Inspection Report

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

Watford General Hospital

Vicarage Road, Watford, WD18 0HB

Tel: 01923244366

Date of Inspections: 21 November 2014
20 November 2014

Date of Publication: May 2015

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

Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✖ Action needed
Cleanliness and infection control	✓ Met this standard
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed
Records	✓ Met this standard

Details about this location

Registered Provider	West Hertfordshire Hospitals NHS Trust
Overview of the service	Watford General Hospital is one of three locations operated by West Hertfordshire Hospitals NHS Trust. It is an acute hospital in Watford with an A&E department. Watford General Hospital provides general and medical, surgical, outpatient and maternity care. It has approximately 600 beds and serves a population of 500,000 people and employs approximately 4,000 members of staff.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Management of supply of blood and blood derived products Maternity and midwifery services 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

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 20 November 2014 and 21 November 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, reviewed information given to us by the provider and were accompanied by a specialist advisor.

What people told us and what we found

We spoke to 29 patients who used the service, 40 members of staff and members of the executive team. We looked at the personal care and treatment records of 21 people who used the service. We observed how people were being cared for and talked with patients using the service. We talked with staff, and reviewed information given to us by the provider. We were accompanied by two specialist advisors. Following the visit, we asked the trust to provide further information in order that a judgement could be made: this information was received at the end of December 2014.

Safety
We found that learning from incidents was not always shared and that safeguarding procedures were not robust. Nurse staffing levels were affected by the high level of staff vacancies, despite on-going recruitment significant pressures on staff were evident in the maternity service. Mandatory training for staff was below the trust's targets. Infection control procedures were effective at the time of our inspection. Record keeping within the hospital had improved since our last inspection.

Effective
Overall mortality rates for the trust had improved and there was some evidence of review of care pathways to give improved outcomes for patients. We found poor nursing care planning in some instances and the care and treatment given to patients was not always meeting their needs. The trust was behind trajectory for staff appraisals at the time of the inspection and most staff did not receive formal supervision on a regular basis. We saw good multi-disciplinary working between different professionals. We found variable levels of staff understanding and recording of patients' mental capacity to make decisions. There were concerns about the hospital's application of the Deprivation of Liberty safeguards (DoLS).

Caring
Overall, staff were very kind and compassionate in their approach to patient care and the

hospital was seeking meaningful feedback from patients and their advocates. Patients' dignity was respected.

Responsive
This domain was not assessed as part of this inspection.

Well led
Whilst the trust had made significant improvements in its governance and risk management processes, we found it was not yet fully embedded throughout the staff team at the hospital. A series of patient safety initiatives had been implemented to address the concerns we had found at our last inspection, these initiatives were in use at the time of the inspection.

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 20 May 2015, 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

Consent to care and treatment ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements.

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

We viewed the information boards at the entrance of each ward and department, these provided information about the ward, the service and where to ask questions should the patient wish to talk to a staff member. On a care of the elderly ward, we spoke with four patients who told us that they received information about their care. One person told us, "Everything is fine. I was supposed to go home on Thursday but they don't really keep me informed. On the whole they are alright." This meant that people who used the service were mostly given appropriate information and support regarding their care or treatment.

In general people were satisfied with the care and treatment they had received and in most cases were very complimentary about the attention and attitude of staff towards them. Comments included, "The staff are very good", "I am well looked after and the nurses come quickly" and "They are all very nice people." All four patients we spoke to on this ward had call bells to hand if they needed to summon staff assistance.

We observed staff engage in activities with people. In three care plans we saw, 'This is Me' booklets which contained personal information about people. In two cases, this guidance was in place and enabled the staff to talk to people about the person's life and their family to support, comfort and orientate them. However, in one case, the booklet was not completed. The work undertaken on this ward and the interactions observed evidenced that people's diversity, values and human rights were respected.

Staff in A&E were aware of the trust's consent policy. Patients we spoke with told us that they were asked for their verbal consent before procedures were undertaken. We found staff placed great emphasis on the triage assessment staff obtaining the necessary consents for patients whose capacity was uncertain. The records identified people's consent by means of a "yes/no" box. The trust might find it useful to note that we found it difficult to locate the ticked form implying consent within the records we read.

We saw that, where appropriate, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) documentation had been correctly completed. The trust had a good relationship with McMillan Curie nurses who were able to support staff with patient's end of life care.

We saw on medical wards that generally patients' consent had been sought and recorded for use of bed safety rails. Nursing staff were aware that doctors would carry out mental capacity assessments when required. In three cases, we saw that a bed safety rails assessment had been completed for a person living with a dementia, but we could not find a clear record in either nursing or medical notes of a mental capacity assessment having been carried out to help inform the decision to use these bed safety rails. This meant that there was a risk that the patients had not given consent for the use of these bed rails.

On Bluebell ward, we found that one patient had a standard authorisation for the Deprivation of Liberty Safeguards (DoLS) in place, but that there was no record of the mental capacity act assessment in either the nursing or medical notes to inform the decision regarding this authorisation. We saw that an urgent DoLS application form had been completed by a junior doctor and stated "lacks capacity" but the medical notes for that day of the authorisation did not record the patients' capacity or the fact the DoLS authorisation had been completed. We also found that there was a gap of 16 days from the expiry of the urgent DoLS authorisation until the application was made for a standard DoLS authorisation. Whilst ward staff had been caring for the patient as though a DoLS authorisation was in place for these 16 days to maintain their safety, in effect there was a risk that this patient had been unlawfully deprived of their liberty as there was no formal DoLS authorisation in place. Senior staff confirmed that documentation regarding mental capacity assessments could be improved and also stated that the local supervisory body had recently confirmed that, due to the significant increase in DoLS applications, an urgent authorisation could be extended to two weeks. However, there would have still have been a period of eight days when a DoLS authorisation was not in place. A mental capacity assessment had been recorded for the application for the standard DoLS authorisation in accordance with trust policies.

We looked at the records and documentation for one patient on a surgical ward (Cleves Ward), they had been admitted for an urgent operation. The combined medical and nursing notes stated that this patient's cognitive state had been assessed and to refer to the Abbreviated Mental Test Score (AMTS) assessment but we could find no evidence the AMTS assessment had been completed. The medical notes recorded that the patient was confused and displayed difficult behaviours and a dementia diagnosis was a possibility. We found that the pre-operation consent form (Consent Form 4) had been signed and dated by a junior doctor but had not been completed fully as the sections to record the outcome of a mental capacity act assessment and best interests' decision had not been completed. There was no record of any involvement of the patient, patient's relatives or advocates and no evidence that that a second opinion had been sought. Senior staff confirmed that this was not in accordance with the trust's policy. This meant that there was a risk that the patient had not given consent for the procedure.

The Chief Nurse told us that training for mental capacity act assessments and best interest decisions were part of the trust's mandatory safeguarding training and that staff were required to attend this training every three years. Staff showed limited awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguard (DoLS); all staff we spoke with said they thought they had received training during induction. The training was part of the trust's mandatory training programme. Staff on medical wards told us there was no specific mental capacity training provided by the trust, and that is was included in the

safeguarding training. Nurses told us they would complete memory test assessments and doctors would complete mental capacity assessments. This meant that there was a risk that staff had not received adequate training to understand when to carry out mental capacity assessments.

The trust provided further information in December 2014 and reported that there were a number of surgical patients identified as living with a dementia, whose records did not have evidence of mental capacity assessments. The trust reported that 60% of out-patients assessments did not pick up on the patients' lack of capacity. The trust provided their action plan which demonstrated how they were going to ensure mental capacity assessments were fully included in all preoperative assessments and repeated on admission for all patients and undertake awareness sessions for staff. An audit to monitor their progress with their action plan was due in February 2015.

Further information provided in December 2014 included a retrospective audit of 14 DoLS applications. This demonstrated that 50% of DoLS applications records did not have evidence that the patient was able to understand the decisions being made; six of out eight cases there was no copy of the DoLS application retained on the patients' records and in three out of the 14 cases reviewed, there was no evidence of involvement of a family member or advocate in the decision being made. This meant that not all records for DoLS applications were complete and there was a lack of evidence that patients and their families had been involved in the process.

The trust's Safeguarding Lead provided evidence that staff in the clinical environments were providing the correct DoLS forms and paperwork to safeguard their patients, however, staff did not keep a copy of this in the patients' records. At times the safeguarding lead had needed to remind ward staff to record the DoLS application on the trust's electronic recording system and complete an incident form. This meant that an adequate system for recording that a DoLS application had been made was not embedded into every day practice.

There was a second audit that reviewed the current documentation across the trust for assessing the mental capacity of patients whose capacity may have been compromised as a result of confusion, delirium or dementia. The trust also reported that there was no standardised approach to documenting the mental capacity assessment within the patients' notes making it difficult to find. This audit showed that out of 91 patients' records reviewed, 56% (51 patients) did not have evidence that the patient was able to understand the decisions being made and that in 45% (41 patients) of cases there was no evidence of involvement of a family member or advocate in the decision being made. This meant that patients' records did not demonstrate that there had been adequate provision of family or advocacy support for patients who had confusion, delirium or dementia.

The trust reported that it was to undertake a series of actions, including reviewing the policy for mental capacity assessments, to address the concerns found in these audits.

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

The trust was performing below target in key performance areas in the period from April 2014 to September 2014. In particular the trust reported 35 grade 3 pressure ulcers, where their target was zero grade 3 pressure ulcers. Only 69% of patients who had a stroke were admitted from A&E to the stroke ward within four hours, which was considerably below the trust target of 90% for the year. There was a target of 93% of patients to be seen at clinic within the 14 day target for cancer referrals, the trust had reached 85%, and 80% of patients received treatment for cancer within the national 62 day target which was below the trust target of 85%. Overall, the trust had a cumulative "Harm Free" care score of 92%, which was below the trust target of 95%.In the trust's Integrated Performance Report for October 2014, the trust reported an overall Hospital Standardised Mortality Ratio (HMSR) of 74% which was better than that of peer trusts.

We visited the accident and emergency (A&E) department and the Acute Admission Unit (AAU). The AAU accepted referrals direct from GP's whilst also supporting A&E by admitting transfers for short stay patients. This helped to relieve the pressure while patients waited for a bed on a ward in the main hospital. All the patients spoken with were complimentary of the care they had received, and said they had felt respected with regard to their privacy and dignity. We saw examples of caring and compassionate interactions with patients, given in a quiet and dignified manner. We heard and saw staff introducing themselves before providing care. Patients told us they understood what had been said to them and had felt informed about their care and treatment options. However, it was noted that confidential information could be heard by other people in the waiting area when personal details were given to reception staff.

Patients, who walked into the A&E department, would be booked in by the receptionist, and directed to the waiting room. Patients who came in by ambulance were admitted via a separate entrance. All patients were seen initially by a triage nurse who completed a baseline set of observations of the patient's general condition, their pain score, their temperature, pulse and blood pressure. The nurse would then allocate the patient a place in the queue or fast track to a doctor depending on need. We spoke with people within the

reception area. They told us they had been seen quickly on arrival, but were unaware how long they would have to wait to be seen by the doctor. Three people said they had been there for up to an hour and would like to have been informed regarding the approximate length of waiting time.

Ambulance personnel told us that most of the time initial assessments took place quickly, However, when the A&E department was very busy the ambulance crew would continue to be responsible for caring for their patient until they could be accepted into the department; the ambulance crew would alert staff if they thought the patient was uncomfortable or deteriorating.

We visited the assessment area and found it to be cold due to the constant opening of doors. Ambulance personnel, patients and relatives we spoke with said they often got cold whilst waiting which could be up to an hour in the corridor. We saw the receptionist arranged for hot drinks and a sandwich to be made available to people waiting.

Staff used the national early warning score (NEWS) and paediatric early warning score (PEWS) tools to monitor the clinical well-being of patients. There were clear directions for staff to follow should a patient's clinical condition deteriorate. We saw evidence that early warning scores were being actively monitored and recorded by staff and there were systems in place to manage deteriorating patients.

Clinical guidance for the treatment of patients with specific needs or diseases was available and being used appropriately by staff. For example, the trust had established a sepsis pathway for adults and children. Three sepsis trolleys (pre-prepared trolleys containing essential equipment and medication to treat sepsis in a timely way) were recently purchased two for A&E and one for AAU. Staff completed the sepsis screening tool for any NEWS score of four or more, or if potential infection was suspected.

We observed excellent interaction between doctors and nurses during the inspection. Staff told us that internal multidisciplinary working was good. We saw a good working relationship between with the Rapid Assessment, Interface and Discharge (RAID) mental health team. RAID is a specialist team supporting physical and mental health services in acute hospitals. However, internal processes meant that patients who had been treated for a medical condition in A&E were not seen by the RAID team until they had been deemed medically fit. This often delayed treatment by personnel who specialised in treating patients with mental health illness, and put additional pressure on staff who did not have the relevant training and skills to manage people with an acute mental illness. The trust told us that If the patients are not medically stable at a first assessment, RAID would return later in the patient pathway. This may be when medically stable or medically fit and each case was individually assessed. In addition senior staff told us of two cubicle beds in A&E which were located in an area which could be directly observed by staff. This meant that patients with there was a risk that patients requiring assessment by RAID had delays in assessment treatment for their mental health and there was a risk that the lack of observable cubicles could present additional potential risks to patients.

In a staff only room near AAU, we found the door was open and inside we found a sharps bin and a stock of needles that were not locked away. This presented a potential risk to patients and visitors as they could have walked into this room from the public corridor.

On the medical wards, we found four patients were not receiving optimum care as staff did not have clear nursing care plans in place to follow for nutritional risks, pressure area care, management of difficult behaviours and diabetes management. We informed senior nurses

of our concerns at the time of visit. Out of four patient records and care plans we looked at, all of whom were living with a dementia, none had effective dementia care plans in place to give clear guidance to staff as to how manage their needs.

On the medical wards we found that patients' risk of venous thromboembolism (VTE) had been assessed and prophylactic treatment had been prescribed and administered, this had been recorded on appropriate scoring tools. We saw evidence that early warning scores (NEWS) were being actively monitored and recorded by staff, who knew what to do if the score was high to recognise the deteriorating patient and to take appropriate action.

On Croxley ward, we saw one patient living with a dementia was refusing personal care support and was at risk of malnutrition and dehydration. This patient did not have effective nursing care plans in place for staff to follow for managing those difficult behaviours .Whilst the trust's patient life story document for people with a dementia ("This Is Me") had been completed, and staff were maintaining behavioural charts, there was no effective care plan to reflect this patient's cognitive state and to meet their physical care and mental health needs. Staff told us there was no specific template for dementia care planning in the hospital. The NEWS score for this patient had not been completed eight times in nine days as the patient had refused. This patient was at significant risk of malnutrition and had lost 4.5 kg in 15 days whilst in hospital. There was no Body mass index score (BMI) recorded for 21 days and the food intake charts showed the patient had been refused meals. The risk assessment for malnutrition the Malnutrition Universal screening Tool (MUST) for this patient was had not been completed for 21 days which was not in accordance with trust policy as it should have been completed every 72 hours. The patient had been seen twice by a dietician and advice had been given but the nursing care plan for nutrition, despite being signed as reviewed daily, did not reflect the significant risk of malnutrition for this patient. We informed the ward matron who arranged for an immediate review by a doctor. This meant that this patient did not receive adequate assessment, plan, treatment or evaluation of her nutrition needs, which left them at risk of malnutrition.

On the same ward, we saw a second patient, who had been assessed as being at high risk of developing skin damage was sitting out in a chair; the records showed that they regularly sat in the chair for between seven hours to 15 hours a day. This patient was not sitting on a pressure relieving cushion on the chair and staff confirmed that one had not been used during their admission. This patient's pressure area care plan stated three hourly repositioning was required and detailed appropriate pressure relieving equipment for use on the bed but the risk assessment and care plan did not state that a pressure relieving cushion should be used when sitting out in a chair. We saw from the daily nursing notes that staff had been reporting skin damage symptoms every day for a period of 12 days. We informed the ward senior nurse on duty, who confirmed that the patient should have been using a pressure relieving cushion when sitting out. This patient's skin assessment chart also gave mobility guidance which conflicted with the moving and handling assessment. The pain management care plan for this patient was not fully completed. This patient also had a wound assessment plan in place but the plan did not give any guidance as to how often the dressing should be changed. This patient's notes also stated they were refusing personal care interventions and was presenting with difficult behaviours. There was no care plan in place to reflect these needs so staff were not given clear guidance as to meet this patient's needs. This patient had also lost 5% of their body weight over the past nine days but their nutritional care plan was incomplete, however, the daily nursing notes did give clear guidance to staff how to support the patient with their nutrition. We informed the ward sister of this concern. This meant that this patient was at risk of harm due to the lack of adequate assessment, planning, treatment and evaluation of their care.

Also on Croxley ward, we saw a third patient, who was at very high risk of malnutrition, had not been referred to a dietician in a timely manner. There was a five day delay in this patient being referred to the dietician and there was no record in the medical or nursing notes of this patient having been assessed by a dietician since their admission despite being at significant risk of malnutrition. We also found that this patient was sitting out in a chair without a pressure relieving cushion being used. This patient was at significant risk of skin damage and the risk assessment and care plan did not specify that a pressure relieving cushion should be used when sitting in a chair. We looked at the daily nursing notes and saw that symptoms of skin damage had been recorded on the previous nine days. We informed the ward sister, who confirmed that a pressure reliving cushion should be used when this patient was sitting out. This meant that this patient was at risk of harm due to the lack of adequate assessment, planning, treatment and evaluation of their care.

On Croxley ward, staff told us they had daily handovers from the senior (band 7) nurses and they were given the relevant information to be able to care for their designated patients. Staff told us that they had had dementia training, which included breakaway skills and managing conflict situations. Support was readily available from the dementia specialist nurse, and also from the RAID team working in the hospital. The ward also had one registered mental health nurse (RMN) who could support patients with mental health needs. Senior staff were aware of the Deprivation of Liberty Safeguards (DoLS) and said no patient on the ward was subject to a DoLS authorisation at the time of our visit.

Croxley ward did not have a day room available for patients and relatives to use and that provision of meaningful stimulation and activities for people living with a dementia was limited due to the high dependency levels of patients on the ward. Staff told us that Bluebell ward provided specialised dementia care for patients and did provide a range of activities. The average length of stay for patients on Croxley ward was 28 days, but some patients had a significantly longer stay. The ward matron told us that five patients on the day of our visit were medically fit for discharge and were awaiting social care placements. The ward worked closely with the hospital's Intensive Discharge Team to facilitate appropriate and timely discharges. One a patient had been in the hospital for 40 days, a multi-disciplinary meeting was held to discuss effective discharge planning. This meant that patients living with a dementia did not always have access to meaningful stimulation and activities to maintain their mental well-being.

The hospital had opened the specialist dementia care ward, Bluebell Ward, in February 2014 and it provided 16 beds for patients living with a dementia. It had separate bays for male and female patients. Senior staff showed us how they had developed specific care pathways for patients admitted to this ward, including a delirium recovery pathway. Staff on this ward said there was effective multidisciplinary team working with good liaison with social services and therapists. We saw the ward was promoting the use of "This is me" document so that staff had written information about patients' individual needs and life history. The ward had a specialist dementia nurse and staff told us how they had accessed workshops for managing challenging behaviours and breakaway training. Staff on the ward had had a dementia awareness one day course and senior staff said they were looking to access a dementia course at a local university. The hospital had a Dementia Implementation group (DIG) which included consultants, dementia nurses and therapists and were developing strategies to promote nutrition and the delirium recovery protocol. Whilst the ward did have its own therapists to support patients and an activity programme, there was no separate day room for patients to use.

On Bluebell ward, we looked at the records and care plans for a patient living with a dementia who was displaying difficult behaviours. A dementia screening assessment and

the "This is Me" had been completed. From the daily nursing notes and behaviour charts, the patient was displaying verbal and physical aggression on staff interventions and refusing personal care and medicines. There was no nursing care plan in place to reflect these behaviours and to give appropriate guidance to staff in how to manage these behaviours safely. Whilst clear nursing care plans were in place for falls prevention, nutrition and pressure area care, there was no reference in the nursing care plans for the fact that a DoLS authorisation was in place. We also saw that there was no nursing care plan in place for the management of this patients' diabetes. This patient had refused medicines, including diabetic medicines, 13 times out of 21 over a 10 day period. Also, from the blood sugar monitoring chart, this patient had refused the test nine times out of 25 over the same period. As there was no clear guidance in place for staff to follow, this patient was at risk of not having their diabetes managed effectively. We informed the senior nurse in charge of the fact this patient did not have effective care plans or guidance in place for the management of their diabetes, refusing medicines and management of their difficult behaviours.

Staff told us that the hospital did not have templates for nursing care plans for people living with a dementia. The dementia lead consultant told us how the ward and the dementia steering group was leading the on-going work for developing the hospital's dementia care service and that the trust's 72 hour care rounding record could be used to record clear guidance for staff to care for patients living with a dementia. The ward was using an appropriate pain assessment tool to assess and support patients' with a cognitive impairment with pain relief management.

On Aldenham ward patients spoke of how they felt well cared for. We saw staff interactions with patients were positive and supportive. Due to increased demand for beds, the ward had been using the gym room for an additional three beds, which had the appropriate facilities in place.

We spoke with two patients who had been admitted to the maternity unit, both were positive about the care they had received from the staff. One patient had had a prolonged wait in the triage area as there had not been a doctor available to see her. Both patients told us that their families had been updated and were included in the decision making process.

We reviewed the notes of two patients in maternity ward; venous thromboembolism (VTE) risk assessments had been completed. Antenatal contact notes had also been reviewed and were up to date with information. We observed an interaction between midwifery staff that a medicines incident had taken place. We spoke with the staff member at the end of the drug round; we were told that an incident would be recorded on the trust's electronic incident reporting system for the missed drug dosage of intravenous antibiotics.

During our visit, we saw an elderly patient being physically carried by a relative into the reception area for the hospital's dermatology clinic. In the clinic, we found 19 patients waiting for their appointment but there was no receptionist on duty in this area, as was the hospital's usual protocol. Some patients said they had waiting for up to 45 minutes. We informed a senior nurse who confirmed that there should have been a receptionist on duty in case of any of the people waiting needed assistance or support whilst they were in the waiting room. The nurse took immediate action to ensure the elderly patient we had initially seen was comfortable.

Safeguarding people who use services from abuse ✖ Action needed

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was not meeting this standard.

People who use the service were not always protected from the risk of abuse, because the provider had not always taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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

The trust had a clear structure in place which included the required Named Professional roles for safeguarding children and adults. Interim arrangements were in place to ensure that all key roles were effectively covered. The Head of Safeguarding supported the Safeguarding Adults Named Nurse and the safeguarding team was supported by the Deputy Chief Nurse. The Named Nurse / Midwife and Doctor were supported by 2 specialist nurses.

On Cleves ward, we found that one patient's combined medical and nursing records detailed a serious incident that should have been reported using the multi-agency safeguarding adults from abuse procedures as an allegation of physical abuse. We immediately brought this to the attention of senior staff, who responded by making an appropriate referral to the local safeguarding authority and to record the allegation as a serious incident on the trust's electronic reporting system. The trust also took immediate action following our inspection to remind all staff of their responsibilities under the trust's safeguarding procedures.

An independent report in December 2014 into the trust's safeguarding processes stated that training programmes for staff for levels 1, 2 and 3 safeguarding children training were reviewed and contained the information and guidance as per the national guidance. Training performance for Safeguarding Children was monitored via the trust's Safeguarding Panel, which was chaired by the Chief Nurse. Performance in November 2014 for level 1 and 2 training met trust targets, but level 3 training was below target at 70%. The report advised the trust to review the content of the level 2 training to ensure that it covered all aspects of adult safeguarding; including standardising the level 2 training alongside that provided by the local authority. This report also advised the trust to consider strengthening safeguarding awareness by signalling safeguarding links within the trust's Whistleblowing Policy. The learning points identified for the trust from this independent review were:

• The trust should ensure that all doctors have an appropriate departmental induction that

covers the need for accurate note taking, the restraint policy and safeguarding.

• The trust should emphasise to staff that when clinical decisions or procedures are difficult or problematic, escalation to relevant senior colleagues is often necessary: such escalation is expected by the Trust and by the senior colleagues involved.

• trust employees should be reminded of their responsibility to be vigilant for evidence of abuse.

Most staff we spoke with were aware of the trust's safeguarding procedures for adults and children, what constituted abuse, and how to report it. Safeguarding checks in A&E were made as a matter of routine within the children's department and there was a process in place for making referrals to the relevant social services department. However, we found that checks were not made as a matter of routine within the adult services. Staff said that it was the responsibility of the triage team to obtain the relevant information and make the necessary referral. We reviewed a patient's record within AAU and saw that a referral had been made when staff identified one particular adult had attended A&E on five previous occasions. This meant that there may have been a delay in making a referral.

Cleanliness and infection control ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for in a clean, hygienic environment.

Reasons for our judgement

All the areas we visited were seen to be clean and odour free. Hand washing facilities and alcohol gel were available in all areas and staff were seen to use them intuitively. Outside each department there was a movement sensor which activated a message reminding all to apply hand gel. This meant that staff and visitors were reminded and encouraged to cleanse their hands regularly in order to ensure that risk and spread of infection was minimised.

We viewed four toilets and showers rooms in a care of the elderly ward and found that all were visibly clean, appropriate hand washing facilities were available, and protective equipment was available for staff to use. Shower curtain had stickers on them to show when they had been changed. Cleaning schedules had generally been completed according to the hospitals protocols. Staff told us that domestic staff were on duty for evenings and weekends. Whilst we noted that some walls and door frames were in a state of disrepair, and could potentially present an infection control risk, the matron for the ward told us this issue was being addressed. Action plans were in place for refurbishment of the decor of ward.

The overall compliance for hand hygiene training as of September 2014 was 85% with infection prevention and control training at 84% for September 2014. We saw that all departments had been asked to ensure that training is up to date and the trajectory to ensure full compliance was to be reported to the board meeting in November 2014.

We observed staff within the AAU make a bed that had been vacated. We observed the surfaces and mattress were cleaned thoroughly. We checked inside the covers of two mattresses and found no issues or concerns. However, the trust might find it useful to note we did not see staff either turn the bed or check the cleanliness of the inside of the mattress. We therefore we could not be assured that the mattress cleaning protocols were sufficient in terms of minimising the risk of infection. We observed the cleaning of equipment and trollies by domestic staff during our visit. We saw the dates for changing curtains had been placed on them.

Staff told us and we confirmed by looking at the policy that if a patient with a known MRSA or C. difficile infection attended A&E or AAU, all staff were notified and suitable precautions taken. We saw staff on AAU caring for a patient who had an infection. They

used the appropriate equipment, and wore personal protection; for example, gloves and aprons. We saw there was sufficient equipment for monitoring and treating all patients. We saw that equipment had been serviced, was in good working order and was clean and dust free. In the trust's Integrated Performance Report for October 2014, the trust reported overall 17 cases of C. difficle infection above the trust target of 13 for the year. There had been one case of Methicillin-resistant Staphylococcus Aureus (MRSA) in the year to date.

Across the departments we observed staff had adhered to the trust uniform policy. During our visit to A&E we observed a senior medical staff requesting a visiting health professional to remove their watch which ensured the uniform policy was working effectively to minimise the risk or spread of infection.

During our inspection of the maternity unit we saw that there was an observed level of cleanliness that was good; housekeeping staff were observed cleaning clinical and non areas. There was hand disinfection solution available at all entrances; this ensured that both staff and visitors were prompted to adhere to cleaning their hands to decrease the risk of the spread of infection. Staff were observed adhering to the bare below elbows policy. Due to the delivery suite being busy we were only able to look inside one empty delivery room, equipment was stored and the room had been prepared for a new admission. We looked under the covers of the mattress and found that it was clean we also observed the bed frame underneath the mattress and found that this was also clean and stain free. We looked into one patient shower room on the delivery suite and observed that an air vent overhead was dusty, as well as dead insects inside of the ceiling light fitting. We brought this to the attention of a senior nurse.

We found that the blood gas analyser (BGA) machine utilised on the delivery suite was based in the sluice, we were told this was due to lack space on the unit. We raised this with the Head of Midwifery who told us that currently no room was available; an environmental space audit would be carried out and the trust was planning for the blood gas analyser to be allocated a room to minimise the potential risk of contamination.

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 people's 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

In July 2014, the National Institute for Health and Care Excellence (NICE) published their guidance in relation to safer staffing. As part of the guidance, NICE recommended that wards implement systems to report and monitor nursing 'Red Flags'. The trust was using a report that showed the number of planned and actual numbers of staff on duty for each shift, nurse to patient ratios and staff to patient ratios. The nurse in charge recorded the RAG (Red, Amber, and Green) status of the shift according to safety and documents any actions and mitigations taken. A new report being introduced in November 2014 was designed to capture the same information as above but would also record the number of planned and actual hours on duty for registered nurses/midwives and healthcare assistants. Shifts on a ward where there were less than 23 hours of registered nurses/midwives on duty (this would equate to less than 2 registered nurses on shift) would register as a red flag event. Shifts where there was a shortfall of more than 8 hours of registered nurse time below planned hours would register as a red flag event. The number of red flag events was being closely monitored and reported through the daily 'onion' meetings.

In the trust Board Meeting minutes for November 2014, the trust reported that recruitment and retention of registered nurses remained a challenge and as of 30 September the vacancy for registered nurses and midwifes was 16.9%. The trust target for vacancies was 5%.

The trust had a staff turnover target of 12%, a sickness rate of 3.5% and a vacancy rate of 5%. We saw the figures for September 2014 which were 17%, 4% and 13% respectively. We were told that agency nurses were used to provide cover and that, where possible, these were regular agency staff. Staff said that ad hoc agency nurses impacted on the efficiency of the departments as they required additional support and slowed down the functioning of the departments.
Within the trust's workforce recruitment and retention group, processes and systems had been reviewed to enable a more efficient and robust process. New exit questionnaires had been developed to understand the reasons for staff leaving the organisation so that a

strategy could be developed to improve retention. The recruitment of Band 5 nurses had now moved from monthly to fortnightly to maximise opportunities to fill registered nurse vacancies. Healthcare assistant recruitment continued to take place every month. The trust was also considering further recruitment overseas for registered nurses to support the local recruitment drives and fill vacant posts.

On the care of the elderly ward we visited (Croxley ward), there was no ward manager on duty and the morning shift was being run by a band 5 nurse. The ward sister was due on duty for the afternoon shift. At weekends, usually a band 6 nurse was in charge of the ward. The ratio of qualified nurses to patients was 1:7 during the day and 1:8 at nights. Staff told us that the hospital had recently reviewed staffing levels and that the staffing levels were now more reflective of patient's needs and dependencies. Staffing levels for each ward were discussed daily at the hospital's daily senior staff briefing meetings (called "onion" meetings) and any urgent cover issues were discussed and actions taken to ensure appropriate staffing levels. Senior nurses said short term staff sickness was an issue at times but normally cover from bank or agencies was supplied. At times, staff from other wards would be asked to ward on those wards that were short staffed.

The hospital used a risk rating for staffing levels and staff on the ward told us they rarely went into the "Red" risk rating. The matron told us the hospital's plan to combine Croxley and Sarrat wards together and they were actively trying to recruit a band 7 nurse to help oversee these wards. The ward carried out a daily assessment of patients' dependency which highlighted risk factors such as the risk of falls, pressure area care, displaying difficult behaviours and those patients with reduced mobility required two staff to support the with persona care tasks. The ward matron would escalate any concerns about staffing levels arising from these assessments to ensure staffing levels were flexible to meet the dependency levels and needs of patients on the ward. Each ward's staffing levels were now published on the trust's website.

Staff told us that when patients were at risk of falls, or of presenting difficult behaviours to other patients, then they could use an additional nurse or support worker to support the patient on a one to one basis. These requests for extra staffing were made to the chief nurse and staff said the response to the request was timely.

The matron told us that nurse recruitment was a continuing concern and that the trust had tried different recruitment strategies to attract new staff. The trust had action plans in place regarding recruitment. Croxley ward had one band 6 nurse vacancy but had appointed to the post and the nurse was due to start shortly.

We looked at the agency staff induction checklist and all new agency staff received a ward induction. We looked at 10 agency induction checklists and they had been completed according to the hospital's policy. Staff told us they used the same bank and agency workers wherever possible to ensure consistency for patients.

Senior staff on Bluebell ward said the ward had no nursing vacancies. The ward had tried to recruit registered mental health nurses but the response to the job advert was poor. At the time of our visit, there were four qualified nurses and four HCAs on duty for 16 patients. This was the planned rota for the shift and there was a qualified nurse to patient ratio of 1:4. Staffing levels were the same at nights. The ward was supported by a specialist dementia nurse and a doctor from the RAID team attended ward rounds.

The Chief Nurse told us that the nursing staffing levels for wards were based on a Safer Nursing Care tool that assessed patients' dependencies and acuity The trust did not yet

have a formal process for staff to have regular clinical supervision but was looking at methods to implement this.

Staff told us they were proud of their work and were willing to speak to us openly during the inspection. We saw that a good rapport existed between all levels of staff during our visit, and there was good leadership from the lead nurses within the areas visited. There was consultant presence in the A&E from 8am until 12 midnight, with overnight middle-grade doctor cover. We spoke with a range of medical staff, who told us that although locums were used, there was adequate cover on the department and that they had no concerns around medical staffing. Staffing levels were reviewed daily to ensure they are safe for both the day and night shifts which ensured the hospital met safe staffing guidelines. These were displayed at the entrance to each unit visited so that patients and visitors could see the planned and actual staffing levels.

Both the A&E and AAU told us they were actively recruiting for staff within their departments. We saw the trust had recruited staff from overseas whose first language was not English. Senior staff within AAU said they had arranged English lessons to ensure they were understood by patients. We noted that there were some initial concerns with effective communication during one treatment episode and this was brought to the attention of senior staff. Senior nurses within A&E said the skill mix was good. However, some senior staff within the cardiac care unit said the skill mix was occasionally difficult with some staff not cardiac trained which impacted on patient's appointments for example, angiograms. On the day of our visit, we saw staff meeting people's medical needs appropriately.

Mandatory training was encouraged in all areas we visited. Staff outlined the mandatory training they had completed. Most of this was done via e-learning. Information received from the trust showed mandatory training statistics for the entire workforce; however, this was not broken down into departments. This meant that it was difficult identify the relevant training statistics for the A&E and AAU departments.

We spoke to two staff that had recently joined the trust. They told us they had received corporate and local induction which had been very helpful and informative. New staff on AAU shadowed an experienced member of staff for three weeks and undertook four night shifts. These supernumerary shadow shifts included the understanding of paperwork and how to undertake the skilled administration of medicines. This meant that new staff received sufficient induction and support to enable them to care effectively for patients.

Nursing staff felt competent to undertake their role and told us that they had the opportunity to develop their knowledge and skills. They told us they had received an annual appraisal. However, not all nursing staff had received a formal one to one supervision. They told us they were able to discuss any issues or concerns with their immediate senior nurse co-ordinator.

On the maternity unit there was a designated lead nurse who had overall responsibility for the unit to manage a 'helicopter view' of issues for the unit. We spoke with staff on all areas of the maternity unit including the delivery suite, antenatal and postnatal wards as well as the Birthing Centre. Some staff members told us that they enjoyed their roles and the care they gave to mothers using the service. However, we were also told about the pressures that staff felt with the high vacancy rate; there were concerns around staffing levels; in one area a health care assistant had not been available for four days the member of staff had contacted the senior member of staff holding the bleep and her impression was 'basically told to get on with it'.

We spoke with the Head of Midwifery and were told about issues that were impacting on the midwifery service included the high vacancy rate. Work was on going to rationalise the vacancy rates and the high use of agency midwives to backfill positions. Staff told us of high levels of sickness in the midwifery team. The vacancy rate remained high at 45 whole time equivalent (WTE) midwives. Staff told us the trust had plans to address the high vacancy rates including a programme of overseas recruitment. New staff told us they had had a supernumerary placement on the midwifery unit with support from mentors. Senior staff told us that they had recruited 15 midwives from overseas. These new staff had had a three month supernumerary period and there had been some difficulties with existing staff having the time to offer effective mentorship also there had been some issues with communication and language barriers.
From the trust's Board Meeting minutes in November 2014, the number of day and night shifts (including long days early and late shifts) planned against actual staff on duty for September 2014 for the maternity wards (including the delivery suite) was:

-Planned midwifes' shifts for days was 712 with actual shifts covered of 612 (giving a percentage of day shifts filled of 86%)
-Planned HCA shifts for days was 240 with actual shifts covered of 197 (giving a percentage of day shifts covered of 82%)
- Planned midwife shifts for nights was 540 with actual shifts covered of 535 (giving a percentage of night shifts covered of 99%)
- Planned HCA shifts for nights was 210 with actual shifts covered of 186 (giving a percentage of night shifts covered of 89%)

29 shifts in the maternity unit for this month were also flagged as "Amber" risk. A visit from the Local Supervising Authority Midwifery Officers (LSAMO) in May 2014 had highlighted concerns about staffing issues and high agency usage, that the skill-mix on shifts could be a challenge, with variable additional support for junior staff, and the number of inexperienced staff. The LSAMO stated that senior midwives found this stressful and demotivating. This was corroborated by midwives telling us of the work pressures in the unit.

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.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

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

West Hertfordshire Hospitals NHS Trust had introduced a programme of assurance visits across the trust to review the level of assurance. The trust had implemented the NHS Institute for Innovation and Improvement 15 step challenge. Most staff we spoke with told us they were aware of the 15 step challenge and how important it was to maintain standards and first impressions to patients and their relatives.

Overall, we found that the trust had reviewed its governance and reporting structures and process to effectively monitor and report on the risks within the organisation. We found that there was a policy in place for reporting serious incidents which included responsibility for decision making. Work had been undertaken to regularly share learning from incidents, complaints, and feedback from patient surveys across the divisions. The trust had implemented a new process for deciding whether incidents reported were serious incidents and to ensure appropriate action had been taken so the trust would be responding appropriately to serious incidents. The trust had reviewed all items on its risk register and that by the end of November, a new format for the risk register for all divisions would be in place with urgent actions outlined. We saw that the trust had continued to improve and decrease its overall mortality to below the expected level for an organisation of this size, which was a positive improvement. We saw that whilst significant work had been undertaken to address the concerns we had found at our previous inspection, there was still further work to be done to fully embed the governance structures and learning from incidents at every level within the staff teams at the hospital.

Wards had introduced the "Test Your Care" audit which reviewed care standards. Areas covered included continence, nutrition, falls assessment, infection control, privacy and dignity, pain management and patient observations. The trust had set a target of 90% compliance for wards. We looked at the records from March to October 2014 and found the AAU's results were consistently below the required target. The year to date results showed an average percentage of between 71% and 84%. We saw action plans in place to ensure the departments addressed areas of concern.

The "Sign up to Safety" initiative was a new campaign launched by the Secretary of State for Health in June 2014. It had five pledges that organisations were required to sign up to and develop a plan to address and demonstrate how the plan will reduce harm to patients over a 3 year period. In the trust's Quality and Safety report for September 2014, the trust's initial plans, as presented the Board in October 2014, for the pledge for "Putting Safety First" were to:

- Follow NICE guidelines for VTE
- Full compliance of Hygiene code and not to exceed our hospital acquired trajectories
- Reduce new pressure ulcers across Trust by 50%
- Improve Maternity services
- Follow sepsis six bundle; improve management, diagnosis and treatment of deteriorating patients.

In the trust's Quality and Safety report for September 2014, the trust reported some areas of concern regarding the management of deteriorating patients had been identified and that proposed actions were to develop the "Test Your Care" tool further to review nursing staff awareness of the signs of the deteriorating patient and that "Safety huddles" meetings were being explored as a way to improve ward communication.

The trust had introduced I Want Great Care (iWGC) to seek feedback from patients. For September the average score for inpatient areas was 52.3%. There were three ward areas in the hospital that were below 30% and ward matrons were producing an action plan for their areas and how they will sustain the improvements.

From the minutes of the trust's Patient Safety, Quality and Risk Committee (PSQR) meeting on 6th November, it was noted that by the end of November, a full Risk Register for all Divisions would be in place with urgent actions outlined. The minutes also stated that following a review of the governance structures that it was acknowledged that there was still some way to go for embedding governance within the surgical division, but that good progress had been made and the division was committed to making governance a priority with the delivery of the division's daily business. It was also reported that there was now a clear Serious Incident process embedded within the trust, managed within the Divisions and that as of 6th November, there were currently 35 Root Cause Analysis reports into Serious Incidents overdue which had not been submitted to the local Clinical Commissioning Group. Additional support had been identified to address this concern. The trust had taken steps to implement action plans to meet the recommendations of recent Parliamentary and Health Service Ombudsman investigations regarding serious incidents.

There was a major incident policy in place in each department we visited and staff told us they had completed major incident training as part of their induction. This ensured that patients who may have been contaminated with chemical, nuclear or biological agents (often abbreviated to CBRN) could be treated appropriately. Major incident equipment was available and accessible.

We found that A&E and AAU underwent an assurance visit on 03 September 2014. The outcomes of these assessments were positive and we noted the general observation, comments and recommendations. We saw that both areas visited had completed many of the recommendations for example; the appropriate labelling of curtains and the environment being cleaned in line with infection prevention and control guidelines. Patients were asked questions during the assessment and the feedback was positive about their experience.

Staff were able to input incidents on the trust's electronic system and could give examples of when they had done so. Staff said they would have no hesitation in reporting incidents. In AAU a member of staff said there was a clear pathway for raising concerns. Staff said that weekly risk meetings which covered for example, serious incidents, medicines and any device alerts enabled them to discuss any issues or concerns and brought them together as a team.

The A&E had specific national and local targets which were reported and updated on the dashboard monthly. For example, patients were to be admitted, transferred or discharged from hospital within four hours. We spoke to nursing and medical staff and found that they were aware of the targets and said the handover time was challenging during high attendance at A&E which often created a "bottle-neck." The records for the year to date showed the trust had achieved a target of 96% which is above the government's standard of 95%. There were also targets for safe patient handovers between the ambulance service and the hospital. The year to date figures showed that the ambulance turnaround time between 30 and 60 minutes was at 60% and over 60 minutes at 2%. An electronic system was in place for tracking how long patients had been in the department to ensure they were treated in a timely way. The number of patients being treated within four hours of arrival had improved and the department was now consistently achieving its target of patient's being treated within four hours.

Senior health care professionals said they had issues with the trust's computer system with too many staff trying to "log" onto the system. On the day of our visit, a registrar attempted to view a patient's x-ray on three separate computers and had to go to another area. We saw the A&E had a computer on wheels but this had not been charged fully and was therefore not in use. We observed that it took over 30 minutes for the x-ray to be viewed.

The trust had introduced the Friends and Family test (FTT). The trust had a target of 30% for feedback received. We saw that A&E's response rates were at 20% whilst AAU's response rates were above 50% with the exception of the triage team who achieved 23%. Senior staff said they were taking action to address the low feedback from patients. Staff told us of continuing work pressures and that their focus was on maintaining the safety of all patients. There were little opportunities for regular, formal supervision and not all staff had had an annual appraisal. From the trust's Integrated Performance Report to the Board for October 2014, the trust reported that overall only 53% of staff had had an appraisal in the year to date which was below the trust target of 95%. The trust told us it had introduced a new appraisal system and was projecting that its target for 95% of staff to have had an appraisal would be achieved by the end of the reporting year.

Information leaflets about how to make a complaint were available in A&E and AAU and were visible for patients. If a patient or relative wanted to make an informal complaint then they would speak to the shift co-ordinator. If they were unable to deal with their concern they would be directed to the patient Advice and Liaison Service (PALS). Patients we spoke with said they did not know how to make a complaint but would talk to staff or the doctor should they need to. We found that complaints with any lessons learnt were discussed at clinical governance meetings in the department although this was not clearly disseminated to the staff teams we visited. From the trust's Integrated Performance Report to the Board for October 2014, the trust reported that overall only 62% of complaints had been responded to within the trust timescale of one month. This meant that people who had made complaints did not always have their complaints responded to within a reasonable timescale.

Staff told us senior nurses attended the hospital's "onion" meeting daily. Band 7 nurses went to this meeting once a week. Monthly senior staff and matrons meetings were held. The trust sent a weekly newsletter to all staff and also a "Team Brief" was cascaded to all staff monthly by the matrons. Member of the trust's executive team held weekly "Talk Time" meetings for open for all staff to attend. Not all staff we spoke with had attended these meetings but they were aware of them. Senior nurses said they could escalate concerns readily and that the Executive team did listen and respond. Staff told us the Chief Executive was very visible and regularly visited ward areas to speak to staff. The Chief Executive had recently won a national award and the hospital's "onion" meeting had been highly commended.

Senior nurses told us that wards carried out regular audits to check performance and patient safety risks. These included a daily pressure area care audit, daily cannula audits, and daily documentation audits (where 10 sets of records were checked). Areas of concern were cascaded to staff teams. Senior staff told us that the quality of record keeping on care of the elderly wards was an issue. Some of the junior staff we spoke with were not aware of the main risks to patient safety in their wards and were not able to tell us about the way the hospital's governance structures worked. This meant that the governance of performance and safety were not embedded in the care of the elderly wards.

The Chief Nurse told us that the trust was reviewing the nursing assessment and care planning documentation for patients and that the project, designed to recommend a new concise nursing care plan strategy and documentation, was due to be completed in April 2015. Audits on nursing care plans had showed some good practice but also some gaps in record keeping. The trust had guidelines for completion of the 72 hour care rounding records. The trust had introduced the "Test Your Care" quality audit system in March 2014 and recently senior staff had produced an assurance framework for this quality initiative. Wards' performance were assessed on range of risks and outcomes and where overall performance was below 80% compliance, the ward matrons would be required to produce an action plan for the ward to address the areas of concern. The Chief Nurse told us an assurance process for this quality audit system had been presented to the trust's Quality Safety Group recently. The trust had also recently implemented a "Stop the Pressure" campaign to reduce the risk of patients developing skin damage. In October, there had been two incidents of newly acquired grade 3 skin damage to patients.

The maternity service was amongst the largest in the south east of England with approximately 5595 births per year. Maternity services recently had a £750,000 investment which had delivered an increase in capacity; there was a new six-bedded transitional care unit (step up and down from the Special Care Baby Unit) for mothers and babies. There was also an increase in three extra delivery beds; two antenatal beds; and four additional triage beds.

In June 2014 the Nursing Midwifery Council (NMC) raised concerns of poor outcomes of maternity patients due to lack of staff. The trust had received the results from the a Local Supervising Authority Midwifery Officers (LSAMO) audit that had been carried out on the 6th May 2014. There were five LSA Standards for the Supervision of Midwives that had to be met, and the completed audit for West Hertfordshire Hospital NHS Trust showed that of the five standards that had been audited, three standards were 'improvement required' and two were 'not met'. Following on from the audit findings, the supervisory team had to develop an action plan to demonstrate how they planned to implement the recommendations. The action plan of how they planned to achieve this was not yet complete. The LSAMO report also stated that despite continuing efforts the engagement

and visibility with the trust board continued to be a challenge for the midwifery team, although improvement had been made from the previous year. A maternity services review had been undertaken and we saw a report from 8th May, which stated the review was focused on 'working relationships as maternity services were not working effectively as a cohesive unit of multi professional staff'. The trust provided us with the Maternity Governance Improvement Plan dated August 2014. We found that areas that were prioritised in the action plan included aligning the governance structure for maternity services, management of incidents and guidelines audit and assurance.

From additional information that we had requested from the trust, an independent report in December 2014 into the trust's safeguarding processes recommended that the trust could further strengthen assurances within its safeguarding reports by including details of the weekly safeguarding supervision meetings that were undertaken in all paediatric areas. The key actions taken as a result of audit findings or strategy meeting recommendations would also provide assurance that clinical practice was effective. It stated the processes in place to review all paediatric attendances via the Emergency Department for any safeguarding concerns was to be commended. The Safeguarding Children Audit Strategy and the Safeguarding Strategic Action Plan 2014-16 detailed the audit programme in place to provide assurance regarding clinical practice. The Safeguarding Children Audit Strategy identified three key audits to be undertaken in 2014 and all three were in the process of completion. Assurance could be further strengthened if the actions from the audit findings were tracked more closely via the Safeguarding Panel, and included within the regular trust Board Reports.

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

The areas visited used a combination of National Institute for Health and care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided. Local policies and procedures were written in line with this and were updated as national guidance changed. The records viewed had been assessed and treated in accordance with guidance.

Records were not kept electronically; paper records were available for all patients in A&E and AAU. We looked at patient notes in both areas visited. Wards had trolleys to keep patient notes in but not all trolleys were lockable meaning there was a risk that patient records could not be stored confidentially. Some records were placed in a unlocked storage section by the nurse's station. Although convenient for staff to locate, this meant that patient records were not adequately secure at all times.

We reviewed 12 sets of patient notes in A&E during our inspection. We saw that information about the assessment and treatment of each patient had been well documented and risk assessments completed as necessary for example, the developing of pressure sores or the risk of having a fall. There was an established protocol to follow for patients assessed as high risk of pressure ulcer development to ensure they received pressure relieving equipment at the earliest opportunity. We observed this protocol being used effectively during our inspection.

The departments used standard documentation to record patient details and assessments used by both nursing and medical staff for each patient. A "triage" process which aimed to refine the process by improving the documentation and refining the medical assessment process had been developed.

The notes we reviewed had been completed in accordance with the hospital policy, and we saw the A&E records were reviewed and checked by senior health professionals which ensured accuracy and timely recording of patients seen within A&E.

On Croxley Ward, we looked at observational charts, repositioning and food and fluid intake charts for three people. There were gaps in the food and fluid intake records, and cumulative totals were not always shown for fluid intake charts, which was the hospital's

policy. One patient, who was at risk of dehydration and malnutrition, did not have accurate records completed for three out of the six days we looked at. A second patient did not have any fluid intake recorded after 6pm on one of the five days' records we looked at. A third patient, who needed repositioning every three hours to reduce the risk of skin damage, had a nine hour gap on their reposition chart on one of the five days records we saw. On another day, there was no recorded repositioning for 11 hours. This meant that there was not always recorded evidence that the patient's care and treatment needs have been met.

On Bluebell ward, we saw that fluid and food intake records for one patient over a six day period have been completed accurately and in accordance with the hospital's policy. We saw that that this patient's NEWS charts had generally been completed accurately with two gaps in observations out of 23.

On Cassio ward, we looked at seven patients' observational records and drug charts. Generally, records were well maintained and completed in a timely manner.

The trust board meeting minutes for November 2014 identified three breaches of information governance whereby staff had either sent data to their personal email address or to a staff member at another NHS trust. The trust launched an investigation and we saw the actions and outcomes taken as a result. This included the introduction of an automatic IT block on similar emails being sent as well as additional training and education for staff regarding the confidential handling of personal identifiable information.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: Where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements.
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.
Regulated activities	Regulation
Diagnostic and screening procedures Maternity and	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met:

midwifery services Surgical procedures Treatment of disease, disorder or injury	People who use the service were not always protected from the risk of abuse, because the provider had not always taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.
Regulated activities	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: There were not always enough qualified, skilled and experienced staff to meet people's needs.
Regulated activities	Regulation
Diagnostic and screening procedures Family planning Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Treatment of disease, disorder or	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

This section is primarily information for the provider

injury	

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 20 May 2015.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk