

Reporting to:	Trust Board
Title	Update following CQC inspection (October 2013)
Sponsoring Director	Sarah Bloomfield - Acting Director of Nursing & Quality
Author(s)	Jo Banks - Acting Deputy Director of Nursing & Quality
Previously considered by	None
Executive Summary	<p>The purpose of this report is to update the Board of the actions and measures put in place to provide assurance of the regulatory requirements and standards expected by the CQC following an unannounced inspection visit to Royal Shrewsbury Hospital on 23rd October 2013.</p> <p>The CQC looked at the personal care or treatment records of people who use the service, observed care being provided and checked how people were cared for at each stage of their treatment. They also talked with staff, reviewed information sent to them by other regulators and talked with local groups of people in the community.</p> <p>During the visit the CQC made a number of observations across 6 wards where concerns had been raised, which resulted in notification that 3 of the 5 health care outcomes reviewed were not being fully met and identified areas where care needed to be improved.</p>
Strategic Priorities <input checked="" type="checkbox"/> Quality and Safety <input type="checkbox"/> Healthcare Standards <input type="checkbox"/> People and Innovation <input type="checkbox"/> Community and Partnership <input type="checkbox"/> Financial Strength	Operational Objectives Providing best clinical outcomes, patient safety & experience.
Board Assurance Framework (BAF) Risks	<input checked="" type="checkbox"/> If we do not deliver safe care then patients may suffer avoidable harm and poor clinical outcomes and experience <input type="checkbox"/> If we do not implement our falls prevention strategy then patients may suffer serious injury <input type="checkbox"/> If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards <input type="checkbox"/> If we do not have a clear clinical service vision then we may not deliver the best services to patients <input type="checkbox"/> If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale and patient outcomes may not improve <input type="checkbox"/> If we are unable to resolve our (historic) shortfall in liquidity and the structural imbalance in the Trust's Income & Expenditure position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment

Care Quality Commission (CQC) Domains	<input checked="" type="checkbox"/> Safe <input checked="" type="checkbox"/> Effective <input checked="" type="checkbox"/> Caring <input checked="" type="checkbox"/> Responsive <input checked="" type="checkbox"/> Well led
<input checked="" type="checkbox"/> Receive <input type="checkbox"/> Review <input type="checkbox"/> Note <input type="checkbox"/> Approve	Recommendation The board are asked to receive this CQC regulatory report and action plan

Report to Trust Board following CQC inspection 23rd October 2013

1.0 Background

- 1.1 The purpose of this report is to update the Board of the actions and measures put in place to provide assurance of the regulatory requirements and standards expected by the CQC following an unannounced inspection visit to Royal Shrewsbury Hospital on 23rd October 2013.
- 1.2 The CQC looked at the personal care or treatment records of people who use the service, observed care being provided and checked how people were cared for at each stage of their treatment. They also talked with staff, reviewed information sent to them by other regulators and talked with local groups of people in the community.
- 1.3 During the visit the CQC made a number of observations across 6 wards where concerns had been raised, which resulted in notification that 3 of the 5 health care outcomes reviewed were not being fully met and identified areas where care needed to be improved.

2.0 Key themes and findings

- 2.1 The CQC identified many areas of good practice and observed positive engagement between staff and patients. The CQC reported that overall, patients described very positive experiences of their care and treatment and that many patients described how staff respected their privacy and dignity.
- 2.2 However, some standards were reported and observed as not being fully met and evidence showed areas where action was needed. The key themes and findings by outcomes and standards are detailed below:
- 2.3 Quality and Management (Care and Welfare of people who use services – Fully Compliant) – When the CQC visited wards, they observed high standards of care being delivered and spoke to patients, the majority of whom fed back very positively about their experience of care.
- 2.4 Quality & Management (Records – Moderate Concern) – The CQC reported that they found evidence where record keeping relating to standards of nursing documentation and care planning was inconsistent based on accuracy and completeness. During feedback they acknowledged that the Trust had reviewed the nursing records, care plans and assessment documentation during 2013 and that new documentation and record keeping training is planned throughout 2014. However, the improved outcome to records that this will deliver will not be seen until the first quarter of 2014 and was not evidenced at the time of the visit.
- 2.5 Involvement & Information – (Consent to care and treatment – Minor Concern) - The CQC reported that they found evidence of records relating to consent to care and treatment whereby documentation was often found to be inconsistent and at times incomplete. This related specifically to two areas; firstly, Do Not Attempt Resuscitation (DNAR) records did not always include evidence of discussion with the patient, their relatives or a capacity assessment where appropriate. Secondly, where patients were required to consent to treatment or interventions, there was not always consistent evidence of Mental Capacity or Best Interest Assessments being carried out.

It was acknowledged that the Trust is reviewing the DNAR policy and recognised that the Trust was working towards compliance with Mental Capacity Act training along with DNAR training amongst medical staff. However, further improvements are required in order to fully meet this standard.

2.6 Quality & Management – (Complaints – Minor Concern) - The CQC reported that they found evidence whereby the Trust’s response to complaints had previously been untimely and that the responses were often unsatisfactory to the recipient. Within their feedback the CQC acknowledged the work that the Trust had already undertaken in relation to reviewing the complaints service and procedures. The CQC also acknowledged that the actions undertaken by the Trust to date in the comprehensive review of the complaints service and procedures had mitigated the level of risk to patients in relation to this outcome.

2.7 Quality and Management – (Respecting and Involving People who use services – Fully Compliant) – Patients privacy, dignity and independence were respected. Improvements in relation to records (see 2.4) would further enhance this standard in relation to involving patients in planning their care.

3.0 Audit & Assurance processes

3.1 The CQC have been made aware of actions already undertaken to deliver some of the improvements required in response to this visit and also existing mitigation.

3.2 The CQC have also received details of the Trust’s planned actions to deliver sustainable improvements to achieve compliance across the three outcomes. This is included within the Trust’s formal response to the visit report and is provided to the Board within the attached information pack.

3.3 Progress against the actions and measurement of improvement will be considered by the Clinical Governance Committee with the Quality and Safety Committee managing the line of accountability.

3.4 A further meeting with the CQC is planned on 28th January 2014 in order to discuss the planned actions in detail and test assurance of improvements.

4.0 Board Action

The board is asked to **note** this report relating to regulatory requirements

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

Royal Shrewsbury Hospital

Mytton Oak Road, Shrewsbury, SY3 8XQ

Tel: 01743261000

Date of Inspection: 23 October 2013

Date of Publication:
December 2013

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

Respecting and involving people who use services	✓ Met this standard
Consent to care and treatment	✗ Action needed
Care and welfare of people who use services	✓ Met this standard
Complaints	✗ Action needed
Records	✗ Action needed

Details about this location

Registered Provider	Shrewsbury and Telford Hospital NHS Trust
Overview of the service	<p>Royal Shrewsbury Hospital is part of Shrewsbury and Telford Hospital NHS Trust. The trust is the main provider of acute services in Shropshire, Telford and Mid Wales.</p> <p>The hospital provides emergency services, medical and surgical investigations and a full range of diagnostic facilities and medical treatments for physical illness or condition, injury or disease.</p>
Type of service	Acute services with overnight beds
Regulated activities	<p>Assessment or medical treatment for persons detained under the Mental Health Act 1983</p> <p>Diagnostic and screening procedures</p> <p>Management of supply of blood and blood derived products</p> <p>Maternity and midwifery services</p> <p>Surgical procedures</p> <p>Termination of pregnancies</p> <p>Transport services, triage and medical advice provided remotely</p> <p>Treatment of disease, disorder or injury</p>

Contents

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'.

	Page
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
What we have told the provider to do	5
More information about the provider	5
Our judgements for each standard inspected:	
Respecting and involving people who use services	6
Consent to care and treatment	9
Care and welfare of people who use services	11
Complaints	14
Records	17
Information primarily for the provider:	
Action we have told the provider to take	19
About CQC Inspections	21
How we define our judgements	22
Glossary of terms we use in this report	24
Contact us	26

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 23 October 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff, reviewed information sent to us by other regulators or the Department of Health and talked with other regulators or the Department of Health. We talked with local groups of people in the community or voluntary sector and were accompanied by a specialist advisor.

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

What people told us and what we found

The unannounced inspection was carried out by a team of five inspectors in addition to a specialist advisor and an Expert by Experience. We visited six wards where concerns had been raised through a variety of sources. Concerns were mainly around people's care, treatment and involvement and the lack of respect for privacy and dignity. People had also raised concerns in relation to how the trust had managed their complaints.

We spoke with patients and staff on all of the wards we visited and spent time observing how care and support was delivered. Our findings were very mixed with some marked differences between wards. There were differences in leadership and therefore effectiveness of systems and processes. We identified a range of concerns about consultation and involvement of patients, documentation of care planning and evaluation and key issues such as 'do not attempt resuscitation' (DNAR) orders.

Prior to our inspection the trust had acknowledged that capacity pressures across the hospital were impacting on people's experiences. They were actively addressing the challenges with health and social care partners. There was also recognition of the issues we identified during our inspection and action was being taken. A member of staff told us that increased admissions had resulted in "huge pressures placed on the workforce".

Overall patients described very positive experiences of their care and treatment. Comments included, "I couldn't be treated any better if I was the King" and, "The care from the doctors is very good and the nurses are excellent". Most patients we spoke with told us that staff respected their privacy and dignity. Other patients commented that

improvements were needed in how staff involved them in discussions and decisions about their care and treatment, for example their diagnosis, progress and discharge arrangements.

Patients we spoke with were not aware of how to make a formal complaint, although they told us they had not had cause to complain. We found information about complaints was not readily accessible for patients and their representatives. We saw the trust had responded to complaints but letters did not contain information for people on what to do if they were unsatisfied with the response provided by the trust. We found the trust had started to redress the identified backlog of complaints and the shortfalls in processes and acknowledged it was very much "work in progress".

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 26 December 2013, 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

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People we spoke with told us they had not been provided with written information about the ward or the facilities available. They said they had only been provided with verbal information such as visiting times. Staff told us patients usually received a verbal welcome which included an explanation of the ward, its layout and where places such as the toilets were located. One member of staff told us, "There's not enough written information for people. They have to keep asking and some of them don't like to, so you're not always sure how much they have remembered". The trust acknowledged this and told us they were in the process of addressing the matter.

We had received concerns about patients and their representatives not being involved in decisions about their care and treatment. Concerns were also raised about people not being respected. Most patients we spoke with during our visit said they usually felt included and involved in their care and treatment. They told us most staff listened to them and respected their wishes. We observed these practices as people were being offered their day-to-day care.

One patient told us, "I'm fully aware of what's going on with my treatment." Another told us that their surgeon had gone to great lengths to discuss their treatment with them and the associated risks. However, one patient told us that they had been woken up to be given an injection that they were not expecting. The patient told us that they did not know what the injection was for. They also told us that when they asked if it would hurt, the nurse replied, "I'm really busy, do you want it or not?". Other comments included, "I've seen one doctor with no bedside manner. No please or thank you. He seemed to be in a foul mood. But other doctors have had a good chat with me and explained things fully" and, "I overheard the doctor telling a nurse that I could go home if my scan was ok but no one told me". One member of staff told us, "I've experienced doctors not involving patients in their care due to the lack of staff. Some doctors have made decisions without discussing it with the patient".

Two people told us they had been patients at the hospital on several occasions over the past six months. They told us they had been admitted for emergency care as well as management of their long-term health conditions. One person said they were pleased the ward staff had listened to and acted on their wishes on two occasions recently. This was when they told them they did not wish to be transferred to another ward to receive their care.

We observed a doctor explaining a patient's treatment plan to them in language that the patient could understand. The doctor checked that the patient understood the plan and that they were happy with it. The doctor gave the patient lots of opportunities to ask questions and answered them all patiently and fully.

Some patients told us they had been admitted to several wards to receive their care and treatment. They said the biggest worry was when they knew they were being admitted to the hospital as their experiences on some of the wards had not been as good as other wards.

Staff spoke about the importance of supporting people to be as independent as possible. One member of staff gave an example of someone with Parkinson's Disease who took a long time to wash but told us it was important to them to do this for themselves.

One patient told us that they had been encouraged to use the bathroom to wash independently after an operation even though they did not feel able to do so. The patient said that they were unable to get out of the bathroom without help. They told us that when they pressed the call button to summon assistance it took 20 minutes for a member of staff to respond. The staff member said they would find a second person to help the patient back to their bed. The patient told us that it was another 60 minutes before assistance finally arrived. We checked the patient's nursing notes but we could find no record of the incident.

Prior to our inspection concerns had been raised about people's lack of privacy and dignity and feeling 'degraded'. During our observations we did not see people's privacy or dignity being compromised. However, on one of the wards we observed three beds that were positioned very close together and separated only by a short plastic shield which did little to screen the patients from each other. We spoke with the ward manager about this and they told us this issue was being addressed.

We saw that staff always pulled privacy curtains around patients' beds during consultations or when carrying out medical procedures or observations. Most patients we spoke with told us that staff always respected their privacy and dignity. One person described how nurses always said, "Knock, knock" when the screens were drawn around their bed before they entered. Some wards had trialled a pink peg initiative which is a visible system used to alert staff that personal care was being provided behind closed curtains. One ward manager told us they were planning to re-introduce this system to provide greater privacy to patients.

The majority of the staff we spoke with demonstrated a good understanding of privacy and dignity issues. Ward managers told us they, "led by example". Staff talked about the importance of involving family when planning care to make sure they knew each person's individual needs and their likes and dislikes. The provider may wish to note that not all staff were aware of how to meet people's cultural needs but were aware of how to access information about specific cultural/ faith needs.

Most staff told us they had completed training on "Fundamentals of Care" which covered privacy and dignity and quality of care. One member of staff said, "It takes you back to the basics". Some staff told us they had attended a dignity champions study day.

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

Our judgement

The provider was not meeting this standard.

Before people received care or treatment most people were asked for their consent and the provider acted in accordance with their wishes. Where people did not have capacity to consent, the provider has not always acted in accordance with legal requirements.

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

Prior to our inspection we had received concerns about a patient's capacity to give consent to treatment, and decisions being made on behalf of the patient without involvement of their relative.

Staff we spoke with told us they made sure people were in agreement for their care and support to be carried out as part of their day-to-day needs. Most patients told us that staff always explained what they wanted to do and asked if it was alright before proceeding. Comments included, "They always ask before taking observations" and, "They always tell me what they want to do and check it's ok to do it". Two patients who had received surgery told us that the doctors had discussed the risks and benefits of their procedure in good detail and made sure they understood exactly what would happen. Both patients told us that they had signed written consent forms.

We observed that staff offered people choice throughout the day. We saw and heard that people who were able to make decisions for themselves were encouraged to do so. Staff told us that there were several people on their wards who did not have the capacity to make decisions for themselves. They said several patients were not able to express their needs and wishes effectively because their health conditions had limited their ability to communicate effectively. This meant that they were particularly vulnerable as they were unable to tell people their views about the care and treatment they received. The trust told us that work was planned around training and care delivery relating to people with dementia.

Health care professionals must work within the requirements of the Mental Capacity Act 2005 and work with others to make sure that decisions are always made in people's best interests. Most staff told us they were aware of the legislation but not all of them felt confident with it. A member of staff told us they always made sure people had consented to all interventions, however minor. They said they knew about principles of informed consent, and were able to describe how this worked in practice.

We observed one person who was extremely confused as a result of their long-term dementia. They had been admitted to hospital for emergency surgery as a result of an accident. Staff told us how urgent decisions about their care and treatment had been needed and that the person had clearly not been able to understand. We looked at this person's care records and saw a detailed assessment of this person's capacity for decision-making. We found staff had clearly followed the hospital's policies and procedures to make sure decisions about the person's best interests had been followed and recorded. We saw staff had demonstrated how they had involved all the necessary people to make the right decisions for the person's care throughout their hospital stay. We found records to show the provision of care to ensure privacy, dignity and comfort had been fully considered to promote the persons rights and well-being.

We looked at consent and how decisions about people's right not to have emergency medical intervention were made. Previous inspections had identified concerns in relation to "do not attempt resuscitation" (DNAR) orders. These are decisions in respect of the wishes of a patient not to undergo cardio-pulmonary resuscitation (CPR) or advanced cardiac life support if their heart were to stop or they were to stop breathing. They can only be drawn up if they can be shown to be in the person's best interests and completed by the multidisciplinary team.

Although work had been done since our last inspection and training delivered, our findings identified that there continued to be an issue about staff understanding, evaluation and recording of people's mental capacity. Omissions in record keeping on some of the wards we visited meant judgements such as the ability of a person's capacity had not been documented. Not all patients' care records showed evidence of consideration by professionals about the person's mental capacity or communication with relatives. This meant there was potential for staff to make decisions about care and treatment on a person's behalf without obtaining proper consent. For example, on one of the wards we visited we saw a person had been admitted for confusion. No mental capacity assessment had taken place so best interest decisions were being made by staff without a formal assessment having taken place. Care records showed that on admission a brief discussion had taken place with their next of kin. No further discussion was recorded regarding their thoughts or wishes for their relative. The trust acknowledged our findings and told us that a full review of the DNAR policy would be undertaken.

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

Our judgement

The provider was meeting this standard.

Most people's care and treatment was planned and delivered in a way that was intended to ensure their safety and welfare.

Reasons for our judgement

The trust acknowledged that they had insufficient beds across their acute sites to meet demand and this was impacting on people's experiences. A "risk summit" meeting was held in April 2013. This is a meeting at which organisations such as regulators, commissioning bodies, performance management authorities, patient representatives and other agencies meet to share concerns and hear what the trust was going to do to put things right. The trust developed a comprehensive action plan to ensure that improvements were made and maintained.

Concerns in relation to meeting capacity were reduced by a ward reconfiguration. The trust was working with other partners to develop alternative models of care for patients who no longer need an acute hospital bed rather than increase the number of inpatient beds across the two acute sites.

Prior to our inspection we gained information from a number of sources in relation to people's care experiences. A number of patients were referred into safeguarding processes in relation to allegations of neglect, mainly around poor or unsafe discharge. For example, patients being discharged from hospital without the appropriate equipment in place or without appropriate care in the community. The majority of investigations were not upheld and the trust had worked with external agencies to ensure that patients were discharged with the appropriate care and support required.

During our ward observations we saw two staff members involved in the discharge of a patient. Staff were friendly, knowledgeable and professional in the way that they offered the person guidance and advice about their health needs. We saw they made sure the person understood the treatment they had received and the care that they would need when they returned home. The person was clearly appreciative of this support.

We also checked the records of a patient we observed being discharged to a care home by ambulance. We saw the ward staff had completed all necessary paperwork which made sure the person concerned had received all of the medication they required as well as written information necessary to pass onto the care home staff. We observed staff inform the ambulance personnel of the person's needs. We saw the nurse telephone the

patient's relative as well as the care home to let them know they were on their way. However, other patients shared different experiences. Comments included, "No one told me what I had to do to demonstrate that I was ready to go home. I thought they would sort all of that" and, "I've been told I'm being discharged today but no one has told me when or what I'm waiting for".

Most staff demonstrated a good knowledge and understanding of importance of appropriate care at each stage of people's care and treatment. Staff told us they continued to experience some barriers to ensuring people were effectively discharged. These included having to wait for medication, social factors, inability to get care in the community and no care co-ordinators being available during evenings and weekends to facilitate patient discharge. Staff told us discharge planning was discussed on ward rounds and as part of multi-disciplinary meetings. They acknowledged that not all discharges ran smoothly. A member of staff told us, "Occasionally we move patients who are close to discharge to a less acute ward if they need the bed". Staff told us they were not always achieving targets for discharges but considered patients were discharged safely. One member of staff told us, "The discharge process is where we need to focus on". Another member of staff said, "The discharge of patients is not perfect due to the high pressure that we are under". One member of staff said they had identified a need to provide patients with discharge leaflets with follow-up information. We were told this was being addressed.

We observed staff treating patients with kindness, patience and care. Patients looked clean and well cared for. We saw staff dealing with one confused patient with compassion and gentleness. Most patients told us that they were "very happy" with the care they received in the hospital. One patient said, "It's thanks to the skills of the surgeon and the nurses who have saved my life". Another patient said, "The effort they are all putting in to keep me alive is incredible. Everyone's attitude is unimpeachable". A patient who had recently received surgery to save a limb described their care and the procedure as "absolutely brilliant". They said the surgeon had worked into the night to save their limb and it was the surgeon's positive attitude that helped alleviate their fears. One patient described their care and treatment as, "Awesome, simply awesome" and said it was due to the, "little things staff did to make patients more comfortable". Other comments included, "I've been waiting two days for a scan but no one seems to know when it will happen". "You get told so many different things by different people but they don't seem to talk to each other".

Some patients commented that some wards were over reliant on agency staff, which meant they did not always receive care from staff who knew them. They told us their care was not as good as the care offered by permanent staff. Some patients told us their care could be better and this was dependent on the ward they had been admitted to and how the ward was staffed.

Staff told us they always received a good handover at the start of every shift and were issued with a handover sheet with details of how people's care needs had changed and were being met. We saw this handover sheet was a computer printout of the needs of all of the patients currently being cared for on the ward. When we checked the care records on one of the wards we found these were not sufficiently detailed to offer staff guidance to fully meet people's needs. We saw the records did not contain all of the up-to-date information provided for staff as part of their handover. The provider may wish to note that discussions we held with permanent staff established they knew more about the individual needs of people than was recorded in their care plans. This meant there was a risk that

people might not receive consistent care.

We saw care records were not personalised to meet the needs of the person they were written for. Although people were being cared for there was a risk because of the lack of personalised approaches. We found most care plans were reviewed daily with any changes in the person's needs clearly documented. We saw that timely referrals were made for the patients to other professionals when required and staff were regularly updating other professionals involved in the patients' care. However, some of the records we looked at had not been updated since people had been admitted to hospital and lacked important information about people's specific healthcare needs when they had changed. This meant staff did not have appropriate written guidance to follow to meet people's needs. We also found conflicting information in one care plan in relation to a person's appetite. On the person's admission the record stated "poor appetite". However, in a nutritional risk assessment completed a day later it stated the person had a good appetite "eats most of 3 meals a day". We spoke with staff who confirmed the patient had a poor appetite since their admission.

We found on some wards that risks to some patients' health and safety were not fully assessed and managed properly and as a result measures had not been put in place in order to maximise the well-being of the people concerned. In one of the patient records we looked at a risk assessment had not been updated to account for the person's changing needs and increased risk. Omissions of important healthcare information meant people were at potential risk of not receiving the right care, treatment and support they required to keep them safe and well.

We looked at the care and treatment being provided to a patient living with dementia. Staff we spoke with told us they had found it difficult to effectively support the person due to their condition and their behaviours that had challenged the staff team. There were no systems in place to support the person. For example, there was no planned approach, no capacity assessment, no management plan and not all staff providing care and support to the person had received training in dementia care or mental capacity. Staff told us they did not receive good support in this area. The trust acknowledged this was an area that required improvement with staff training and said they were involving the Alzheimer's Society to provide more consistent care for people with dementia. They also advised that the Royal College of Nursing were involved in a review and on-going programme in relation to making improvements in this area.

A member of staff shared a recent letter from a relative of someone with dementia who had been on one of the wards we visited. It stated, "A marvellous team of people of whom the NHS should be very proud".

Healthwatch Shropshire, the independent consumer champion that gathers and represents the public's views on health and social care services, shared people's experiences with us. The majority of views were positive from patients with some concerns from representatives about people being discharged from hospital with no support.

People should have their complaints listened to and acted on properly

Our judgement

The provider was not meeting this standard.

There was a complaints system available. Comments and complaints people made may not always have been responded to or managed appropriately.

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

Since our last inspection we had received concerns from a range of people in relation to the poor management of people's complaints. We advised people that we were unable to investigate individual complaints and provided them with information about how to complain directly to the trust. Some people had since expressed concern in relation to how their complaint had been managed by the trust. Concerns included the time taken to investigate their complaint and the response provided. Comments included, "Their response contained no answers to the questions we raised, just a lot of apologies as to why we were not kept informed regarding our relative's care needs" and, "They can't even take it as a serious complaint". We have provided people with the necessary details so that they can take their complaint further if desired.

During our visit we saw that although posters invited people to contact the hospital if they were unhappy, the relevant leaflets were not readily available. None of the patients we spoke with had seen a hospital leaflet explaining how they could complain. We found that the majority of leaflet dispensers were empty across the hospital. This meant that people may not be able to access information about how to register a complaint about their care and treatment. Patients told us that they would complain to the ward manager or matron. They were largely confident that their complaints would be taken seriously.

Two patients told us they were aware of the hospital complaints process and had raised concerns about treatment they had received in the past. One person was not happy with the response they had received and told us the matter was still being dealt with. Another person shared information about the formal complaint they had made and said they were awaiting the outcome. One patient told us an agency member of staff had not provided them with helpful advice when they told them they intended to complain about their working practice. They said they were told "not to bother complaining as any complaints against agency staff would just be filed by the Patient Advice and Liaison Service (PALS)".

As part of our inspection we reviewed the trust's complaints procedures. The complaints manager told us that they were new in post and were in the process of revising complaints

policies and procedures. The provider may wish to note that some staff were not familiar with the new complaints manager.

We found the trust had started to redress the identified backlog of complaints and the shortfalls in processes and acknowledged it was very much "work in progress". The trust's complaints policy was in the process of being updated, however we were shown two leaflets which we were told were available throughout the trust for patients. One leaflet contained details about the complaints process and provided information for people on how to complain and who to contact if they were unhappy with the trust's response to their complaint. The second leaflet contained information about PALS and how people could access the service. These leaflets did not contain information about how long it would take the trust to respond to complaints received.

The complaints manager told us that information on how to complain was also available on the trust's website. We checked the trust's website and found that a copy of the complaints leaflet was available.

We discussed how people could access support in order to make a complaint. The complaints manager told us that the trust had an interpreter service available should people need the complaints leaflet translated into a different language, however we were told that there was nothing in place to make the process accessible to people with visual or hearing impairments.

The complaints manager told us that they had recently implemented standard operating procedures (SOP) within the complaints and PALS department. These procedures were designed to improve the complaints handling process and reduce the trust's response times. We reviewed the SOP relating to both the complaints and the PALS departments and found that the revised processes had been clearly set out and the process included defined points when people should be sent information about the progress of their complaint. However, intelligence we received suggested that not all complaints had been acknowledged by the provider.

The complaints manager told us that they had delivered training on the revised process to matrons and ward managers throughout the trust. This was reflected in discussions we held on the wards we visited. Senior staff considered the complaints process had much improved. We reviewed copies of the training material and found that staff had been provided with information about how to structure complaint responses and details about the requirement to respond within strict deadlines. Senior ward staff demonstrated a good understanding of the revised procedures.

We reviewed the records of five complaints that had been closed since April 2013. These records were chosen at random and contained three complaints that had been received since June 2013. We found that the trust had sent people an acknowledgement of receipt of their complaint. This acknowledgement letter provided information about how the complaint would be handled and stated that people could expect the trust to respond to their complaint within a stated timescale.

The three complaints we reviewed that had been received since June 2013 had been responded to within 35 days. We reviewed the final response letters. We found that the letters provided information answering people's complaints; however these letters did not contain information for people on what to do if they were unsatisfied with the trust's response. We discussed this with the complaints manager. They told us that information

for people about who to contact if they were dissatisfied was available for people within the trust's complaints leaflet and on the trust's web site. However, people who had received a response from the trust about their complaint told us they had not been advised of this information. This meant that people might not know how to take their concerns further.

We asked the complaints manager to explain how information about complaints was analysed and how action plans were developed and tracked. They told us that they were starting to provide each care group with a detailed report relating to complaints received from their area. They said they had also developed a system of tracking progress of action plans that had been put in place. We reviewed a copy of a care group report and also a copy of the August complaints report for the Quality and Safety Committee. The reports contained details about the number and type of complaints received alongside information about the numbers of patients seen. Reports also contained information identifying trends and actions and learning from complaints. This meant that details relating to the number and type of complaints received was being reviewed by both people delivering the care and people managing the delivery of care.

We also reviewed a copy of a spread sheet which tracked the action plans that had been put in place following the complaint. This process had just been implemented and we discussed the appropriateness of the action plans submitted with the complaints manager. We found that some action plans were not detailed enough. The complaints manager told us that they were already working with the care groups to ensure that all action plans were appropriate.

We spoke with staff from different disciplines at ward level. Discussions identified that most staff knew what to do should a patient wish to complain about the service or their care and treatment. Staff told us that they welcomed complaints and tried to resolve these at ward level. One member of staff told us, "I would encourage anyone to talk to the ward manager if they were not happy with anything". Staff told us complaints were shared at ward meetings. A ward manager showed us the action they had taken after receiving three recent complaints all relating to basic nursing care. They said they had spoken with staff on an individual basis in addition to writing to them advising them that the care provided had not been to an acceptable standard.

Some complaints and concerns raised on the ward did not get reported to PALS or the complaints department if they were resolved on the ward. Therefore there was a risk that complaint numbers were not accurate. Staff were not aware if there was a trust policy on reporting complaints resolved on the ward and not all staff spoken with were familiar with PALS. Feedback gained from Healthwatch Shropshire showed a person had tried to contact PALS on several occasions about their concerns but just got the voicemail.

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

Our judgement

The provider was not meeting this standard.

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

We have judged that this has a moderate 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

As part of our inspection we reviewed a number of patient records across the six wards we visited. We found some of the records did not include all of the appropriate information in relation to people's care and treatment. This meant people were not protected from the risks of unsafe or inappropriate care and treatment. We found there was no consistency in the way records were maintained across the hospital. For example some wards had introduced their own systems for recording, for example, assessments for monitoring pressure wounds. This meant it might be difficult for staff such as bank or agency staff to maintain a consistent approach.

Some care plans reviewed were incomplete and in some cases important information had been omitted. They were not signed by the patient and also failed to show people's involvement in their care and treatment although most patients told us they had been consulted. We saw the care records did not contain all of the up-to-date information provided for staff as part of their handover. This meant the provider could not demonstrate they had accurate permanent records of care and treatment carried out on some patients. We saw lack of adequate record-keeping practices to demonstrate the service was operating safely and effectively. For example, the lack of on-going risk assessments on some records meant care records did not reflect up-to-date guidance for staff to safely care for people.

Staff had written in one person's care records about the deterioration in their skin health. We saw care records lacked up-to-date information about their care and any pressure relieving equipment that was in use by the ward to keep the person's skin healthy and intact. This meant staff did not have written guidance to make sure they knew how to use this equipment effectively for the people concerned. We shared this information with senior ward staff during our inspection visit. They acknowledged information was missing and took immediate action to improve the care records of the person concerned.

Staff we spoke with on some wards openly agreed that care records lacked appropriate detail and some were in need of improvement. They told us they had already shared

these comments with senior management. Where we identified omissions in care planning on one of the wards, we found there was no formalised system for following up any issues in recording. For example care plan evaluations for one patient was signed as done but none of these care plans were in the file, as confirmed by the ward manager. We also found records were not always readily accessible. For example, body maps were completed on each shift but not always kept in order so it not easy to find the current version. The most recent audit of care plans on this ward was dated May 2013. A member of staff confirmed there were no more recent documented audits. This meant care records were not being monitored to drive improvement. The trust acknowledged record keeping was an area that required improvement and told us that training had been arranged for November 2013 in relation to new care planning documentation that was due to be implemented shortly.

We also found some positive examples of record keeping. We saw clear nursing records with care plans and risk assessments regularly evaluated and updated. However, records did not, at any stage, detail any discussion with the patient about their condition or treatment. Omissions in record keeping on some of the wards we visited meant judgements such as assessments of mental capacity had not been documented. This meant there was potential for staff to make decisions about care and treatment on a person's behalf without obtaining proper consent. This inspection identified similar shortfalls in relation to DNAR orders to previous inspections and is reported earlier in this report. The trust advised us they were due to provide staff with training on the introduction of new nursing records, including revised care planning documentation that they would be implementing shortly. They also told us that they would check the effectiveness of these revised records and the training programme by auditing nursing records regularly.

This section is primarily information for the provider

✘ Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: Before people received care or treatment most people were asked for their consent and the provider acted in accordance with their wishes. Where people did not have capacity to consent, the provider has not always acted in accordance with legal requirements. Regulation: 18
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints How the regulation was not being met: There was a complaints system available. Comments and complaints people made may not always have been responded to or managed appropriately. Regulation 19(1)(2)
Regulated activities	Regulation

This section is primarily information for the provider

Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010
Surgical procedures	Records
Treatment of disease, disorder or injury	How the regulation was not being met: People were not always protected from the risks of unsafe or inappropriate care and treatment because accurate records were not always consistently maintained. Regulation 20 (1)(a)

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 26 December 2013.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

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

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

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

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

You can tell us about your experience of this provider on our website.

How we define our judgements

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

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

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

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

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

How we define our judgements (continued)

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

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

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

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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

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

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

Phone: 03000 616161

Email: enquiries@ccq.org.uk

Write to us
at: Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Website: www.cqc.org.uk

Copyright Copyright © (2011) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.

Report on actions you plan to take to meet CQC essential standards
Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RXW
Our reference	INS1-707023266
Location name	The Royal Shrewsbury Hospital (Inspection date – 23 rd October 2013)
Provider name	Shrewsbury and Telford Hospital NHS Trust

Regulated Activities	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Involvement & Information - Consent to care and treatment
Surgical procedures	How the regulation was not being met:
Treatment of disease, disorder or injury	Where people did not have capacity to consent, the provider has not always acted in accordance with legal requirements.
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
<p>Actions: The Trust is taking the following actions in response to the above findings:</p> <ol style="list-style-type: none"> 1. The findings relating to consent, capacity assessments and DNAR decisions have been shared with all wards that were visited during the inspection as direct feedback. Wider awareness, actions and expectation setting following this review will be achieved by discussion at the following forums; Ward Manager Meeting, Nursing and Midwifery Forum, Clinical Governance Executive and Care Group Board meetings. Information will also be included in trust wide communications, e.g. "Message of the Week" and discussed at Executive Director Committee, Quality and Safety Committee and Trust Board. 2. The Mental Capacity Act forms part of the statutory training programme for nurses and AHPs within the Trust. Compliance with training and the evaluation of training will be assured through the Trust safeguarding group. Statutory training compliance is also a KPI on the recently introduced Quality Dashboards that are central to the Quality Assurance Framework, which is being implemented across the Care Groups. Performance against the dashboard KPIs is measured and challenged from Ward to Board level through clear lines of accountability. Any further lack of knowledge and confidence will be assessed and reviewed through supervision and the appraisal process. 3. Action already has been taken by the Medical Director to remind senior doctors of the responsibilities that they and members of their clinical teams have in ensuring that statutory, legal and regulatory body requirements are followed as regards consent and assessment of capacity. This has been through an education programme (DEEP – Doctors' Essential Education Programme) delivered during October 2013, the slides of which are available as a continuing learning resource. This was based on GMC guidance in this area. Further, more focused training will be provided in the detailed elements of the Mental Capacity Act during 2014, initially this will be targeted at those clinical areas where this issue has been identified as a problem, or is particularly relevant, but will then 	

be disseminated more widely.

4. A review of the DNAR policy and practice is being undertaken and will be approved by the Resuscitation and Deteriorating Patient Committee which is chaired by the Medical Director.
5. Clinical audit of consent processes, particularly those relating to patients with Dementia, and also DNAR records will be conducted on a quarterly basis with results reported into the Clinical Governance Executive and cascaded throughout the Quality Assurance Framework. Audits of practice will not be anonymised to enable the Medical Director and Director of Nursing and Quality to follow up individual practice issues as identified in point 6.
6. Where it is identified that sub optimal care has been provided, individual discussions will be had with clinicians to set clear expectations and offer any further support as required. Failure to improve practice following this intervention may result in formal human resources processes regarding accountability being followed.
7. The review of the DNAR policy discussed in point 4 above will include a revised DNAR form. This will include discussing and documenting ceilings of care, and is one of the work streams of the Trust priority to improve End of Life Care. This work will be completed by the Resuscitation and Deteriorating Patient Committee and presented to medical staff during the next DEEP sessions, being planned for February/March 2014.

Who is responsible for the action?

Acting Director of Nursing and Quality & Medical Director

**How are you going to ensure that improvements have been made and are sustainable?
What measures are you going to put in place?**

Improvements will be made, sustained, measured and assured via the following systems and processes.

1. Evidence of completion will be seen from records of meetings held and communications bulletins. Actions and assurance will be discussed on a minimum of a quarterly basis at key meetings and monthly for actions such as statutory training compliance. The Clinical Governance Executive will be accountable for the delivery of required actions and will be held to account by the Quality and Safety Committee who will provide challenge and receive assurance of improvements in practice.
2. MCA training figures and compliance will be evaluated at each safeguarding group meeting. Statutory training compliance is monitored through the Quality Dashboards. Areas of shortfall will then be escalated and acted upon through the Quality Assurance Framework on a monthly basis. Impact of training will be measured through audits of records and feedback by the Trust MCA Lead to the Safeguarding Committee reporting to the Clinical Governance Executive.
3. As has occurred on the two previous occasions that DEEP lectures have been provided, an attendance record will be kept, published, and issues of non attendance followed up through the Care Group Medical Directors. In addition, the lecture materials will be presented online for reference and learning. The Medical Director is working with the Head of Education to ensure that the full training records of all medical staff are published

internally as a means of encouraging all doctors to complete all required elements; this will be followed up at strengthened Job Plan reviews that are being introduced in the next financial year.

4. The Medical Director and Director of Nursing and Quality have oversight of the review and implementation of the DNAR policy which will be ratified by the 1st May 2014. Improvement will be assessed through quarterly audit of practice and subsequent follow up of sub optimal practice by individual clinician.
5. See point 6 below.
6. Training attendance records and audits of DNAR decisions will provide assurance of improvements in this area. The Trust's clinical audit team will develop methods of measuring the quality of consent and mental capacity assessments. Where individual staff are identified as providing sub-optimal care, once advised of their responsibility regarding this standard, any further observation of poor practice may result in formal human resource management processes being followed in line with professional accountability. This will be achieved using direct line management accountability and reporting into the Quality Assurance Framework.
7. In addition to the above actions, the Medical Director and Director of Nursing and Quality will review records on ward visits and walkabouts to test assurance of improvements in clinical practice across the Trust.

The Trust is committed to ensuring that patients without capacity have their care and treatment provided in their best interests by staff with appropriate knowledge and understanding of their care needs, and that there is a process in place to assess and manage those patients within the requirements of the Mental Health Act, 1983 and the Mental Capacity Act, 2005. All staff have a responsibility to ensure that people's consent, views and experiences are taken into account when services are provided and delivered in relation to their care.

Who is responsible?

Acting Director of Nursing and Quality & Medical Director

What resources (if any) are needed to implement the change(s) and are these resources available?

Resources available:

1. Training for MCA will be delivered for nurses and doctors
2. DEEP training on MCA, ceilings of care and DNAR decision making will be delivered for all senior doctors.
3. Audit of records regarding DNAR decisions as part of the Trusts planned record keeping audits.

Date actions will be completed:

Individual actions will be completed by 1st June 2014. However, actions around training of nursing and medical staff and

	clinical audit are continuous.
How will not meeting this regulation until this date affect people who use the service(s)?	
The Trust acknowledges and shares the concern that until these steps have been taken it is possible that required practice in assessment of capacity, the process of consent, documentation of that process and similar for DNAR decisions cannot be absolutely confirmed. Nonetheless steps already taken (DEEP in Oct 2013), raising awareness of issues, and current developments such as the revision of DNAR decision making and its documentation will mean that the gap between current practice and known best practise will be closed rapidly.	
Completed by (please print name(s) in full)	Sarah Bloomfield; Edwin Borman
Position(s)	Acting Director of Nursing and Quality; Medical Director
Date	9 th January 2014

Regulated Activities	Regulation
Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Quality & Management - Records
Surgical procedures	How the regulation was not being met:
Treatment of disease, disorder or injury	<i>People were not always protected from the risks of unsafe or inappropriate care and treatment because accurate records were not always consistently maintained.</i>
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
<p>Actions: The Trust is taking the following actions in response to the above findings:</p> <ol style="list-style-type: none"> 1. The findings relating to the quality of nursing record keeping have been shared with all wards that were visited during the inspection as direct feedback. Wider awareness, actions and expectation setting following this review will be achieved by discussion at the following forums; Ward Manager Meeting, Nursing and Midwifery Forum, Clinical Governance Executive and Care Group Board meetings. Information will also be included in trust wide communications, e.g. "Message of the Week" and discussed at Executive Director, Quality and Safety Committee and Trust Board. 2. The nursing assessment and care planning documentation has been reviewed by the Senior Nursing Team with multidisciplinary engagement from clinical staff. One of the aims of the review has been to provide more consistent and logical records for staff to complete. The revised records are now being printed and there is an implementation plan in place to roll out the new documentation and training programme across the site starting with ward managers in January 2014. The training for the revised documentation will specifically include the quality and detail of evaluations of care plans. The revised patient assessment booklet contains guidance from the NMC on best practice in record keeping, to support staff when completing records in addition to the training they will receive. 3. Training in relation to record keeping is also included within the training ("Fundamentals of Care") referencing the importance of good record keeping on the patient experience and the 6Cs as cited by the Chief Nursing Officer. This commenced in June 2013. This programme looks particularly at the requirements of this regulation using a peer review 	

approach to reflect upon practice and values. This training has to date been evaluated very positively and the objective is for all registered adult ward nurses to complete this programme.

4. A nursing audit programme has been developed in partnership with the Clinical Audit Team for the coming year. Included in this programme is an on going audit of nursing records, the baseline audit of which was completed at the end of 2013 and the regular ward audits commence in February 2014. This audit reviews completion of assessments in terms of both quality and timeliness. The regular audits will feature on the new Quality Dashboards for each ward which are central to the Quality Assurance Framework across the Trust.
5. The Ward to Board metrics which are completed by the Matrons will be adapted to include both the quality of nursing evaluation records and also the patient's view on their understanding and involvement in their plan of care. In addition to these changes a new range of metrics has been introduced to explore the experience of relatives and carers. Elements of all metrics will also be collected by both patient representatives and university Practice Engagement Team members to ensure external challenge.
6. Information on patients understanding and involvement in their care planning will be collected by patient representatives when completing patient stories. This will be fed back through care groups and the Patient Experience and Involvement Panel.

The Trust is committed to ensuring that people are protected, through the maintenance of accurate records, from the risks of unsafe or inappropriate care and treatment. We will deliver improvements in this area through better records, training and measurement of quality. This will be managed through the new Quality Assurance Framework which is replicated at each level of the organisation from ward to board to ensure consistency of quality, assurance and accountability.

Who is responsible for the action?

Acting Director of Nursing & Quality

**How are you going to ensure that improvements have been made and are sustainable?
What measures are you going to put in place?**

Improvements will be made, sustained, measured and assured via the following systems and processes.

1. Evidence of completion will be seen from records of meetings held and communications bulletins. Actions and assurance will be discussed on a minimum of a quarterly basis at key meetings and monthly for actions such as the quality of record keeping. The Clinical Governance Executive will be accountable for the delivery of required actions and will be held to account by the Quality and Safety Committee who will provide challenge and receive assurance of improvements in practice.
2. Following the implementation of the revised nursing records, a twice yearly review group will be convened to ensure that records reflect current evidence based practice and promote quality. This group will also consider the themes and trends of documentation

audits in order to inform changes to records. A patient representative will sit on this group.

The training attendance for the revised documentation implementation will be monitored through the Ward Manager Meeting and Nursing and Midwifery Forum. Areas of poor compliance will be addressed directly with the Ward Manager with repeated poor compliance being reported up to the Head of Nursing and ultimately Director of Nursing and Quality via the Quality Assurance Framework.

3. The “Fundamentals of Care” programme will continue throughout 2014 with attendance records being monitored using the framework described in point 2.
4. Nursing documentation audits will be fed back in detail to each Ward Manager and included in the Quality Dashboards which are central to the Quality Assurance Framework (QAF). These dashboards are discussed in detail each month with the Ward Manager and will be reported up through the QAF at centre, care group and corporate levels. Areas failing to show or sustain improvements in record keeping quality will be provided with additional support and training from the Senior Nursing Team and Clinical Practice Educators where required. Where it is identified that sub optimal care has been provided, individual discussions will be had with staff to set clear expectations and offer any further support as required. Failure to improve practice following this intervention may result in formal human resources processes regarding professional accountability being followed.
5. Ward to Board findings will be fed back in detail to each Ward Manager and poor performance included in the Quality Dashboards which are central to the Quality Assurance Framework. These metrics are managed through the QAF as described in point 4. Patient and university representatives will feedback directly to the Ward Manager and Matron in real time with formal reporting through the QAF.
6. The Patient Experience and Involvement Panel will receive audit and ward to board results for the Trust in addition to their own findings and will provide challenge in this area. The Deputy Chair of this panel is a member of the Quality and Safety Committee which will ensure triangulation of issues and concerns being reported up through the QAF. Furthermore, the Trust is currently in the process of increasing patient representation at other levels of the organisation with particular focus on the Care Groups and Clinical Governance Executive.
7. In addition to the above actions, the Director of Nursing and Quality, and Senior Nursing Team will review nursing assessments and care plan records on ward visits and walkabouts to test assurance of improvements in clinical practice across the Trust.

Who is responsible?

Acting Director of Nursing & Quality

What resources (if any) are needed to implement the change(s) and are these resources available?

Resources available:

1. Training for “Fundamentals of Care” – Funding provided from LETB and internal training budget. Training delivered and evaluated by Clinical Practice Educators.
2. Audit of records regarding standards of record keeping as part of the Trusts planned record keeping audits.

Date actions will be completed:	Actions relating to awareness, communication and revised nursing records will be completed by the end of February 2014. Audits and management through the QAF are a continuous assurance process.
How will not meeting this regulation until this date affect people who use the service(s)?	
Not meeting this regulation could result in people not being protected from the risks of unsafe or inappropriate care and treatment because accurate records are not maintained. Communication with Ward Managers, Matrons and Head's of Nursing regarding making improvements and maintaining quality whilst awaiting revised records has taken place in order to mitigate risk to patients in this interim period.	
Completed by (please print name(s) in full)	Sarah Bloomfield
Position(s)	Acting Director of Nursing and Quality
Date	9 th January 2014

Regulated Activities	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Quality & Management - Complaints
Surgical procedures	How the regulation was not being met:
Treatment of disease, disorder or injury	<i>There was a complaints system available. Comments and complaints people made may not always have been responded to or managed appropriately.</i>

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Actions: The Trust is taking the following actions in response to the above findings:

1. Prior to July 2013, the Trust response time for all complaints was set at 8 weeks (40 working days); however performance against this target was poor with a subsequent backlog of complaints occurring. Since this time the Trust has appointed a new complaints manager and the complaints process has been reviewed and changed using a revised SOP. The response time target has now been reduced to 35 days and we are meeting this target consistently in over 90% of cases.
2. The Trust has completed work in relation to the backlog of complaints since the inspection in October with no outstanding cases from before this period.
3. The Trust is in the process of reviewing the complaints policy, this includes a revision of our complaints and PALS service information. Improvements to signage and information for patients to take away are planned throughout the Trust to increase visibility and awareness for patients wishing to raise a concern. Bedside information packs are being developed which will provide a wide range of important information to inpatients including how to complain or raise a concern.
4. Complaint responses are now checked for quality of information and readability by the Complaints Manager before submission to the Chief Executive. Any responses that are

inadequate, defensive or lacking sufficient detail are returned for improvements with a clear deadline for response. Training and support is provided where required.

5. A management of change process designed to provide an improved and integrated complaints and PALS team has been concluded since the October visit. The revised team structure will ensure a consistent and accessible service across both hospitals is in place. Recruitment is currently in progress to vacant posts. Funding was made available to meet the increased requirements following this review.
6. From February 2014, a quarterly report will be submitted to Trust Board identifying trends and themes of complaints with emphasis on lessons learned and action taken. These issues will also be discussed at Care Group and ward level through the QAF.
7. All complaint responses will include information for the recipient on what to do if they are not satisfied with the response.

The Trust is committed to ensuring that people who use our services and comment or complain are listened to and acted upon effectively. All staff have a responsibility to ensure that they listen to patients and ensure that patients are aware of and informed about the complaints process.

Who is responsible for the action?	Acting Director of Nursing & Quality
------------------------------------	--------------------------------------

**How are you going to ensure that improvements have been made and are sustainable?
What measures are you going to put in place?**

Improvements will be made, sustained, measured and assured via the following systems and processes.

1. Response time performance against the 35 day target is reported to the Quality and Safety Committee and is currently 93%. Areas that consistently fail to comply with this deadline will be followed up by Care Groups using the QAF.
2. This action is now complete, however further issues arising will be identified and managed through the reporting mechanism in point 1.
3. The revised policy and improved information/visibility will be delivered by the Complaints Manager and monitored through line management accountability. All patient information will be ratified through the Trust process which includes a readability panel.
4. Responses from Care Groups will be continuously monitored in relation to quality with focused support given in areas that fail to deliver improvements or sustain performance. The number of complaint meetings with patients and relatives held prior to a final response being sent has increased as this is viewed as a proactive way of addressing complex complaints.
5. The implementation of the revised team structure will be monitored through line management accountability of the Complaints Manager. This will include a review of the changes following 6 months of implementation. Feedback on the service review will be reported to the Quality & Safety Committee.
6. The quarterly report will be evidenced by board minutes of the public session of the meeting. Actions arising from Trust Board will be tracked for completion by the Quality &

Safety Committee.	
7. This change will be reported through to Quality & Safety Committee on completion.	
Who is responsible?	Acting Director of Nursing & Quality
What resources (if any) are needed to implement the change(s) and are these resources available?	
Revised and integrated complaints and PALS teams following management of change process. Funding has been made available to complete this work.	
Date actions will be completed:	Many of the actions required in response to this regulation have been completed since the inspection in October. However, it is anticipated that other actions with the exception of on going monitoring and review will be complete by the end of February 2014.
How will not meeting this regulation until this date affect people who use the service(s)?	
Failure to meet this regulation could result in people not being able comment or complain about their care leading to them feeling unprotected from the risks of unsafe or inappropriate care and treatment. It may also place other patients at risk from poor experiences due to the inability to understand common themes and learn from issues arising across the Trust. As many actions in relation to this regulation are already complete, it is felt that the risk to patients has already been reduced.	
Completed by (please print name(s) in full)	Sarah Bloomfield
Position(s)	Acting Director of Nursing and Quality
Date	9 th January 2014