-over of each shift. This meant staff were aware of the patients who needed particular attention in relation to having an infection or being susceptible to infection. These patients were nursed in a side room, and gloves and aprons were used whenever staff went into their rooms. Each room was identified as an isolation room as required and relevant infection control care pathways were available. Confidentiality was protected because no obvious patient information was visible to other visitors. This meant procedures were in place to identify when a patient had an infection and then prevent the spread of the infection to others on the wards.

We saw that all but one ward had a link nurse for infection prevention (IP). The link staff attended regular meetings and fed information back to their ward staff. All link nurses attended "harm free care meetings" and made contact with other ward members. This meant a process was in place for the Trust to share infection control good practice or
concerns with the wards.

We found that all staff, doctors and nurses with the exception one person on one ward, used personal protective equipment according to policy and were compliant with the rules for hand hygiene. We saw good facilities including hand wash basins, liquid soap, paper towels in dispensers and alcohol hand rub was available to staff and visitors. All staff were bare below the elbow so that hand washing could be thorough and clothes kept as clean as possible.

We saw poster banner stands at ward entrance. These displayed life size photographs of managers and staff showing their commitment to hand decontamination. This was in an effort to enthuse staff to cooperate with the hand-washing policy. This showed that staff were encouraged to comply with the most important aspect of infection control.

Patients were offered hand wipes prior to meals although a comment from one patient indicated that these were not always available. The Trust may wish to monitor the availability of hand wipes to ensure they are always offered before and after a meal.

We found that the majority of equipment was clean and correctly stored. The exceptions to this were the glove and apron dispensers. The inside of these dispensers were very dirty and had not been cleaned between refills. This could be a source of contamination. We brought this to the attention of the senior ward staff and saw that the dispensers were cleaned immediately. This meant there were effective systems in place to respond to areas of contamination. The Trust may wish to revise the cleaning schedule to include the inside of glove and apron dispensers so that staff are prompted to check these areas.

Wards were checked for cleanliness by members of staff from an adjacent ward. We saw that the results were documented and presented to all staff and board members. This further encouraged staff to prioritise adherence to infection control policies and procedures so that people were protected from the risk of contracting an infection at the hospital.
Staffing

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

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

The patient's and ward staff we talked with had mixed views about the staffing levels however patients said they liked the staff.

Patients at the Manchester Royal Infirmary (MRI) told us:
"Staff are caring, no bad attitudes, never rushed and seem to work at a good pace."

"The nurses always introduce themselves at the start of each shift. We have good banter on this ward. It's a good little ward. There is a lot of agency staff though." The patient was able to name the agency staff. This showed that the same agency nurses were used and so they became known to the patients and accustomed to ward routines.

We were also told: "Staff are very pleasant – you can just ask if you want anything."
And: "They're just marvellous. I couldn't fault them."

Other comments included: "Definitely not enough staff. You have to grab their attention."
And: "I think they are understaffed. Sometimes you have to wait too long."

Some staff felt that at times there were not enough staff to deal with the workload:
Comments included: "Sometimes there have not been enough staff. We have had quite a few agency staff. They vary. Some are regulars, some just come once."

A health care assistant told us: "I enjoy it. I am learning lots of new things. I feel well supported." This person also said: "We don't always have enough qualified...especially on nights, they have to pull them from other wards, its' been happening more and more recently."

Nursing staff confirmed that the Trust was taking steps to increase the number of staff. We were told: "Staffing is much better – we have had an increased percentage of staff on sick leave, but (we) are now fully staffed. We now have a nurse to each bay to improve patient care – on late shifts it can happen that the nurse in charge also has patients."

Another nurse said: "We're a good team and work well together to try and provide the best care we can."
We were also told: "We've got three new staff nurses. They're really good..."
And: "(The ward manager) likes to make sure staffing is ok. I think we are doing really well. (We're) working well after reconfiguration."

Newly qualified nurses said guidance and time was given to help them settle into the job.
We were told: "It's been great. We've had a lot of support. I've got two preceptors, they're always on shift. We were given a supernumerary period and it was extended from 4 weeks to 6 weeks. It's great to know you get a lot of support."

We saw that a staffing notice was posted at the entrance of each ward. This showed the planned staffing levels and the actual staff on duty. During our inspection we saw that for most of the time the actual staffing matched the planned numbers. This meant that systems were in place to provide nursing staff in the numbers and skill mix required.

We found however that having the correct number of staff did not always mean that patients received care and support promptly. This was because we saw instances where staff delayed responding to call bells or requests for assistance. We noted that this could be due to groups of nurses and health care assistants being distracted by issues and discussions concerning work or their private lives. Although in itself this is not a problem we did note that at times staff in a huddle did not postpone a conversation and respond to call bells. On occasion an ambulant patient would also approach staff on behalf the person calling. The Trust may wish to consider monitoring staff response time to call bells.

We discussed the availability of medical staff with a doctor. He felt that there was a good skill mix of junior and senior doctors throughout the hospital. We were told there were plenty of opportunities to update medical practice and increase knowledge. The doctor felt that one area for improvement in relation to staffing was the provision of speech and language therapists (SALT), or staff who could complete eating and swallowing assessments for people with dementia.

We discussed this issue with a member of the senior management team responsible for the speech and language therapy department. We were told that there were plans to review the numbers of allied health professional, however the SALT service met the required quality indicators because priority was given to patients with a cerebral vascular accident (CVA), also called a 'stroke', in line with national guidance. We also discussed the doctor's observation about SALT when we fed-back information about the inspection with the senior management team.

We looked at staffing at the children's hospital. Parents mainly told us they were satisfied with staffing. One parent said they were happy with staffing levels and felt comfortable leaving her (relative) in their care when not able to be present.

Another parent said there were: "... no problems" with staff."

We were also told: "The staff are very good and got him sorted straight away."
And: "The staff are very friendly and make me feel comfortable." Although this parent also felt that the call bell system was slow.

Another parent told us: "Nurses should spend more time on the ward rather than at the nurse's station."
Senior nurses we talked with took steps to promote safe care through having enough staff on duty. Nurses explained that agency staff were always used to provide the extra numbers. We were told that every effort was made to use the same staff. Staff felt the hospital always provided safe care but the 'little extra time' with relatives could not always be provided.

At the children's hospital we found that the skill mix of qualified nurses was risk assessed and allocated accordingly. For example on most wards 80% of staff had to be qualified but this was increased to 90% on the intensive treatment unit. We found that a consultant paediatrician was on site at all times and every patient was seen daily by the consultant. This meant that the continued wellbeing of children was promoted because suitably skilled and qualified staff were made available.

Discussion with the senior management team confirmed that they were aware of vacancies at the hospital. We were told that agency nurses were used at the quietest times and they tried to use the same staff. These findings meant that the Trust took steps to ensure sufficient staff were available to meet the needs of patients at the MRI and RCH.
Assessing and monitoring the quality of service provision

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

Our judgement

The provider was meeting this standard.

The provider had a significant number of effective systems in place to identify, assess and manage risks to the health, safety and welfare of people using the service.

Reasons for our judgement

We found that the Trust had a well-developed governance structure to check quality and spearhead improvements at the Manchester Royal Infirmary. We found that there was an established Council of Governors with the appropriate sub-committees and working groups that appeared to be working effectively. This meant safe and effective care could be promoted because individuals and groups were responsible for guaranteeing this throughout the Trust.

The Trust is organised into ten divisions with a management structure for each. We found that each division had appropriate mechanisms for reporting their performance to the formal Board sub-committees. There were a total of eight sub-committees, two of which dealt mainly with quality assurance concerning direct patient care. These were the risk management and clinical effectiveness sub-committees. These sub-committees were then broken down to smaller committees with responsibility for dealing with specific topics such as safeguarding, infection control and medication management. These findings confirmed that quality assurance and improvement was monitored at the highest level. This also showed that systems could be effective because initiatives were targeted and developed to deal with specific divisions and areas.

Although the Trust had well-developed systems and processes in place for governance and quality risk management these seemed to be complex at times. There were numerous quality monitoring projects and strategies and it was at times difficult to identify how each of these had influenced patient care. We also found that staff felt over burdened by the level of initiatives they were expected to put in place. We were told: "There are that many initiatives that it can be hard to reconcile them and just do your job." The provider may wish to review and take account of the number of quality assurance strategies and plans in place. They may wish to ensure priorities for the initiatives are clear and that staff are aware of the end dates and expected outcomes relating to the additional tasks or changes they are asked to make.

We saw appropriate mechanisms in place for investigating and monitoring incidents. We saw evidence that the Trust learned from untoward events. The wellbeing of patients was
promoted because plans were put in place to reduce the risk of an incident being repeated.

We found that complaints procedures were adequate and a patient liaison service (PALS) was well established. Systems were in place to capture information, monitor the nature and management of complaints and review the activities of the PALS team. Policies and procedures showed that there were different levels of investigating complaints depending on the type of concern raised. We saw robust systems for investigating and resolving complaints. We noted that the Trust was keen to bring about a local resolution if possible. Meetings with complainants were organised to try and resolve issues quickly. We also noted that the Trust responded to complaints posted on the NHS Choice website and attempted to deal with these. This meant when possible comments and complaints made by patients were directly responded to. The provider may wish to consider why issues reported on NHS Choice were not resolved at department or ward level.

We found that patients were given the opportunity to award satisfaction ratings about the care they received. This was through the Patient Experience Tracker (PET). These were completed monthly as a part of the Trusts quality improvement programme. A hand held device was used to record the answers which patients gave to a series of questions about different aspects of their stay in hospital. Areas commented on included cleanliness, communication, nutrition, pain control, privacy, dignity, quality of support to meet personal hygiene needs and involvement in care. The results were collated, analysed and shared with the ward each month. The target was for each ward to get feedback from at least two patients per day. We saw that the results were made available to patients, relatives and other visitors because these were displayed on a quality notice board outside each ward. This meant that systems were in place for seeking the opinion of patients so that their experiences could influence the development of the service.

We found that it was not always possible to see how the PET results had brought about improvements at the ward level. The provider may wish to produce a simple document explaining the improvements made on the ward in response to the results from the PET process.

We saw that the Trust paid special attention to gaining the opinion of children. This was through the 15 Steps Challenge. This is an initiative to enable young people to become actively involved in monitoring the service to make sure it is child friendly. This initiative was in place alongside the adult quality improvement toolkit. The aim of the 15 Steps Challenge is to help nurses and others gain insight into how children, young people and their families feel about the care provided. We found that the toolkit used at the children's hospital had been developed with the involvement of young people.

We saw that a monthly youth forum had been launched and members included current and ex-patients. Membership also included a youth governor and youth ambassador to help with the process of managing the meeting and completing the audits. Teachers from local schools also participated in the forum.

We reviewed the findings of the most recent 15 Steps Challenge ward visits. These took place in November and December 2013. We saw that recommendations and suggestions had been made relating to ward décor, signage and food. We reviewed the Trusts response to these suggestions and noted that plans had been made to consider how to respond to the results. These findings meant that children and young people were given the opportunity to influence the development of the children's hospital.
Records

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

Our judgement

The provider was not meeting this standard.

Patients were not fully protected from harm because a significant number of records were not fully fit for purpose.

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

Reasons for our judgement

We spoke to people using the services but their feedback did not relate to this standard.

We found that improvements were needed to ensure that record keeping was robust and met the required standard.

We looked at a sample of medical and nursing records on each ward we visited. We found evidence of poor record keeping on all but one of the wards we visited.

We found that many entries in the medical notes were illegible. One nurse commented: "It can be a nightmare to read the doctors notes." This meant there was risk to patients because staff had to consult with each other to decide what was written and so the patient could receive the wrong treatment and the record did not provide clear and unequivocal evidence of a patient's treatment pathway.

We saw that on some wards information about the same patient could be recorded in a number of different places. This meant communication was not effective because it was difficult to track the care required or provided.

There was no standard way of setting up or indexing files and so information could be overlooked or time was wasted searching for information. One nurse told us: "(We) need to improve records for day case/medical investigations as it can be confusing with so many pieces of different paperwork."

We looked at an assortment of completed paperwork. This included admission details, assessments, treatment plans, notes from meetings, observation charts and daily records. We saw omissions in most of the patient's records we looked at. The exception to this was Ward 7, on this ward all reports, assessments and observations had been completed in full. Also on ward 7, the nursing and medical files were well set out in chronological order and information was easy to find. This was not found on other wards. This meant the provider needs to take steps to ensure that the records made are always of a good
standard and presented in a way which makes information easy to access.

We saw that important information about the management of a safeguarding concern had not been recorded at the time the matter had been dealt with. This meant information available to medical, nursing and social care staff was incomplete. We did not see any harm to the patient in this instance but the Trust needs to ensure that staff are consistent in updating records as quickly as possible.

We discussed these findings with the senior management team at the Trust. We found that they were aware of the need to improve the quality of record keeping. We were sent a comprehensive progress and improvement plan about how the Trust would accomplish better record keeping throughout the organisation. The trust told us that they had commenced implementation of this plan. This has included investment in a records improvement team to work with front-line staff. We were also told that the electronic patient record is being piloted in one division of the trust. We assessed that implementation of this plan would go a long way towards achieving the required improvements. The provider has set target dates so that the success of the plans can be measured and additional steps taken to ensure poor record keeping in the Trust is not prolonged. We will review the effectiveness of the plan at future inspection visits.
This section is primarily information for the provider

### Action we have told the provider to take

**Compliance actions**

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

<table>
<thead>
<tr>
<th>Regulated activities</th>
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<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010</td>
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<tr>
<td>Nursing care</td>
<td><strong>Meeting nutritional needs</strong></td>
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<tr>
<td>Surgical procedures</td>
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<tr>
<td>Treatment of disease, disorder or injury</td>
<td><strong>How the regulation was not being met:</strong></td>
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<td></td>
<td>The provider failed to provide a choice of suitable and nutritious food</td>
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<td></td>
<td>and hydration to meet service users' needs. Food provided did not meet</td>
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<td></td>
<td>the needs of children and teenagers who used the service. Health and</td>
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<td>Social Care Act 2008 Regulation 14 (1) (a) (b).</td>
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<th>Regulated activities</th>
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<td>Diagnostic and screening procedures</td>
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<td><strong>Records</strong></td>
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<td>Treatment of disease, disorder or injury</td>
<td><strong>How the regulation was not being met:</strong></td>
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<td>The registered person needs to ensure that service users are protected</td>
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<td>against the risk of inappropriate care and treatment arising from a lack</td>
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<td>of proper information due to illegible and incomplete records and</td>
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<td></td>
<td>assessments in relation to the care and treatment provided. Health and</td>
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This report is requested under regulation 10(3) of the Health and Social Care Act 2008
(Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 09 May 2014.

CQC should be informed when compliance actions are complete.

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

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

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

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

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of 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>Met this standard</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<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>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>
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. 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:

- Respecting and involving people who use services - Outcome 1 (Regulation 17)
- Consent to care and treatment - Outcome 2 (Regulation 18)
- Care and welfare of people who use services - Outcome 4 (Regulation 9)
- Meeting Nutritional Needs - Outcome 5 (Regulation 14)
- Cooperating with other providers - Outcome 6 (Regulation 24)
- Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
- Cleanliness and infection control - Outcome 8 (Regulation 12)
- Management of medicines - Outcome 9 (Regulation 13)
- Safety and suitability of premises - Outcome 10 (Regulation 15)
- Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
- Requirements relating to workers - Outcome 12 (Regulation 21)
- Staffing - Outcome 13 (Regulation 22)
- Supporting Staff - Outcome 14 (Regulation 23)
- Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
- Complaints - Outcome 17 (Regulation 19)
- Records - Outcome 21 (Regulation 20)

**Regulated activity**

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
## Glossary of terms we use in this report (continued)

### (Registered) Provider

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

### Regulations

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

### Responsive inspection

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

### Routine inspection

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

### Themed inspection

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

<table>
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