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

Date of Inspection: 17 October 2012

Tel: 01325380100

Date of Publication: November 2012

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

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<td>Action needed</td>
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<tr>
<td>Care and welfare of people who use services</td>
<td>Met this standard</td>
</tr>
<tr>
<td>Meeting nutritional needs</td>
<td>Met this standard</td>
</tr>
<tr>
<td>Supporting workers</td>
<td>Met this standard</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>Met this standard</td>
</tr>
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</table>
### Details about this location

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<th>Registered Provider</th>
<th>County Durham and Darlington NHS Foundation Trust</th>
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</thead>
<tbody>
<tr>
<td>Overview of the service</td>
<td>University Hospital of North Durham provides acute services to people who live in County Durham and Darlington. It is located near Durham city centre.</td>
</tr>
</tbody>
</table>
| Type of services | Acute services with overnight beds  
Community healthcare service  
Rehabilitation 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  
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 17 October 2012, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

We visited four wards, ward 2 (acute stroke unit), ward 6 (respiratory medicine), ward 15 (plastic surgery), ward 16 (elective orthopaedics) and the accident and emergency department on this inspection. It was an early evening inspection that started at 1600. Nearly all the patients we spoke with were satisfied with the care and treatment they had received. Comments included "Everything's good, I'm well looked after". There were also many positive comments about staff. Comments included "I have nothing but admiration for them"," Couldn't ask for better."

However, we did find sometimes patient's dignity and privacy was not being respected.

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 14 December 2012, 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>Respecting and involving people who use services</th>
<th>Action needed</th>
</tr>
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<tr>
<td>People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run</td>
<td>✗</td>
</tr>
</tbody>
</table>

#### Our judgement

The provider was not meeting this standard.

People's privacy, dignity and independence were not respected.

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

The staff we spoke with could give examples of how they respect privacy and dignity. Most of the patients we spoke with said they were treated with dignity and respect. They told us that staff spoke quietly when discussing personal matters. People said;

"They always ask before they do anything"

"They treat me with respect".

We saw staff using privacy curtains to maintain people's dignity and heard them speak with people politely and respond to their requests promptly.

The staff also told us about a 'quiet room' on the ward. They told us this is used to discuss issues with patients and family members where they felt a little more privacy was required. For example, if delivering news relating to conditions that people may find upsetting.

On ward 2 (acute stroke unit) we spoke with the relatives of three patients receiving treatment. They all said the nursing and medical staff had spent time to give them the appropriate information and support. On two of the wards we saw the results of the last month's patient survey which showed that a 100% of patients thought their privacy and dignity had been maintained.

However, on ward 15 we spoke to people who had been in a waiting area all day. This was an area at the end of the ward with a few seats and coffee table. We spoke with the staff nurse on duty who told us this area was used for patients who only required a local anaesthetic and, rather than send them home and delay the treatment, they used this area as a holding place. She advised that some days it could be used by one or two people but on other days up to six people. The day we visited we were told three patients had used this area; we saw two of these patients and talked in detail with one.

Patients told us that they had to get changed into gowns in the nearby toilet then sit in this area and wait to be taken to theatre. There was a mixture of male and female patients and some young adults throughout the day. They told us staff asked them personal information
in front of the other people sitting in the area.

In A&E whilst speaking to one of the patients in the short stay bay a doctor walked into the room without knocking or announcing himself, looked around and walked out saying "I'm looking for someone".

These examples show people's privacy and dignity was not maintained in some situations.

In the accident and emergency department (A&E) we spoke with five patients in the main waiting area. They told us they were taken somewhere private to discuss their problems but felt they could have been better informed about their treatment process. People said: "Yes, there was somewhere private to discuss my problem" "I wasn't kept up to date; they didn't tell me what I was waiting for next" "No explanation as to how other people took priority; they didn't tell me what category I was in so I didn't know how long I would be waiting for" "They said it could be up to three hours but didn't say who I would see next or what would be happening" "I wasn't told what category I was in or that other people would take priority" "The triage nurse explained what would happen"

We saw there was a white board which informed people how long the waiting time was dependant on which 'category' of care they were in. However, as people were not told the category which applied to them they were unable to use this information.

On ward 15 people waiting for day surgery told us that they were not kept informed as to when treatment was likely to take place or how long they could be kept waiting for.

Another person on A&E was concerned she had not taken her prescribed tablets when they were due and when she queried this with staff no one had responded to her. All of these experiences demonstrated that people had not been involved in decisions relating to their care and treatment.

The information CQC holds for the trust in the quality and risk profile (QRP) does not highlight any issues of concern for this outcome area. The QRP is a tool used in monitoring compliance with standards of quality and safety. It highlights where risks and issues may lie by pulling together information from a variety of sources, and providing an estimate of risk.
Care and welfare of people who use services  

Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

On the wards we visited all the patients (and relatives of patients) we spoke with told us they were happy with the care they were receiving. Comments included:

"Everything's good, I'm well looked after"
"It's alright here"
"I'm seen by the doctor every day"
"You can see they have in mind what happens to me."
"It's all been so good. It's hands on."

We looked at care records on each of the wards. These showed relevant assessments had been completed for people. Where people had been transferred from other wards and departments their records had come with them. Records showed people were assessed on the day they arrived on the ward. Assessments included methicillin resistant staphylococcus aureus (MRSA) screening where appropriate, nutritional screening tools, moving and handling and falls risk assessments, bed rail assessments and pressure sore prevention screening tools.

The provider should note when we checked "do not resuscitate" orders we found in the sample checked only 2 out 4 had all relevant sections completed. Two had not been signed by a senior doctor as required and it had not been recorded if the order had been discussed with the patient or relatives.

Records showed the ongoing involvement of doctors, respiratory team, pharmacists, physiotherapists and occupational therapists. Where tests had been requested as part of their initial assessment, the results of the tests were present within the records. All of the records we looked at reflected the information people had told us about their conditions they were admitted with.

When we arrived in A&E at 20:00 hours we saw the main waiting area was full. We saw all the rooms in the short stay area were occupied; both the paediatric treatment rooms were being used for adults, the monitoring bay had no space and both the resuscitation rooms were in use.

The provider should note that, after patients had been identified as needing to be
transferred to a ward within in the hospital, delays in this happening meant pressure was put on treatment areas within A&E.

For example we spoke with one patient in the short stay ward area who had been there since 05.30 hours. She had been seen by doctors and was told they were waiting for a bed in ward 3. This lady told us she was uncomfortable and just wanted to go to sleep. Another patient, in this area, told us she had been waiting three hours and we saw another person had to wait six hours.

We were told several patients were due to be transferred to Ward 3 (medical admissions unit) but this ward had no beds available. This meant patients had to stay in A&E until a suitable bed became available. We spoke with the consultant in charge of the department who confirmed there were often issues with patient flow to other wards within the hospital.

We spoke with five patients in the main waiting area who all told us they had been seen by the triage nurse within 15 minutes of arrival at the department. However one person had waited 45 minutes before seeing the triage nurse. This showed the majority of patients were seen within the target time of 15 minutes even when the department was busy.

We spoke with a nurse in the 'monitoring bay'. The nurse told us the longest time a patient had been in the monitoring bay that day had been 6 hours and they were due to go up to a ward in a few minutes. This patient was moved before we left the bay. We saw an elderly lady who had been admitted from a care home had been seen and assessed by a doctor within 2 minutes of being booked in by the ambulance crew. She was awaiting blood results before being allowed to return to the home.

We spoke with a relative of a lady who had come in at 16.00. They told us they were waiting for a bed to become available and X-rays to be done. The relative was very complimentary about the care provided and the staff in A&E. She said her relative had been seen immediately on arrival and said "They treat her wonderfully."

These examples demonstrate people experienced care, treatment and support that met their needs, however we saw in some cases delays in transferring patients to other wards within the hospital meant some people became anxious and uncomfortable.

The information CQC holds for the trust in the quality and risk profile (QRP) does not highlight any issues of concern for this outcome area.
Meeting nutritional needs

Food and drink should meet people’s individual dietary needs

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We had not planned to inspect this outcome on this visit but evidence collected identified issues of concern.

The provider should note when patients were in the short stay ward area attached to A&E and having day surgery on ward 15 the provision of food and drink was limited. For example we spoke to one patient in the short stay ward area who had been there since 5.30 in the morning. This person said they had been told they would be given a light meal at 17.30 but only received some toast at 20.30. Another patient in this area told us they had been in the department since 09.00 but only been offered a sandwich at 18.00. However on our visit we did see a hot drink being offered to two elderly patients in suitable plastic cups and another person we spoke with did tell us they had been offered something to eat.

We spoke with patients on ward 15 who had been waiting for minor surgery under local anaesthetic since that morning. One person said they asked for some water and were told "no". Another said they were told they could only have something to eat if there was enough left after the inpatients had been served their meals. The trust stated it was standard practice to provide food and drink for patients on ward 15 waiting for minor surgery.

These examples showed sometimes the provision of food and drinks was either not clearly explained to patients or it was not provided.

The information CQC holds for the trust in the quality and risk profile (QRP) does not highlight any issues of concern for this outcome area.
Supporting workers

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

Met this standard

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

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

We looked at training records used by the provider to record and monitor staff training. We found evidence of updates to training around care and safety had taken place. This meant people were being cared for by suitably trained staff.

The nine staff we spoke told us they attended training sessions every year. These included topics such as moving and handling, fire safety and safeguarding. We saw a training matrix which confirmed this was the case for all staff. We also saw staff had access to other specialist courses that were relevant to the ward they worked on. For example staff on ward 2, the acute stroke unit had been on stroke care and the management of patients with dysphagia (difficulty in swallowing) training.

Staff said they were able to approach supervisors or managers if they felt they needed more training. Sometimes group sessions were carried out on the wards if new equipment was being used. One person said they had just booked onto a tissue viability (the maintenance of skin integrity) course; another said they were due to go on training for blood transfusions.

The nurses we spoke with told us they had an annual appraisal and records we saw confirmed this. However records for healthcare assistants showed some staff had not had an appraisal for over 2 years.

The provider should note there was no structured supervision process for staff. Nursing staff on three different wards told us that supervision was available if they requested it but it was not offered routinely. They were happy that they would happen if needed.

We spoke with staff about the support they received from their management team. Staff told us they felt well supported and members of the senior team were always available for advice.

The information CQC holds for the trust in the quality and risk profile (QRP) does not highlight any issues of concern for this outcome area.
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 to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

People who used the service were asked for their views about their care and treatment and they were acted on.

The provider did on-going surveys where patients could feedback their views. On the wards we saw the patient feedback from recent surveys, which were done every month on all the wards. These results showed people were normally very satisfied with the care and treatment they had received. For example we looked at some patient satisfaction questionnaires called "A moment of your time". We looked at the ones people had completed since 01 October 2012. Seven forms had been completed altogether. Feedback was generally positive. Comments included:

'Despite the amount of people waiting to be seen, my treatment commenced immediately'
'I have no complaints'
'Everything very good – very hard working'
'Treat well and well mannered staff'
'Everything was great'

Staff told us they could give their views at staff meetings and complete an annual staff survey. We saw that the provider had acted upon comments or suggestions received.

During our inspection, we looked at the quality monitoring systems the provider had in place at ward level. We saw the provider had a comprehensive range of daily and weekly checks in place to ensure the quality of the service was monitored closely. For example we saw the results of recent audits (checks) for cleanliness, environment and checking patient observations. Senior nurses used a performance framework to monitor a full range of ward activity. We saw a copy of the framework and the results for September 2012 for ward 2. Areas monitored included complaints, staff appraisals, records and environment checks. A traffic light system was used to highlight areas of concern. This meant the provider was assessing and managing risks relating to the health, welfare and safety of people who used the service.

We saw information was available to patients on how to complain if they were unhappy with care they had received. We saw these complaints were monitored every month as part of the ward performance framework and learning points identified and fed back if
required.

The information CQC holds for the trust in the quality and risk profile (QRP) does not highlight any issues of concern for this outcome area.
## 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 activity</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td></td>
<td>Respecting and involving people who use services</td>
</tr>
</tbody>
</table>

**How the regulation was not being met:**

The provider did not have suitable arrangements in place to ensure the dignity, privacy and independence of service users. (Regulation 17 (1) (a)). The provider did not provide service users with appropriate information and support in relation to their care or treatment. (Regulation 17(2) (b)).

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 14 December 2012.

CQC should be informed when compliance actions are complete.

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

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

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

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

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service’s records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

<table>
<thead>
<tr>
<th><strong>Met this standard</strong></th>
<th>This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action needed</strong></td>
<td>This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.</td>
</tr>
<tr>
<td><strong>Enforcement action taken</strong></td>
<td>If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.</td>
</tr>
</tbody>
</table>
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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.
Essential standard

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

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

Regulated activity

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

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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