Inspection Report

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

Arrowe Park Hospital

Arrowe Park Hospital, Arrowe Park Road, Wirral, CH49 5PE

Tel: 01516785111

Date of Inspections: 19 September 2014
18 September 2014

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We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed
Records	✖ Action needed

Details about this location

Registered Provider	Wirral University Teaching Hospital NHS Foundation Trust
Overview of the service	Arrowe Park Hospital is situated in the Upton area of Birkenhead, on the Wirral peninsula. It is one location of Wirral University Teaching Hospital NHS Foundation Trust and is one of the biggest and busiest acute trusts in the North West, serving patients across the Wirral peninsula and surrounding areas. They provide a full range of 'acute' health services for adults and children, an Accident & Emergency (A&E) unit and a Maternity Unit.
Type of services	Acute services with overnight beds Community healthcare service Diagnostic and/or screening service Hospice services Long term conditions services Rehabilitation services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Nursing care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

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'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an announced 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 18 September 2014 and 19 September 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

We conducted this inspection in response to a number of concerns that were reported to us relating to poor patient care and unsafe discharges. Specific concerns were raised that Ward 1 (surgical day case unit) was being used for patients being transferred from Accident and Emergency (A&E) and related to unsuitable bathing facilities for a mixed sex unit. We raised these concerns with senior hospital management alongside concerns around shortfalls in nutritional action plans for patients and requested an investigation into the care of a patient as a result. We found the system in place for monitoring the care practices for patients was inadequate which puts patients at risk of not having their needs met.

We visited six wards and departments in the hospital, spoke to patients and staff of different grades and reviewed case notes. We observed inconsistencies in the care being delivered in each area we inspected. All the nurses and support workers we observed talked to patients in a kind and professional manner.

We visited the following wards:
Accident and emergency (A & E)
Wards 21 and 22– Care of the Elderly Wards
Ward 1 –Surgical Day Case Unit
Ward 20 – Urology Ward
Ward 33 – Heart Assessment Centre, Cardiology and Renal Ward

On the above wards and departments we spoke with care support workers, staff nurses, ward managers, the deputy associate director of nursing for medicine and the matrons for surgery. In addition we spoke with the director of nursing and midwifery, the associate director of operations for medicines and acute specialties, associate director of operations for surgery and the head of human resources.

We identified some concerns regarding staff providing safe and appropriate care.

We found that the trust needed to take more action to ensure the records made by staff were accurate and promoted the wellbeing and safety of patients because records were incomplete on the care of the elderly wards.

We found the trust had some established quality governance systems in place from ward to board level. We did not have confidence that quality assurance and monitoring processes were sufficiently robust to effectively assess and monitor the quality of service that people received. Areas of ongoing work that required further improvement include the board assurance framework and the risk register.

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 28 November 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

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 not meeting this standard.

Patient's privacy, dignity and independence were not always respected.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Before our inspection we had received some concerning information in relation to poor patient care and during this inspection we saw instances where patients' dignity was not fully respected.

We looked at the trust's nursing strategy 2013-2018. The strategy set out the framework for delivering care and aims to ensure nurses, midwives and nursing assistants were clear on what was expected of them and how they would be monitored. This included a set of nursing and midwifery care standards in relation to privacy and dignity, clinical care, nutrition, hygiene, comfort, safety and communication. Each standard had a set of actions to define what they meant. For example, the privacy and dignity standard stated: "Patients will have clean, appropriate nightwear and bed linen at all times and patients will receive gold standard framework end of life care and will be cared for with compassion when they are at the end of their lives."

We were told that nurses, midwives and nursing assistants were involved in the development of the strategy and each member of staff had received a copy to sign and read. The document included a statement which said: "I confirm that I will uphold the values and behaviours described in the nursing and midwifery strategy to deliver exceptional patient care, every patient, every time".

We heard staff speaking with patients in a respectful way. We saw that family contact was encouraged and where necessary this was outside of the ward visiting hours. Visitors were observed coming and going throughout the day, except at lunch time as the ward managers told us they tried to keep this time 'protected' to ensure the environment was calm.

On wards 21 and 22 (care of the elderly) we observed some of the patients did not look

well cared for with little attention spent on their hair, facial hair and finger nails. We observed that some patients were wearing non matching hospital pyjamas with missing buttons, which were poorly fitting and exposed continence products. We spoke with a staff member who told us they: "Had too many patients to care for and [they] had been unable to carry out all personal care". Another staff member said: "I was going to go back and shave the men as necessary". This showed that care was not always person centred and delivered in line with patients' individual needs.

Although we found patients' privacy and dignity was mainly respected when carrying out personal care, we saw one example of when a patient's privacy and dignity could have been better promoted by using the curtains around the patient's bed as the patient was receiving end of life care.

Limited information was obtained from some of the patients we spoke with due to their communication difficulties or dementia care needs, however we spoke with six visiting relatives. One relative told us: "One day [my relative's] catheter bag was on the floor and sometimes the straps are not attached. It's a worry and it's not good."

During our inspection we visited ward 1 (day surgery unit). The trust told us that during extremely busy periods (escalation periods) this ward would sometimes be opened as an inpatient ward for short periods. We noted that the environment on ward 1 was not tailored towards maintaining patients' privacy and dignity. The ward was a mixed sex ward, however on discussion with staff it emerged that there was only one shower room on the ward that was adjacent to the male patient bay areas. The bay areas did not have appropriate storage facilities such as patient lockers which meant patients could not store their personal effects safely.

We looked at the trust's escalation policy which defined the processes to be followed to manage patient safety, flow and capacity. It defined the roles and responsibilities of staff in the event of escalation and includes a checklist for the opening of escalation areas to ensure they are fit for use. The policy also contained standard operating procedures for surgical specialities in the event that Ward 1 needed to be converted to an inpatient area. One of the requirements that must be in place to enable patients to be admitted to Ward 1 was "Admitted patients must be transferred to a bed with a patient locker, table and chair." This meant the ward had not been opened in line with the trust's policy as no patient lockers were available. The policy did not mention the lack of single sex shower facilities and how this should be managed.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

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

During the inspection we highlighted some concerns relating to patient care on wards 21 and 22, both care of the elderly wards. We found examples where patients were not having their care needs met in a timely way and concerns regarding the staff providing safe and appropriate care. We identified issues in relation to poor communication between relatives and professionals. We also had concerns that a patient was not being regularly reviewed to ensure their care remained appropriate.

We observed a patient who had bed rails in situ. The patient's records showed a bed rails assessment had been completed, however the assessment did not recommend the use of bed rails as the patient could potentially try to climb over the rails. The bed rails in use were without any protection and we noted the patient was moving around in the bed. We were concerned this may lead to the patient sustaining an injury and asked if padded rail covers (also called "bumpers") were available. However, the nurse told us: "We haven't had bumpers for years". The inspector highlighted a bruise on the patient's leg to the staff, which staff were unaware of. We looked at the body map for this patient and there was no record of bruising recorded. This meant that without the appropriate detailed risk assessment and protective covers in place this patient was at further risk of harming themselves.

For frail elderly patients we observed some patients required additional one to one support to ensure their safety and care was monitored. An early warning score system was in place to monitor patients' conditions. Early warning scores are sets of observations that alert nurses and doctors to a possible deterioration in the patient's condition and allow prompt action to be taken to prevent further illness or complications. We had concerns that shortfalls in monitoring and safety checks of patients led to them not always being comfortable and having their essential needs met. We saw from completed observation charts on the day of the inspection that nurses had not completed all required observations. This meant there was a risk that doctors would not be alerted in a timely way to changes in a patient's condition and patients were at risk of not always receiving appropriate care and treatment.

We spoke with the ward manager about the usual arrangements over lunch and how they supported vulnerable patients. We were told there was usually a lunch time coordinator but due to two clinical support workers absence on the day of this visit, this had affected their usual organisation. We saw that patients were provided with a choice of suitable, nutritious food and drink.

The trust used the 'Red Tray' system to identify patients who needed additional support with their meals. We were told that patients on the red tray system would be supported to prepare for their meal, in addition these patients would be allocated a care support worker or nurse to provide one to one to support and encouragement when meals and drinks were served. This meant nutritional intake could be monitored and changes made as necessary. We saw that information about dietary needs including thickened fluids to prevent choking, pureed diet or if 'nil by mouth' was displayed above the bed of each patient. This was to inform housekeeping staff who served drinks and snacks and remind nursing staff and visitors so that patients were not accidently put at risk. This meant that a system was in place to communicate dietary need so that health and wellbeing was promoted.

However we had concerns that patients were not always in receipt of sufficient amounts of food and fluids. During our inspection we spoke with six relatives of patients. Comments from relatives included: "When we arrived here I was told, the care is terrible, you shouldn't keep your relative here", and "The weight has dropped off my husband since he came here. I have to sit by him as much as possible to assure myself he is getting some of the attention he needs." Another patient's relative told us, "It is evident to my eyes, the weight they have lost".

We selected four care records at random and found they contained a malnutrition universal screening tool (MUST). This is used to identify if patients were at risk of not eating or drinking sufficient amounts. Where patients had been identified as being at risk, we found they had been referred to a dietician. However, we also found that all four patients had lost significant amounts of weight during their stay in hospital. The ward manager told us patients for whom they were concerned would be highlighted on the ward's white board and on the patients' individual records. On ward 21 we found, the board had not been completed. We were told this was due to the ward having only moved back the previous night following re decoration. We were unable to confirm whether patients had been supported to have sufficient amounts of food and drink because food and fluid intake charts had not been fully completed. We asked the trust to look into these patients' needs during our inspection and we were provided with an action plan to address the shortfalls.

The atmosphere in the A & E department and some of the wards we inspected was calm and relaxed. Patients told us they were happy with the care they received and did not have any concerns relating to staffing levels or staff competence. They told us they would contact the trust's Patient Advice and Liaison Service (PALS) if they had any concerns about their care and treatment.

We spoke with six patients and their relatives on Wards 21 and 22. We received some mixed views about the care received. One patient told us they had been on the ward for two weeks and they had no concerns relating to their care. They told us they had no concerns relating to staff and that the nurses responded promptly when called. The patient was aware of how to contact PALS (patient advisory liaison service) if they had any concerns. Another patient's relative told us how they had raised a complaint regarding the

care of their relative. However, the relative had been invited to attend a case conference to discuss their relative's care and discharge arrangements.

We had some concerns around the management of patients being discharged back into the community. One patient's relative was distressed about the plans and communication around their relative's proposed discharge into a care home; they did not feel they were being supported with the arrangements and that staff did not appreciate how 'traumatic this was for them after 63 years of marriage'. Although the relative visited regularly they did not feel they had been kept informed about what was happening and when.

We discussed patients awaiting discharge with a doctor, they told us there were nine patients who were medically fit for discharge on Ward 22 but they were delayed leaving the ward due to lack of social care arrangements. This put additional pressure on the hospital in terms of patient flow and placed vulnerable patients at the potential risk of hospital acquired infections which could create additional medical and social concerns.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not always enough qualified, skilled and experienced staff to meet patients needs.

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

We spoke with staff on all the wards and departments we inspected due to concerns raised with us prior to the inspection of a bullying culture that was allegedly present in the trust. Staff we spoke with had no concerns regarding bullying and we found no evidence to support this concern. However staff told us they had little opportunity to take their breaks and morale for staff on some of the wards was generally low.

In addition concerns were raised regarding staffing levels and the skill mix of staff. One area of concern highlighted was when inpatient beds were used on Ward 1.

The planned and actual staffing levels were displayed on a notice board in each ward we inspected. This showed the expected and the actual staffing levels for registered nurses and care support workers. We saw the wards were generally staffed in line with their expected levels on the days of this inspection. We were told by ward managers existing staff were able to work overtime and bank and agency were used to provide additional cover during periods of staff sickness or leave.

Comments from staff we spoke with on the care of the elderly wards included: We are "too busy" and 'I've been too busy to spend time with patients to encourage fluids this morning as I've had 15 patients to support" and "I am leaving the ward because I go home feeling dissatisfied about the quality of care I can give these frail patients. I have not had the training and support I should have received".

On one care of the elderly ward we observed two patients who were in need of immediate attention from staff on more than one occasion. We had serious concerns about the deployment of staff on the ward as we were unable to locate staff to meet these patient's needs in a timely way. We alerted staff to a patient's nasal oxygen not being effective due its position, a patient who was causing themselves harm due to their bed rails and for a patient whose condition was deteriorating. Due to the nature of these concerns these patients required close observation and staff were not available in the bay to observe and meet or respond to the patients' needs in a timely way.

Senior staff confirmed that ward 1 was frequently used as an inpatient ward to relieve bed pressures across the hospital, including patients from both medical and surgical specialties. We looked at a sample of bed occupancy figures. This showed from the 2 September to 17 September 2014 the ward had 26 medical patients occupying beds on this surgical ward. We discussed our concerns with senior management for surgery who told us the majority of patients only stayed overnight while they were awaiting beds in a more appropriate ward and additional staff were made available to provide care for patients. The associate director of nursing for surgery confirmed that the hospital had cancelled elective surgery to reduce the number of day case patients when the ward had been used for inpatients.

The trust's escalation policy checklist stated to ensure ward 1 was appropriately staffed there must be a "minimum 1 registered nurse per shift to be deployed from substantive post within medicine."

The associate director of nursing for surgery told us that as part of the escalation process only patients with low acuity should be identified to stay on ward 1. Acuity refers to the level or intensity of nursing care a patient requires. Staff from other wards should then be sourced to provide specialist (e.g. medical or surgical) support for patients staying overnight. However, the ward staff we spoke with told us that the patients were not always accompanied by appropriately trained staff and staff on ward 1 were required to care for these patients.

Staff talked about the skill mix of staff and how at times they were moved to other wards where they did not always feel they were as effective as they could be. We saw nurses were moved on a regular basis from one ward to another. Staff told us this was 'frustrating' and did not always leave their ward with the continuity of staff or with staff who knew the patients'.

In A & E we did not highlight any concerns with the levels of nursing staff on the day of the inspection. The A & E department appeared to be appropriately staffed with an appropriate skills mix. The environment appeared calm and staff were able manage the flow of patients appropriately. The A & E department was managed by an A & E coordinator, whose role included preparing staffing rotas and monitoring patient flow. The coordinator was supported by a team of nurses and clinical support workers. We spoke with nursing staff who told us the number of nursing staff and the skills mix within A & E was appropriate unless there were issues with sickness or leave.

Concerns were raised that when staff were off sick or on leave the staffing was 'stretched'. Some concerns were raised in relation to the need for changes in the skill mix. One nurse told us there were not enough band 6 nurses on each shift (due to sickness and leave) and this had an impact on their workload. However, staff confirmed that they were able to cope with the extra work to ensure patient safety was not impacted. They told us they regularly missed their breaks because they were busy.

We had received some information of concern relating to the use of additional beds within ward 14(Urology). This ward was closed at the time of our inspection. The matron for urology, general and special surgery told us the urology ward had moved to ward 20 from ward 14 during July 2014. We did not highlight any concerns with the levels of nursing staff or skills mix on the day of the inspection. Ward 20 was a 29-bedded ward that was staffed appropriately and there was no physical capacity on this ward to increase the number of patient beds.

During our inspection we received information of concern that Ward 33 regularly had nursing staff transferred to support shortages on other wards which would leave nursing staff on night duty with a high number of patients to support. From the records we reviewed, we found that this was correct. There were instances when nurses from the ward were moved to support shortages on other wards and backfill did not always occur. This meant there were occasions when two nurses were responsible for 29 patients. This meant there were times when the hospital was not adhering to the trust's target staffing levels of 1:10 at night.

The ward manager for ward 33 told us the majority of nurses were experienced and not newly qualified nurses. The ward manager told us the skills mix of the staff on the ward was not always appropriate for the types of patients on the ward. For example, there were no renal specialty trained nurses on the ward on the day of our inspection (due to leave or sickness).

The ward manager told us all the nursing staff had undergone basic induction training in renal care so patients were not at risk. They told us that they planned to train all the nursing staff in cardiology and renal specialties in the future so they could be better utilized. There were no specific timelines for when this would take place.

The ward manager confirmed that one nurse was frequently taken off the ward during the night shift to support escalation beds elsewhere in the hospital. We spoke with two nurses (band 5), who told us it was difficult to provide suitable care for high dependency (dialysis and cardiology) patients with only two nurses on the night shift. They told us they often had to miss their breaks due to the increased workload. They also told us they felt the workload was better managed when there were three nurses on the ward during the night shift.

We looked at the trust's workforce and organisational development strategy 2013-2016 to support us in making a decision if the trust had an appropriate risk assessment and escalation in place for staffing. The strategy aimed to ensure the trust had "the right people, at the right time, with the right knowledge and skills and the right approach". The strategy set out objectives such as "Improve the capacity of the organisation to maximise the deployment of its workforce in order that the trust can meet/respond to organisational challenges and deliver safe and reliable services". In response to staff sickness there had been a drive in "wellbeing" interventions in hotspot areas such as a self-care course, a stress working group and a flu vaccination campaign.

We saw that a board report containing planned and actual staffing on a shift by shift basis at ward level for the previous month was presented monthly. The minutes for the Quality and Safety committee (10 September 2014) showed the July 2014 report and outlined the operational challenges faced. The report identified that July was a key holiday period and access to bank nursing staff had been a challenge, this had led to a reliance on overtime and agency nurses. Data showed that at times, the older people's assessment unit, ward 33 and HAC, neonatal unit and ward 38 had not met the trust's 90% staffing fulfilment target for registered nurses on nights. The reasons given for these shortages were: outstanding vacancies, additional beds open at the beginning of the month, short notice sickness and staff relocated to contingency areas .However, the report also stated that despite these difficulties the data for June and July showed that Royal College of Nursing and other professional guidance of 1:8 (days) and 1:10 (nights) had been met.

During the inspection the trust provided us with details of staffing on ward 1 and the number of instances it had been used as an inpatient ward. From 1 September to the 17

September, the ward had been used as an inpatient facility on 11 occasions. Staff to patient ratios were within recommended levels (1:8 during the day and 1:10 at night) with the exception of Thursday 9 September when the ratio of nurses to patients at night was 1:14. In terms of skill mix, at least one of the nurses per shift was from a substantive post usually within medicine and an agency has then been used to back fill. It is not clear from this report whether there was a mix of surgical and medicine nursing staff. There is a comment at the end of the report which states "When staff were moved from wards this relates to inpatient wards so ward 1 would be staffed by our own hospital trust nurses to ensure appropriate clinical skill set."

We reviewed records from 26 August to 19 September 2014 which showed the trust had a system in place for reviewing staffing levels on a daily basis. These reports showed that staffing shortages were being covered and every effort was made to ensure appropriate skill mix by ensuring agency staff were supported by permanent staff. However, there was limited flexibility to cope with additional sickness absence or opening of escalation wards.

One email sent on 31 August 2014 from the deputy associate director of operations, medicine and acute division states: "It has been a challenging weekend for staffing and bed availability particularly Saturday which has involved considerable time and effort to manage. The impact upon flow has been kept to a minimum but could have had significant effect on performance." Another email sent by one of the matrons from medicine and acute specialities on 6 September states "There have been the usual difficulties in trying to ensure all areas adequately staffed. Again a number of staff and bank staff are sick or did not attend which caused added pressure." On 7 September the staff planning email showed that a registered nurse night shift was not covered on two wards and patient acuity was not covered on one ward (ward 33). This confirmed there were constant challenges to meeting adequate staffing arrangements.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Good evidence was seen of analysis, learning and assessing risks to quality. However, there were some shortfalls in the quality governance systems in place at ward level. As a result we found systems in place did not always identify and manage risks accordingly.

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

A review of the majority of risk and governance systems in place was undertaken via document review and interviews with staff. In addition we reviewed how systems were implemented at ward level.

The trust described its comprehensive process for managing alerts, such as Central Alert System broadcasts in its 'Actioning Safety Alerts Policy'. Monitoring reports for alerts were also provided and reviewed. In addition to the central alert system broadcasts, the trust also monitored internal alerts as a mechanism to share key safety issues arising from internal investigations or findings.

There was a Clinical Audit Policy and Procedure in place which described the process for developing the annual clinical audit plan against agreed priorities and how to register and undertake a clinical audit. A quarterly report was produced to monitor progress against the annual plan, including completion of reports and associated action plan. This process appeared to be well embedded. We could see evidence of audits being presented locally at 'Good Practice Days' held bi-monthly in the medicine and acute specialties division and being discussed in service level governance meeting minutes.

Where audit findings identified non-compliance, evidence was seen of risk assessment and inclusion on the risk register.

An internal audit was undertaken during 2013/14 by an external audit and consultancy provider. The audit concluded there was 'significant assurance' around the clinical audit processes. We saw evidence that some of the actions agreed following this audit had been completed during our inspection. However during our inspection we found there were issues with the quality of care provided on some wards. These issues had not been identified as part of the trust's "nursing audit" process. This meant the systems in place had not identified some of the risks to inappropriate care and treatment at ward level.

The trust's Concerns and Complaints Handling Policy described the processes available for staff when a concern or complaint was raised. This ranged from resolving issues at ward and department level to the formal complaints process. The trust had made some significant improvements in complaints over the last 12 months. These improvements included increasing the proportion of complaints that were responded to within agreed timescales. .

The trust also planned to introduce a 'Complaints Scrutiny Team' with the first meeting scheduled for December 2014. The aim of the group will be to review eight to ten randomly selected complaints to consider the quality of the responses and if appropriate identify learning as a result of each complaint.

The executive director team received a monthly complaints summary to track progress and learning from complaints. The trust had 10 referrals made to the Parliamentary and Health Services Ombudsman during 2013/14. Of these 10, no complaints were fully upheld and two were partially upheld.

There were comprehensive governance structures in place throughout the trust. The board of directors received assurance from the quality and safety committee for the majority of quality governance issues. Reporting into this committee was the patient and family experience group, clinical governance group, workforce and communications group and the risk management group.

In addition to the formal board committee structure there was a monthly trust-wide clinical governance team meeting to keep on track of operational governance issues. All divisions also had a clinical governance meeting and service level meetings. We were also provided with divisional exception reports and evidence of learning being shared at ward and department meetings. The structure appeared to work well with good evidence of issues, risks and learning being communicated in all directions.

We saw evidence of analysis and learning from incidents at all levels of the organisation via meeting minutes.The quarterly 'serious incident trend' report also monitored compliance with incident management. This was particularly poor with regards to the incident report being received within two working days for serious incidents. Compliance with the time to complete the investigation was variable and, similar to complaints, was more likely to go over agreed timeframes in the acute care and medical specialties division. This division had more serious incidents than the other divisions with 21 of the 42 in the quarter one report being from this division.

We reviewed a selection of serious incidents from all divisions. It was not clear from the report template that root cause analysis tools and techniques were used. We saw there was no formal section for care or service delivery problems. We saw evidence of learning from serious incidents.

The trust had a positive patient safety incident reporting culture. However, during the inspection staff told us about staffing level problems that they were not reporting as incidents despite telling us staffing was an issue on a regular basis. This meant the trust could not be assured that analysis of incident reports provided an accurate picture of issues within the hospital.

The trust undertook a review of its systems and processes in relation to all NICE guidance issued from January 2012 to December 2013. The monitoring systems in place reported

that the trust was 'unassured' about compliance with 75% of guidance. The trust had recently changed its process to accept other forms of evidence from the divisions to confirm assurance. From 79 pieces of guidance that were recorded as 'non-compliant' or 'not assured', only three had not had a risk assessment completed for inclusion on the risk register.

Following our inspection the trust told us that when guidance is published, the lead for each piece of guidance must complete an initial response form. This meant that initially most guidance would be un-assured. Therefore whilst the report was correct in that 75% of the guidance in the report was unassured when disseminated after publication, only 24% of the guidance remained unassured at the time the report was written in February 2014. The trust hoped that its new streamlined processes, with clear responsibilities, will improve compliance and help support service improvement through the NICE Quality Standards.

The trust had a Quality Improvement Strategy 2013-16. This document had measurable outcomes and was monitored annually. A progress report in June 2014 showed progress in most areas but acknowledged that not all milestones had been met.

For example, the priorities for 'patient experience', 'Improve care for patients with dementia' and 'ensure patients are supported with eating and drinking based on their individual needs' were both areas highlighted by the inspection team as being concerns in the ward areas.

As part of the inspection we reviewed the risk register including high level risks scoring 15 and above and the Board Assurance Framework. The Board Assurance Framework was aligned to the strategic objectives, with clear risk descriptions, appropriate controls and sources of potential assurance identified. However, the Board Assurance Framework did not include any risk scores, which could make it difficult for the board to understand the level of risk it was carrying, where it was aiming to be by the end of the financial year and tracking progress along the way. We were told that this had been identified and the trust planned to review the Board Assurance Framework and look at risk scoring and ranking.

The risk register reflected the risks that staff told us about during the course of the inspection along with potential risks we identified through document review. Overall the risk descriptions described the condition, cause and consequence although the quality was variable. On discussion with the associate director of risk it was agreed that the risk ratings were not always consistent or appropriate to the actual risk presented. The associate director of risk had introduced a training programme to educate staff about forthcoming changes in risk management. We were provided with the risk assessments to accompany this risk register and found them to hold far more detailed information than the risk register itself. Some of the actions completed on the risk register had dates of 2010. There was no indication on the risk register of the dates when the risks were identified, which made it difficult determine whether risks were being managed in a timely way.

There appeared to be a strong risk culture within the trust with the risk register used appropriately for risks to quality through non compliance with NICE, clinical audit findings, external reports, internal audit findings and quality impact assessments for cost improvement programmes. Annual reports were also undertaken for key governance areas, such as risk management, clinical audit, complaints, and incidents to identify further areas for improvement for well-embedded systems and processes.

We saw information displayed on the wards that demonstrated performance data and

analysis of audits and incidents. Ward level data was then reported on in the 'safety thermometer' and ward 'dashboards'. Evidence was seen of quarterly ward health and safety inspections having taken place and discussed at ward meetings.

Overall we found that the trust had systems in place to monitor and assess quality and safety. However some of these systems were not fully embedded and were not always effective in identifying and managing the risks at ward level.

Records ✖ Action needed

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 adequately protected from the risks of unsafe or inappropriate care and treatment due to inadequate care records.

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

This outcome was added because we found additional issues during the inspection with the accuracy of record keeping within the medical, care of the elderly wards. We also found shortfalls in the completion of records for checking of resuscitation equipment and drug fridges.

We looked at the nursing documentation for six patients during this inspection. We found that when patients were admitted to hospital their needs were assessed and nursing documentation was completed. Assessments reflected individual patients' needs and included general and specific assessments such as risk of falls, pressure ulcers, bed rail use, modified early warning score (MEWS) and nutrition. Where risks were identified a specific plan of care was documented. Assessments seen included those undertaken by nursing, medical and other allied healthcare professional staff.

Our review of the documentation and risk assessments showed there were some shortfalls. For example, we had concerns about the accuracy of a bed rails risk assessment for one patient. The assessment showed bed rails were not recommended as the patient may have attempted to get out of bed or may lead to increased confusion. However, we found bed rails were in use for this patient and the rationale for using bed rails had not been recorded as required.

We looked at the nutrition and dietetics forms for three patients. These showed patients had been seen by a dietician, following referral due to their weight loss. The dietician's actions plans included comments such as: "commence food charts", "encourage high protein diets with milky drinks", "request strict food records please", "unable to locate food record charts", "provide snack between meals and a pint of full fat milk daily".

Where the dietician had reviewed patients, their reports stated: "Not meeting the fluid recommendation a patient required". Another report stated: "Unable to locate food record charts. Please monitor plan. Strict food records", "Fluid intake remains poor" and "Currently not meeting fluid recommendation". On checking food intake records we found

them to be unavailable or incomplete. This meant there was a risk that patients were not receiving appropriate food and drink because records did not accurately reflect nutritional intake.

We could not find evidence in the records that patients were checked regularly in line with trust policy to make sure they were clean, comfortable, had access to fluids and a call bell to hand. These quality and safety checks would ensure patients were comfortable and had their essential needs met. We looked at the MEWS (Modified early warning scores) chart for a patient who was visibly unwell. This showed there had been no recording of the patient's observations since "12:10" the previous day. It was not clear from the record whether this was 12:10 am or pm.

Staff used a checklist for the discharge of patients from the wards. Patients on the care of the elderly wards were discharged directly from the wards, whereas other patients awaiting discharge were transferred to a discharge lounge. We looked at the records for two patients who had been discharged during the inspection or were in the process of being discharged (one on ward 33 and one on ward 21). The checklists had not been completed.

We spoke with two patients on ward 1 who were due for discharge, they told us they hadn't been spoken with about their discharge plans. However records completed by the staff stated discussions had been held. The staff we spoke with told us they had a verbal discussion with patients so they had all the relevant information they needed. This showed that patients were not always provided with a clear written record of their discharge plan.

We spoke with a social worker on a care of the elderly ward. We looked at the assessment information they had been provided with in order to make a judgement on the patient's current abilities. We had concerns about the lack of detailed information provided on the assessment and the lack of a summary for this patient in relation to their rehabilitation, mobility and required level of supervision. The social worker had raised their concerns with the ward manager.

We saw there were booklets called 'This Is Me' for patients with dementia or their families to complete. This was a tool used for caring for people with dementia to inform staff about their needs, preferences, likes, dislikes and interests to enable individualised care and support. We found that some had not been completed at all. One staff member told us: 'Clearly it's not possible, if no relatives visit'. We were concerned that there was no other detailed personal record of the patient's likes or dislikes readily available to inform the staff. This meant patients were at risk of receiving inappropriate care due to a lack of proper information about them and their needs.

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 activity	Regulation
Nursing care	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: Patients' rights to privacy and dignity were not always respected and upheld. Regulation 17 (1) (a) and (2) (a), Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Nursing care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The care and welfare of patients at the trust were not always being met, or met in a timely way. Regulation 9 (1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Nursing care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met:

This section is primarily information for the provider

	The trust did not always have sufficient members of suitably qualified persons on duty to meet patients needs and patients needs were not always met in a timely way. Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Nursing care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: Systems in place did not always effectively identify and manage risks relating to the health, welfare and safety of service users. Regulation 10 (1) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Nursing care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were not adequately protected from the risks of unsafe or inappropriate care and treatment due to inadequate care records. Regulation 20 (1) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 28 November 2014.

CQC should be informed when compliance actions are complete.

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

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.

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