

Colchester Hospital University NHS Foundation Trust

Quality Report

Colchester General Hospital
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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust

Are services at this trust safe?

Are services at this trust effective?

Are services at this trust caring?

Are services at this trust well-led?

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out an unannounced inspection of Colchester General Hospital on the 4th and 5th April 2016. The purpose was to look specifically at safety and caring elements of the surgery, medical care and end of life care services, which were some of the key areas of concern from the September 2015 inspection. These areas were reflected in the section 29A warning notice served on the trust on 30th December 2015; the trust was required to have complied with the warning notice by 18th February 2016. This focused inspection was to assess if significant improvements had been made.

The areas inspected in April 2016 included a selection of wards/departments that were identified as a concern in the September 2015 inspection, as well as areas where concerns were not identified during the previous inspection but local intelligence suggested that risks may have increased in those areas. This included concerns regarding risks of patients deteriorating without appropriate monitoring or escalation. The local inspection team had also received six complaints specifically regarding end of life care in the previous six months, which was a higher number than would be expected. An inspection of the emergency department was also included due to an increased number of complaints from the public, poor performance on the trust's quality metrics dashboard and an increased rate of serious incidents with four deteriorating patient deaths and five reported misdiagnosis incidents.

The inspection team also undertook a further announced inspection on 13th April 2016. During this inspection they met and interviewed members of the board and trust executive management team. The purpose of this announced inspection was to assess whether improvements had been made to the overall governance systems and processes within the trust. We also needed to assess whether any improvements were sustainable or had been sustained since our previous inspection.

Colchester Hospital University NHS Foundation Trust is comprised of two main hospital sites which are Colchester General Hospital and Essex County Hospital. Essex County Hospital is scheduled to close during 2017 and the only services currently provided on site are

outpatient services and ophthalmic eye surgery under local anaesthesia. Colchester General hospital has 560 beds and provides district general hospital care to 370,000 people in North Essex. For this inspection The local inspection team focused on a selection of inpatient wards and the emergency department only.

Colchester Hospital University NHS Foundation Trust and the Colchester General Hospital location were rated as inadequate at our last inspection in 2015. Following the publication of our inspection report in January 2016 I informed the trust they were required to make significant improvements, or a further decision would be taken with regards to the future of services at the Trust.

I will not be providing a rating to Colchester Hospital University NHS Foundation Trust or Colchester General Hospital for this inspection. The reason for not providing a rating was because this was a very focused inspection carried out to assess whether the trust had made significant improvement to services within the prescribed time frame.

In medical care our key findings were:

- The inspection team noted that on the Emergency Assessment Unit the conditions imposed on them on 29 January 2015 were being met.
- The inspection team identified significant concerns regarding the nursing leadership on Peldon ward with concerns raised to us regarding the bullying culture of the ward. Nurses on this ward were treated as either "English" or "Foreign" nurses with staff raising examples of unfair treatment by service leads.
- Patients spoken to on Peldon Ward were aware of the poor culture of the ward and reported to us that they were aware staff could be "sharp at times".
- Two members of staff formally raised concerns to the inspection team using the whistleblowing policy. One of these concerns was of such a serious nature they were escalated to the director of nursing and medical director for immediate action and support for those involved.
- Poor culture for safeguarding patients were noted on Peldon ward, with practices noted to prevent or limit

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the movement of people with dementia on the ward who were referred to as 'wanderers'. The practice involved placing a patient in bed and tilting the head back and feet up to prevent them from getting out of bed. We subsequently raised two safeguarding alerts to the local safeguarding authority following this inspection.

- The inspection team were concerned about the care provided to patients on Peldon ward and requested that the trust take immediate action to ensure that patients were protected from the risk of harm or abuse.
- The culture and levels of staff support in endoscopy had improved. However the disrepair of endoscopy equipment resulted in delays and cancellations to patient care and treatment due to the equipment being out of service.
- There were observed improvements in how patients on Birch ward were cared for, with more positive staff interactions with patients. However the quality and recording of patient care in the records of patients on Birch ward was identified as a concern.

In surgery our key findings were:

- The inspection team noted improvements in previous wards of concern including Aldham ward and the allocated staffing on Mersea Ward. However, due to high rates of sickness this improved level of staffing could not be achieved.
- There was a notable decline in the care and safety of Brightlingsea ward where there was poor record keeping, care planning, medicines management and risk assessment. This ward has been raised as a concern by CQC on previous inspections, and the concerns about the ward's deterioration were raised to the executive team again on this inspection.
- Poor practice with safer surgery checklists was found on the previous inspection in 2015. A review was undertaken to see if improvements had been made. Serious concerns with the completion of the safer surgery checklist were noted. Staff do not routinely complete the 5th step by undertaking a debrief. Staff

were observed to have completed post operation checklists prior to procedures commencing. Staff were also not routinely checking anaesthetic machines.

- The audit rates show 100% compliance for previous three months yet several incidents had been recorded where the checklist were not completed. The inspection team checked the audit data and incident reporting but these did not correlate, therefore the data for the audits was not accurate.

In end of life care service our key findings were:

- The inspection team found that awareness amongst the staff regarding end of life care had improved, e-learning training had been provided, though not all staff had completed it.
- Staff were more engaged in end of life care and were responsive to concerns identified by the inspection team. However, there remained a lack of awareness of when to place a patient on the individual care records for last days of life. The inspection team identified three patients during the first day of inspection who were not on the care plan who should have been.
- The inspection team also found that where the individual care record for last days of life was in use, the completion of this record was not consistent.
- There was a lack of recording of discussions with family and patients. There was a lack of evidence that information was provided about what they might expect which had reportedly caused some anxiety.
- The completion of DNACPR forms had not improved with the many reviewed being completed poorly or incorrectly. Several were seen with reasons for DNACPR given as 'Dementia'.
- Use of the Mental Capacity Act was poor in relation to end of life care. The majority of staff in the trust, according to the training matrix, have received training in MCA. However, this is not well reflected in the care being provided.
- There was a notable lack of syringe drivers available. Staff were reverting to the use of sub cutaneous ports for use when equipment not available. One

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patient, who died the day prior to inspection, was reviewed post inspection by the trustwide team following concerns about a potential overdose of PRN (as prescribed) medication. We raised our continued serious concerns regarding the care for patients at the end of their life, and those nearing the end of their life to the trust executive team.

In the Emergency Department our key findings were:

- The inspection team observed that the nursing staff were working more cohesively. However there was a lack of integration with the medical staff.
- In December 2014 we imposed a condition on the trust's registration to ensure that streaming occurred within the department. The inspection team noted at our inspection in September 2015 that this was working well and appeared to be embedded in the department. However at this inspection we noted that at times of peak activity this process was abandoned. This impacted upon the risk of harm to patients.
- There was a noticeable lack of clinical leadership. Nursing leadership was good and was much improved and they were working to manage risks. However the doctors were disengaged in the delivery of a safe, effective and responsive service.
- The streaming process did not function effectively due to staff shortages. There was no contingency plan in place for the event that there was a shortage of staff.
- The inspection team saw that first assessment of patients was taking up to 50 minutes. However, the 15 minute assessment times were showing at over 95%. This gave rise to concerns that the data provided by the department was not accurate.
- There were many patients in the corridor area near the ambulance bay, and still in ambulances due to the department being full. There was a lack of clinical oversight in this area from an experienced nurse and a lack of doctors reviewing patients.
- There was a lack of mobile rapid assessment and treatment process (RAT) leading to a lack of escalation/ recognition of the acutely unwell patient.

- The inspection team identified and escalated five patients who were not well. These patients had incorrectly calculated NEWS scores. Two further patients were escalated due to a lack of care, hydration and pain relief.

Our key findings from our interviews with the executive management team and trust board were:

- Whilst improvements had been made in some areas, there remained a lack of robust grip and proactive identification of risk.
- There was insufficient pace to address the wide range of significant improvements required.
- There was a lack of action and response by the board on key issues such as A&E performance and safer surgery checks, despite knowing the risks were there and presenting an immediate risk to patient safety.
- The senior team stated that they felt that there had been significant improvement. However, they also acknowledged that the trust in the longer term would not continue to be able to provide services without the support of an external organisation.

Based on the findings of this inspection I authorised that urgent enforcement action be taken against the trust in respect of the emergency department streaming process and patients' being cared for in the corridor area. I also authorised for enforcement action to be taken on the surgery service in respect of ensuring that safer surgery checklists are completed and patients are protected from the immediate risk of harm. The trust has been in special measures for more than two years and subsequently based on the inspection findings I cannot recommend a further extension to special measures.

I have recommended to the secretary of state that a solution needs to be found, and a partnership agreement with Ipswich Hospital NHS Trust is being established. CQC will continue to monitor this trust closely to ensure that patients receive safe, effective, responsive and well led care.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Colchester Hospital University NHS Foundation Trust

Sites and locations

Colchester Hospital University NHS Foundation Trust comprises of two locations registered with CQC. However all acute activity takes place on the Colchester General Hospital site with primary care including ophthalmology and outpatient services provided at Essex Count Hospital.

The trust has a scheduled plan to close the Essex County Hospital site during 2016 with all services moving to the Colchester General Hospital site.

Population served:

Patients predominantly come from north Essex and the hospital serves a population of approximately 370,000 and provides oncology and radiotherapy cancer services

to approximately 750,000 people across North and mid Essex. The town is expected to see the fastest growth of any town in England over the next decade and has seen a 15% increase in population over the past 10 years.

Deprivation:

Deprivation in Colchester and Tendring is significantly better than England average, however about 16.3% (5,200) and 24.9% (5,800) of children live in poverty in Colchester and Tendring, respectively.

Life expectancy for both men and women in Colchester is similar to the England average while in Tendring it is lower than the England average.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Fiona Allinson, Head of Hospital Inspection, Care Quality Commission

Inspection Lead: Leanne Wilson, Inspection Manager, Care Quality Commission

The inspection was attended by two Head of Hospital Inspections, two inspection managers and two

inspectors, and of the six CQC staff who attended four had previously inspected this trust. Nine specialist advisors including five consultant grade doctors, three registered nurses and former CQC head of enforcement, supported the inspection. Of the specialist advisors four had previously inspected this trust.

How we carried out this inspection

We undertook an unannounced inspection of Colchester General Hospital on the 4th and 5th April 2016. The purpose was to look specifically at safety and caring elements of the surgery, medical care and end of life care services, which were some of the key areas of concern from the September 2015 inspection. These areas were reflected in the section 29A warning notice served on the trust on 30th December 2015. The trust was required to have complied with the warning notice by 18th February 2016. This focused inspection was to assess if significant improvements had been made.

The areas inspected included a selection of wards/ departments that were identified as a concern in the September 2015 inspection, as well as areas where concerns were not identified during the previous inspection. Local intelligence supported that the risks have increased in those areas inspected. This included concern regarding risks of patients deteriorating without appropriate monitoring or escalation were noted in medicine, surgery and the emergency department. We had also received six complaints specifically regarding

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end of life care in the previous six months, which was a higher number than what would be expected. An inspection of emergency department was also included due to:

- an increased number of complaints from the public.
- poor performance on the trust's quality metrics dashboard.
- an increased rate of serious incidents with four deteriorating patient deaths and five reported misdiagnosis incidents.

We also undertook a further announced inspection on 13th April 2016. During this inspection we met and interviewed members of the board and trust executive management team. The purpose of this announced inspection was to assess whether improvements had

been made to the overall governance systems and processes within the trust. We also needed to assess whether any improvements were sustainable or had been sustained since our previous inspection.

We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff. We talked with patients and staff from the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Colchester General Hospital.

What people who use the trust's services say

The experience of patients using Colchester General Hospital was mixed during this inspection. On Peldon ward two patients raised to us that they felt that staff attitude was a concern and one patient told us that the staff "could be sharp at times". We heard from many patients prior to the inspection and we received eight examples of positive care and more than 100 examples of negative experiences.

Prior to the inspection we received numerous complaints from patients regarding the complaint process within the hospital, and reported to us that they did not feel listened to. This is correlated with the increase in the number of complaints being raised to the Parliamentary Health Service Ombudsman with the trust being in the top five of trusts with reported concerns in England.

Facts and data about this trust

Size and throughput

Beds: 640 (plus 86 day beds)

- 591 General and acute
- 34 Maternity
- 15 Critical care

Staff: 4,021

- 442 Medical
- 1,106 Nursing
- 2,473 Other

Revenue: £267,576,000

Full Cost: £289,894,000

Surplus (deficit): -£22,318,000 (Deficit)

Summary of findings

Effective (trust wide)

HSMR Weekday – 103.48

Weekend – 109.14

Total 104.9

The current SHMI of 104.9 and rank is 106/136 of trusts in England.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>We have not rated this key question because this was undertaken as a focused inspection to assess whether significant improvements had been made to the safety of services. Overall we found that significant improvements had not been made to how safe services were at Colchester Hospital University NHS Foundation Trust.</p> <p>There remained a lack of recognition, when assessing patients that they were at the end of their life. Whilst noted improvements were made with regards to testing and servicing of syringe drivers, there was a shortage of syringe drivers which placed patients at the risk of harm through inconsistent care. End of life care training was provided to all staff by e-learning, however this training was only at level 1 and did not cover the provision of how to recognise or care for the dying patient. Though some progress had been made since our previous inspection overall we concluded that significant improvement had not been made to the provision of end of life care. Improvements were not sufficient to be considered as significant because patients remained at risk of harm through poor end of life care.</p> <p>Within Medical Care services Birch ward was identified as a ward of concern in July and September 2015. On this inspection we found that the care provided to patients on this ward had improved. Some concerns remained with regards to the completion of records and ensuring that patients all had call bells within reach. We identified significant concerns with regards to the safeguarding and deprivation of liberty of patients on Peldon ward. We raised our concerns to the local safeguarding authority. The executive management team when asked were not aware of the concerns regarding Peldon ward. There were concerns with regards to the disrepair of equipment in the endoscopy unit. There were repeated failures of machines and equipment resulting in delays to service delivery.</p> <p>In surgery we noted that there had been improvement to safety and recognition of patients on Aldham ward. Patients were now being appropriately escalated. There were also notable improvements in the care provided to patients and record keeping on Mersea ward. However we noted that there had been deterioration in the safety of Brightlingsea ward and theatres. We identified inappropriate management and administration of medicines on Brightlingsea. We also identified that in theatres staff were not adhering to the requirements of the safer surgery checklist. This placed patients</p>	

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having surgery at a greater risk of incidents or never events. The audit rates for safer surgery showed 100% compliance for previous three months. However, several incidents have been recorded where the checklist were not completed. This should correlate with the audit data however it does not. The trust executive team were aware of the concerns with regards to the culture in theatres and the safer surgery checklist but have not taken an action on this. The team were taking assurances from audit data and that no recent never events were reported.

Equipment

- The trust used syringe drivers for patients who required a continuous infusion to control their symptoms. These met the current NHS Patient Safety guidance. These syringe drivers were designed to protect patients from harm when used to administer a continuous infusion of medication. This is because the syringe drivers used were tamperproof and had the recommended alarm features.
- Staff could access syringe drivers through the trust's equipment library. There was also a small stock of syringe drivers on West Bergholt ward. Staff in the electro-biomedical engineering (EBME) department told us there should be a total of 122 syringe drivers within the trust.
- When patients were discharged to the community, the syringe drivers often went with the patient. At the time of our inspection, the trust could not account for 15 of their syringe drivers. It was therefore not possible to ascertain whether these syringe drivers had been in use or were being used in the community without having received their annual service. The trust had started to record when syringe drivers had been issued to patients throughout the wards.
- We reviewed four syringe drivers, one in EBME and three on West Bergholt ward and found them to be within their annual service date. The date of the last service and the next service due date was clearly displayed on each syringe driver.
- Staff in EBME told us they had set up a system for retrieving syringe drivers. They also encouraged staff to report any syringe drivers they were unable to access as an incident. At the time of our unannounced inspection no incident reports had been completed as the system had only just been set up.
- Two members of staff on Layer Marney ward told us that syringe drivers were not always available. If this occurred, staff were unable to administer a continuous infusion to assist the patient with their symptoms. We were told this had happened at least once this year.

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- A member of staff told us of a patient who had recently died and a syringe driver had not been available. In order to replicate the effects of the syringe driver, nursing staff were administering anticipatory medication every two hours through a subcutaneous port that had been inserted to enable this to happen.
- On Birch ward a bay was used for storing of equipment this area was not locked or secure. There were large pieces of equipment in the room which presented a risk to patients, for example there were weights balanced on the window ledge.
- A blood glucose machine had not been tested since 19 February 2016 because of manufacturer problem with testing solution. However, when we asked staff about this there was no plan in place to resolve this issue.
- New boxes of blood glucose monitoring equipment were due to roll out to wards when 80% of staff had completed training. Birch had 80% of staff trained but no date had been provided for the new machines to arrive.
- Within the endoscopy service there had been multiple equipment failures and breakdowns over the previous six months. This meant that there had been several list cancellations due to a lack of available equipment provide patient care.
- Staff within endoscopy raised concerns regarding equipment breakdowns on incident forms, and to their managers. They were unsure what was happening with regards to equipment upgrade and replacements.
- Over the Easter weekend all machines used to sterilise the scopes failed and were not able to be used for four days, which had a significant impact on the delivery of the service.
- We checked the resuscitation trolley and equipment on Brightlingsea ward. The defibrillator had been serviced. The defibrillator pads were available and the intubation sets were fully stocked and in date. However, extension plug sockets on side of trolley had broken corner and wires to extension lead plug were loose and starting to fray. We brought this to the attention of the person in charge who reported this for repair.
- The falls prevention equipment bag on Brightlingsea ward contained sterile supplies that were beyond their expiry date. For example, a suture pack and forceps had expired in November 2015. We brought this to the attention of the person in charge who updated the equipment with in date items.

Medicines

- We looked at the medical records of the patient who had died. We found a prescription for a syringe driver that was designed

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to run over a 24 hour period. The prescription included 10mg diamorphine, 5mg midazolam, 1200mcg glycopyrronium and 6.25mg levomepromazine. This was not administered as no syringe driver was available. Another prescription for anticipatory medicines had been written to be administered as required. The prescription did not include an interval to give the medication or a maximum dose that should be administered in a 24 hour period.

- We looked at what medication had been administered to the patient and found the patient had been administered 2.5mg diamorphine, 2.5mg midazolam and 200mcg glycopyrronium once followed by 400mcg glycopyrronium a further four times between the hours of 12.20pm and 8pm. Doses were given at 12.20, 14.00, 17.00, 19.00 and 20.00. This meant between the hours of 12.20pm and 8pm the patient had received a total dose of 12.5mg diamorphine; 12.5mg midazolam and between 1800mcg of glycopyrronium. We looked at the symptom observation chart for this patient and found no indication from 2pm onwards that the patient was in pain, agitated or had any respiratory secretions or that the patient required the medication to be administered so frequently.
- A relative on West Bergholt ward told us that medication rounds were often delayed, and this meant that patients did not receive their medicines and pain relief in a timely way.
- The records of medicines charts we examined on Peldon ward showed that most of the drug charts we examined were up to date and completed.
- On Peldon ward a patient prescribed intravenous (IV) medicine had experienced a delay in receiving their medicine. They were required these medicines at 04:20 but at 14:00hrs we identified these had not been given. We escalated this to staff who were not aware of this.
- We identified on Peldon ward that the nursing staff had not restarted a patient's IV antibiotic drip. We saw this had alarmed for 6 minutes before someone addressed they weren't running.
- On Brightlingsea ward we found two tubes of opened, unlabelled metanium cream in open unlocked cupboard. We brought this to attention of person in charge who informed us that sometimes consultants verbally instruct nurses on ward rounds to use cavilon and metanium for patients without prescribing the medicines. They informed us that this was why topical creams would not always be recorded on drug charts and may be recorded in nursing notes. The nurse disposed of the creams so they could no longer be used because it could not be identified which patients these were used on.

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- On Brightlingsea ward we observed a domestic sweeping the floor. The sweepings included one small white, round tablet which they went to place in the domestic waste bin. They were not aware of the procedure for safe disposal. We spoke with the person in charge who said the tablet needed to follow the controlled drugs disposal pathway. We also identified that there was no records of staff recording tablets found on the floor for disposal or checking.
- On Brightlingsea ward we checked the medication store which was locked. We found three boxes of Arachis oil enemas which had been prescribed to a patient but was stored for use in the general stock of medicines. The person in charge immediately disposed of these boxes.
- On Mersea ward the medication room was locked. However the medicine stock cupboard was left open and was unlocked, which was not in accordance with the trust policy.

Records

- We reviewed the medical and care records for five patients. Patient records were not always well maintained. We found some contained loose pages that had not been filed. This meant that some records were difficult to navigate and there was a risk that some records could be misplaced or lost.
- There was no consistency in where Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were kept. On some wards they were kept with the nursing notes and on others they were kept in the medical records. In one set of records we reviewed the DNACPR form was mixed in with the notes and was not immediately accessible should the patient require resuscitation.
- We saw where a patient on West Bergholt ward had been seen by the specialist palliative care team. The patient was experiencing pain and the specialist palliative care nurse reviewed the patient's pain control medication. We saw conflicting entries in the patients' medical records where it stated the patient was in pain yet a zero had been recorded for the pain score in the observation chart for the same time period.
- On Birch ward we examined five sets of patient records. Of these three contained no evidence of regular care rounding. However we did observe staff carrying this out, but they were not documenting this in the records.
- On Birch ward there was inconsistent completion of intake and output charts. In some cases there was no evidence of input or output where required.

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- Food charts completed and up to date for all five patient records on Birch ward we looked at.
- On Peldon ward there was ad hoc completion of input output charts, which meant that the care provided was not consistent.
- On Brightlingsea ward the ward sisters undertook weekly records audit checks to ensure they were appropriately completed. The results of the weekly audit ranged from 61% to 97% and results were shared with staff each week.
- We examined the records of five patients on Brightlingsea ward and found that in all but one instance the records of risk assessment, observations, NEWS and care rounds were appropriately completed. However the notes were difficult to navigate and not in an order, which would help care to be delivered quickly. The records were not stored securely, but were left open and on trolleys.

Assessing and responding to patient risk

- Staff on the wards told us that the specialist palliative care nurses come onto the wards every morning Monday to Friday to assess whether there were any deteriorating patients they needed to see.
- Patients' at the end of their life were not always being identified in a timely way. This meant that there was a lack of clarity with regards to the ceiling of care to be provided, including treatment for patients who have high early warning scores, was not being appropriately assessed.
- During this inspection we identified four patients who should have been on the individual care record for the last days of life. However these patients were not a specific care plan. We raised these patients to the attention of the senior managers to take immediate action to ensure that their care was provided appropriately.
- On Layer Marney ward we saw evidence where a patient had been referred to the specialist palliative care team at 06.20am. They were seen by the specialist palliative care nurse at 09.15am that same day. However we were concerned that this referral was delayed as the patient, who was admitted, died later that day.
- On Layer Marney ward we saw an individual care record was started by a specialist palliative care nurse at 12.30pm. We saw an initial assessment had not been completed and a second assessment had only been completed at 4pm.
- A relative on West Bergholt ward told us they had to request for mouth care to be undertaken for their relative because their mouth was dry. We also observed another patient on Birch

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ward who had a very dry mouth and there was no indication that mouth care had been undertaken. However, we saw another patient who had been placed on an individual care record on Birch ward who was receiving regular mouth care.

- One end of life care link nurse on this ward told us they did not think all patients had “nice, tidy deaths” by which they clarified patients are often awake and not settled.
- A senior member of staff on West Bergholt ward told us that since September there had been an improvement in the identification of patients who were thought to be in the last year of their life.
- On Birch ward we observed an infusion pump alarming for 7 mins before nurse attended to rectify this. This meant that the patient was not receiving appropriate medication in a timely manner.
- Out of 19 call buzzers we observed on Birch ward 10 were out of reach of patients.
- Staff demonstrated an awareness of NEWS, were able to articulate how they would escalate patients and what they would do. There was good awareness of patient specific parameters and we saw these documented. Two doctors spoken to on Birch ward were positive about nursing staff escalating NEWS. They felt they were able to escalate to the consultant if required.
- On Peldon ward we identified one patient who was nil by mouth. We identified that there was no evidence that oral care had been provided for three days. A nasogastric feeding tube (NG) had put in but put pulled out by the patient. Therefore they had not received food for two days. This has not been addressed by staff.
- The trust, commissioned a review of practice in theatres following nine reported surgical never events in the previous 12 months. The trust received the report in March 2016 with two on site visit days having taken place in February 2016. The report highlighted that the ‘vast majority of staff were unaware of the never events that have occurred in the organisation’. Further, it was reported that there concerns with cultures and safety practice in theatres.
- During our inspection we observed theatre preparation for surgery. On arrival in a theatre we observed that the patient was on the operating table and was being positioned and secured. We identified an instrument checklist, which was placed behind the top right hand corner of the white narrow swab count board in the theatre. The checklist was filled in completely and included tick marks along the various items in the surgical tray, to denote the mandatory first check and final check of

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instrument counts. The final check had tick marks along the entire list, despite the procedure not having yet commenced. This meant that staff in theatre could not be assured that all instruments had been returned to the tray following the operative procedure.

- We spoke with four nurses in theatres regarding the Five Steps to Safer Surgery. We were informed by more than one nurse that the debrief does not occur so the theatre team routinely do not complete the fifth required step.
- We spoke with the management team who undertake audits of the checklists. They told us that if there were any gaps on the forms then they would give the forms back to the theatre nurse for the case to be completed for the audit, with all the boxes ticked.
- We reviewed the Safer Surgery audit compliance rates for the previous three months and observed a rate of 100% compliance. If the observed fifth step, which includes a debrief, is not routinely taking place and the above practice of requiring theatre nurses to complete all checks in retrospect, then the compliance rates for these audits are not accurate.
- Part of the recommended safer surgery checklist sign in process is the checking of the anaesthetic machine. However, we found gaps in the checking of the log books for the anaesthetic machines in theatres 1, 4, 7 and 14 and their associated anaesthetic rooms.
- On arrival in the emergency department on 04 April 2016 the department was at full capacity with patients waiting in the corridor area. The corridor was overseen by a healthcare assistant who was required to routinely undertake observations of a patient's temperature, blood pressure, pulse and pain score whilst patients were waiting to be assessed. The nurse in charge was also required to routinely check on patients in the corridor as well as oversee the department each shift.
- On two separate occasions during the inspection we observed the Hospital Ambulance Liaison Officer ('HALO') linked to the department, escalate the acuity of specific patient's in the corridor to the healthcare assistant. The HALO was not satisfied with the response. We then observed the HALO go round to the main area of the department to find the nurse in charge to get them to provide assistance for these acutely unwell patient's due to their concerns regarding their deterioration.
- On the second occasion we observed two patients in the corridor of the emergency department whom we had identified should have been escalated as a concern for potential risk of

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deterioration. We escalated these patients to the nurse in charge who went to review them and subsequently made immediate arrangements to have them assessed. This indicated that the current process in place was not robust.

- The rapid assessment and triage bays were fixed bays within the department. When available, patients are assessed in these bays and moved to their appropriate location. These bays were full with acutely unwell patients. We did not observe that there was any member of the medical workforce on duty flexing the system to undertake the rapid assessment and triage of those patients still waiting in the corridor area after the designated cubicles were full. We observed the nurse in charge ask on three separate occasions for a consultant to “walk” the waiting area with them “for patient safety reasons”. The doctor, whom we observed was asked, did not want to do this because they were “busy”.
- Throughout the inspection we saw a lack of support from the medical staff to the nursing staff to help resolve the capacity concerns within the department. This was evidenced with a rate of 40% of patients seeing a doctor within 60 minutes within the department, which is lower than the trust’s target and quality indicator of 50%.
- There was a shortage of nursing staff providing initial streaming at the front door of the emergency department. This was escalated by the matron to the site management team. However we observed that there was no contingency or support arrangements in place. This meant that the department remained short of staff streaming patients at the front door for the entire shift, which finished at 8pm. This lack of streaming meant that patients who were potentially at high risk of clinical deterioration would not be identified at the earliest opportunity due to time delays at the front door.
- The target for initial clinical assessment within 15 minutes of presentation was reported by the trust to have been achieved for all but two cases on Monday 04 April 2016. However our observations of the initial clinical assessment process identified a minimum time delay of 50 minutes to see the one streaming and assessment nurse due to the volume of patients attending. We also noted staff shortages in this area that day. We were therefore not assured that the data collected and being represented by the trust was an accurate reflection of the activity.
- Patients who were assessed as part of the streaming process were at risk of not always being identified as potentially being at risk of clinical deterioration. There was one sign in the

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department which stated if a person has chest pains they should inform the receptionist. However there were no other flagging conditions noted and it was unclear why this had been chosen over other conditions to be raised.

- We observed the emergency department waiting area where a patient who attended the department following a discussion with another trust, where they were receiving their cancer treatment. The patient had neutropenic sepsis, and they were assessed by the streaming nurse and asked to take a seat in the waiting area where they sat and waited to be called through. If the department was following national guidance this patient should have been immediately escalated to a medical staff member within the department.
- Another patient, with a fitted internal defibrillator, attended the department feeling unwell and was assessed by the streaming nurse and was asked to take a seat in the waiting room. This patient was not assessed appropriately and should also have been escalated through to the department for medical review.
- Another patient who came to the emergency department following a gastrointestinal bleed at home was observed to be acutely unwell in the waiting room. This patient had been streamed and seated in the waiting room to wait to see a doctor. Their condition had not been escalated. We observed the doctor come through to the waiting area and once the doctor visually saw the patient they immediately sought assistance as they recognised how clinically unwell they were.
- During the inspection of the emergency department we identified and escalated five patients who were not well with incorrectly calculated NEWS scores. Two further patients were escalated due to a lack of care, hydration and pain relief. These instances demonstrate that we were not assured that patients were being escalated through the streaming system to receive priority treatment when acutely unwell in the emergency department.
- On Brightlingsea ward we examined the records of a patient who had been admitted with abdominal pain. The surgeons diagnosis was patient had incarcerated right inguinal hernia. However a strangulated femoral hernia was found during operation which required a bowel resection. Our specialist advisors felt that this patient's clinical presentation was consistent with femoral hernia and should have been operated on immediately. This meant that there was a delay in the care of this patient.

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Are services at this trust effective?

We have not rated this key question because this was undertaken as a focused inspection to assess whether significant improvements had been made to services. Overall we found that significant improvements had not been made to how effective services were at Colchester Hospital University NHS Foundation Trust.

For end of life care there had progress with regards to the introduction of the individual care record for the last days of life across the wards we inspected. However due to staff failing to recognise the dying person patients were still at risk of not receiving appropriate care in line with current evidence-based guidance and best practice. Training programmes for syringe drivers had been introduced throughout the trust. However we identified several staff on wards who were using them who had not been trained or assessed as competent to use the syringe drivers. There remained a lack of consistency in how people's mental capacity was assessed and not all decision-making is informed or in line with guidance and legislation when a do not attempt cardiopulmonary resuscitation order (DNACPR) is completed. We found DNACPR's completion in line with best practice had not improved. We observed many examples where decisions not to resuscitate were made without appropriate mental capacity assessments being in place. In three cases we found that the patient was not made aware of the decision taken by medical staff not to resuscitate, despite the patient having capacity.

In medical care we identified that the staff on Peldon ward did not have a good understanding of the Mental Capacity Act or Deprivation of Liberty Safeguards. Two incidents of patients being deprived of their liberty without appropriate authority were identified on this ward. We subsequently raised two safeguarding alerts in respect of the care of the patients on this ward to the attention of the local safeguarding authority.

In the emergency department we observed several patients who had been in the department for a substantial length of time with conditions, such as head injuries, pain or asthma which would require them to be on a dedicated care pathway. These patients were waiting due to the delays in medical staff not assessing these patients and this meant that they were without any clinical assessment, treatment, or plan to be initiated. Therefore we felt that the effectiveness of the emergency department was not as effective as it was in September.

Evidence-based care and treatment

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- The trust used an individual care record (ICR) for the last days of life. However we found the individual care record was not being consistently used when it should have been.
- Staff on Birch ward told us that it was more difficult to start an individual care record for end of life care at the weekend. They told us that this was because the doctors often did not know the patients and felt they should not be the instigators of the individual care record.
- On West Bergholt ward we spoke to a family member who had been told their relative may not survive the week. The patient had expressed a wish to die at home but the patient's relative told us they felt it was now too late to move them.
- We discussed this patient with a senior member of staff on the ward and asked why the patient had not been commenced on the individual care record. The member of staff told us they thought the patient probably should be on an individual care record and they would discuss this with the doctor. This member of staff told us the ward was very busy and short staffed, which had impacted the care. They felt the patient should be on the individual care record, but told us that they were often not involved in multidisciplinary conversations around end of life care. On the second day of our inspection we learned this patient had died the previous evening.
- On Langham ward we spoke with a junior doctor who was reviewing a patient. The junior doctor had sought guidance from their seniors and a decision had been made to complete an individual care record for this patient. We looked at the individual care record and found it to be thoroughly completed by the junior doctor. They had included a ceiling level of care for the patient. A ceiling of care allows the patient and their family to be involved in the level of treatment that they felt appropriate for the dying person. The junior doctor knew the patient well and it was clear from their completion of the individual patient record that they had a person-centred approach to care. The completion of this document formed the basis for end of life care for this patient.
- On Dedham ward we asked if there were any patients who had individual care records in place. We were told there were none. We reviewed the nursing and medical records of a patient who had been identified as requiring palliative care. We saw the patient had an individual care record in place. The sister in charge of the ward had been unaware of this despite the patient being on the individual care record for three days. Staff on Dedham ward told us the palliative care consultant and nurses had been to the ward several times to talk to staff about the individual care record.

Summary of findings

- We reviewed the individual care record for a patient on Dedham ward and found it had been inadequately completed. The record did not detail the relative's telephone number or the patient's GP, there was no completion of a mental capacity assessment, or a recognising dying assessment, there was no detail relating to who conversations had taken place with and no detail for communication around changes in goals of care. In addition nothing was documented in relation to discussions around medication review, what to expect with the dying process, and who to contact in the event of death.
- On Birch ward we asked if there were any patients who had individual care records in place. We were told there were none. However we were told there was one patient who was being reviewed and would probably be given an individual care record. We reviewed the nursing and medical records for this patient and found the patient had an individual care record in place. The sister in charge of the ward had been unaware of this despite the patient being on the individual care record since the previous day. The nurse caring for the patient told us there was a plan to start a syringe driver to keep this patient comfortable. When we returned to the ward in the afternoon the syringe driver had not been started. The nurse told us this was because the doctor was seeking advice from the specialist palliative care team. On the second day of our unannounced inspection we saw the syringe driver had been started.
- On Birch ward we reviewed the records of a patient who had been admitted to the ward from the emergency assessment unit in the early hours of the morning. Although the patient had extensive cancer, the patient was admitted with a chest infection. The patient was known to the specialist palliative care team and was being cared for in the community. The patient's relative told us the patient did not want to come into hospital but all attempts to enable the patient to be at home had failed. There were no beds at the hospice and attempts had been made to access Macmillan support in the community but this had been unsuccessful. Anticipatory medication had been prescribed and we saw that between 11pm and 7am, the patient had received 2.5mg of midazolam three times for agitation. Although this patient had been identified as being at end of life an individual care record had not been commenced for this patient.
- We spoke with the deputy sister about this patient who told us the doctors wanted to give the patient intravenous antibiotics for 24 hours before deciding whether to put an individual care record for end of life in place. At no point during our unannounced inspection did the specialist palliative care team

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come to review the patient. On the second day of our unannounced inspection we saw this patient had responded to their antibiotics and their condition had improved. We also saw the patient had been reviewed by the specialist palliative care nurse and plans were being made to facilitate a transfer to a hospice bed. The patient's relative was involved in discussions.

- Ceiling levels of care were not always documented in patients' care records. For example we looked at the records of a patient on Birch ward who had a DNACPR order in place and who had been identified as being in the last year of their life. We saw an entry in the patient's medical records to stop antibiotics and inform the patient's family that they were gravely ill. A further entry was made in the records five days later to continue intravenous medicines as the patient was unlikely to tolerate a naso-gastric tube. However two days later an entry stated they would continue to slow the IV treatment. At the time of our unannounced inspection the patient was still receiving intravenous antibiotics.
- We observed this patient refusing diet and fluids but there had been no discussion in relation to plans for replacing the patient's cannula and whether it was appropriate to continue with non-essential medication. We spoke with a junior doctor who told us the patient was responding to the antibiotics and was more settled. On the second day of our unannounced inspection we saw the patient had been reviewed by the specialist palliative care nurse and the patient's condition had improved. We saw that a conversation had taken place with the family.
- On Dedham ward a senior member of staff told us they were in the process of developing a 'heart failure pathway' for patients who were identified as being in the last 12 months of their life. This would entail liaising with the patient's General Practitioner (GP) to further discuss advance care planning. There was a vision that the heart failure pathway would involve collaborative working with the health care professionals caring for the patient in the community to enhance the patient's quality of life and respect the patient's wishes.
- In the emergency department we observed one patient who was in the corridor area with a head injury, who had been in the department for approximately 80 minutes. Another patient with asthma for more than 60 minutes and a third patient with a fracture for approximately 90 minutes. A fourth patient with chronic pain had waited for more than 120 minutes. These patients were waiting due to the delays in medical staff not

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assessing these patients and this meant that they were without any clinical assessment, treatment, or plan to be initiated. Therefore nursing staff were not enabled to commence their patient pathways at the earliest opportunity.

Competent staff

- A junior doctor told us they felt they had appropriate training in end of life care and was familiar with the individual care record used throughout the trust. The junior doctor had also received some training in having difficult conversations with patients.
- Some staff told us they had undertaken an e-learning module relating to end of life care. A physiotherapist told us they appreciated undertaking the e-learning as they felt it reminded them of what should be done for patients receiving end of life care.
- The trust had planned for further face-to-face end of life care training to take place. We saw an email confirming the trust had secured funding for a 30 credit level six or level seven module in managing care at the end of life which was being run by a local university. Nine wards had been selected and one person from each of these wards was being nominated to undertake the module.
- On all the wards we visited staff told us there was an end of life care link nurse.
- We spoke with an end of life care link nurse who told us they had been an end of life care link nurse for around a year and had previously been a pain link nurse. The link nurse had undertaken the e-learning course and had a study day run by the local hospice. They were due to attend the module being run by the university. The link nurse also had a set of competencies they were required to complete.
- Staff on Laver Marney ward told us they had received training in using the syringe drivers and had completed competencies. We spoke with an agency nurse on Birch ward who told us they had not received training on using the syringe drivers but would never be put in a position where they had to be responsible for supporting patients with a syringe driver. There would always be a permanent member of staff who would be trained to do this.
- We asked two members of staff on Mersea ward if they had undertaken syringe driver training and both told us they had not. The deputy sister told us they were not sure whether staff had received this training but felt their ward manager would be able to tell us. One staff nurse on Mersea ward told us they just

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picked it up how to use them as they had gone along. The ward manager was not on duty so we could not confirm this at our unannounced inspection. An end of life care link nurse had just been put into place on this ward.

- On two wards we visited we saw an end of life resource folder. This contained the individual care record for end of life care, a purple butterfly, the trust's end of life care strategy for 2016-2017, information in relation to the last few days of life and recognising death and managing symptoms.
- A junior doctor informed us that training was often cancelled when on Black alert over last 8 months. They had attended three sessions during that time, however the sessions for training were meant to be weekly.
- On Peldon ward two healthcare assistants informed us that they were being asked to train the pre-registered nurses, however they did not want to be trained by the healthcare assistants. The process for the education of pre-registration nurses on this ward were not clear.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- On Peldon ward the staff did not have a good understanding of the Mental Capacity Act or Deprivation of Liberty Safeguards.
- Two incidents of patients being deprived of their liberty without appropriate authority were identified on Peldon ward. There was a poor culture for safeguarding patients on Peldon ward, with practices noted to prevent or limit the movement of people with dementia on the ward who were referred to as 'wanderers'. The practice involved placing a patient in bed and tilting the head back and feet up to prevent them from getting out of bed. Personal care and hygiene needs of patients were not being met. We subsequently raised two safeguarding alerts in respect of the care of the patients on this ward to the attention of the local safeguarding authority.
- On Brightlingsea ward we examined the records of a patient who was subject to a Deprivation of Liberty Safeguard (DoLS). The original application was put in urgently in March with an expiry date for the 17th March 2016. We found no standard authorisation for this patient on file or a further application to keep the DoLS in place. There was also no care plan in place to treat patient as though DoLS in place whilst awaiting local supervisory body to confirm standard authorisation request. We were informed by the ward staff that the safeguarding team have advised ward the urgent authorisation has been extended.

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This was an agreement formed between the local Council and the Trust to state that there would be an automatic extension of urgent DoLS applications due to the backlog the Council were experiencing.

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)

- We reviewed 22 do not attempt cardio pulmonary resuscitation (DNACPR) forms. Seven were completed in line with Resuscitation Council UK guidelines. Of those not accurately completed, 10 did not clearly document end of life care discussions with patients or those who were close to them. The reasons stated on the forms for not having discussions included 'frailty' and 'the patient was unwell'.
- Discussions did not always take place with families. Of the 18 DNACPR forms we reviewed 10 did not evidence that discussions had not taken place with the patient's family, and there were no entries of discussion in the patient's records. Reasons written on the forms included the family not being present.
- We saw one example where documentation showed a patient had full mental capacity to make decisions but the DNACPR decision had not been discussed with the patient because the patient was 'too drowsy'. We saw no evidence of a discussion taking place following this.
- On Langham ward we saw where a DNACPR form had been completed stating the patient was unable to comprehend conversation and retain information. However, a mental capacity assessment undertaken in the emergency admissions unit stated the patient had capacity, and does not have any impairment.
- On West Bergholt ward we reviewed the medical and nursing notes for a patient who was admitted to the hospital via the emergency assessment unit. We saw documentation within the emergency assessment unit records stating "I have discussed DNAR and patient would like to be resuscitated unless 'they' are reaching their last days of life". It was also documented that the patient had capacity to make decisions in the emergency assessment unit.
- The patient was admitted to West Bergholt ward and we noted a DNACPR form was completed the next day with no discussion taking place with the patient as documented patient too unwell. There was no discussion with the patient's family as documented 'partner not present' – states will discuss ASAP. A further mental capacity assessment had not been undertaken or documented.

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- We saw one good example of a DNACPR form being completed by a junior doctor on Langham ward. The junior doctor had liaised with their registrar and had completed the DNACPR form with the involvement of the patient's family. The doctor had undertaken a mental capacity assessment and it was clearly documented that the patient lacked capacity to make decisions around their resuscitation status. We also saw comprehensive evidence of the discussions that took place between the junior doctor and the patient's daughter in the patient's medical records.
- On Langham ward we saw where a mental capacity assessment had been undertaken and a patient had been assessed as lacking capacity when they were admitted to hospital. An urgent application had been made to deprive the patient of their liberty which was granted for seven days. Three days following the expiration of the urgent authorisation a junior doctor contacted the safeguarding team to seek clarification as to whether a further application needed to be made. The safeguarding team told the junior doctor that once the urgent authorisation expired then a standard authorisation would become valid for a further 28 days. We saw no evidence within the patient's medical records to indicate a standard authorisation had been granted. We could therefore not be assured that this patient was being lawfully deprived of their liberty.
- On Birch ward we noted the patient had a DNACPR form in place but this had no date of writing on the form. Reason given for writing the DNACPR order was that the patient had advanced malignancy and was close to end of life. The decision had not been discussed with the patient because the patient was too unwell. The decision had not been discussed with the relatives because according to the form the relatives were not present. No assessment of the patient's mental capacity had been undertaken.
- On Dedham ward we saw that a Treatment Resuscitation and End of life Care (TREC) form was completed for patients who had a DNACPR order in place. This form contained a flow diagram to indicate ceiling levels of care for patients who were at the end of their life. Staff told us these forms had recently been introduced and thought they were being piloted on some wards. The forms were not being used in the emergency assessment unit.

Are services at this trust caring?

We have not rated this key question because this was undertaken as a focused inspection to assess whether significant improvements

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had been made to services. However, whilst inspecting we do speak and observe care given to patients and have reported what we saw and heard. Overall, whilst we found improvements in the care provided to staff in some areas we inspected, we found a decline in the care provided to patients in other areas. Therefore we have determined that significant improvements had not been made to how caring services were at Colchester Hospital University NHS Foundation Trust.

For end of life care we received several concerns about the way patients were treated including examples of delays in receiving pain relief, and a lack of information provided at the end of the patient's life about what to expect and patients and relatives did not feel well supported or cared for. Six concerns were raised with us before the inspection about how bad news was broken to patients and families with examples provided which people informed us was not caring, empathetic or compassionate. Whilst we felt that caring in end of life care had improved since our previous inspection, significant improvement was still required to ensure that patients care needs at the end of their life were identified and delivered appropriately.

In Medical care whilst we felt that the care provided to patients on Birch ward had improved since our last inspection, and staff were more caring towards meeting patients' needs, we were concerned about the care provided to patients on Peldon ward. We undertook a formal observation of patient care which highlighted that there were concerns regarding the care provided on this ward. On Birch and Peldon wards the handovers could be heard throughout the ward, which meant that confidential and personal information was not treated privately.

Compassionate care

- On Langham ward we witnessed a very caring and compassionate approach which was adopted by a junior doctor whilst they were talking to a patient's family about the patient's blood results and plan for end of life care. We also observed on three occasions different relatives come up to this doctor to thank them for all their care and support. Even the way this doctor wrote in patients' medical records was done so in a compassionate, caring and person centred manner.
- A relative on Birch ward told us how their relation had been supported to have a wash that morning. The relative expressed they didn't feel this was appropriate as they felt the patient was too unwell. When the relative returned to the patient, they felt the patient's bedsheets were wet. This was from the water used to wash the patient. The relative had to ask staff to change the sheet.

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- Staff on Dedham ward told us they were in the process of developing post bereavement meetings for families to take place around six weeks following the death of a patient.
- Six concerns were raised with us before the inspection about how bad news was broken to patients and families, how involved they were in discussions regarding end of life, how patients were reportedly not treated with dignity at the end of their life. The wards these concerns related to were Birch ward, Brightlingsea Ward, Peldon Ward, Mersea Ward and West Bergholt ward.
- In one case the family had not been informed that the patient had died until they were asked to come to the hospital to collect the death certificate.
- In another case the family felt that the staff were not empathetic or understanding about their situation, they had not experienced watching a person die before and the experience of this without support caused them distress.

Short Observation Framework for Inspection (SOFI) Peldon Ward

- We completed a SOFI observation on Peldon Ward during the morning shift when the ward appeared busy, and sat in a bay where several staff were present. Short Observational Framework for Inspection (SOFI) is a specific way of observing care to help us understand the experience of people who use the service, including those who were unable to talk with us.
- We heard the audible interactions of a patient who was being assisted with personal care behind a curtain. The two staff members entered the bay and did not ask for consent to wash the patient, and did not introduce themselves to the patients. The staff appeared to proceed to wash the patient, and there was no interaction with the patient. We heard conversations between the staff in the bay with each other that did not include the patient for example discussing staffing one member of staff was heard to say “agency staff or one of ours”.
- A phlebotomist entered the bay and headed toward a patient bed. There was no introduction to the patient and they stood at the foot of the bed with a piece of paper. A member of ward staff approached the phlebotomist and said “be careful he is aggressive, I will help you”. The phlebotomist responded, “he was ok yesterday”. The patient was looking at both members of staff at the time. No interaction was attempted with the patient, the phlebotomist and member of staff then left the bay.

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- A domestic assistant was cleaning around the sink area in the bay adjacent to a patient's bed. The patient attempted to speak with the domestic assistant. However the domestic assistant did not attempt to interact with the patient and appeared to ignore them.
- A security member of staff was present in the bay, and we observed their positive interactions with a patient in the bay then displayed a positive response.
- Further interactions were noted between a healthcare assistant and a patient in the bay. The patient appeared distressed and was asking to go home. The healthcare assistant reassured the patient as to why they were in hospital and that they were looking for a care home for the patient. Although the patient didn't appear to understand what the healthcare assistant was saying, their mood state changed and appeared positive
- We observed the interaction between a catering assistant and a patient. The catering assistant was removing an empty patient beaker from the patient's tray table. The patient said, "Someone threw that drink over me" the catering assistant replied, "I am sure they didn't" and left the bed space. The staff member failed to listen or address the patient's concern or escalate them to the ward manager.
- A ward cleaning audit was being carried out. We heard a patient say to a staff member "what are you doing?" The member of staff replied "just checking your bed sir." No further explanation was offered and the staff member moved to the next bed space.
- Following completion of our SOFI we left the bay and stood at the nurse's station to review medical notes. We heard loud screaming noises coming from the bay. It appeared a patient receiving personal care behind the curtain had become distressed. Two members of staff were present behind the curtain and we saw a third enter once the noises were heard. We proceeded to the entrance of the door to the bay and could not hear that there was any interaction to reduce the distress of the patient. One senior member of staff outside the bay said to us, "it sounds awful doesn't it?"

Are services at this trust well-led?

We have not rated this key question because this was undertaken as a focused inspection to assess whether significant improvements had been made to services. Overall, whilst some improvements had been made in some areas, there remained a lack of robust grip and proactive identification of risk. In addition, there was insufficient pace to address the wide range of significant improvements

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required. There was a lack of action and response by the board on key issues such as the emergency department performance and safer surgery checks, despite knowing the risks were there and presenting an immediate risk to patient safety.

The trust has been found to be reactive when issues have been raised by regulators but a lack of effective governance systems meant that the trust were not proactive in the identification and resolution of issues raised. This was evident through the deterioration of wards such as Brightlingsea, West Bergholt and Peldon ward, which the trust was not aware of. We found that the arrangements for governance and performance management did not always operate effectively. An example of this is lack of improvement is highlighted through the reporting of incidents and serious incidents with the correct grading. For this inspection we identified many incidents which had not been graded or escalated appropriately. Staff morale throughout many areas we visited remained low, and the staff survey results supported that culture was not significantly improving.

The senior team stated that they felt that there had been significant improvement but also acknowledged that the trust in the longer term would not continue to be able to provide services without the support of an external organisation.

Governance, risk management and quality measurement

- The governance system within the trust was not fit for purpose and requires immediate review to ensure that risks are identified, monitored and managed appropriately. There was a disconnect between the divisions and the senior leadership team particularly in relation to governance and risk management.
- We reviewed the incidents reported prior to the inspection. These demonstrated that the level of harm a patient experienced as a result of an incident was not always correctly graded.
- We reviewed a selection of 100 incidents reported between 01 October 2015 and 31 March 2016. We identified 18 incidents which had been incorrectly graded with 'no harm' or 'low harm'. For example a misdiagnosed fractured neck of femur was graded as 'low harm'. Another incident where a woman who was 29 weeks pregnant was provided advice from the labour ward on tightening, however they went on to have her babies at home, one of whom did not survive. This incident was graded as 'low harm'. A further incident included a patient sustaining a grade 3 pressure ulcer which was graded as 'no harm'.

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- The trust is quick to react when a concern is raised with them by the regulators to resolve the issues raised. However the trust cannot prove a track record of sustained improvements across all areas. For example in September 2015 the Care Quality Commission identified significant concerns regarding safeguarding, culture and patient safety on Aldham Ward and Birch ward, which had improved on this inspection. However Brightlingsea ward and Peldon ward had deteriorated. The concerns raised were similar themed concerns to those raised previously about other wards, which the trust had failed to identify. Following the inspection in September after the attention had been removed from Brightlingsea further concerns were reported on this inspection, which demonstrates that improvements are not being sustained.
- The trust submitted weekly data to the commission with assurances that performance in the emergency department was improving. Their audits on the safer surgery checklist also identified to the trust that they were achieving 100% compliance with completing safer surgery checks. During this inspection we identified that the safer surgery checklist compliance data was not accurate. We asked the trust board members whether they were assured by the data they received from the surgery division on this. They informed us that they were not but had been taking assurances by the fact that no recent never events had been reported. Following our inspection we were informed that a never event occurred on 05 April 2016.
- During the inspection the trust was reporting a performance of 97% in the emergency department on first assessment, a 60 minute performance of 39%, and 4 hour time of 63%. The first assessment time was not accurate as we observed that the waiting time for first assessment was exceeding 50 minutes. This meant that the recorded times provided were not accurate.

Leadership of the trust

- The team was relatively stable since our previous inspection with the newest member of the team being the director of workforce and organisational development. The chief operating officer position was also changing. This was a stable situation for this trust board as it had undergone several changes over the previous two years. The team were learning to work together and build a team working dynamic and relationship, which was not yet established.
- We were not assured following our interviews with the trust board members that the team understood the risks the trust faced. Not all senior staff could articulate a way of driving

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delivery at a pace that would show improvements to patient care. We asked about how assured the senior team were as to the robustness of the data used to assure them. Most of the senior team stated that they had been reasonably reassured by the data they had been presented with demonstrating improvements. However when presented with our findings of our unannounced inspection that they had doubts about the robustness of the data they had been taking assurance from to demonstrate improvements.

- We raised our concerns regarding the safer surgery checklist and the concerns we had identified with pre-completed checklists and accuracy of the audits taking place. The responses provided were that these concerns were known to the trust having been highlighted through the independent report; however no actions had been taken to improve the service. We were surprised that having received the report on the culture and safety of the theatre department no senior executive had been to the department. The report highlighted significant concerns within the department but the senior team had taken reassurances from a series of emails from the author of the report rather than robustly reading the report and determining an action plan in response.
- There were no assurances around the results of the audits being undertaken and whether or not they were accurate. The audits on safety checks within the theatre department were being retrospectively completed to ensure that auditing data demonstrated improvement. However due to lack of oversight by the senior team they were unaware of this inaccurate data being submitted. This meant that patients could not be assured that they would receive safe care within this department. Similarly information from the emergency department was not robust during our inspection. This was a concern that the trust had recognised, and that there were plans in place to create an action plan. However were not assured that severity and implication of the risk had been recognised with poor practices increasing the risk of never events to patients.
- The medical director was able to robustly discuss issues and actions taken in respect of the HSMR and other data reported to the board.

Culture within the trust

- We were concerned about the nursing leadership, culture and staff morale on Peldon ward. There was a clear divide between overseas nurses and nurses from the UK. Nurses from oversea

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or black and minority ethnicity provided us with clear examples of where they felt that they had been mistreated for being “foreign”. They reported to us that they were not supported by the nursing leaders of the ward.

- Several staff reported to us that they felt the ward manager was unsupportive and was not approachable. We observed examples of Peldon ward manager shouting at staff across the bays and in front of patients, which was not appropriate. We spoke with the ward manager and felt that they were not being supported by the senior nursing management team to deal with the pressure they were experiencing.
- During the inspection a staff member formally approached to raise concerns using the whistleblowing procedure. We also raised our concerns about what they shared with us immediately to the executive management team for the trust for urgent action to ensure that staff were protected and the patients were kept safe.
- Concerns were raised to us also about how staff were recruited to staff nurse vacancies on the ward. Staff felt that people are given jobs in the trust to fill vacancies and might not always be the suitable candidates, with appropriate skills. The trust senior team assured us that this was not the case. However staff continued to express this view.
- Staff reported that they do not feel supported by the senior management team. A number of examples were given including a reluctance to raise concerns internally and reporting incidents. Staff stated that they failed to do this as they felt that they would not be listened to and they did not receive feedback on incidents reported. They stated that they “don’t see any improvements”.
- The morale amongst all staff on Peldon ward was very low. We raised this to the trust management team who were not aware of any concerns about the culture on Peldon ward prior to our inspection.
- The culture on Aldham ward with regards to the treatment of staff and patients, as well as staff morale had much improved on this inspection.
- Prior to this inspection we received four whistleblowing concerns, and during the inspection we received a further two whistleblowing concerns. We remain concerned that the culture of openness within the organisation is not progressing at a pace which would demonstrate significant improvement.
- The trust returned six positive, seven similar to expected and 19 negative findings from 32 questions in the 2015 staff survey, which placed them within the bottom 20% of all trusts in England for the third consecutive year.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Section 31 HSCA Urgent procedure for suspension, variation etc.

We have exercised our powers under S. 31 of the Health and Social Care Act 2008 to impose conditions on the Trust's registration because we believe that patients in receipt of care in the accident and emergency department at Colchester General Hospital will or may be exposed to the risk of harm if we did not impose these conditions urgently.

The trust did not have an effective process in place to ensure that patients arriving at the department are streamed in a timely way and escalated when their clinical presentation requires it means that patients are placed at the risk of harm. The trust was not responsive to the clinical and care needs of patients who arrive by ambulance who were placed into a corridor waiting area or in the ambulance bay. There was a lack of a continuous rapid assessment and treatment, and staff deployment throughout the department during times of high capacity and demand, which meant patients were placed at risk of harm through clinical deterioration.

Regulated activity

Surgical procedures

Regulation

Section 31 HSCA Urgent procedure for suspension, variation etc.

We have exercised our powers under S. 31 of the Health and Social Care Act 2008 to impose conditions on the Trust's registration because we believe that patients in receipt of care in surgical services at Colchester General Hospital will or may be exposed to the risk of harm if we did not impose these conditions urgently.

The trust did not have an effective process in place to ensure that safer surgery checklists were appropriately

This section is primarily information for the provider

Enforcement actions

completed prior to and after surgical procedures. The trust did not have an accurate monitoring system in place to ensure their assurance of the checklists being completed was accurate. There was a poor culture around the completion of the checklists which, meant that patients are at immediate risk of harm.