

**SCRUTINY BOARD (HEALTH AND WELLBEING AND ADULT  
SOCIAL CARE) MEETING – 18<sup>TH</sup> APRIL 2012**

**ADDITIONAL INFORMATION CIRCULATED IN RESPECT OF  
AGENDA ITEM 11 – LEEDS TEACHING HOSPITAL NHS TRUST  
CARE QUALITY COMMISSION (CQC) COMPLIANCE - UDATE**

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# Review of compliance

<p>Leeds Teaching Hospitals NHS Trust Leeds General Infirmary</p>	
<p><b>Region:</b></p>	<p>Yorkshire &amp; Humberside</p>
<p><b>Location address:</b></p>	<p>Great George Street Leeds West Yorkshire LS1 3EX</p>
<p><b>Type of service:</b></p>	<p>Acute services with overnight beds Community healthcare service Diagnostic and/or screening service Hospice services Rehabilitation services Urgent care services</p>
<p><b>Date of Publication:</b></p>	<p>April 2012</p>
<p><b>Overview of the service:</b></p>	<p>Leeds General Infirmary is run and operated by Leeds Teaching Hospital NHS Trust, one of the largest trusts in</p>

	<p>the country, providing health care to one million people per year in Leeds and across Yorkshire. The hospital also provides a number of specialist services across the Yorkshire region and beyond. This includes specialist services for children. Leeds General Infirmary has an accident and emergency department and provides acute hospital services.</p>
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# Summary of our findings for the essential standards of quality and safety

## Our current overall judgement

**Leeds General Infirmary was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.**

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

### Why we carried out this review

We carried out this review to check whether Leeds General Infirmary had made improvements in relation to:

- Outcome 04 - Care and welfare of people who use services
- Outcome 08 - Cleanliness and infection control
- Outcome 13 - Staffing

### How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 29 February 2012, carried out a visit on 1 March 2012, checked the provider's records, observed how people were being cared for, talked to staff and talked to people who use services.

### What people told us

We visited ward 22, which specialises in ear nose and throat surgery, maxillofacial surgery and has six orthopaedic beds, ward 53 (orthopaedics) and ward 55 (orthopaedics) for this visit over a two day period. We spent time observing how care was delivered to people who use the service on these wards. We spoke with a number of people who use the service and staff and we looked at medical and nursing records for some people using the service.

The majority of people we spoke with were, in the main dissatisfied with their care and support, saying this was mainly due to shortage of staffing. Comments we received from people on ward 53 included:

"Staff are slow to answer the call bell. One day I had to wait between 30 minutes and 45 minutes for a nurse to answer the bell."

"Some staff can be a bit sharp but I think this is because they are so busy."

"Nurses don't always have time to explain what is happening."

"Staff are good but they are very busy and can not spend time with you."

"Unless you ask they do not tell you what is going on."  
"Staff give good care but they are very busy and always rushed."

There were a number of times when we observed care that was not appropriate or given in a timely manner on ward 53. People did not receive the assistance they needed at meal times. People's requests for assistance or reassurance were at times ignored. We saw that people were laid in their beds in undignified or uncomfortable positions and we had to intervene to get staff to attend to people. We saw a person spoken to quite sharply by a staff member.

Staff on wards 53 and 55 told us they were often short staffed and this affected their ability to give people adequate care. They said, they feel rushed, and have no time to interact with people who use the service when short staffed. They said people often have to wait over 30 minutes to go to the toilet and on occasions there is frequent bed wetting and poor personal care given as a result of being short staffed.

People we spoke with said the wards were very clean. Comments included:

"Seems clean, always see plenty of cleaning."

"Very clean."

"They clean like maniacs."

"The ladies then come round and inspect the cleaning."

"They are pretty thorough."

"Washing of hands and wearing aprons is standard procedure, they all do it."

## **What we found about the standards we reviewed and how well Leeds General Infirmary was meeting them**

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

We have assessed this outcome area as a major concern.

The delivery of care is not always safe and effective. The service needs to take action to improve and maintain their arrangements for assessing, planning and delivering care treatment and support to protect people against the risks associated with unsafe or inappropriate care, treatment or support.

In view of the major concerns identified in this outcome area the Care Quality Commission served a Warning Notice on the Registered Provider on 17 March 2012.

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

Overall, people who use the service can be confident that systems are in place to manage the prevention and control of infection.

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

We have assessed this outcome as a major concern.

There are often times on wards 53 and 55 when there are insufficient staff, and it is difficult to get more staff quickly, to provide care that is safe, effective, meets people's needs and minimises risks to the people they are looking after.

In view of the major concerns identified in this outcome area the Care Quality Commission served a Warning Notice on the Registered Provider on 17 March 2012.

### **Actions we have asked the service to take**

We have taken enforcement action against Leeds Teaching Hospitals NHS Trust.

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

### **Other information**

In a previous review, we suggested that some improvements were made for the following essential standards:

- Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

Please see previous reports for more information about previous reviews.

**What we found  
for each essential standard of quality  
and safety we reviewed**



The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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

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

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

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

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

## Outcome 04: Care and welfare of people who use services

### What the outcome says

This is what people who use services should expect.

People who use services:

\* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

### What we found

#### Our judgement

There are major concerns with Outcome 04: Care and welfare of people who use services

#### Our findings

##### What people who use the service experienced and told us

The majority of people we spoke with were, in the main dissatisfied with their care and support, saying this was mainly due to shortage of staffing. Comments we received from people on ward 53 included:

"Staff are slow to answer the call bell. One day I had to wait between 30 minutes and 45 minutes for a nurse to answer the bell."

"Some staff can be a bit sharp but I think this is because they are so busy."

"Nurses don't always have time to explain what is happening."

"Staff are good but they are very busy and can not spend time with you."

"Unless you ask they do not tell you what is going on."

"Staff give good care but they are very busy and always rushed."

Others said that staff were not prompt enough when they needed the toilet urgently. And one person when asked if staff were kind said, "We all have our off days."

Some people we spoke with said they were satisfied with their care, they said staff answered the buzzer, "Especially when you need the toilet."

Our observations of people's care showed that interaction from staff was good some of the time on ward 53 and at all times on ward 22. Staff were polite and showed care and concern for people's welfare. We saw good examples of this when staff were giving people their medication, taking time to give explanations and ensure privacy for people.

However, there were a number of times when we observed care that was not appropriate or given in a timely manner on ward 53. The following are examples of our observations on ward 53:

People were at times trying to attract staff's attention by raising their hand or calling them, staff didn't always hear them or notice them. We intervened and attracted staff attention for people on a number of occasions. Had we not intervened we believe some needs would not have been met.

One person apologised to us for banging on their table to attract attention but said it was the only way they could get staff to attend to them.

We saw that a person who needed assistance to eat their meal waited 10 minutes for assistance. The food was cold by then. They began eating, while waiting, using a fork and their fingers, spilling a lot of food down them. This compromised their dignity and by the time assistance was offered the person appeared to have lost interest in the food and therefore didn't eat it.

We saw that a person being assisted back into bed was asking questions such as "why are you taking my pants off" nurses did not answer them. We also saw that the person was distressed and saying "don't be rough with me". The nurses didn't offer reassurance but just kept asking the person to put their head up and telling them they were going to move them from side to side. This did not reassure the person.

We saw that a person was offered meal choices and twice they said they didn't want anything but seemed resigned to having it when it was brought to them. The person commented that an apple was too hard for them and the nurse appeared to ignore this.

We saw that a person who was moving her food tray was told quite sharply to sit down. The patient seemed visibly upset by this, particularly as no reassurance or explanation was given by the nurse.

We saw another person shouting out for assistance as a nurse passed the bay. This was ignored so we pointed it out. The nurse said she needed to get another staff member to assist but didn't tell the person this. A few minutes later the person was 'hanging' their legs over the side of the bed, looked in danger of falling and their dignity was compromised. We intervened to get staff to come immediately.

We saw that a person was slumped down in the bed, asleep, and the bed covers had come adrift leaving them exposed and in an undignified position. The side of their head was resting on the bed rails rather than a pillow. Two nurses had been in and out of the bay and not noticed the person's position. We alerted them to this and they came to make the person more comfortable.

Staff on wards 53 and 55 told us they were often short staffed and this affected their ability to give people adequate care. They said, they feel rushed, and have no time to interact with people who use the service when short staffed. They said people often have to wait over 30 minutes to go to the toilet and on occasions there is frequent bed wetting and poor personal care given as a result of being short staffed.

Other staff said that people have to wait longer than they should for personal care or medication and there is not enough time to make detailed records due to staffing levels.

### **Other evidence**

When we last visited the service in August 2011 we assessed this outcome area as a moderate concern. We therefore issued a compliance action stating the service must improve to achieve compliance with this outcome area.

We found at the August inspection that, in nursing records, some assessment fields had been left blank, not all entries had been signed and dated by staff, care plans did not fully reflect the individual needs of the people who use the service and in some records care had not been regularly evaluated. We said This could lead to people's care needs being missed or overlooked.

In October 2011, the care provider sent us their action plan to say how they were going to improve the service. They said they would be raising staff's awareness of the need to complete care records properly and then introducing more checks on this. They said they had also reviewed nursing documentation to 'reduce the volume of documentation and make documentation easier and simpler to use in practice.'

We looked at nursing and medical records during this visit on wards 22 and 53. In nursing records we found many fields were still left blank, for example, falls risk assessments, wound management plans, hygiene and continence assessments.

We could see no evidence of discussion of care needs with people who use the service and no evidence that care was individualised. For example, The files did not detail if the person needed assistance with personal needs and how they preferred this to be done. It did not document what they were able to do for themselves.

We found that nursing notes were chaotic and did not appear to have a format for filing information in a manner that was consistent and logical. For example, one person had three charts for recording blood glucose scores all in use at the same time. This makes it difficult to monitor the entries and when bloods were taken. We found that blood glucose was not measured at consistent times and before meals as it should have been. It was also unclear from medication charts when insulin had been given.

We saw from an incident report that a person using the service had developed a pressure sore. The nursing records did not record any treatment or follow up in response to this for a further seven days. It was unclear if any treatment had been given at the time of the discovery of the pressure sore.

We saw that the structure of medical notes was not well organised. Information about episodes of care were not filed together. This made it difficult for staff to find the most recent information about the person's care.

During the visit we looked at nursing records audits that had been carried out during December 2011. The results referred to the trust as a whole. A number of themes were highlighted from the audit. Care planning management was identified as one. The report on the results said, 'not all areas are modifying care plans or ensuring that the planned care is individualised to the patient's particular needs. Care may have been delivered or undertaken but there is not always documentary evidence to support this.'

The report also identified the actions the trust is going to take in response to this. They said they are going to put education plans in place to make sure staff are aware of the need to document the 'whole patient assessment pathway' and carry out another audit to check this is understood.

We also discussed complaints received with regard to ward 53. We were told there had been two complaints since December 2011 from people using the service or their relatives. One complaint referred to a person using the service who was confused and not properly supervised. The other was a person complaining that there was not enough attention to detail in that they had not been offered a hair wash. And that staff appeared 'sharp' if they didn't want the care offered at the time the staff offered it. We were told these complaints had been resolved and action taken to prevent any re-occurrence.

We also looked at staff survey results from a survey undertaken in January and February 2012 and included staff's views from two of the ward areas visited. The results showed the following:

43% of staff either agreed or strongly agreed that they felt over burdened by their work load.

40% of staff said they either agreed or strongly agreed that they could not meet all the conflicting demands on their time at work

24% of staff said they disagreed or strongly disagreed that they were able to do their job to a standard they were pleased with.

This showed that a significant proportion of staff in their recent survey made statements that appear consistent with our observations during this inspection. That staff were very stretched and unable to meet people's needs properly at all times.

### **Our judgement**

We have assessed this outcome area as a major concern.

The delivery of care is not always safe and effective. The service needs to take action to improve and maintain their arrangements for assessing, planning and delivering care treatment and support to protect people against the risks associated with unsafe or inappropriate care, treatment or support.

In view of the major concerns identified in this outcome area the Care Quality Commission served a Warning Notice on the Registered Provider on 17 March 2012.

## Outcome 08: Cleanliness and infection control

### What the outcome says

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

### What we found

#### Our judgement

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

#### Our findings

##### What people who use the service experienced and told us

People we spoke with said the wards were very clean. Comments included:

"Seems clean, always see plenty of cleaning."

"Very clean."

"They clean like maniacs."

"The ladies then come round and inspect the cleaning."

"They are pretty thorough."

"Washing of hands and wearing aprons is standard procedure, they all do it."

##### Other evidence

When we last visited the service in August 2011 we assessed this outcome area as a moderate concern. We therefore issued a compliance action stating the service must improve to achieve compliance with this outcome area.

We saw that the care provider had standards for hygiene and cleanliness but these were not effectively maintained and managed in all areas. The processes in place did not always promote the prevention and control of infections.

In October 2011, the care provider sent us their action plan to say how they were going to improve the service. They said that by the end of January 2012 they would 'Increase attendance of nursing/Allied Health professional staff on cleaning monitoring audits with a focus on high risk areas.' They also said they would make sure all staff were aware of mattress storing arrangements and arrangements for authorisation for changing a room's use, therefore making sure that any risk regarding infection prevention and control or otherwise can be identified.

During this visit we walked round the wards, observed toilet, bathroom and shower areas, kitchens, sluices, treatment rooms, commodes, bays on the ward and corridors. We checked a mattress and observed staff's practice when cleaning a mattress. We saw that commodes were cleaned properly between patient use and labelled as cleaned.

The areas we visited were generally clean, odour free and tidy. General ward environments, bay areas, single rooms and patient bed areas looked clean and well maintained. Alcohol hand gel was available at the base of each bed as well as at the entrance and exit to the ward. We observed that staff were cleaning their hands between patient contact and on entering and exiting the ward. They also wore appropriate personal protective equipment when undertaking care tasks with people who use the service.

We saw good practice from staff when providing care for people who were in isolation due to infection control risks.

We did however note some issues that posed a risk to the control and spread of infection. We found a pillow being stored on the floor of a clean linen cupboard; this was removed when we pointed it out. We saw a chair in a shower room that had rusty legs; again this was removed when we told the staff.

We also saw that there were toilet brushes and holders in all toilets. There did not appear to be any system in place for ensuring the cleanliness of these, however, none of them looked visibly unclean or unhygienic. Staff were not sure of the policy regarding the use of toilet brushes. Some thought disposable toilet brushes should be in use. We discussed this issue with a divisional nurse manager who gave us assurances that they would find out the policy on the use and cleaning of toilet brushes and make sure this was implemented.

We saw some toilet pans were soiled. They did not appear to have been checked by staff when they had assisted people to the toilet. We spoke with staff about this and they arranged to clean the toilets but commented they didn't always have time to clean toilets.

We looked at the records of bed and bed space cleaning. We saw that nursing tasks were not always being recorded as completed and neither were the tasks by the patient environment team. It was therefore not clear if tasks such as replacement of suction and oxygen fittings were done each time the bed area was cleaned. We discussed this with staff in charge on the wards. They agreed to follow this up with staff and confirmed that bed areas and equipment were cleaned for each patient but agreed the documentation didn't back this up.

### **Our judgement**

Overall, people who use the service can be confident that systems are in place to manage the prevention and control of infection.



## Outcome 13: Staffing

### What the outcome says

This is what people who use services should expect.

People who use services:

\* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

### What we found

#### Our judgement

There are major concerns with Outcome 13: Staffing

#### Our findings

##### What people who use the service experienced and told us

People who use the service told us that the wards were very busy and there were not always enough staff. Comments from people on ward 53 included:

"Not enough staff on duty – last Sunday one nurse for 30 patients and very busy on the ward. Nurses are always rushing around."

"At weekends they are short staffed."

"Not enough staff."

"Run off their feet."

"Staff are too busy".

As mentioned in outcome four of this report people told us they had to wait for long periods of time for staff to answer buzzers and attend to their care needs such as going to the toilet.

Our observations on ward 53, as mentioned in outcome four, showed that people were not always given appropriate care or care was not always given in a timely manner. People did not receive the assistance they needed at meal times. People's requests for assistance or reassurance were at times ignored. We saw that some people were laid in their beds in undignified or uncomfortable positions and we had to intervene to get staff to attend to people.

We saw that on both days of our visit they were short staffed on wards 53 and 55. They were short of one staff on the night shift on ward 53 and one on the early shift on ward



55.

We also spoke with staff on duty on both the evening night and day shifts in wards 53 and 55. Staff on wards 53 and 55 told us they were often short staffed and this affected their ability to give people adequate care. They said, they feel rushed, and have no time to interact with people who use the service when short staffed. They said people often have to wait over 30 minutes to go to the toilet and on occasions staff said that people who use the service are incontinent in their bed before they can get to them and poor personal care is given as a result of being short staffed. They also said they do not have time to complete care records properly. Some staff said the 'pool' of staff was not meeting needs and demand and not enough staff were volunteering to do 'pool' shifts. They said the bank can't fill the shifts at times, despite being put out a month in advance.

Other comments included:

"Been short staffed for the past few months."

"Staffing very rarely as planned."

"Sometimes only three staff on at night- very difficult, can be up to three consecutive nights, told sister repeatedly that they couldn't cope- nothing happened."

We were also told that there are a number of times on nights when there is only one qualified nurse on. (We found one example of this when looked at a months worth of rotas).

Some staff on ward 53 told us the ward had gained 10 extra patients since moving to this ward from the ward they were previously located on. They said staffing levels have not been uplifted a third to support this increase in patients. One staff said levels were more or less the same. We contacted the trust following this inspection and they told us that staffing ratios had been increased in accordance with the increase in patient numbers. However, they said their ability to maintain these ratios was affected by the opening of ward 55 in December 2011 when some staff were moved from ward 53 to cover this ward. Ward 55 is a ward that has been established to provide additional capacity within the hospital to help manage operational pressures during the winter period. The trust did however say that they also used bank staff to support the wards during this time.

### **Other evidence**

When we last visited the service in August 2011 we assessed this outcome area as a moderate concern. We therefore issued a compliance action stating the service must improve to achieve compliance with this outcome area.

We said the health and welfare needs of people who use the service were not always being met because there were often insufficient staff to ensure needs were being met.

In October 2011, the care provider sent us their action plan to say how they were going to improve the service. They told us they had recognised the need to 'grow the nursing and midwifery workforce' and were developing the way in which they would do this.

They said they had calculated the staff numbers they needed based on patient's needs and had used a nationally recognised tool to assess this. They told us that in July 2011 their vacancy rates were in the usual range they expected and that the majority of

vacant posts were covered by bank staff.

Since the August inspection the trust also said that they had improved recruitment practice and sickness and absence monitoring. They told us they had improved staff deployment by introducing 'e-rostering'. (This is a computer assisted system for developing rotas.)

They also said that from December 2011 they would be asking people who use the service, "Were there enough nurses to look after you in hospital?" through the use of a survey. And they were taking action on looking to reduce staff sickness levels.

Our review of rotas on ward 53 during this visit showed that for 43 out of 92 shifts the ward was under its planned staffing levels (nearly half of all shifts). On ward 55, 10 out of 21 shifts were short of the planned numbers. And on two of the occasions when fully staffed, all staff on duty on ward 55 were agency staff. It was not clear if these staff were familiar with the ward.

On ward 22 approximately 20% of shifts were under the planned staffing levels. However, we were told that a trained apprentice was filling the role of a clinical support worker on this ward and if counted in the numbers means they are working to planned numbers. We saw care needs were being met well on ward 22. For example, staff were prompt in reviewing mobility needs and support and meals were given out in a timely manner. We saw staff gave good explanations when delivering care.

However we noted that all staff interviewed on ward 53, and those on 55 said staff were often moved between wards to help, meaning that they were then short on the ward they came from. We also witnessed that qualified staff on ward 53 were moved to help on ward 55 for long periods (we observed 3 hours on one of the days of our visit). This means that on many occasions where the documentation shows staffing to be at planned levels, it is in fact not. The trust does not document this type of staff movement. This means that the records used to manage and monitor staffing are not a useful tool for managers to know and understand the staffing needs for each ward.

Staff gave mixed views on the policy of completing incident reports when short staffed. Some said they were encouraged to do this, others said they had been told not to. One staff member said they believe there is reluctance from staff as they feel it's a waste of time as 'nothing changes'. Another staff member showed us a letter received from the trust asking staff not to discuss staffing levels with patients or members of the public. We were informed after the inspection that this was a general letter about professional conduct during a period of change, to remind staff of their responsibility to act professionally at all times. We were also told that the letter advised staff of the process for raising concerns through their managers. We saw one incident report had been completed recently on ward 53, despite there being many occasions when they had been short staffed. The incident report said staffing levels were 'contributing to low standards of patient care'. The section for identifying the action taken and lessons learned had not been completed.

During this visit, we also spoke with the deputy director of nursing who explained how staffing ratios were worked out. They said that a system is used to allocate an agreed number of nursing staff (qualified and unqualified) to bed ratio and the ward speciality is factored in to this. They said extra staffing is allocated to some areas with greater

needs, for example those wards with a high number of side rooms or specialist areas such as rehabilitation wards.

Rotas are planned by ward sisters and matrons using what is known as a shift calculator, to explore the different ways to best utilise their staffing. It is not clear how staff ratios to beds can be increased in response to changing needs such as acuity-how sick people are or their dependency levels, other than by use of the bank or pool staff. Staff reported to us that the bank or 'pool' of staff does not meet the demands of staff that are required to cover such situations.

The deputy director of nursing said that at times of staff shortages there is an agreed 'absolute' minimum number of staff; which is three- made up of two qualified staff and one unqualified on wards with between 24 and 30 beds. She stressed that this is not what they work to or want to see but what they have agreed can be the absolute minimum in times of emergency. On the day of our visit we saw they were working to the minimum on ward 53 and rotas showed they were below this minimum skill mix on another day.

We asked the clinical site manager what is done to reduce the impact of being short staffed. They said they talk to ward staff to see if they can manage, look at dependency levels, put a cap on admissions and provide 'part cover' from other wards if they can. They also said they make sure reports are completed and that these go out to the chief executive officer, chief nurse, divisional nurse managers and matrons daily, informing them where there have been problems.

As mentioned in outcome four of this report, we looked at staff survey results from January and February 2012 and a high percentage of staff said they felt over burdened by their work load and could not meet all the conflicting demands on their time at work.

We looked at patient surveys carried out in the orthopaedics area in February 2012. Most people said they found staff helpful and courteous. We could find no evidence that people using the service were asked to comment on whether they thought there were enough staff to provide care for them. This is despite the trust saying that this would be part of their action plan and surveying people's views.

### **Our judgement**

We have assessed this outcome as a major concern.

There are often times on wards 53 and 55 when there are insufficient staff, and it is difficult to get more staff quickly, to provide care that is safe, effective, meets people's needs and minimises risks to the people they are looking after.

In view of the major concerns identified in this outcome area the Care Quality Commission served a Warning Notice on the Registered Provider on 17 March 2012.

## Action we have asked the provider to take

### Enforcement action we have taken

The table below shows enforcement action we have taken because the service provider is not meeting the essential standards of quality and safety shown below. Where the action is a Warning Notice, a timescale for compliance will also be shown.

Enforcement action taken			
Warning notice			
This action has been taken in relation to:			
Regulated activity	Regulation or section of the Act	Outcome	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services	
	<b>How the regulation or section is not being met:</b>	<b>Registered manager:</b>	<b>To be met by:</b>
	We have assessed this outcome area as a major concern.  The delivery of care is not always safe and effective. The service needs to take action to improve and maintain their arrangements for assessing, planning and delivering care treatment and support to protect people against the risks associated with unsafe or inappropriate care, treatment or support.		31 March 2012
Regulated activity	Regulation or section of the Act	Outcome	
Nursing care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services	
	<b>How the regulation or section is not being met:</b>	<b>Registered manager:</b>	<b>To be met by:</b>

	<p>We have assessed this outcome area as a major concern.</p> <p>The delivery of care is not always safe and effective. The service needs to take action to improve and maintain their arrangements for assessing, planning and delivering care treatment and support to protect people against the risks associated with unsafe or inappropriate care, treatment or support.</p>		31 March 2012
<b>Regulated activity</b>	<b>Regulation or section of the Act</b>	<b>Outcome</b>	
Surgical procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services	
	<b>How the regulation or section is not being met:</b>	<b>Registered manager:</b>	<b>To be met by:</b>
	<p>We have assessed this outcome area as a major concern.</p> <p>The delivery of care is not always safe and effective. The service needs to take action to improve and maintain their arrangements for assessing, planning and delivering care treatment and support to protect people against the risks associated with unsafe or inappropriate care, treatment or support.</p>		31 March 2012
<b>Regulated activity</b>	<b>Regulation or section of the Act</b>	<b>Outcome</b>	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services	

	<b>How the regulation or section is not being met:</b>	<b>Registered manager:</b>	<b>To be met by:</b>
	<p>We have assessed this outcome area as a major concern.</p> <p>The delivery of care is not always safe and effective. The service needs to take action to improve and maintain their arrangements for assessing, planning and delivering care treatment and support to protect people against the risks associated with unsafe or inappropriate care, treatment or support.</p>		31 March 2012

## Enforcement action taken

Warning notice			
This action has been taken in relation to:			
<b>Regulated activity</b>	<b>Regulation or section of the Act</b>	<b>Outcome</b>	
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing	
	<b>How the regulation or section is not being met:</b>	<b>Registered manager:</b>	<b>To be met by:</b>
	<p>We have assessed this outcome as a major concern.</p> <p>There are often times on wards 53 and 55 when there are insufficient staff, and it is difficult to get more staff quickly, to provide care that is safe, effective, meets people's needs and minimises risks to the people they are looking after.</p>		31 March 2012

<b>Regulated activity</b>	<b>Regulation or section of the Act</b>	<b>Outcome</b>	
Nursing care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing	
	<b>How the regulation or section is not being met:</b>	<b>Registered manager:</b>	<b>To be met by:</b>
	<p>We have assessed this outcome as a major concern.</p> <p>There are often times on wards 53 and 55 when there are insufficient staff, and it is difficult to get more staff quickly, to provide care that is safe, effective, meets people's needs and minimises risks to the people they are looking after.</p>		31 March 2012
<b>Regulated activity</b>	<b>Regulation or section of the Act</b>	<b>Outcome</b>	
Surgical procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing	
	<b>How the regulation or section is not being met:</b>	<b>Registered manager:</b>	<b>To be met by:</b>
	<p>We have assessed this outcome as a major concern.</p> <p>There are often times on wards 53 and 55 when there are insufficient staff, and it is difficult to get more staff quickly, to provide care that is safe, effective, meets people's needs and minimises risks to the people they are looking after.</p>		31 March 2012
<b>Regulated activity</b>	<b>Regulation or section of the Act</b>	<b>Outcome</b>	

Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing	
	<b>How the regulation or section is not being met:</b>	<b>Registered manager:</b>	<b>To be met by:</b>
	<p>We have assessed this outcome as a major concern.</p> <p>There are often times on wards 53 and 55 when there are insufficient staff, and it is difficult to get more staff quickly, to provide care that is safe, effective, meets people's needs and minimises risks to the people they are looking after.</p>		31 March 2012



# What is a review of compliance?

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

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

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

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

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

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

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

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

## Information for the reader

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## Care Quality Commission

<b>Website</b>	<a href="http://www.cqc.org.uk">www.cqc.org.uk</a>
<b>Telephone</b>	03000 616161
<b>Email address</b>	<a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a>
<b>Postal address</b>	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA

**LEEDS TEACHING HOSPITALS NHS TRUST NURSING STAFF LEVELS**

**1. Background**

The formulas used to work out how many nurses should be deployed have been agreed between the Trust and nursing unions, including the Royal College of Nursing and UNISON. The Trust has committed to fund the nursing establishment (the actual number and levels of posts) in line with the Blueprint agreement for the next five years, until 2017. The document that contains these figures have become known in hospital shorthand as the nursing “blueprint”.

The Trust currently funds **3945** registered and **1333** unregistered nurse posts. This number will increase by over 200 over the next five years. This number of nursing posts compares favourably to all other teaching hospitals.

**2. Safe/Minimum staff levels**

Only the local assessment of the Ward Sister and the management team that supports her/him can decide what the minimum safe standard is because it will vary according to a number of factors. These would include the number of patients, the severity of their condition, conditions on the ward and the experience of staff and the skill mix available to the Sister at the time.

When the CQC inspected us in February this year care observed on one hospital ward was deemed not to be acceptable. The most serious instance of poor care they observed was when a patient was being attended by two nurses. Staff levels were not the pivotal factor in determining how a patient was treated - it was the behaviour of individual members of staff. We are taking separate actions to address unacceptable professional practice.

**3. Staff availability on shifts**

There are several reasons why a shift may not have a full complement of nurses available:

- Vacancy
- Sickness Absence
- Poorly managed patterns of annual leave
- Poorly managed leave for completion of mandatory training
- Maternity leave

**Vacancy**

We are confident that the number of nurse posts we have committed to fund is correct. However, we are currently around 306 registered nurses and 155 unqualified nurses short of the “optimum level” we would like. These vacancies do have an effect on the availability of nursing care on a ward and this effect is not evenly spread around the hospital. It is more difficult to recruit staff to work on what are perceived to be ‘difficult shifts in busy wards’.

We need to know in advance when people are going to be missing from a shift. Ward sisters should return roster information 6 weeks in advance, which gives us time to fill expected absences. We are automating this system (E-rostering). We are also increasing the sanctions for missing this deadline.

We attempt to fill any gaps with overtime or agency shift work and in most cases are successful; however, we find it most difficult to fill gaps in wards where older people are treated.

ITEM 11: CQC COMPLIANCE UPDATE – SUPPLEMENTARY INFORMATION

We have increased advertising and our presence at nursing conferences in attempt to improve awareness. We are having specific difficulty recruiting to older people’s wards and we are considering how we can make these roles more attractive to qualified candidates who have a choice.

In the last round of interviews for recruiting non-qualified nurses (two weeks ago) we shortlisted 90 applicants and were only able to appoint 30. The two main reasons for non-appointment were a lack of appropriate training to work in the acute sector and low levels of numeracy and literacy skill. In response we are seeking the support of local colleges to address these problems.

**Sickness**

We have tightened up local management procedures and have taken a series of measures to improve sickness absence, for example we ran a successful flu vaccination programme for staff. As a result sickness absence is reducing across the Trust. The reduction is shown in table 1 below.

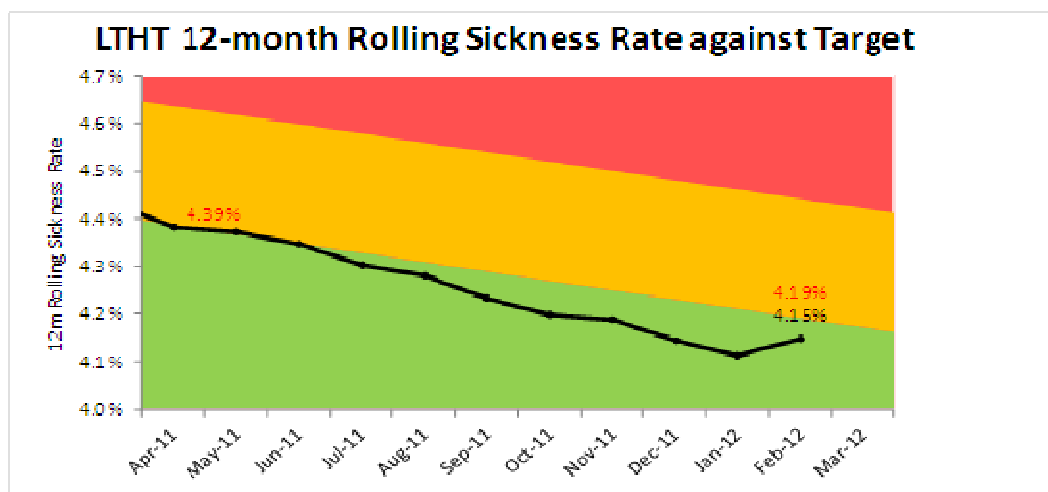


Table 1

**Other factors**

Many of the other reasons for low staff availability are to do with a lack of local management information or poor local management of resource. We are working with ward leaders to improve performance and skills in absence management.

**4. Summary**

CQC inspection reports have highlighted the need for continuing vigilance on professional standards. They have also emphasised the importance of making sure the right number of staff are available to ensure the risks of poor patient care is lowered.

There is a responsibility upon us to fund nursing posts and to improve our recruitment to them. That is why we have made an early commitment to do so and to increase our nursing workforce over a five year period. It is also important to remember that our hospitals are treating more patients and those patients have more complex needs than every before so we are constantly assessing our nursing availability and matching it to the prevailing circumstances.

LTHT  
April 2012