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

University Hospital North Durham

North Road, Durham, DH1 5TW

Tel: 01325380100

Date of Inspections: 21 November 2013
20 November 2013
19 November 2013

Date of Publication: January 2014

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

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<th>Standard</th>
<th>Met Standard</th>
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<tbody>
<tr>
<td>Care and welfare of people who use services</td>
<td>✔️ Met this standard</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>✔️ Met this standard</td>
</tr>
<tr>
<td>Records</td>
<td>✗ Action needed</td>
</tr>
</tbody>
</table>
### Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>County Durham and Darlington NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of the service</td>
<td>University Hospital of North Durham provides services to a population of more than 250,000 in County Durham. The hospital provides a full range of outpatient clinics and diagnostics, inpatient surgery, children's services and consultant led maternity services. It handles emergency trauma surgery and other major surgery and is located in Durham.</td>
</tr>
</tbody>
</table>
| Type of services | Acute services with overnight beds  
Community healthcare service  
Diagnostic and/or screening service  
Long term conditions services  
Mobile doctors service  
Hospital services for people with mental health needs, learning disabilities and problems with substance misuse  
Remote clinical advice service  
Rehabilitation services  
Community based services for people who misuse substances  
Urgent care services |
| Regulated activities | Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Family planning  
Maternity and midwifery services  
Surgical procedures  
Termination of pregnancies  
Transport services, triage and medical advice provided remotely  
Treatment of disease, disorder or injury |
When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 19 November 2013, 20 November 2013 and 21 November 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by other regulators or the Department of Health, talked with other regulators or the Department of Health 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

The inspection team consisted of one compliance manager, three compliance inspectors, two specialist professional advisors (one in Elderly Care and one in Governance) and an expert by experience who obtained patient views. The inspection focused on two main areas. Firstly, the care of elderly patients including those with dementia type illnesses. Secondly on the systems that were in place for monitoring the quality of the service and how the hospital ensured their governance processes resulted in the continuous improvement of patients’ care.

We visited wards 1, 2, 3, 5, 11 and 12. We spoke with 84 patients and / or relatives during the inspection and reviewed the records of 38 patients. We spoke with matrons, ward managers, ward sisters, nurses and healthcare assistants. We also spoke at length with the trust's lead managers and members of the board in relation to governance. In total we spoke with 48 members of staff.

All of the wards we visited were very busy during the inspection. We observed many interventions from medical and nursing staff throughout the days. Although very busy, each ward visited was noted to be very responsive to patient calls. Nurse call activations were responded to quickly; as were patients calling out to staff from their rooms.

The observed care of the patients on the wards we visited appeared to be of good quality. The staff were observed to be diligent, warm, professional and appropriate in their interactions with patients. The provider may find it useful to note that decision making in
relation to DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) was found to be inconsistent. A DNACPR order means if someone's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR).

Patient feedback on the care received was mainly positive. Patients considered the staff to be kind, courteous and considerate. They felt they were being kept fully informed by doctors, consultants and the nursing staff regarding their treatment. They felt that the staff caring for them were skilled to do so appropriately. Where people told us they had raised issues, or we spoke with staff about problems they disclosed to us, we saw these matters had already been or were resolved.

We found patients had their health care needs assessed and received appropriate treatment to meet them. Comments from patient's and relatives included "From being admitted the care has been wonderful, the nurses never stop they are rushed off their feet", "The doctors have been very good, discussing everything with me", "The nurses do their job very well, I am very content with how they look after me" and "When my wife phones they give her all the information. We have no complaints, honestly."

We found there were appropriate arrangements in place to assess and monitor the quality of service provision, including clear evidence of a governance structure and focus operating within the hospital.

We spoke at length with the trust's lead managers and members of the board in relation to governance arrangements and assessing and monitoring the quality of service provision. The majority of the staff we interviewed were dedicated, committed and passionate and wanted to improve patient care. There was an evident culture of openness where people were prepared to admit when things had gone wrong and had acted appropriately to learn from incidents and improve patient care. We found there was a genuine willingness to engage and learn from others.

We saw examples that demonstrated good practice and improving quality. These included the development of care groups and the continuous quality improvement processes. Representatives from the care groups we spoke with said they felt they were able to drive quality and make improvements from within their own care groups and from the bottom up.

We found the majority of the assessments and plans for care we saw had been reviewed regularly and updated when required. We found some records had not been updated as regularly as required. This meant that accurate records in respect of each patient were not always being maintained. We have told the hospital to take action to address this and will return to check on this again.

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

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

We have asked the provider to send us a report by 04 February 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>
<thead>
<tr>
<th>Care and welfare of people who use services</th>
<th>Met this standard</th>
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<tbody>
<tr>
<td>People should get safe and appropriate care that meets their needs and supports their rights</td>
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Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people’s safety and welfare.

Reasons for our judgement

Ward 1 – Elderly

Ward 1 is a ground floor ward and can be accessed from the main corridor. It also has adjoining doors to Ward 2. The ward entrance has secure key-pad entry and remote switch opening to exit due to the care provided to older people with confusion and dementia type illnesses. The primary focus of the ward was the acute care and treatment of older patients. We were specifically told this was not a specialist dementia care ward; however a number of patients would have this diagnosis.

We saw there had been considerable effort to make the ward more understandable and safer for people who were confused or disorientated. This included pictorial signs on doorways such as bathroom and toilet areas, red paint surrounds around doorways to bathing and toilet areas to make the entrances more obvious and ‘painting out’ of areas that may present hazards to a confused person. For example, some door and entrance ways had been painted the same colour as the surrounding walls, to make them less obvious. This meant reasonable adjustments had been made in order to help meet people’s needs.

We spoke with a total of 17 patients and visitors on Ward 1 about the care and treatment they had received. People were complimentary about the care received and being kept informed about their treatment by the doctors and consultants. Comments included "From being admitted the care has been wonderful, the nurses never stop they are rushed off their feet", "The nursing care is brilliant; if I need pain killers I get them" and "The doctors have been very good, discussing everything with me." This meant people were satisfied with the care and treatment provided.

We spoke with staff who told us they had handover sheets which gave them key information for patients, pertinent to that day. These were used to support verbal handovers between staff. When we asked about particular patients staff were able to
either answer immediately or refer to the handover sheet that they had with them. This meant staff were aware of the needs of people they were providing care and treatment to.

As part of the inspection we observed and listened to staff interacting with patients. All interactions were noted to be professional, warm and appropriate. We saw the staff were skilled in managing patients who were exploring the ward, keeping them engaged and safe. We saw the staff used a bell to indicate meal times so that patients were aware, but also so that staff responded to assist patients to eat. We saw patients being assisted to eat and drink. The staff focused upon the patient and communicated appropriately during the assistance. We observed one patient was supported to eat their meal at a portable table in the corridor, as they wished to eat there. This showed the staff were flexible and amenable in responding to this patient's needs and wishes.

We saw the ward was supported by Physiotherapists and Occupational Therapists and there was a continued presence of medical staff on the ward. In addition, the ward received support from the Mental Health Team. There was input from the Acute Liaison Psychiatry Nurse and there was a project running to provide specialist mental health support into the ward. This included input into risk assessments and providing support to the staff, particularly for the management of challenging patients. The staff we spoke with felt this had been really beneficial to the patients. This meant support was being provided to help meet people's individual needs.

We saw two patient's records we looked at included a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) form. A DNACPR order means if someone's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). A DNACPR order should not affect other aspects of care and treatment, for example treatment of life threatening anaphylaxis, choking, infection, nutrition or hydration. All other care and treatment should be provided at all times. For one of the two forms, we saw it had been recorded there had been no involvement of the patient or their relatives in this decision. The other form indicated a member of the patient's family had been involved. This inconsistency in involvement of the patient and or family in such decisions was also reflected across some of the other wards we visited during the inspection.

We looked at the care records for six patients on this ward. We saw the risk of these people receiving unsafe or inappropriate care, treatment and support was reduced, as clinical staff had undertaken an assessment of their needs. Assessment on the ward was recorded in an assessment booklet, which contained both the nursing and medical assessment by the doctor. The booklet was set out in a way to guide staff to capture and record information relevant to the person's episode of care. This included a medical and social history, the results of routine medical tests and observations carried out, and an assessment of need against the areas of daily living.

We saw there were a set of risk assessments carried out by nursing staff to identify particular risks around nutrition, skin integrity, moving and handling and falls. We saw where patients were identified to be at risk of falls, a falls care bundle booklet had been completed. This process had been recently introduced to better manage falls risks. The hospital's standard stated it must be completed within four hours of admission. All the forms we looked at complied with this standard. We saw each person had a plan of care based on their assessed need. This meant care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.
The majority of the assessments and plans for care we looked at had been reviewed regularly and updated when required. We did see a few examples where records had not been updated as regularly as required. This is covered in more detail later in the report.

Overall, we found care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Ward 2 – Stroke

Ward 2 is a ground floor ward and can be accessed from the main corridor. It also has adjoining doors to Ward 1. The primary focus of the ward was the care and treatment of stroke patients. We were told some patients presented with other diagnoses, either as a result of assessing for potential stroke or bed pressures within the hospital. We saw at one end of the ward there was a gymnasium for physiotherapy treatment and occupational assessment.

We spoke with a total of 15 patients and visitors on Ward 2 about the care and treatment they had received. People were complimentary about the care received and being kept informed about their treatment by the doctors and consultants. Comments included "The nurses do their job very well, I am very content with how they look after me", "Nothing is too much trouble. They got me a cup of tea in the night as I couldn't sleep" and "I see the doctor daily who discusses my care and tells me the test results." This meant people were satisfied with the care and treatment provided.

We saw the ward was very busy during the inspection. We observed many interventions from medical, nursing and paramedical staff throughout the day. We saw staff on the ward were responsive to patient calls. Nurse call activations were responded to quickly, as were patients calling out to staff from their rooms.

We spoke with staff who told us they had handover sheets which gave them key information for patients, pertinent to that day. These were used to support verbal handovers between staff. When we asked about particular patients staff were able to either answer immediately or refer to the handover sheet that they had with them. This meant staff were aware of the needs of people they were providing care and treatment to.

As part of the inspection we observed and listened to staff interacting with patients. All interactions were noted to be professional, warm and appropriate. We observed patients being assisted to eat and drink. We saw the staff focused upon the patient and communicated appropriately during the assistance. We also saw that the staff used a bell to indicate meal times. This was so patients were aware, but also to help ensure that staff responded to assist patients to eat.

We looked at the care records for six patients on this ward. We saw the risk of these people receiving unsafe or inappropriate care, treatment and support was reduced, as clinical staff had undertaken an assessment of their needs. Assessment on the ward was recorded in an assessment booklet, which contained both the nursing and medical assessment by the doctor. The booklet was set out in a way to guide staff to capture and record information relevant to the person's episode of care. This included a medical and social history, the results of routine medical tests and observations carried out, and an assessment of need against the areas of daily living.
We saw there were a set of risk assessments carried out by nursing staff to identify particular risks around nutrition, skin integrity, moving and handling and falls. We saw where patients were identified to be at risk of falls, a falls care bundle booklet had been completed. This process had been recently introduced to better manage falls risks. The hospital's standard stated it must be completed within four hours of admission. All the forms we looked at complied with this standard. We saw each person had a plan of care based on their assessed need. This meant care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

We saw three of the six care records we looked at contained 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms. We found for two of the three forms, it was noted the patient had not been involved in the decision. For one of these two patient's it was noted the decision had been made in discussion with the patient's family. The doctors we spoke with said they made decisions based on medical intervention. The provider may find it useful to note that decision making in relation to DNACPR was found to be inconsistent. It did not always reflect the requirements which were set out in legislation, or take account of published research, guidance or good practice. This was also reflected across some of the other wards we visited during the inspection.

The majority of the assessments and plans for care we looked at had been reviewed regularly and updated when required. We did see a few examples where records had not been updated as regularly as required. This is covered in more detail later in the report.

Overall, we found care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Ward 3 – Medical Admissions Unit

Ward 3 is a ground floor ward and can be accessed from the main corridor. The ward manager told us that most people admitted to the ward had come via the accident and emergency department (A&E) or had been referred directly by their GP. We found the ward had an eight bedded assessment unit, eight bays with four beds each and four single occupancy rooms. We saw people received care, treatment and support in single sex accommodation. Each bay was assigned to a single gender, with nearby gender assigned toilets and bathing facilities.

We spoke with a total of 14 patients and visitors on Ward 3 about the care and treatment they had received. People were complimentary about the care received and on being kept informed about their treatment by the doctors and consultants. Comments included "The nurses are great, I wouldn't say a thing against them", "They couldn't improve the care, its 100%, they look after me alright man, a good set of lasses" and "The doctors work all day, but came at night to see if I was alright." This meant people were satisfied with the care and treatment provided. Some patients said they felt there was a need for more nurses, as they were rushed off their feet. We saw the ward was busy, however the staff were seen to be responsive to patient calls, including when patients activated their call bells.

We spoke with nurses and healthcare assistants about the people they were caring for. Everybody we spoke with was able to describe the needs of people they were responsible for. They told us 'handovers' took place at the beginning and end of every shift they worked. The staff we spoke with showed us this process was supported by a 'handover sheet' and staff carried this with them throughout their shift. This meant important
information relating to the care of patients on the ward was captured and communicated between staff.

We looked at the care records for seven patients on this ward. Of these seven sets of records, six were for people who were aged 65 or over. We saw that the risk of these people receiving unsafe or inappropriate care, treatment and support was reduced, as clinical staff had undertaken an assessment of their needs. Where people had first entered the hospital via A&E, ward staff had access to the medical assessments, tests and diagnosis made by A&E staff prior to transfer to the ward. They also had access to supporting information gathered by staff in A&E. This helped to ensure continuity of care.

This information was used as a basis for a more detailed assessment of need which took place on the ward. The ward manager told us this assessment was normally undertaken at transfer or within an hour of the person's admission to the ward. Assessment on the ward was recorded in an assessment booklet, which contained both the nursing and medical assessment by the doctor. The booklet was set out in a way to guide staff to capture and record information relevant to the person's episode of care. This included a medical and social history, the results of routine medical tests and observations carried out, and an assessment of need against the areas of daily living.

We saw that clinical staff had assessed the cognitive abilities and screened for dementia on admission. This was routinely completed where a person was over the age of 75 or for younger people if deemed necessary. This took place within 72 hours of a patient's admission to the hospital. Where the person's score on the dementia screening indicated concerns, a referral was made to the psychiatric liaison team for further assessment. This meant people received support for their mental, as well as physical health.

We saw there were a set of risk assessments carried out by nursing staff to identify particular risks around nutrition, skin integrity, moving and handling and falls. We saw where patients were identified to be at risk of falls, a falls care bundle booklet had been completed. This process had been recently introduced to better manage falls risks. The hospital's standard stated it must be completed within four hours of admission. All the forms we looked at complied with this standard. We saw each person had a plan of care based on their assessed need. This meant care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

The majority of the assessments and plans for care we looked at had been reviewed regularly and updated when required. We did see a few examples where records had not been updated as regularly as required. This is covered in more detail later in the report.

We saw each of the care records were personalised to that person, and recorded details about their individual needs, including religious and ethical beliefs. These measures meant patients were not given any foods, treatments or tests that may cause offence or contravene their beliefs.

The ward manager told us that there was a protocol in place on the ward for assessing pain levels. They said a person's level of pain was assessed on admission to the ward, and appropriate medication was prescribed and administered to help manage this. Pain was then reassessed at least four times a day, at each medication round (breakfast, lunch, tea time and night time) to make sure pain relief was given appropriately or at any time in between if someone complained of or appeared to be in pain. This meant people's needs in relation to pain were being managed effectively.
We saw that each patient on the ward was assessed on a regular basis by means of an early warning score. This was based on regular observations taken by staff. This meant staff could quickly identify if someone was deteriorating and take immediate action to reduce the risk of further deterioration. The early warning scores were used to trigger additional assessment by a qualified nurse or the medical emergency team as appropriate. This meant there were arrangements in place to deal with foreseeable emergencies.

We spoke with the ward manager about end of life care. They said they would try and make arrangements to promote the dignity of patient's at the end of their life. This included the provision of a single occupancy room where this was available, or checking for availability on other wards to give people privacy. In addition, relatives and friends would be granted open visiting, so they could spend as much time as they were able to with their loved ones. The ward had previously accessed other healthcare professionals, such as palliative care or MacMillan nurses to advise on symptom control and give additional information about support to families. The ward manager told us they tried to keep the lines of communication open with families, to keep them informed and to also gather information about personal preferences and wishes to help them meet the person's needs at the end of their life. These measures meant staff treated people with dignity and compassion to support them at the end of their life.

Overall, we found care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Ward 5 – Medicine

Ward 5 is a first floor ward and can be accessed from the main corridor. We saw people received care, treatment and support in single sex accommodation. Each bay of four beds was assigned to a single gender, with nearby gender assigned toilets and bathing facilities. We spoke with the matron, ward manager, a sister, two staff nurses, a pharmacist and a healthcare assistant on ward five.

We spoke with a total of 14 patients and visitors on Ward 5 about the care and treatment they had received. The people we spoke with were positive about the care received and on being kept informed about their treatment by the doctors and consultants. Comments included "I get brilliant care, the nurses are very, very nice; they come when needed", "The nurses are fantastic; if I ask for something I get it" and "The doctors are lovely, they keep me fully informed; I know exactly what my problems are." This meant people were satisfied with the care and treatment provided. One patient said they were cold and we saw they had a blanket over them. We saw the nurse came and took their temperature, which they said was normal. The nurse told us this person was currently 'nil by mouth' and were awaiting some tests.

We spoke with a pharmacist who was working on the ward. They explained to us how they were fully involved with the management of people's medicines from the point of arrival on the ward through to discharge. This included checking people's medication on arrival with the individual, their relatives or GP, through to ensuring people were discharged with sufficient medication. They told us they had good working relationships with the doctors and nursing staff and were encouraged to join ward rounds when available to do so. All of the staff we spoke with said they felt having pharmacist support on the ward was positive. This meant people's medicines were being managed appropriately.
We spoke with three qualified nursing staff about the assessment process they undertook when people were admitted to the ward. They said where a patient had been initially admitted to another ward within the hospital, their notes would come with them on transfer to Ward 5. The records we viewed confirmed this. They told us qualified nursing staff would undertake a re-assessment of the patient's needs. This ensured they had a baseline assessment on the ward and could confirm they had captured the needs of the person to assist in planning care. They also told us about the importance of monitoring early warning scores while the patient was on the ward. They said this helped to identify if they were deteriorating and what, if any action needed to be taken.

We looked at the care records for six patients on this ward. We saw that the risk of these people receiving unsafe or inappropriate care, treatment and support was reduced, as clinical staff had undertaken an assessment of their needs. The ward manager told us this assessment was normally undertaken at transfer or within one to two hours of the person's admission to the ward. They said ward staff worked on the principal of "doing (the assessment) on arrival" and as a minimum a "bed end" assessment was completed immediately by the nurse who received the patient. Assessment on the ward was recorded in an assessment booklet, which contained both the nursing and medical assessment by the doctor. The booklet was set out in a way to guide staff to capture and record information relevant to the person's episode of care. This included a medical and social history, the results of routine medical tests and observations carried out, and an assessment of need against the areas of daily living.

We saw that clinical staff had assessed the cognitive abilities of patients and screened for dementia on admission. This was routinely completed where a person was over the age of 75 or for younger people if deemed necessary. Where the patient's score on the dementia screening indicated concerns, we saw a referral was made to the psychiatric liaison team for further assessment. This meant people received support for their mental, as well as physical health.

We saw there were a set of risk assessments carried out by nursing staff to identify risks around nutrition, skin integrity, moving and handling and falls. We saw where patients were identified to be at risk of falls, a falls care bundle booklet had been completed. This process had been recently introduced to better manage falls risks. The hospital's standard stated it must be completed within four hours of admission. All the forms we looked at complied with this standard. We saw each person had a plan of care based on their assessed need. This meant care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

All the staff we spoke with at ward level told us about arrangements put in place to reduce the risk of falls. The staff also told us about the equipment they could access to support people at risk of falls. Equipment included an electrical falls monitors, which attached to people's clothes and gave an audible alarm if it detected a person had fallen, high low beds and cot side beds. There were also non slip socks for people to wear to provide traction against the floor. They told us about changes to the environment that had been made to reduce the risk of falls and we saw evidence of these changes. They told us they felt these measures had reduced the severity of falls on the ward and reduced the risks associated with falls.

Most of the assessments and plans for care we viewed had been reviewed and updated when required. We did see a few examples where records had not been updated as often as required. This is covered in more detail later in the report.
All the ward staff we spoke with said that the Trust had arrangements in place to ensure staff took account of published research and guidance. This included updates during regular mandatory training, updates and news alerts on the staff intranet, and policies and procedures for staff to follow. This meant the Trust had taken steps to ensure care and treatment was appropriate and safe, as it was based on and took account of relevant research and guidance.

The staff we spoke with told us about the reasonable adjustments put in place to meet people's identified need and to reflect their values and diversity. They told us this was included as part of their overall assessment of need. If they could not gather this information from the person themselves because of communication difficulties or dementia type illness, they told us about the steps they would take to gather this information. This included speaking to the person's next of kin and family or speaking to staff if the person had come from a care setting. One staff member told us how they had taken account of a hospital passport which accompanied a patient with a learning disability. This helped them understand the person's needs and how they preferred to be communicated with.

Staff told us they had a red tray system in place on the ward. This helped to identify those people who may need more prompting or assistance to eat and drink. They told us where a need was identified, staff were assigned to provide this support. Staff told us they thought this system worked well. We observed a lunch period on the ward and saw this was in place. We saw this helped people to receive adequate nutrition and hydration. We saw where assistance was provided, staff balanced the need to support people with promoting the autonomy and independence of people. This was done in a way that supported the dignity of the person being assisted.

Staff told us they were able to refer patients on for support from other health care professionals. This included occupational therapists, dieticians, physiotherapists and psychiatry and mental health nurses. One staff member gave us an example of how they had involved other healthcare professionals to support the discharge of a bariatric patient back into their local community. Bariatric refers to the branch of medicine that deals with the causes, prevention, and treatment of obesity.

A staff nurse gave us examples of how they would ensure the dignity and respect of a patient with dementia. They told us they would provide the same level of respect and privacy to a patient with dementia as they would to any other patient. For example they would ensure curtains were closed before undertaking any personal care task or tests. If the person was agitated because they were in an unfamiliar environment, they would take the time to reassure and orientate the person.

The staff nurses we spoke with told us about the things they would do to provide comfort, privacy and dignity when someone was identified as being at the end of their life. They told us they would make sure that the person was comfortable, and had adequate hydration and nutrition. In addition they would ensure the person's mouth was kept moist and that they were given any medication as prescribed to help them manage symptoms and pain levels.

Overall, we found care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Ward 11 – General Medicine
Ward 11 is a second floor ward and can be accessed from the main corridor. The ward manager told us that patients were admitted to the ward via a number of routes. These included from A&E, the chemotherapy unit in University Hospital North Durham, consultant clinics and direct from people's homes. Although the ward was general medicine, the majority of patients were admitted with respiratory conditions. There were 41 beds across the ward. This included an eight patient high dependency unit (made up of two bays of four) and five single occupancy rooms. We saw people received care, treatment and support in single sex accommodation. Each bay was assigned to a single gender, with nearby gender assigned toilets and bathing facilities.

We spoke with a total of 12 patients and visitors on Ward 11 about the care and treatment they had received. The people we spoke with praised the care they'd received. They were also complimentary about their treatment by the doctors and consultants. Comments included "When my wife phones they give her all the information. We have no complaints, honestly", "The care is marvellous, on the go all the time. You press the bell and they come straight away, if you ask for something you get it and they ask if you need anything" and "The doctors tell you everything, no punches pulled. They keep me informed of my progress." This meant people were satisfied with the care and treatment provided.

We spoke with nurses and healthcare assistants about the people they were caring for. Everybody we spoke with was able to describe the needs of people they were responsible for. They told us 'handovers' took place at the beginning and end of every shift they worked. The staff we spoke with showed us this process was supported by a 'handover sheet' and staff carried this with them throughout their shift. This meant important information relating to the care of patients on the ward was captured and communicated between staff.

We spoke with two pharmacists who were working on the ward. They explained to us how they were fully involved with the management of people's medicines from the point of arrival on the ward through to discharge. This included checking people's medication on arrival with the individual, their relatives or GP, through to ensuring people were discharged with at least 7 days' supply of medication. They told us they had good working relationships with the doctors and nursing staff and were encouraged to join ward rounds when available to do so. All of the staff we spoke with said they felt having pharmacist support on the ward was positive. This meant people's medicines were being managed appropriately.

We looked at the care records for eight patients on this ward. Of these eight sets of records, four were for people who were aged 65 or over. We saw that the risk of these people receiving unsafe or inappropriate care, treatment and support was reduced, as clinical staff had undertaken an assessment of their needs. Where people had entered the hospital via A&E or another ward, staff had access to the medical assessments, tests, diagnosis and supporting information captured as part of the assessment process prior to transfer to Ward 11. This helped to ensure continuity of care. We saw staff used this information as a basis to plan care for people.

There were also a set of risk assessments carried out by nursing staff to identify particular risks around nutrition, skin integrity, moving and handling and falls. We saw where patients were identified to be at risk of falls, a falls care bundle booklet had been completed. This process had been recently introduced to better manage falls risks. The hospital's standard stated it must be completed within four hours of admission. All the forms we looked at complied with this standard. We saw each person had a plan of care based on their
assessed need. This meant care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

The majority of the assessments and plans for care had been reviewed regularly and updated when required. We did see a few examples where records had not been updated as often as required. This is covered in more detail later in the report.

We saw each of the care records were personalised to that person, and recorded details about their individual needs, including religious and ethical beliefs. These measures meant patients were not given any foods, treatments or tests that may cause offence or contravene their beliefs.

The ward manager told us that a person's level of pain was assessed on admission to the ward. Where this was identified as a risk, a frequency for pain to be re-assessed would be given and a pain management tool used to assess this on an on-going basis, particularly for acute and chronic pain. They also told us they had sought advice from the palliative care team in relation to symptom control and pain management. We observed a qualified nurse talking to a patient about pain management and pain relief. We saw they gave the person information about how to manage pain levels, medication already taken and that which was prescribed to still be taken. We saw this helped the person make their own decision about how to manage their own pain. We also saw the staff member reassured this person that if ever they were in pain to let staff know, as there may be different options available to them to help with the pain. This meant people’s needs in relation to pain were being managed effectively.

We saw that each patient on the ward was assessed on a regular basis by means of an early warning score. This was based on regular observations taken by staff. This meant staff could quickly identify if someone was deteriorating and take immediate action to reduce the risk of further deterioration. The early warning scores were used to trigger additional assessments by a qualified nurse or the medical emergency team as appropriate. This meant there were arrangements in place to deal with foreseeable emergencies.

We saw that clinical staff had assessed the cognitive abilities and screened for dementia on admission. This was routinely completed where a person was over the age of 75 or for younger people if deemed necessary. This took place within 72 hours of a patient's admission to the hospital. Where the person's score on the dementia screening indicated concerns, we saw a referral was made to the psychiatric liaison team for further assessment. This meant people received support for their mental, as well as physical health.

We spoke with the ward manager about end of life care. They said they would try and make arrangements to promote the dignity of patient's at the end of their life. This included the provision of a single occupancy room where this was available or checking for availability on other wards. Also by allowing relatives and friends open visiting, including overnight, so they could spend as much time as they were able to with their loved ones. These measures meant staff treated people with dignity and compassion to support them at the end of their life.

Overall, we found care and treatment was planned and delivered in a way that was intended to ensure people’s safety and welfare.
Ward 12 – Orthopaedics

Ward 12 is a second floor ward and can be accessed from the main corridor. It also has adjoining doors to Ward 11. The ward provides care and treatment for patients with orthopaedic conditions. We saw at one end of the ward there was a gymnasium for physiotherapy treatment and occupational assessment.

We spoke with a total of 12 patients and visitors on Ward 12 about the care and treatment they had received. People were complimentary about the care received and on being kept informed about their treatment by the doctors and consultants. Comments included "Because of my condition I got upset yesterday and the nurse comforted me and had been very kind" and "The nursing care is spot on." People also said the doctors communicated everything and were monitoring their care. Consent for treatment was sought. This meant people were satisfied with the care and treatment provided.

We spoke with staff who told us they had handover sheets which gave them key information for patients, pertinent to that day. These were used to support verbal handovers that took place at the beginning and end of every shift they worked. Each member of staff we asked about a patient was able to either answer immediately or refer to the handover sheet that they had with them. This meant staff were aware of the needs of people they were providing care and treatment to.

As part of the inspection we observed and listened to staff interacting with patients. All interactions were noted to be professional, warm and appropriate. We observed patients being assisted to eat and drink. We saw the staff focused upon the patient and communicated appropriately during any help that was provided. We saw staff responded quickly to patient calls and staff always appeared to be active. We saw staff on the ward were supported by Physiotherapists and Occupational Therapists and there was a continued presence of medical staff on the ward. This meant support was available to help meet people's individual needs.

We looked at the care records for five patients on this ward. We saw the risk of these people receiving unsafe or inappropriate care, treatment and support was reduced, as clinical staff had undertaken an assessment of their needs. Assessment on the ward was recorded in an assessment booklet, which contained both the nursing and medical assessment by the doctor. The booklet was set out in a way to guide staff to capture and record information relevant to the person's episode of care. This included a medical and social history, the results of routine medical tests and observations carried out, and an assessment of need against the areas of daily living.

We saw one patient's records we looked at included a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) form. We saw it had been recorded there had been no involvement of the patient or their relatives in this decision. This was also reflected across some of the other wards we visited during the inspection.

We saw there were a set of risk assessments carried out by nursing staff to identify particular risks around nutrition, skin integrity, moving and handling and falls. We saw where patients were identified to be at risk of falls, a falls care bundle booklet had been completed. This process had been recently introduced to better manage falls risks. The hospital's standard stated it must be completed within four hours of admission. All the forms we looked at complied with this standard. We saw each person had a plan of care based on their assessed need. This meant care and treatment was planned and delivered
in a way that was intended to ensure people's safety and welfare.

The majority of the assessments and plans for care we had been reviewed regularly and updated when required. We did see a few examples where records had not been updated as regularly as required. This is covered in more detail later in the report.

Overall, we found care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.
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 an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

Governance

We spoke at length with the trust's lead managers and members of the board in relation to governance arrangements and assessing and monitoring the quality of service provision. The majority of the staff we interviewed were dedicated, committed and passionate and wanted to improve patient care. There was an evident culture of openness where people were prepared to admit when things had gone wrong and had acted appropriately to ensure action was taken to improve care for patients. There were robust systems and processes in place to investigate incidents, PALS (Patient Advice and Liaison Service) issues, complaints and concerns. The approach we saw was particularly patient centred. We found there was a genuine willingness to engage with and learn from others.

We looked at three sets of papers from board meetings. On reviewing board papers there appeared to be a significant proportion of discussion at Part II meetings. Part II meetings are not open to the public, whereas Part I meetings are. While certain issues such as 'commercial in confidence' and staff related issues need to be discussed in Part II meetings, we found many patient safety issues were discussed at Part II meetings.

We spoke with the Director of Nursing. They told us until April 2013, board meetings had been held in private. We saw patient safety had been covered within Part I and Part II board meetings since April 2013. They also said that all their patient safety reports had been Part I agenda items at the last board meeting. We saw evidence to confirm this. The Trust acknowledged they may not have got the balance right between the Part I and Part II agenda items; however there appeared to be a commitment to resolve this matter.

The majority of staff spoken with recognised that the trust was on a quality improvement journey. Most people had a very high regard for the Director of Nursing, Medical Director and Chief Executive. They told us these people were highly committed people, with a genuine desire to improve the quality of patient experience.

We found the trust had developed a structure for monitoring the quality of clinical services,
from the board to the ward and vice versa. We saw examples that demonstrated good practice and improving quality. These included the development of care groups and the continuous quality improvement processes. The trust had a devolved structure of 3 care groups: ‘Acute and long term conditions’, ‘Care closer to home’ and ‘Surgery and diagnostics’. Representatives from the care groups we spoke with said they felt they were able to drive quality and make improvements from within their own care groups and from the bottom up. They also said they felt the care groups were encouraged to become semi-autonomous, whilst at the same time working within the corporate structures. We saw an example of an integrated governance report produced by the Acute and long term conditions care group. We also saw a 'key messages' document this group had produced for their staff in October 2013. It included information about improving the standard of healthcare records, blood sampling, complaints and audit activity around medicines. This demonstrated how the provider was attempting to improve the quality of services being provided at ward level through the cascade of information.

We found each care group had a patient safety manager assigned to them. The patient safety managers were experienced members of staff with skills that included the ability to investigate and write serious incident reports. We spoke with the Associate Director of Nursing, Patient Safety and Governance who told us patient safety managers supported their care groups with Root Cause Analysis (RCA) and Serious Incident (SI) investigations. We found there was evidence of good working relationships between patient safety managers and care groups.

We saw the board had used an externally commissioned report and its findings to make further improvements to the governance structure of the organisation. The trust is required to self-certify itself against Monitor’s quality governance framework. Monitor is the sector regulator for health services in England. Their job is to protect and promote patients’ interests by ensuring the whole sector works for their benefit. As part of this, the trust commissioned an external body to carry out a review. We saw the report from this review resulted in several recommendations to help the trust improve its quality governance systems and processes. We found a good number of the recommendations within this report had been implemented and had improved the processes, systems and structure to quality governance. This meant the provider was seeking to improve the service based on advice provided by other expert bodies.

We also found the appointment of a Senior Associate Director for Assurance and Compliance had been a positive step. It was evident their work had improved the risk register and board assurance framework. For example, we saw the board report of 23rd October 2013 included a report on the 'Assurance Framework and Corporate Risk Register.' We saw that all risks contained within the 'Assurance Framework' were related to the corporate objectives of the trust. We saw each objective had a lead named person and lead committees assigned to them. For example objective 1 (reducing avoidable death) was assigned to the Medical Director and Director of Nursing and the committee that oversaw this was the 'Quality and Healthcare Governance Committee.' We also saw for each objective the 'Assurance Framework' clearly listed the risks, the controls in place to achieve it, sources of assurance, any gaps in the controls and insurance against these, and finally the action plan to remedy any gaps in the controls and assurance. This meant the provider was assessing and managing risks relating to the health, welfare and safety of people who used the service.

We saw the trusts’ committees were either operational or there to provide assurance. We saw each committee had clearly defined terms of reference. For example, there were 2
committees of the board to provide assurance; the 'Quality and Healthcare Governance Committee' and the 'Planning and Workforce Committee.' The Quality and Healthcare Governance Committee had objectives which included 'seek assurance of the implementation of the quality strategy' and 'seek assurance of regulatory compliance', for example through CQC and external visits. This meant the committees in place had clear roles.

We saw the trust had a robust incident reporting system in place for staff to use. We saw there was a policy and procedure for the reporting of serious incidents and this met the requirements of the NHS Litigation Authority. We also saw there was a robust process for reporting, investigating and sharing the learning from serious incidents. For example, we saw the Safety Committee regularly reported on incidents and reference was also made in the Care Closer To Home Integrated Governance Report of June 2013. The trust had also compiled a serious incident falls report October 2012 to March 2013. This had resulted in some changes to policy and practice at ward level. Some environmental changes had also been made within the hospital in order to reduce the risk of falls. This demonstrated the trust was investigating and learning from serious incidents.

We spoke with the Chairman of the Audit Committee who told us the committee considered all aspects of quality and performance. We saw the Audit Committee had recently received the internal audit progress report. This showed that a wide range of areas had been subject to audit, including patient feedback and involvement, whistleblowing, recruitment and selection and key financial systems. This demonstrated that the committee monitored quality and performance, in addition to financial performance.

We spoke with the Associate Director of Information about how they monitor performance targets and waiting times. They told us the trust was constantly monitoring targets and were aware there was an issue with performance against the combined target for A&E and urgent care centres. They said acute sites were giving the most performance concerns as there had been a year on year increase in activity of around 8%. This had placed additional pressures on the trust in meeting key performance targets. The trust had held discussions with partners and was working collaboratively to resolve these issues.

Overall we found there were appropriate arrangements in place to assess and monitor the quality of service provision, including clear evidence of a governance structure and focus operating within the hospital.

Ward 1 – Elderly

We looked at the quality monitoring systems in place on the ward during our inspection. It was evident from the patient's records we viewed, and from observing the clinical team, that patients were regularly reviewed and their care and treatment amended to meet their changing needs.

We spoke with the Modern Matron, who was working on the ward that day to cover for the Ward Manager. They told us about the service monitoring they completed on the ward. They talked about the range of audits completed on a regular basis and showed us evidence to confirm this. We were shown evidence of the 'Safety Thermometer Audit' that was completed on a monthly basis. The NHS Safety Thermometer provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and
system progress. The audit covered areas such as Pressure Ulcers, Falls, Venous Thromboembolism (VTE), Catheters and Urinary Infections. This meant patients were being protected against the risk of inappropriate or unsafe care.

We were told the ward was in the process of seeking recognition for the 'Quality Mark for Elder-Friendly Hospital Wards' and had completed 'Stage 1: Assessing Quality'. The ward had also recently re-instated Multidisciplinary Team meetings. We were told there had been some resistance to this; however these were felt to be important and had recommenced. We saw the meetings included input from the Mental Health Team. We attended one of these meetings during the inspection. We saw that it was very comprehensive and highlighted a significant amount of good clinical practice that was not always captured in the patient files.

All of these measures meant the provider was monitoring the quality of care and services provided to people.

Ward 2 – Stroke

We looked at the quality monitoring systems in place on the ward during our inspection. It was evident from the patient's records we viewed, and from observing the clinical team, that patients were regularly reviewed and their care and treatment amended to meet their changing needs.

We spoke with the Modern Matron who told us about the service monitoring they completed on the ward. They talked about the range of audits completed on a regular basis and showed us evidence to confirm this. We were shown evidence of the ‘Safety Thermometer Audit’ that was completed on a regular basis. The audit covered areas such as Pressure Ulcers, Falls, Venous Thromboembolism, Catheters and Urinary Infections. This meant patients were being protected against the risk of inappropriate or unsafe care.

We also saw a Ward Performance Framework Data Collection Tool was completed on a regular basis and the results of this were fed back to staff. The audit reported on areas such as compliance with the completion of nursing assessments, care plans and risk of pressure damage scoring for patients.

We saw appropriate systems were in place for the reporting of serious incidents. We were shown an action plan for a 'Root Cause Analysis' in respect of an incident where a patient had suffered a fracture on the ward. This showed the identified issue, the desired outcomes, the agreed action plan and any progress to date, the person responsible for seeing this through and the date by which any actions should be completed. This demonstrated that incidents were being investigated and any lessons learned were being acted upon.

All of these measures meant the provider was monitoring the quality of care and services provided to people.

Ward 3 – Medical Admissions Unit

We spoke with the Ward Manager about audits and quality checks carried out on Ward 3.
They told us a number of audits were carried out. For example, there were audits of documentation standards carried out on a regular basis. These included checks on the completion of the falls bundle, VTE assessment, dementia screening and early warning scores (EWS). They highlighted where non-completion of either the VTE assessment or dementia screening was identified and this was reported to the Ward Manager in an exception report for them to action. We saw audits were also carried out on infection control, hand hygiene, high impact interventions, and analysis of falls. We found the ward had implemented the Royal College of Physicians handover audit tool. This meant the provider gave due regard to appropriate professional and expert advice.

We saw a safety thermometer audit report for the ward was circulated to managers on a monthly basis. The audit covered areas such as Pressure Ulcers, Falls, VTE, Catheters and Urinary Infections. This meant patients were being protected against the risk of inappropriate or unsafe care.

We spoke with staff working in a number of roles on the ward to check their understanding on what their responsibilities were around reporting incidents. All of the staff we spoke with said they had a responsibility to report incidents and knew how to do this. This meant appropriate arrangements were in place for the reporting of incidents.

The ward manager told us that in addition to the 'Friends and Family Test', volunteers spoke with five patients on the ward to gather their feedback. Also five staff members were surveyed each month to gather their views. They said complaints and incidents from across the care group were discussed at the quarterly governance meetings. Matrons fed this information back at ward level to share any learning. They also told us the falls bundle that had been implemented was as a result of a serious incident that had taken place on a ward.

These measures meant the provider was regularly monitoring the quality and safety of care provided on the ward to inform improvements.

Ward 5 – Medicine

We looked at the quality monitoring systems in place on the ward during our inspection. We spoke with the Ward Sister who told us about the monitoring they completed on the ward. They were able to describe to us and provide evidence of a range of auditing carried out. This included audits of patient's observation charts, blood sugars and fluid balance charts. They told us the completion of fluid balance charts on the ward had improved significantly, however they were still aware of the need for improvement in this area.

We also spoke with the Matron for Ward 5 who told us about the 'Safety Thermometer' audit that was completed on a regular basis. The audit covered areas such as Pressure Ulcers, Falls, VTE, Catheters and Urinary Infections. They said they felt that "the ward owned the audit" and the results for the ward were discussed regularly with ward staff. They said any concerns highlighted by the audit would result in reviews of care with patients. They added "I like to be out there (on the ward) as I think you can feel it." This meant patients were being protected against the risk of inappropriate or unsafe care.

We spoke with staff working in a number of roles on the ward to check their understanding on what their responsibilities were around reporting incidents. All of the staff we spoke said they had a responsibility to report incidents and knew how to do it. This meant appropriate
arrangements were in place for the reporting of incidents.

We spoke with a health care assistant and two staff nurses about quality assurance, audit activity and improvements made to the ward. They told us they were kept up to date with the outcomes of audits and quality assurance processes in a regular newsletter from the ward manager. They told us this newsletter also included lessons learnt from complaints and serious incidents. They said they were given sufficient information to help improve their practice and improve quality of care on the ward. We saw examples of newsletters during our inspection to confirm this.

Staff told us that performance on the ward, as measured against five key indicators, was displayed in the ward area to inform staff, patients and visitors. This included month on month figures for number of complaints received, falls and hospital acquired infections. We saw this information was displayed in the ward area.

Staff told us they sought the views of patients on the care they had received through the 'Friends And Family Test.' They told us the ward clerk arranged for patients to be provided with this questionnaire upon discharge. Feedback from the trust was received on the results on a monthly basis, including any actions to be taken. This meant the provider was seeking and acting on feedback from patients.

All of these measures meant the provider was monitoring the quality of care and services provided to people.

Ward 11 – General Medicine

We spoke with the Ward Manager about audits and quality checks carried out on Ward 11. They told us that a number of audits were carried out. There were regular audits of documentation standards carried out, including on completion of the falls bundle, cannula care, pressure care and observations.

Staff told us that performance on the ward against key indicators was displayed in the ward area to inform staff, patients and visitors. This included month on month figures for number of complaints received, cannula care, falls and pressure sores. We saw this information was displayed in the ward area.

The ward manager told us that as a ward they had taken measures to improve the number of returned friends and family tests. This included handing forms out at discharge, but also on a weekly basis to patients on the ward. This meant the provider was seeking feedback from patients on the quality of services provided.

The ward manager told us that any staff member could raise an incident report on the Trust's safeguarding system. The expectation was this would be done within 24 hours of the incident taking place. We saw every incident related to the ward would be highlighted to the ward manager, who would need to investigate and comment on the incident. We spoke with staff working in a number of roles on the ward to check their understanding on what their responsibilities were around reporting incidents. All of the staff we spoke said they had a responsibility to report incidents and knew how to do it. This meant appropriate arrangements were in place for the reporting of incidents.

The ward manager told us complaints and incidents from across the care group were
discussed at the quarterly governance meetings. Matrons fed this information back at ward department level to share learning. This information was then cascaded to key senior sisters who were delegated to cascade the information to ward staff.

All of these measures meant the provider was monitoring the quality of care and services provided to people.

Ward 12 – Orthopaedics

We looked at the quality monitoring systems in place on the ward during our inspection. It was evident from the patient's records we viewed, and from observing the clinical team, that patients were regularly reviewed and their care and treatment amended to meet their changing needs.

We spoke with the Modern Matron and Ward Manager. They told us about and provided evidence of service monitoring carried out on the ward. This included evidence of the ‘Safety Thermometer Audit’ that was completed on a regular basis. The audit covered areas such as Pressure Ulcers, Falls, VTE, Catheters and Urinary Infections. This meant patients were being protected against the risk of inappropriate or unsafe care.

We saw a range of other audit activity was regularly completed on the ward. Examples included audits on the number of medication incidents reported, patient accidents and incidents, hospital acquired pressure sores and complaints.

We were told newsletters were used as a mechanism to provide staff with updates on any issues noted by audits of the ward or as a result of Matron or Ward Manager observations. We were shown examples of these from the months of October and November 2013. The newsletters included feedback from audits (for example on an audit of medication records) and other information of note, for example information on training for the new falls bundle and on extended pharmacy opening times. We saw the newsletters were sent out with a signature sheet to ensure staff confirmed they had read them. We saw a completed signature sheet which showed a high level of compliance. This meant systems were in place to share information and any findings or lessons to be learned from audit activity.

All of these measures meant the provider was monitoring the quality of care and services provided to people.
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.

People were not being protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always being maintained.

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

Ward 1 – Elderly

We looked at the care records for six patients on this ward. We found most records relating to patient's current episode of care were kept on wards as paper copies. They were kept in record trolleys outside the bay in which the patient was staying. We saw some trolleys could be closed and locked with other trolleys being of an open type. This meant patient's records could be located promptly when required and as far as was practically possible, patient's records were being kept securely.

We saw the most frequently accessed records, for example the observation recording sheets, were kept separately at the end of the patient's bed. This meant these records could be frequently accessed and were available even when other records were being updated. We saw the outcome of some medical tests and assessments were stored electronically.

Care plan records were found to be limited in detail, typically to one line statements. They appeared to be used as a record of consideration of patient care, rather than a tool to inform nurses of the care and outcomes required. A number of the staff we spoke with felt the forthcoming introduction of core care planning documentation would improve the quality of care planning and the recording of this.

We found the majority of the assessments and plans for care we saw had been reviewed regularly and updated when required. We found some records had not been updated as regularly as required. For example, we saw some patient's fluid balance charts had not been routinely totalled. Some patient's monitoring charts had few or no outputs recorded. The reverse of the charts identified the need to check fluid balance against weight; however none of the records we viewed demonstrated this had been completed. We saw one patient's file had some totals completed and an intravenous fluid regime had been commenced.
We saw another patient had diabetes, however there was no plan in place to monitor their condition in relation to this illness. The patient's care records stated they were 'diet controlled', however their medication records indicated the person was on insulin. We spoke with the nursing staff, who confirmed the patient was on insulin medication.

We saw each patient had a disclaimer form within their records file against liability for lost property. We saw one patient's form had completed entries, with records in other patient's files being either incomplete or unsigned.

We also saw patient's records included an Emergency Care Assessment document. The content of the documents were generally completed appropriately. However, the document required that entries on pages had name, signature, designation, bleep number, date and time annotated in the sections at the bottom of the page. We found this was not always complied with for some of the records we viewed, being either partially, or not filled in at all.

All of this meant accurate records in respect of each patient were not always being maintained.

Ward 2 – Stroke

We looked at the care records for six patients on this ward. We found most records relating to patient's current episode of care were kept on wards as paper copies. We saw they were kept in boxes inside the bay the patient was staying in, or in a file holder for individual rooms. This did not provide a secure process for protecting records from unauthorised access. However, we saw the files were in regular use, staff were present in these areas and the need for authorised ready access took priority. This meant patient's records could be located promptly when required and as far as was practicably possible, patient's records were being kept securely.

We saw the most frequently accessed records, for example the observation recording sheets, were kept separately at the end of the patient's bed. This meant these records could be frequently accessed and were available even when other records were being updated. We saw the outcome of some medical tests and assessments were stored electronically.

Care plan records were found to be limited in detail, typically to one line statements. They appeared to be used as a record of consideration of patient care, rather than a tool to inform nurses of the care and outcomes required. A number of the staff we spoke with felt the forthcoming introduction of core care planning documentation would improve the quality of care planning and the recording of this.

We found some patient's care records had not been updated as regularly as required. For example, we looked at patient's observation records. We found most had been completed appropriately. However, we saw one patient's file stated 4-hourly observations were required but only three sets of observations had been completed the previous day, and only one set on the day of the inspection up to and including lunchtime. We saw another patient's file stated observations should be done 4-times daily but the records indicated they were being done twice daily. We also saw for this patient the ward whiteboard had been updated but the care file had not.
We looked at Individualised Care Round forms for patients. We were told these forms were to be completed hourly or 2-hourly and were used as a means of recording and managing pain, patient's physical position, patient's needs and whether things such as call bells and drinks were within reach. We saw some charts appeared to be missing, one patient's chart did not indicate whether the checks should be done hourly or 2-hourly and there were some unrecorded sessions. We also saw where there was a concern in respect of pressure areas for a patient, there were gaps in the recording of positional changes. This meant there was a risk of this patient's condition deteriorating as records relating to positional changes were incomplete.

We saw a patient's nutritional risk assessment dated 18/11/2013 stated that they weighed 72kg, but when weighed again on 19/11/2013 had a weight of 89kg. We spoke with nurse responsible for the person's care who told us there was most probably an error with the scales used. However there was no reference to this in the patient's records. For another patient we saw the ward staff had identified a nutritional risk and the patient had been referred to Speech and Language Therapy (SALT). We saw a plan was in place to monitor their nutritional intake and weight; however the patient's charts had not been completed daily. This meant the dietician could not assess the person's diet upon review.

We also saw patient's records included an Emergency Care Assessment document. The content of the documents were generally completed appropriately. However, the document required that entries on pages had name, signature, designation, bleep number, date and time annotated in the sections at the bottom of the page. We found this was not always complied with for some of the records we viewed, being either partially, or not filled in at all.

All of this meant accurate records in respect of each patient were not always being maintained.

Ward 3 – Medical Admissions Unit

We looked at the care records for seven patients on this ward. We found these were personalised to the patient the record belonged to. The ward manager told us that electronic records had just been implemented recently for all historical medical records. This change meant staff had immediate access to any records relating to previous episodes of care within local hospitals to help ensure continuity of care. We saw all records had a patient identification sticker attached to them. This meant it was easy to identity which records belonged to which person.

We found most records relating to patient's current episode of care were kept on wards as paper copies. They were kept in record trolleys outside the bay in which the patient was staying. The ward manager explained they had tried different approaches in an attempt to maintain the confidentiality of care records. They recognised there was a balance to be had between records being inaccessible to those who do not have a legal right to look at them (for example visitors, family and friends) and being easily accessible to healthcare professionals who needed to access these records frequently or immediately in the case of an emergency. They had found the record trolleys provided this balance for the ward. They told us staff would challenge anyone found to be looking at records that did not have a right to do so. We asked a range of staff on the ward about this. All of the staff we spoke with knew who could and couldn't have access to patient's records and said they would challenge people if they needed to. They demonstrated their awareness of the Data
Protection Act. This meant as far as was practicably possible, patient's records were being kept securely.

We saw the most frequently accessed records, for example the observation recording sheets, were kept separately at the end of the patient's bed. This meant these records could be frequently accessed and were available even when other records were being updated. We saw the outcome of some medical tests and assessments were stored electronically.

Care plan records were found to be limited in detail, typically to one line statements. They appeared to be used as a record of consideration of patient care, rather than a tool to inform nurses of the care and outcomes required. A number of the staff we spoke with felt the forthcoming introduction of core care planning documentation would improve the quality of care planning and the recording of this.

We found the majority of the assessments and plans for care we saw had been reviewed regularly and updated when required. We found some records had not been updated as regularly as required. For example, we saw one patient had been assessed for the use of bedrails. The tool indicated this should be re-assessed daily to ensure this type of care remained safe. However the records indicated this had not been reviewed since the patient had been admitted to the ward three days previously. This meant there was a risk this patient was receiving unsafe or inappropriate care as an accurate record was not being maintained.

We also saw patient's records included an Emergency Care Assessment document. The content of the documents were generally completed appropriately. However, the document required that entries on pages had name, signature, designation, bleep number, date and time annotated in the sections at the bottom of the page. We found this was not always complied with for some of the records we viewed, being either partially, or not filled in at all. This meant an accurate record in respect of each patient was not always being maintained.

All of the staff we spoke with, including the ward manager, nurses and healthcare assistants told us they had access to the trusts policies and procedures electronically on the intranet. This meant they could be sure they were accessing the latest and most up to date documents at all times.

Ward 5 – Medicine

We looked at the care records for six patients on this ward. We found these were personalised to the patient the record belonged to. The ward staff we spoke with told us about the records management processes in place on the ward. They told us about the recent changes to this, with historical records being in the process of being scanned into an electronic format. This change meant staff had immediate access to any records relating to previous episodes of care within local hospitals to help ensure continuity of care. We saw all records had a patient identification sticker attached to them. This meant it was easy to identity which records belonged to which person.

We found most records relating to the current episode of care were kept on wards as paper copies. We saw they were kept in boxes inside the bay the patient was staying in. The ward manager told us staff would challenge anyone who was looking at records who
did not have a right to. The staff we spoke with, including nurses and healthcare assistants confirmed this. They also said they had annual training on information access and data protection matters.

We saw the most frequently accessed records, for example the observation recording sheets, were kept separately at the end of the patient's bed. This meant these records could be frequently accessed and were available even when other records were being updated. We saw the outcome of some medical tests and assessments were stored electronically.

Care plan records were found to be limited in detail, typically to one line statements. They appeared to be used as a record of consideration of patient care, rather than a tool to inform nurses of the care and outcomes required. A number of the staff we spoke with felt the forthcoming introduction of core care planning documentation would improve the quality of care planning and the recording of this.

We found the majority of the assessments and plans for care we saw had been reviewed regularly and updated when required. We found some records had not been updated as regularly as required. For example, we saw a patient had been catheterised and a catheter pathway document commenced as required. The pathway document indicated that a review should be completed and recorded 3 times a day (morning, afternoon and at night). We saw on days 1 and 2 following catheterisation this was recorded as completed. However for days 3, 4 and 5 following catheterisation the review record had only been completed once each day (at night). This meant there was a risk this patient was receiving unsafe or inappropriate care as an accurate record was not being maintained.

We saw another patient had been assessed as being at risk of dehydration, so fluid balance charts had been put in place. We saw these had not always been totalled to give the fluid intake and output in a day. This meant information was not available to determine whether the patient's had taken in enough fluid during each day.

We also saw patient's records included an Emergency Care Assessment document. The content of the documents were generally completed appropriately. However, the document required that entries on pages had name, signature, designation, bleep number, date and time annotated in the sections at the bottom of the page. We found this was not always complied with for some of the records we viewed, being either partially, or not filled in at all.

This meant an accurate record in respect of each patient was not always being maintained.

All of the staff we spoke with, including the ward manager, nurses and healthcare assistants told us they had access to the trusts policies and procedures electronically on the intranet. This meant they could be sure they were accessing the latest and most up to date documents at all times.

Ward 11 – General Medicine

We looked at the care records for eight patients on this ward. We found these were personalised to the patient the record belonged to. The ward manager told us that electronic records had just been implemented recently for all historical medical records.
This change meant staff had immediate access to any records relating to previous episodes of care within local hospitals to help ensure continuity of care. We saw all records had a patient identification sticker attached to them. This meant it was easy to identify which records belonged to which person.

We found most records relating to the current episode of care were kept on wards as paper copies. We saw they were kept in boxes inside the bay the patient was staying in. The ward manager told us staff would challenge anyone who was looking at records who did not have a right to. The staff we spoke with, including nurses and healthcare assistants confirmed this.

We saw the most frequently accessed records, for example the observation recording sheets, were kept separately at the end of the patient's bed. This meant these records could be frequently accessed and were available even when other records were being updated. We saw the outcome of some medical tests and assessments were stored electronically.

Care plan records were found to be limited in detail, typically to one line statements. They appeared to be used as a record of consideration of patient care, rather than a tool to inform nurses of the care and outcomes required. A number of the staff we spoke with felt the forthcoming introduction of core care planning documentation would improve the quality of care planning and the recording of this.

We found some patient's care records had not been updated as regularly as required. For example, we saw one patient had been referred to a Speech and Language Therapist (SALT) who had assessed them as needing a pureed diet and thickened fluids. However we saw the care plan associated with nutrition and hydration for this patient had not been updated to reflect this. It still stated the patient was on a normal diet. We spoke with the nurse for this patient. They were able to give an overview of the needs of this person, and confirmed the person needed a pureed diet and thickened fluids.

We also saw where a patient had been identified as having pressure ulcers, the associated entry in the care records was not dated. This meant it was not possible to identify when these sores had developed. The management information we viewed stated that no pressure sores had developed on the ward in 2013 up to and including October.

We saw another patient had been assessed for the use of bedrails. The tool indicated this should be re-assessed every 12 hours to ensure this type of care remained safe. However the records we saw indicated this had not been reviewed at the assessed frequency, as it had been re-assessed daily rather than 12 hourly. This meant there was a risk this patient was receiving unsafe or inappropriate care as an accurate record was not being maintained.

We also saw that some fluid balance charts had been completed for patients at risk of dehydration, however these had not been totalled to give the fluid intake and output in a day. This meant information was not available to determine whether the patient's had taken in enough fluid during the day.

All of these issues showed that accurate records in respect of each patient were not always being maintained.

All of the staff we spoke with, including the ward manager, nurses and healthcare
assistants told us they had access to the trusts policies and procedures electronically on
the intranet. This meant they could be sure they were accessing the latest and most up to
date documents at all times.

Ward 12 – Orthopaedics

We looked at the care records for five patients on this ward. We found most records
relating to patient's current episode of care were kept on wards as paper copies. Patient's
historical notes were kept in the notes trolley, close to the nurse's base. This meant
patient's records could be located promptly when required and as far as was practicably
possible, patient's records were being kept securely.

We saw the most frequently accessed records, for example the observation recording
sheets, were kept separately at the end of the patient's bed. This meant these records
could be frequently accessed and were available even when other records were being
updated. We saw the outcome of some medical tests and assessments were stored
electronically.

Care plan records were found to be limited in detail, typically to one line statements. They
appeared to be used as a record of consideration of patient care, rather than a tool to
inform nurses of the care and outcomes required. A number of the staff we spoke with felt
the forthcoming introduction of core care planning documentation would improve the
quality of care planning and the recording of this.

We found the majority of the assessments and plans for care we saw had been reviewed
regularly and updated when required. For example, we found all the 'falls care bundle'
booklets we viewed had been completed appropriately. This process had been recently
introduced to better manage falls risks. The hospital's standard stated it must be
completed within four hours of admission. All the records we viewed complied with this
standard. We saw one was recorded as done on admission and another within 15 minutes
of admission.

We found the standard of record keeping on the ward was generally very good. We saw
the ward had learned from a patient's previous episode of care where they had developed
a pressure ulcer which could have been prevented. The ward staff had ensured people
received positional changes in line with NICE (The National Institute for Health and Care
Excellence) guidance to reduce the risk of this. It was evident that this was normal good
practice.

We found a small number of records had not been updated as regularly as required. For
example, we saw one patient had a grade 2 pressure ulcer recorded on admission.
Positional change was noted as a requirement in this patient's records; however the
recording of this was not consistent. This meant there was a risk of this patient's condition
deteriorating as records relating to positional changes were incomplete.

We saw fluid balance charts were generally well completed, with totals recorded for each
day. We found there were a small number of shortfalls in recording, including one where a
patient was noted as being catheterised but the output was not recorded. A "Urethral
Indwelling Catheter Pathway" had been commenced for this patient.

We also saw patient's records included an Emergency Care Assessment document. The
content of the documents were generally completed appropriately. However, the document required that entries on pages had name, signature, designation, bleep number, date and time annotated in the sections at the bottom of the page. We found this was not always complied with for some of the records we viewed, being either partially, or not filled in at all.

All of this meant although the standard of record keeping on the ward was generally very good, accurate records in respect of each patient were not always being maintained.
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>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Records</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>Service users were not protected against the risk of unsafe or inappropriate care and treatment as an accurate record in respect of each service user was not always being maintained (Regulation 20(1)(a)).</td>
</tr>
</tbody>
</table>

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 04 February 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.
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.

✅ **Met this standard**

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

❌ **Action needed**

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

❌ **Enforcement action taken**

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

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non-compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

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

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

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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
### Glossary of terms we use in this report

#### Essential standard

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

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

#### Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
<table>
<thead>
<tr>
<th><strong>(Registered) Provider</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>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’.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Regulations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.</td>
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<table>
<thead>
<tr>
<th><strong>Responsive inspection</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>This is carried out at any time in relation to identified concerns.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Routine inspection</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Themed inspection</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>This is targeted to look at specific standards, sectors or types of care.</td>
</tr>
</tbody>
</table>