## County Durham and Darlington NHS Foundation Trust

### University Hospital North Durham

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<th>Region:</th>
<th>North East</th>
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| Location address: | North Road  
  Durham  
  Co Durham  
  DH1 5TW |
| Type of service: | Acute services with overnight beds  
  Rehabilitation services  
  Community healthcare service |
| Date of Publication: | January 2012 |
| Overview of the service: | The University Hospital of North Durham is located just outside of the city centre. The hospital provides acute services to the people who live in Darlington and County Durham. |
Our current overall judgement

University Hospital North Durham was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review

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

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 25 August 2011, carried out a visit on 26 August 2011, checked the provider's records, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We visited the University Hospital of North Durham on 25 and 26 August 2011. During the two days we were there, we spent time on the following wards: Accident and Emergency including X.Ray, ward 3 Acute Medical Admissions and Ambulatory Care, Ward 7 Child Health, Ward 10 Post Natal, Ward 1 Elderly Medicine, Ward 12 Orthopaedics inpatients and outpatients and Ward 13 Surgery.

Generally the comments we received from patients that we spoke to were positive with many patients being satisfied with the care they received. What we saw during our visit to some of the wards at University Hospital North Durham differed from what some patients told us. Opinions about the food were varied with some people saying that they liked the food and others saying that there was not always something suitable for them to eat.

What we found about the standards we reviewed and how well University Hospital North Durham was meeting them

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

Overall University Hospital North Durham had not met this outcome.

Not all patients were treated with dignity and respect.

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

Overall University Hospital North Durham had met this outcome but to maintain it we have set improvement actions.

Consent to care and treatment procedures were being followed; however this was not always recorded in the care plan. The reasons for not consulting with patients or their representatives were not always clearly documented on DNAR forms.

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

Overall University Hospital North Durham had met this outcome, but to maintain it we have set improvement actions.

Although most patients said they were kept informed about their care and treatment, on ward 1 we found that some care records were incomplete and lacking in detail as to how the older patient or patient with a dementia type illness should be cared for.

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

Overall University Hospital North Durham had not met this outcome.

Patients’ nutritional needs were not always being met and support was not always given to those that needed it.

**Outcome 07: People should be protected from abuse and staff should respect their human rights**

Overall University Hospital North Durham had met this outcome, but to maintain it we have set improvement actions.

Staff knew how to make appropriate safeguarding referrals for vulnerable children and adults, but some staff were unaware of how their actions could be seen as abusive towards older people.

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

Overall University Hospital North Durham had met this outcome, but to maintain it we have set improvement actions.

On wards 1 and 3, the disposal of sharps had not been managed in a safe way and some hand gel dispensers in the public areas of the hospital were empty.

**Outcome 09: People should be given the medicines they need when they need them, and in a safe way**

Overall University Hospital North Durham had met this outcome because medicines were managed in a safe way.
Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

Overall University Hospital North Durham had met this outcome but to maintain it we have set improvement actions.

The design and layout of the premises did not always meet the needs of the patients on some of the wards. For example the lack of signage and quiet areas for patients with a dementia type illness on ward 1, the right to privacy for patients attending the ambulatory care unit and improved signage directing people to the orthopaedic clinic.

Outcome 11: People should be safe from harm from unsafe or unsuitable equipment

Overall University Hospital North Durham had met this outcome but to maintain it we have set improvement actions.

Not all patients had access to equipment that would ensure their safety and independence for example the lack of leg raisers to use with wheel chairs and not enough electronic tags available to ensure the safety of babies.

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

Overall University Hospital North Durham had met this outcome but to maintain it we have set improvement actions.

We observed that staffing levels were not always sufficient to meet the needs of patients and in particular, older patients and those with a dementia type illness.

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

Overall University Hospital North Durham had met this outcome but to maintain it we have set improvement actions.

Not all staff had received appropriate training to meet the needs of the patients they cared for and in particular the needs of older people and those with a dementia type illness. More regular and appropriate supervision would enable staff to respond to older peoples’ needs in a more responsive and timely manner.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Overall University Hospital North Durham had met this outcome but to maintain it we have set improvement actions.

Systems were in place to monitor the quality of services provided and complaints were responded to. However, the quality assurance systems in place failed to identify the issues of concern that were identified by inspectors within this report.
**Actions we have asked the service to take**

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

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

**Other information**

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*
Outcome 01: Respecting and involving people who use services

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
There are moderate concerns with Outcome 01: Respecting and involving people who use services
Except in respect of Maternity and midwifery services, where the provider is compliant.

Our findings

What people who use the service experienced and told us
On ward 1, patients told us that they were treated with dignity and respect. They said they were able to make informed choices and their privacy was maintained. Three patients said that they felt valued and well cared for. One person said, "They are the professionals so I leave it to them to decide."

Another patient said, "I have been very well looked after, the doctors and the nurses have taken good care of me, they must have done, because I am going home today". Patients told us they were provided with individual lockers for their personal belongings with a lockable drawer for valuables.

We spoke to the parent of a patient on the children's ward. They told us that they were very happy with the ward and the staff. They explained that they were able to stay overnight in their child's room.

On ward 3 patients told us that they were kept well informed about their treatment, and likely outcomes. One person said, "They've told me what's happening and what they are going to do. Then they'll let me know tomorrow whether it's worked and what they'll do next."
One person told us that they had experienced "very good care" in the Accident and Emergency unit (A&E) during the night. They said that A&E staff then directed them to go to reception to get support for a bus or taxi home. However they found the reaction of reception staff to this request was challenging as the person "had not been given the right form", so they left without support. This person did not understand why reception staff did not contact A&E about it.

The patients we spoke to on ward 12 told us that the staff were very respectful and helpful when helping them to bathe and get dressed. However patients said that they were sometimes not consulted about their views as to the most appropriate care.

One patient told us that when she was assisted to the toilet she was told to ring the buzzer when she was ready to be collected, but was then often left waiting on the toilet for a few minutes. The patient said she hadn't been asked whether she would prefer for the staff member to wait outside for her, or for her to press the call buzzer.

One patient had a young son who had to travel to visit her each day. She thought that the visiting times were not flexible enough for her needs, as she could only see him for an hour a day.

Most of the patients we spoke to made very positive comments about the attitude of nursing and care staff. One visitor said, "Staff have looked after my relative very well. They're very nice and friendly." The patients we spoke to said they felt staff were busy but very respectful and caring.

**Other evidence**

On ward 1 we saw staff asking about patients' wellbeing and asking them for consent with support and treatment that they were offering. However, for those patients with a dementia-type illness, we saw on more than one occasion that staff were rather dismissive, or ignored their behaviour. For example, one patient was wandering around the corridor, and twice they were led back to their bed without any explanation or any attempt to interact with them in a positive way. Another patient was trying to show a different member of staff a bruise on their arm, and again they were led back to their bed without any recognition or response to their request.

We saw one new patient admitted onto the ward who was very distressed and disorientated and was crying out constantly. During this time, we saw that staff were extremely busy with other admissions and discharges, so no staff were available to provide any positive intervention or offer reassurance to this patient. We saw that other patients were becoming visibly upset by this patient's behaviour. We also saw the word "feed" written above one person's bed. Using language in this way did not promote the dignity of patients.

Although we saw that privacy curtains were used around individual beds, on wards 1 and 3 we saw that some patients were accommodated in single rooms off the main corridors where staff, visitors and other patients passed by. We saw that the doors to most single rooms were open and that some patients needed additional support with their clothing to make sure that they were not exposed and that their dignity was maintained.

On ward 3 we also witnessed poor practice relating to the movement of patients. We
saw that a gentleman was being transferred from ward 3 to ward 1 in a wheelchair. Neither the porter nor the nurse involved in the transfer took the time to communicate with or explain what was happening to the gentleman.

We also saw that staff were unable to respond appropriately with patients with a dementia-type illness. For example one lady who was in a ward at the end of a corridor was crying out, we had to prompt a nurse to offer the lady reassurance. We also observed an elderly gentleman walking up and down the corridor; this gentleman was becoming more and more agitated, again no one took the time to reassure him.

One member of staff told us, "Patients are getting older, but we haven't got the staff to specialise or sit with them." Staff also told us that they had not received training in managing challenging behaviours or dementia-type illnesses. When we raised our concerns with senior management we were told that there were training modules available for staff in dementia care and managing violence and aggression, however, none of the staff we spoke to had benefitted from this training.

One member of staff on a busy outpatients unit said, "I think we provide a very good service, but sometimes we cannot please patients because they might have been waiting in A&E for a few hours before they get to us and they want to be seen straight away. As long as we tell them approximately how long they will be they are usually ok."

During our visit we raised our concerns directly with both the ward managers involved and with the senior management team during the feedback session.

In May 2011 the County Durham Local Involvement Network (LINk) Enter and View group visited the University Hospital North Durham. They provided the Care Quality Commission with a copy of their report (June 2011). The Enter and View group visited the outpatients department and spoke with seven members of staff and surveyed a sample of patients. Nineteen patients completed and returned their surveys. The LINk report states that "the overall view of the patients we surveyed was very happy with the department in general. They were happy with the way they were treated throughout their appointment, particularly in terms of dignity and being given information about their condition. The majority were happy with the length of time they had to wait for their appointments ... however, 53% stated that their appointment did not start on time and 90% of these patients stated that they were not told how long they would have to wait or the reason for the delay. Some of the patients stated that this had an adverse effect on their well being..... 53% of patients said that staff did not tell them who to contact if they were concerned about their condition."

In July 2011 the Joint Information Gathering Group (JIGG) for County Durham LINk prepared a report about University Hospital North Durham. They used information from a range of different information sources including the trusts own data and that of other external groups including the Care Quality Commissions' national surveys. The JIGG sent the Care Quality Commission a copy of the report they produced.

The report said that one of the reasons that The University Hospital North Durham was selected as the subject of the report was due to "Anecdotal feedback from LINk members suggested that a number of issues and concerns about services being provided for them by University Hospital North Durham." Although the report acknowledged a number of areas where the trust had performed well including the
management of bedsores and falls, it also identified issues and areas for improvement and further exploration.

These were some of the issues that the report raised. "Patients not being told how long they had to wait, patients not being told what side effects from medication to look out for or who to contact if concerned, staff not introducing themselves to patients, not providing patients with copies of letters to their GPs. Instances of patients not being treated with dignity and respect and poor staff attitude, the attitude of some nursing staff, privacy issues and communication issues including instances of nurses talking as if patients not there."

Our judgement
Overall University Hospital North Durham had not met this outcome.

Not all patients were treated with dignity and respect.
Outcome 02:
Consent to care and treatment

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
The provider is compliant with Outcome 02: Consent to care and treatment

Our findings

What people who use the service experienced and told us
On ward 1 no one could recall if they had been consulted about their care and treatment, however we saw staff asking patients about their well being.

One patient on the post natal ward told us that their "whole level of care had been fantastic". They explained that they had an emergency caesarean section and the doctor had fully explained the procedure before they had signed the consent form. Another told us that the different options for pain relief had been explained to them and that their consent to treatment had been gained.

Other evidence
On ward 1 we saw staff asking about patients' wellbeing and asking them for consent with support and treatment that they were offering. We looked at six care records. When we looked at the care records we found little or no documented reference in patients' care plans about obtaining their consent to treatment and support. For patients who lacked mental capacity (that is, were unable to make decisions) we were told that arrangements were in place for someone to act on their behalf. We were told that best interest meetings had been arranged for some patients who had no one to represent them.

In two patient's medical records on ward 1, we found a Do Not Attempt to Resuscitate
document (DNAR). Both had been signed by a single consultant. There was no record or reference to the person or their representative having been consulted regarding this directive or any reason why they had not been consulted.

During our feedback session we raised our concerns about the DNAR documents that we had seen and we were told by senior trust staff that this was normal practice and in accordance with The General Medical Council Guidelines. After our visit we asked for a copy of the trust's resuscitation policy and notes on completion of the DNAR form.

We also obtained copies of the Cardiopulmonary Resuscitation Standards for Clinical Practice and Training: A Joint Statement from the Royal College of Anaesthetists. The Royal College of Physicians of London, The Intensive Care Society and The Resuscitation Council UK (2008) which stated “The overall responsibility for a DNAR decision rests with the most senior healthcare professional responsible for the patient’s care. When a DNAR decision is made it should be recorded clearly, together with the reasons for it and the names and designation of those involved in the discussion and decision. If no discussion takes place either with the patient or with those close to them, the reasons for this should be clearly recorded."

We also looked at the Resuscitation Council (UK) (2009) Recommended Standards for recording “Do not attempt resuscitation” (DNAR) decisions which includes the statements “As an integral part of their resuscitation policy, all healthcare organisations should therefore ensure: Effective communication and explanation of DNAR decisions when appropriate with the patient and effective communication and an explanation of DNAR decisions when appropriate and with due respect for confidentiality with the patient's family, friends, other carers or other representatives.”

The Resuscitation Council (UK) provides best practice guidance as to how DNAR records should be completed. We compared the best practice form with the form used by the trust. The form used by the trust was similar but not identical to that presented in the best practice guidance.

As stated earlier both of the DNAR records that we looked at had been signed by a single consultant but there was no record or reference to the patient or their representative having been consulted regarding this directive or any explanation or reason why they had not been consulted. We also saw that one of the records was not dated.

We concluded that staff had failed to follow the trust guidance and best practice guidance on completing DNAR forms in that no reason had been recorded for not consulting with the patient or their representative.

**Our judgement**
Overall University Hospital North Durham had met this outcome but to maintain it we have set improvement actions.

Consent to care and treatment procedures were being followed; however this was not always recorded in the care plan. The reasons for not consulting with patients or their representatives were not always clearly documented on DNAR forms.
Outcome 04:  
Care and welfare of people who use services

What the outcome says  
This is what people who use services should expect.

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

What we found

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<th>Our findings</th>
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<td><strong>What people who use the service experienced and told us</strong></td>
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<td>One patient on ward 10 told us that they thought the handover between shifts was very professional ensuring that all staff were well informed about individual patient's needs. Another patient said that &quot;the care I received has been brilliant&quot; and &quot;my bed linen is always changed if I request it&quot;.</td>
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<td>One person told us, &quot;I have been shown how to bath my baby properly and there is plenty of support if you need help to breastfeed your baby.&quot; Another said, &quot;Excellent, would recommend anyone to come here. Very friendly, they speak to you, the girls popped around to say congratulations, makes you feel like you are not a number, you matter.&quot;</td>
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<td>All of the patients we spoke with on ward 12 Orthopaedics felt that they had been kept informed about their care and treatment. One person said, &quot;The doctor has told me all about my results and what they plan to do during the operation, as well as the likely risks. But I've got every confidence in them because I was here five years ago and they did a good job then.&quot;</td>
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<td>Another person from ward 13 male surgery told us, &quot;This is my fourth time in this hospital and on all occasions I have received very good care. I came in as an emergency one day and they operated the next. The nursing staff have been very helpful and kept me pain-free.&quot;</td>
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Other evidence
What we saw during our visit to some of the wards at University Hospital North Durham differed from what some patients told us.

For example: On ward 1 we looked at six patient's care records. The care plans or records that we looked at were not "person centred" (this means they were not written in a way that described how each person preferred to be supported with their care). The care plans that we looked at were based on the activities of daily living. We saw that some areas of the care plans did not describe accurately the specific needs of the person. For example under the heading mobility, it stated, "needed 2 staff", but the record did not explain how, when, for what reason or what aids should be used. The communication section was left blank on all of the records that we saw. We also saw in one care plan the sections for pain, eating and drinking and safety had not been completed. None of the plans that we looked at described how the person's independence would be promoted.

We found no care plans written for any kind of behavioural needs. We found no risk assessments for patients who might challenge staff or their care, treatment and support, or for those patients likely to be become aggressive or cause self-harm or harm towards staff or other patients. This means that staff and other patients could be placed at risk of harm from patients who may become aggressive because there were no planned interventions in place to keep them or other patients safe. After the inspection we were told by the trust that the mental health liaison nurses who work on ward 1 make entries regarding behaviour needs into the medical notes, not on the care plan.

When we visited another trust location earlier this year we identified similar problems with the standard of recording in care plans. We told the trust senior management about our concerns then and actions were taken to improve the standard of care plans at that location. We were concerned that the lessons learned from our earlier visit to the first location had not been transferred to and applied within this location.

We looked at a selection of care records on the other wards we visited. We saw that there were appropriate assessments of each person's needs such as pain management and mobility. We saw that high risk assessments were re-assessed at every shift to make sure that they were still appropriate, such as bed rails for a person with dementia. We saw that care plans were detailed to help staff provide the right care.

We spoke with a specialist nurse who worked with people who were having a termination of a pregnancy. The nurse told us about the procedures that would be followed for early and late terminations including follow up support. We asked about any special procedures that might be followed for use with vulnerable people for example people with a learning disability. We were provided with copies of all the procedures that were in place for use with people with a learning disability.

**Our judgement**

Overall University Hospital North Durham had met this outcome, but to maintain it we have set improvement actions.

Although most patients said they were kept informed about their care and treatment, on ward 1 we found that some care records were incomplete and lacking in detail as to how the older patient or patient with a dementia type illness should be cared for.
Outcome 05: Meeting nutritional needs

What the outcome says
This is what people who use services should expect.

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

What we found

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<td>There are moderate concerns with Outcome 05: Meeting nutritional needs</td>
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<td><strong>What people who use the service experienced and told us</strong></td>
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<td>During our visit to ward 1 we spoke with six patients. Although patients' experience of food was mixed, the majority of patients told us that they liked the food or felt that it was as good as it could be when catering for large numbers of people. They told us that they were given choices about what they ate. Patients told us that there was enough to eat and drink. One person told us &quot;The food is excellent. I've thoroughly enjoyed every meal I have had&quot; and &quot;the meals are beautiful&quot;.</td>
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One patient on the ambulatory ward told us that they had to attend the day ward twice that week. They told us, "Today has been fine but Tuesday I came in the morning and it was half past three before I had a drink offered. Today I had tea at eleven and lunchtime."

One patient on ward 12, who had facial injuries, told us that they could not chew food. They said that they were unable to get soft foods that they would be able to manage, other than one flavour of soup which they did not like. They said that they had asked for yoghurt but was told that this was only available at one meal per day. This same patient said that there was little to eat at breakfast time which was appropriate for their needs. They told us that at one point during their stay they had fainted in the afternoon and felt that this was because they had had no food that day.

We spoke to another patient who said, "They put mayonnaise on everything." When we asked staff whether there was any option to request no mayonnaise we were told that the patient had been on the ward for five days and had not eaten any food with mayonnaise on it. It was only on the day of this visit that the patient had been told that...
she could request food without mayonnaise.

In general, patients had mixed comments about the food provided. One person said, "It's palatable. It's a hospital, not a holiday." Several other patients told us that the food was not very good. Patients said, "The food is not so great – it comes all the way from Wales then is heated up here."

Other evidence
On some wards staff were aware of a catering request form that they could use to order out of hours meals and special meals if they were made aware of a patient's dietary needs, such as coeliac disease. Overall, our conversations with staff revealed that not everyone was aware of the out of hours catering request forms. One member of staff told us that when patients came up onto the ward out of hours they could "make them a jam sandwich."

On ward 3 we were told by one member of staff that only snack boxes were available outside of meal times and that there was no opportunity for a hot meal. These snack boxes were available for patients who were newly admitted and had missed a meal, or for patients who were hungry between meals.

Staff gave us copies of the forms they used and we asked the trust to provide us with copies of the forms they expected staff to use. We were sent the trust procedure for out of hours meal provision for the service and ordering of individual frozen meals from 7:30pm – 7:30am. The procedure identifies the out of hours meal selection for University Hospital North Durham as being roast pork dinner, roast chicken dinner, cottage pie dinner, beef hotpot dinner, bean casserole and ratatouille and vegetables. In addition to the procedure we were given copies of the snack box ad hoc request form, and we had two versions of the patient feeding ad-hoc request form.

None of the patients that we spoke to were aware that the ward had snack boxes.

On ward 1 we saw lunch being served and patients being supported to eat. Staff served meals from a hot trolley. Different coloured trays were used, blue for those who could eat and drink independently and red for those who required assistance to eat and drink. We saw that some staff offered support sensitively and discreetly and did not rush the meal. We saw that patients were given choices that they had selected from the previous day, and were asked about their enjoyment of their meal by some of the staff.

However, not all staff provided support appropriately. We saw some patients being assisted by staff who were standing over them, and we saw a lack of sensitivity, dignity and little communication during this process. We heard staff referring to patients who needed assistance as "feeders".

We saw five patients whose meal was served to them on a blue tray. We saw that two of those patients had fallen asleep, and the other three patients still had not touched their meal after 20 minutes. These patients were not given the help or prompting they needed to eat or drink. There was little support to help them and when the meals were cleared away, most of it was uneaten.

Staff said that patients' care plans were used to identify those who were at risk of poor nutrition or hydration, and that dieticians would be involved to assess patients as well.
as the speech and language therapist and physiotherapists where appropriate. Staff said that a nutritional screening tool would also be used as part of this process, and that food and fluid charts were set up according to individual needs and risks. We looked at a sample of food and fluid charts. The quality of information recorded varied and did not always follow the guidance provided by the trust. For example we saw records that had not been completed for two consecutive days. (25 and 26 August 2011). We were told that relatives were encouraged to visit at mealtimes to assist their relatives to eat. We saw two relatives assisting their relatives to eat their lunch.

When we visited another trust location earlier this year, we identified similar problems regarding the support provided to people who needed assistance with eating. Improvements were made at the first location however; the improvements had not transferred across to this location.

On ward 10 we saw lunch being served from a heated trolley. The menu showed that there were six choices for a main meal. However patients were being told that two of those options were no longer available.

The Joint Information Gathering Group (JIGG) report provided to us stated that based on findings from the National Inpatients Survey the University Hospital North Durham were rated as "very poor on food quality".

During the feedback session we told senior management of the trust about our concerns.

**Our judgement**

Overall University Hospital North Durham had not met this outcome.

Patients' nutritional needs were not always being met and support was not always given to those that needed it.
Outcome 07:
Safeguarding people who use services from abuse

What the outcome says
This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement
The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We did not ask people about this outcome area.

Other evidence
In discussions, staff were very clear about their responsibilities to report potential safeguarding issues. Staff told us that they had mandatory training in protection of adults and children procedures. Staff demonstrated that they knew the point of contact to report any allegations or concerns relating to safeguarding. They were able to give us examples where they had followed these procedures in order to safeguard a patient who would have been at risk if they had returned home.

We also spoke with the local authority children's safeguarding team who confirmed that the paediatrics team met with them on a regular basis and made appropriate referrals.

However in other outcome areas within this report, we described our observations that indicated poor practice in relation to patients who may have a dementia type illness. Staff did not show any awareness that their actions could be seen as abusive towards those vulnerable groups.

Our judgement
Overall University Hospital North Durham had met this outcome, but to maintain it we have set improvement actions.

Staff knew how to make appropriate safeguarding referrals for vulnerable children and
adults, but some staff were unaware of how their actions could be seen as abusive towards older people.
Outcome 08: Cleanliness and infection control

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

What we found

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

Our findings

What people who use the service experienced and told us
We did not ask people about this outcome area.

Other evidence
Although we did not fully review this outcome area we did observe that ward 1 was extremely clean and there were good hand hygiene facilities available throughout the ward for staff, patients and visitors to use. Wards 3, 7 and 10 were also clean. Ward 10 had established procedures for the control of legionella in an unused shower room and for the removal of waste.

On ward 1 we saw that storage and treatment room doors were not lockable. In one treatment room we saw an open sharps box left on a shelf. This could potentially place patients at risk if they were to enter this area. We also found a used sharp box with a used cannula in an unlocked visitor'/meeting room on ward 3. The boxes were removed when we identified our concerns.

We also noticed that hand gel dispensers were empty in the main reception area and at the restaurant entrance.

During the feedback session we told senior management of the Trust about our concerns.

The 'Enter and View' visit report compiled by the Local Involvement Network (Link) completed in June 2011 also identified empty hand gel dispensers as a concern and made the recommendation that "hand gel dispensers need filling up and kept topped up on a regular basis."
Our judgement
Overall University Hospital North Durham had met this outcome, but to maintain it we have set improvement actions.

On wards 1 and 3, the disposal of sharps had not been managed in a safe way and some hand gel dispensers in the public areas of the hospital were empty.
Outcome 09: Management of medicines

What the outcome says
This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement
The provider is compliant with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We did not ask people about this outcome area.

Other evidence
Although we did not fully review this outcome area, we were able to observe part of a medication round being administered on ward 1. We saw that medicines were handled safely, securely and appropriately. Medicines were given to patients safely, and patients were asked if they needed assistance to take their medicines. We observed staff washing their hands after every administration. We also saw that a pharmacist based on the ward addressed all patients by name and explained why they were there prior to reviewing their medication charts.

Our judgement
Overall University Hospital North Durham had met this outcome because medicines were managed in a safe way.
Outcome 10:
Safety and suitability of premises

What the outcome says
This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement
The provider is compliant with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
Some patients described the waiting area of Accident and Emergency unit as "dingy" and "drab". One person told us, "It's not very nice, it's very dim and there were not enough seats. There was cleaning equipment everywhere at 7am."

Other evidence
The trust had a single sex ward accommodation policy in place, and we saw that this was happening in practice. For example on ward 1 we saw that there had been improvements to the environment to help make sure that patients had good access to same sex accommodation and bathrooms where possible.

We saw that ward 1 had not been adapted or decorated for patients with dementia, for example, toilet doors and hand washing facilities displayed only written signs on them such as 'WC'. There were no pictorial signs to help patients to become orientated around the ward or to help them to maintain their independence. We saw one patient with dementia trying to step over the large coloured squares of the floor design which were at the entrance to each ward area. Staff told us that this happened frequently with some patients and this increased the risk of falls. We saw that all toilets had been fitted with red seats and this helped patients with dementia to identify the toilets more easily.

We saw that storage and treatment room doors were not lockable. In one treatment room we saw an open sharps box left on a shelf. This could potentially place patients at risk if they were to enter this area.

We saw that the double doors leading to ward 2 were unlocked allowing people to
move from one ward to another, however, this also meant that patients with a dementia
type illness could potentially leave ward 1 unobserved which could have compromised
their safety. We saw that there were no communal lounges or a quiet area for patients
to use. This meant there was nowhere where they could relax, socialise with each
other, watch TV or have the opportunities to become involved in meaningful therapeutic
activities during their stay on the ward.

When we visited another trust location earlier this year we saw that adjustments had
been made to a ward that provided care for older people including those with a
dementia type illness. We are concerned that some of this best practice had not
transferred to this location.

We saw that each bed had a privacy curtain, and we observed that there were no gaps
when it was closed.

We saw that the corridors in ward 3 were cluttered with supplies and laundry trolleys.
We saw that this made it difficult for two-way traffic through this ward. For example, we
saw that a porter could not negotiate a trolley-bed when a person in a wheelchair was
trying to get past. We saw that the visitors’/meeting room was dimly lit and unkempt.

The access to ward 2 was through the ambulatory care ward which meant that patients,
staff and visitors who walked through this area during the day time were at risk of being
able to see and hear what care and treatment was being provided to day care patients.

Staff told us that the orthopaedic clinic did not have its own sluice or toilet. This meant
staff had to carry urine and other clinical matter (such as body fluids) through the
waiting area, then across the main corridors into the A&E clinic.

Staff from the orthopaedic clinic said, "It's a long walk from the main reception" and
there were no signs until patients reached the area. Staff said that the doors to the
clinic were heavy and would be difficult to open for someone using a wheelchair or
crutches. Staff felt access to this clinic would be easier for patients if there were
automated doors.

During the feedback session we told senior management of the Trust about our
concerns.

The 'Enter and View' visit report completed by the LINk identified five recommendations
to improve the patient areas at this hospital. These included the gradient of the ramp
from the main entrance to the main outpatients department: the payphone in the main
outpatients waiting area that needed lowering to a level that could be reached by
people in wheelchairs: the installation of seats at intervals in the very long internal
corridors: more space for wheelchairs in clinic areas and better signage directing
patients to the orthopaedics department. We did not check if all these
recommendations had been followed.

**Our judgement**
Overall University Hospital North Durham had met this outcome but to maintain it we
have set improvement actions.
The design and layout of the premises did not always meet the needs of the patients on some of the wards. For example the lack of signage and quiet areas for patients with a dementia type illness on ward 1, the right to privacy for patients attending the ambulatory care unit and improved signage directing people to the orthopaedic clinic.
Outcome 11: Safety, availability and suitability of equipment

What the outcome says
This is what people should expect.

People who use services and people who work in or visit the premises:
* Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
* Benefit from equipment that is comfortable and meets their needs.

What we found

**Our judgement**
The provider is compliant with Outcome 11: Safety, availability and suitability of equipment

**Our findings**

**What people who use the service experienced and told us**
We did not ask people about this outcome area.

**Other evidence**
We saw that some patients in the orthopaedic outpatient clinic were in wheelchairs with their legs in plaster propped up on chairs. This meant there were fewer chairs available and made it difficult for other patients to negotiate the waiting area. Staff told us that there were no wheelchairs with leg raisers at this clinic and that they often had to use towels to help support patients to hold their legs up.

We found that two babies on ward 10 were not able to have electronic tags fitted to them as none were available. These tags are used to improve the security and safety of the baby whilst they are in hospital.

During the feedback session we told senior management of the Trust about our concerns. They told us that additional leg raisers and electronic tags would be purchased.

**Our judgement**
Overall University Hospital North Durham had met this outcome but to maintain it we have set improvement actions.

Not all patients had access to equipment that would ensure their safety and
independence for example the lack of leg raisers to use with wheel chairs and not enough electronic tags available to ensure the safety of babies.
Outcome 13: Staffing

What the outcome says
This is what people who use services should expect.

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

What we found

<table>
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<th>Our judgement</th>
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<tr>
<td>The provider is compliant with Outcome 13: Staffing</td>
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<th>Our findings</th>
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| **What people who use the service experienced and told us**
All of the patients we spoke with had positive comments to make about the staff. One person said, "The staff have been so kind and helpful. I've been here before and the service remains very good."

**Other evidence**
On ward 3 staff said, "We need extra hands, it is sometimes difficult to meet patients needs. We get complaints, having to prioritise patient toileting. It is a good team but we sometimes run out of hands." And "Sickness is quite high on the ward. We rarely have three team assistants on duty. Normally staffing is alright." The ward manager told us that the skill mix was being reviewed and that there were adverts out for more nursing assistants.

One member of staff from the post natal ward told us, "On the whole I like working here and I work with a good team but understaffing can put pressure on everyone". They explained that when the labour ward was busy, midwives and healthcare assistants from the post natal ward had to help in the delivery suites or in theatre. The ward manager on the post natal ward explained that they had been recruiting staff over the summer and that 1 qualified midwife had just started work, a further 2 midwives had been recruited and both needed to complete their induction. A further 4 student midwives were due to register in October and had been appointed as maternity assistants until they were fully registered. We asked the Trust to provide us with vacancy rates for maternity services at this hospital for the previous six months. We were provided with figures for February through to July. These figures showed that

maternity services had been running with vacancies every month and that the birth to midwife ratio was up to 1:39 in July compared to 1:32 in February.

The orthopaedic surgery wards had separated into a planned surgery ward and a trauma ward. In the trauma ward the number of patients was unpredictable and the staff explained that the service had to be more flexible. Staff told us that the ward aimed to have 5-6 staff on during the day but on the day of this visit there were only 4 staff (including one relief staff). Staff said, "The difference between working with five or six staff to only four is enormous."

On ward 7 staff told us, "Staffing levels have been diabolical the last couple of months due to maternity and sickness." They also commented, "Staffing levels are improving at the minute but if it is full, it is heavy." And "Sometimes there are no breaks when we are busy."

In some wards staff told us that they felt there was sufficient staff to provide an efficient service.

We know from our earlier visits to another trust location that a computerised system for checking staff rotas was used to ensure that the most appropriate skill mix was in place. This means that the correct mixture of nurses and health care or nursing assistants needed to meet patients' needs was planned for and working on the wards.

During the feedback session we told senior management of the Trust about our concerns.

Our observations of staffs' inability to respond to patients needs in a timely manner indicated that at times, staffing levels and or the deployment of staff was not always good.

**Our judgement**

Overall University Hospital North Durham had met this outcome but to maintain it we have set improvement actions.

We observed that staffing levels were not always sufficient to meet the needs of patients and in particular, older patients and those with a dementia type illness.
### Outcome 14: Supporting staff

**What the outcome says**
This is what people who use services should expect.

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

**What we found**

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<tr>
<td>The provider is compliant with Outcome 14: Supporting staff</td>
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<table>
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<tr>
<th>Our findings</th>
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</table>
| **What people who use the service experienced and told us**
We did not ask people about this outcome area. |
| **Other evidence**
One member of staff from ward 10 told us that they had an annual supervision and appraisal. However they had no other regular supervision sessions, although they said that a session could be organised if they specifically requested it. They had completed their annual mandatory training session and also attended safeguarding training in the last 12 months. This member of staff explained that there had been no formal risk assessment of their duties whilst pregnant. |
| Staff in an outpatients clinic said, "We have little time for one-to-ones, and no scheduled supervision, but we have regular team meetings and regular debriefs." Another staff said, "We have worked together for several years and we are an efficient team. We have team meetings but if I asked for supervision time with my manager I'm sure this would be arranged." |
| Most but not all of the staff we spoke with said that they felt supported by their line managers. None of the staff we spoke with could confirm that they had had any planned supervision sessions with their immediate supervisor but felt that they could request this at anytime. |
| We asked to see a list of recorded supervision sessions for staff on ward 7 and minutes from the last two team meetings held on that ward. The manager on the ward at the time of our visit said that they could not get access to the minutes but that they could be |
sent on. After our visit we asked the senior management of the trust for copies of the last two team meetings for this ward and a list of recorded supervision sessions held for staff. We were provided with copies of clinical governance meetings for the last twelve months. Unfortunately these minutes did not confirm that staff on ward 7 had received appropriate supervision. On ward 10 we were told that team meetings were held every 1 or 2 months but that no written records were kept.

Following our visit to another trust location we identified concerns over staff supervision and were told by trust senior management that all group supervision sessions would be held as part of ward staff meetings and that a written record would be kept. We were told that this would be monitored by the trust. The improvements made at the first location were not transferred to and implemented at this location.

We asked some staff about the induction they had received. They told us, "I had a three day induction at Darlington, it was fantastic. I learnt a lot of things that do get put into practice." And "Induction wasn't brilliant. I have told people about my concerns. My mentor was not always here the days I was. Nothing got signed off; I was always told 'do it in a minute.'" And "I am not sure of the routine in theatre. I am asked to assist the nurse in the count of instruments. I have information about instruments, but no pictures." And "Some mandatory training is paid for and there are others on the intranet. I will go to training in my own time, they offer loads of courses." And "I had the usual Trust induction, my preceptorship did not really happen, it should be as long as you need it. I was allocated a mentor, but we never worked together. I have a booklet but am not able to sign things off. It is the same for all newly qualified staff. I have raised concerns with the matron who said they would look into it, but no change." "The lack of support is scary!" On ward 7 staff told us that staff "morale was poor" and that there was a "high turnover of staff." When we asked about staff meetings on ward 7 we were told "I have been to one or two but not many, they can get cancelled." And "They try to do regular ward updates and meetings but they are few and far between. I have a yearly appraisal which is probably overdue." And "We try to do staff meetings once a month; we had one a couple of months ago."

We asked the trust senior management to provide us with information about preceptorship and in particular ward 7 preceptorship students. The information sent to us stated that it was the trusts policy that the preceptor and preceptee would work 40% of their time or two shifts per week together for the first six weeks. The policy also stated that this relationship should last between four and six months but not longer than a year. We were given information about the amount of time that each preceptee on ward 7 had spent with their nominated preceptor which was within the expected 40% range, however we were also told that none of the preceptees had completed their formal contact dates and that all of the preceptees on ward 7 were starting the formal programme in October 2011.

As stated throughout this report, we saw that there were patients with dementia care needs in several of the wards we visited. Some of the patients were agitated and would have benefited from more reassurance from staff. In discussions with staff, they commented that there had been an increase in the number of patients with dementia care needs, but none of the staff we spoke with had any training in dementia care. We were told that there were plans to provide dementia care training in the future.

During the feedback session we told senior management of the trust about our
concerns. We have since been told that following the concerns we raised, a risk assessment was put into place for the pregnant employee who did not have one.

The Joint Information Gathering Group (JIGG) report stated that based on the 2010 Care Quality Commission National NHS staff survey for this Trust showed that there were “particularly low scores from Trust staff recommending the Trust as a place to work or receive treatment”. And that the survey also indicated a “declining belief in staffs ability to contribute to improvements at work and in their motivation”. The report also said that the JIGG were concerned about the apparent mismatch between the "high levels of staff being appraised and their reported levels of stress, poorly structured appraisals and low confidence in the Trust's commitment to work life balance or opportunity to develop their potential".

**Our judgement**
Overall University Hospital North Durham had met this outcome but to maintain it we have set improvement actions.

Not all staff had received appropriate training to meet the needs of the patients they cared for and in particular the needs of older people and those with a dementia type illness. More regular and appropriate supervision would enable staff to respond to older peoples' needs in a more responsive and timely manner.
Outcome 16: Assessing and monitoring the quality of service provision

What the outcome says
This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
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<tbody>
<tr>
<td>The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision</td>
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<table>
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<tr>
<th>Our findings</th>
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<tbody>
<tr>
<td>What people who use the service experienced and told us</td>
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<tr>
<td>We did not ask people about this outcome area.</td>
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<table>
<thead>
<tr>
<th>Other evidence</th>
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<tr>
<td>On wards 3 and 7 we noticed that the up to date results of the trust in-house quality audits were not displayed on the notice boards in each ward. On ward 3 we were told that the person who used to keep them updated had left. On ward 7 the manager on duty could not offer an explanation as to why they had not been updated.</td>
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<tr>
<td>On ward 1 we were told that there were a number of strategies for the trust to monitor the quality of the service and to listen to the views of patients. These included visits to the wards by senior trust staff, regular audits of different aspects of care delivery, focused audits and training and discussions with staff about different policies and procedures.</td>
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<tr>
<td>We spoke to senior trust staff about these and they confirmed that there were audits in place and action plans drawn up to address areas where patients' needs were not being met.</td>
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<tr>
<td>We requested copies of the patient surveys for the wards we had visited. We were told that the trust regularly seeks the views of patient experience, including their experiences of care and treatment. We were told that patients' views and comments contributed to improving standards where possible.</td>
</tr>
</tbody>
</table>
We were told that there were systems in place to continuously identify, analyse and review risks, adverse events, incidents, errors and any near misses. Information was then used to implement systems and methods of any non-compliance to resolve identified issues quickly.

We looked at two complaints that ward 10 had received and saw that investigations had been completed and responses given to each complainant.

None of the staff we spoke with were aware of the Care Quality Commission Essential Standards for Quality and Safety. These standards are used to determine whether any provider of care is meeting the regulations that they are registered under.

We were concerned that the trust had a range of systems including checklists and audits in place to monitor quality, however, during our visit we were concerned that we were able to identify areas where best practice had not been followed, policies and procedures had not been adhered to and learning and improvements had not been transferred from one location to another following Care Quality Commission visits and feedback.

During the feedback session at this location, we told senior management of the trust about our concerns over the lack of manager knowledge and awareness of the Care Quality Commission Essential Standards for Quality and Safety. They told us that managers had been told about the Care Quality Commission Essential Standards for Quality and Safety.

**Our judgement**

Overall University Hospital North Durham had met this outcome but to maintain it we have set improvement actions.

Systems were in place to monitor the quality of services provided and complaints were responded to. However, the quality assurance systems in place failed to identify the issues of concern that were identified by inspectors within this report.
## Improvement actions

The table below shows where improvements should be made so that the service provider maintains compliance with the essential standards of quality and safety.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 02: Consent to care and treatment</td>
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<tr>
<td></td>
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<td><strong>Why we have concerns:</strong> Consent to care and treatment procedures were being followed; however this was not always recorded in the care plan. The reasons for not consulting with patients or their representatives were not always clearly documented on DNAR forms.</td>
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<td>Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010</td>
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<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 9 HSCA</td>
<td>Outcome 04: Care and</td>
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<tr>
<td>Regulatory Standard</td>
<td>Why we have concerns:</td>
<td>Outcome</td>
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<tr>
<td>Welfare of people who use services</td>
<td>Although most patients said they were kept informed about their care and treatment, on ward 1 we found that some care records were incomplete and lacking in detail as to how the older patient or patient with a dementia type illness should be cared for.</td>
<td>07: Safeguarding</td>
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<td>Staff knew how to make appropriate safeguarding referrals for vulnerable children and adults, but some staff were unaware of how their actions could be seen as abusive towards older people.</td>
<td>08: Cleanliness and infection control</td>
</tr>
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<td></td>
<td>On wards 1 and 3, the disposal of sharps had not been managed in a safe way and some hand gel dispensers in the public areas of the hospital were empty.</td>
<td>10: Safety and suitability of premises</td>
</tr>
<tr>
<td></td>
<td>The design and layout of the premises did not always meet the needs of the patients on some of the wards. For example the lack of signage and quiet areas for patients with a dementia type illness on ward 1, the right to privacy for patients attending the ambulatory care unit and improved signage directing people to the orthopaedic clinic.</td>
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<th>Outcome 11: Safety, availability and suitability of equipment</th>
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**Why we have concerns:**
Not all patients had access to equipment that would ensure their safety and independence for example the lack of leg raisers to use with wheel chairs and not enough electronic tags available to ensure the safety of babies.

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<th>Outcome 13: Staffing</th>
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</table>

**Why we have concerns:**
We observed that staffing levels were not always sufficient to meet the needs of patients and in particular, older patients and those with a dementia type illness.

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<th>Service</th>
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<th>Outcome</th>
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<td>Outcome 14: Supporting staff</td>
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<tr>
<td><strong>Why we have concerns:</strong></td>
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<tr>
<td></td>
<td>Not all staff had received appropriate training to meet the needs of the patients they cared for and in particular the needs of older people and those with a dementia type illness. More regular and appropriate supervision would enable staff to respond to older peoples' needs in a more responsive and timely manner.</td>
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<td>Surgical procedures</td>
<td>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 14: Supporting staff</td>
</tr>
<tr>
<td>Maternity and midwifery services</td>
<td>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 16: Assessing and monitoring the quality of service provision</td>
</tr>
<tr>
<td>Surgical procedures</td>
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<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 16: Assessing and monitoring the quality of service provision</td>
</tr>
</tbody>
</table>
to identify the issues of concern that were identified by inspectors within this report.

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

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

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

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

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

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 01: Respecting and involving people who use services</td>
</tr>
<tr>
<td></td>
<td><strong>How the regulation is not being met:</strong></td>
<td></td>
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<tr>
<td></td>
<td>Not all patients were treated with dignity and respect.</td>
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<tr>
<td>Surgical procedures</td>
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<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 05: Meeting nutritional needs</td>
</tr>
<tr>
<td></td>
<td><strong>How the regulation is not being met:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patients' nutritional needs were not always being met and support was not always given to those that needed it.</td>
<td></td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 05: Meeting nutritional needs</td>
</tr>
<tr>
<td></td>
<td><strong>How the regulation is not being met:</strong></td>
<td></td>
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<tr>
<td></td>
<td>Patients' nutritional needs were not always being met and support was not always given to those that needed it.</td>
<td></td>
</tr>
</tbody>
</table>
The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

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

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

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

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

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

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

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

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions:** These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

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

<table>
<thead>
<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
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<tbody>
<tr>
<td>Author</td>
<td>Care Quality Commission</td>
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<td>The general public</td>
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<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
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