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

## Whipps Cross University Hospital

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Date of Inspections: 18 June 2013
17 June 2013

Date of Publication: August 2013

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

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Diagnostic and screening procedures  
Management of supply of blood and blood derived products  
Maternity and midwifery services  
Surgical procedures  
Termination of pregnancies  
Treatment of disease, disorder or injury |
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Summary of this inspection

Why we carried out this inspection

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

This was an 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 17 June 2013 and 18 June 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We spoke with one or more advocates for people who use services, talked with people who use the service, talked with carers and / or family members and talked with staff. We received feedback from people using comment cards, reviewed information given to us by the provider, reviewed information sent to us by other authorities and talked with commissioners of services. We talked with local groups of people in the community or voluntary sector and were accompanied by a specialist advisor.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

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

What people told us and what we found

We inspected maternity and surgery services at Whipps Cross hospital and found evidence that essential standards of care were not being met. We found evidence of care that was not safe, effective or responsive to people’s needs. We saw examples of people being treated in an uncaring way.

We saw examples of poor care, unacceptable staff behaviour and poor infection control in maternity services. In surgery, theatre processes and communication arrangements put people’s safety at risk. Surgery and maternity were both too busy, did not have enough staff to look after people’s needs, and lacked bed capacity, which meant they were not as effective as they should be and not always responsive to people's needs.

The management at Whipps Cross are not adequately managing risks in either maternity or surgery. As a result of one inspection in maternity and surgery, we identified serious shortfalls in eight of the 16 essential standards which all hospitals are required by law to comply with. The trust has failed to identify and take action to address some of these shortfalls. Urgent action needs to be taken by the trust to ensure that the care provided to people improves and that the hospital management and systems to monitor the quality and safety of care are effective.
Maternity services

We found serious shortfalls on the maternity department. Some emergency neo-natal resuscitation equipment had not been checked which could result in the delay of care to a new born baby in an emergency if found to be faulty. Women and babies were not protected from the risk of infection. The wards were unclean in places, poorly maintained and needed repairing. Infection control practice amongst staff was poor on occasions.

Some staff failed to be compassionate and caring. Women's confidentiality was sometimes compromised by staff. Records were inaccurate and did not always reflect women’s current health status.

Sometimes, there were not enough beds in the maternity department. This resulted in the ward occasionally shutting and women in labour being re-directed to another London hospital not of their choice. There was not always a doctor available in the triage area of the labour ward. This meant some women waited up to four hours to be seen.

Surgical services

There were not enough staff on duty on two wards. This led to people receiving unacceptable levels of care. One person had wet the bed because staff were unable to get to them in time due to their workload.

There were not enough beds available for people. This meant that people waited too long in the recovery areas after surgery while staff attempted to find a bed. Operations were often cancelled because of bed shortages. People were having poor outcomes after surgery as the 90 day post-surgery mortality rate was higher than the national average. Following a series of never events in surgery, we found that action had been taken to improve safety. However, further work needed to be done.

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 10 August 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Whipps Cross University Hospital to protect the health, safety and welfare of people using this service.

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

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.
There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

Respecting and involving people who use services  ❌ Action needed

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

Our judgement

The provider was not meeting this standard.

People's privacy and dignity was not always respected. Staff did not always close treatment room doors when discussing a women's treatment and it could therefore be heard by other members of public. Also some women had information delivered to them in a non private environment which did not respect the privacy.

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

Maternity services

People were involved in their care, enabled to express their views and were involved in making decisions about their care and treatment. Patients and staff told us and we saw evidence in medical notes which demonstrated that women were introduced to their midwife and were orientated around the ward upon arrival. However, one woman on the postnatal ward told us that the midwife did not introduce themselves when they were caring for them.

On the labour ward the midwives confirmed that they and a doctor discussed each woman's condition with them. They advised women on whether they could eat and drink and the arrangements for visitors. If the woman was in labour, they discussed the woman's birth plan, ideally before it was too late in the labour.

In the antenatal clinic, we were told that all women were given pregnancy packs which included information regarding diet, lifestyle and pain relief. We were told that staff gave women information and worked with them to find out what their choices and views were to promote choice and involve them.

People's privacy and dignity was not always being observed. On the postnatal and antenatal wards we established that women's privacy was being maintained. Some rooms were divided into four bays and separated by curtains. The interim clinical lead for the antenatal and postnatal wards told us that women's privacy and dignity was respected as staff would talk in a low tone so that other women could not hear what was being discussed. They also told us that sensitive information was not discussed in the bay and
they would take women to the discharge room. The private bays on the postnatal and antenatal wards provided women with more privacy.

On the labour ward, staff explained how they ensured that women's privacy and dignity was respected. Staff knocked and waited for confirmation before entering rooms and used drawsheets for examinations. However, while curtains provided sufficient visual privacy in the four bedded bay, people in other bays could hear conversations.

In the antenatal clinic, we saw that treatment doors were left open and staff conversations could be heard between women and their consultants.

Most women who use the service understood the care and treatment choices available to them, but were not always offered choices or appropriate information and support regarding their care or treatment. Four of the seven women we spoke to in the antenatal department told us they had not been offered a choice of where they could receive treatment and thought this hospital was the only one available for them. We observed women being given conflicting information on their decision on where to give birth. We saw how one woman was told by a member of the home birth team that they could no longer have a home birth. The decision was not delivered in private but in the waiting area of the antenatal clinic. The same woman told us that their consultant had said a home birth was possible. She told us: "I am left feeling very confused."

We observed a pregnant woman who had been in the triage service on the labour ward for two and a half hours ask a midwife how much longer they would have to wait to see a doctor. The answer did not support the woman as they were told “the doctors are busy in theatre.” We observed shortly afterwards the woman’s partner ask the same question and the same answer was given. We asked about the support of medical staff to triage and we were informed that labour ward doctor’s provided cover and that they were not always available when required.

People were supported in promoting their independence. On the post natal and ante natal wards, we were told that people who needed support with access to the ward were helped with this. They were provided with appropriate mattresses and we saw that there were shower and toilet facilities that supported people with disabilities. There were provisions in place to support other disabilities. We were told a multidisciplinary team was available if required.

Whipps Cross University Hospital serves a diverse population. People’s diversity, values and human rights were respected most of the time, although there were some shortfalls. For people where English was not their first language, a language line facility was available. This enabled women to hear what was being said to the interpreter. We were told by staff on the ante natal, postnatal and labour wards that if a face to face meeting was needed with the interpreter, this needed to be booked in advance.

Within the antenatal clinic we saw that all the magazines, signs, leaflets and posters were in English. There were no alternative languages for people. There were no magazines, posters or information leaflets available in the scan room. The trust might find it useful to note that providing information in other languages via signs and literature in the waiting rooms would show diversity was being respected.
Consent to care and treatment

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Surgical services

Before people received any care or treatment they were asked for their consent. The trust acted in accordance with their wishes. People on the Plane Tree day surgery ward felt they were given information explaining what the operation would involve. One person said, "I was given loads of information." Another person said, "All the staff involved me in my care." People told us they were given enough time to think about their treatment and that risks were fully explained to them.

On Plane Tree day surgery ward, we found that people signed patient agreements which showed they understood the information that was presented to them about their care and treatment. Staff were knowledgeable about how to obtain people's consent before they administered care and treatment. However, staff told us that consultants were meant to obtain people's consent during the pre-operation assessment, although instead, consent was usually obtained on the day of people's operations.

Most staff said they ensured that people had signed consent forms before they arrived in theatre. Some staff said that occasionally consent forms were not signed although this did not happen often. Several staff told us that the consent process was reviewed and monitored and had improved recently. Doctors told us that consent was never sought in the anaesthetic room unless in an emergency situation. We reviewed 10 consent forms and found that consent for surgery was sought by a consultant or a registrar. We found these detailed and explaining risks of the procedure. Doctors told us that any changes in the law affecting consent would be discussed at clinical governance sessions.

We observed a pre-operative assessment "sign-in" and found staff explained the process and went through the World Health Organisation (WHO) checklist. They asked the patient to confirm their consent and that it was their signature. In the ophthalmic theatre we checked five consent forms. All had adapted consent forms for cataract surgery with risks and benefits printed on. All were completed within the last few months and had most information apart from the Department of health (DOH) consent forms which have a carbon copy for the patient to keep so that they could further consider the risks and
benefits. There was, however, no space to record the confirmation of consent which was being done on the day of surgery, when the consent had been sought in a clinic consultation beforehand.

People we spoke with on Rowan ward told us they were asked questions about their care and treatment before nurses administered care to them. The doctors and nurses we spoke to told us that they obtained verbal consent before delivering care. We saw this in practice for taking blood samples and observations.

Where people did not have the capacity to consent, the trust acted in accordance with legal requirements. Staff told us that best interests decisions were sought for people who did not have capacity and we saw evidence of this.
Care and welfare of people who use services  

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

Our judgement

The provider was not meeting this standard.

People experienced care, treatment and support that did not always meet their needs or protect their rights.

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

Maternity services

Care and treatment was planned but not always delivered in a way that was intended to ensure people's safety and welfare. Senior managers confirmed there were not enough maternity beds due to the number of births and the average length of time women stayed after giving birth. The Local Supervising Authority (LSA) 2011-2012 report stated that maternity services had been suspended at the hospital on 21 occasions - 8 occasions due to insufficient capacity and 13 occasions due to insufficient community midwifery staff on call to provide a home birth service. The labour ward had also been closed once in June 2013 and twice between April and December 2012. When the ward was closed, the LSA was informed and women were redirected to other London hospitals. This meant that women had to deliver their babies at hospitals that were not their first choice and not necessarily near to where they lived. The midwives described moving women who had just delivered into an area used for theatre recovery so that women in labour could get a room on the delivery suite. This was described as necessary when postnatal beds to transfer delivered women to were not available.

Some women on the postnatal ward received poor care. Staff were seen on occasions not to be supportive, considerate to women's needs or compassionate. We saw a woman in a blood stained gown and bed. About 10 minutes later we saw the same woman crying in the corridor. The midwife on duty asked the woman "Why are you crying?" The woman replied "I am in pain". "Pain!" the midwife repeated in a sarcastic manner. The midwife got some medication and handed her a white pot which contained tablets without telling the woman what the tablets were. We observed the same midwife bringing the wrong formula milk (as it was different to what the woman had previously been feeding her baby). When asked by the woman, the midwife did not accept she had brought the wrong milk and did not offer the woman the correct alternative.

Another woman told us they had been complaining of pain for a while but had not been given pain relief. There was a very strong offensive smell coming from the woman's bed. We later observed a relative help the woman change the incontinence sheets on her bed.
Meanwhile, there were three midwives working on the postnatal side of the ward and they were all seated at the station most of the time completing paperwork.

People's care was not always delivered safely. Serious incidents averaged two per month which was in line with their target of no more than five incidents per month. There had not been any maternal deaths in the last year. However, there were some unexpected admissions to Neonatal Intensive Care Unit (NICU) which were related to a failure by midwives to carry out the correct observations at the right time and escalating matters when required. The hospital had reported this to the board and had implemented some training on Neo-Natal Early Warning Systems (NNEWS) to address this, but this was still a work in progress at the time of the inspection.

We looked at three neonatal notes of babies in the transitional care unit and found that NNEWS was in use and escalated where appropriate. However, it would be useful for the trust to note that for one baby there were delays in treatment as blood samples taken from the baby had been lost on three separate occasions. This resulted in delayed treatment for that baby as antibiotics could not be administered without the blood test results.

Surgical services
We inspected the surgical department because we had become aware of the high number of never events that had occurred in surgery in the last 12 months. In particular, we had been concerned that basic procedures were not being followed during surgery resulting in accidents, such as swabs being left inside patients after surgery. As a result, we looked how the surgical teams were checking that surgical procedures were safe prior to, during and after surgery.

Staff were able to clearly explain the pre-assessment process. We reviewed five pre-assessment forms and found that people were given an initial assessment before they received care and treatment. One care plan listed a person was allergic to penicillin, although this was not noted on the care plan cover sheet under allergies.

We looked at 10 World Health Organisation (WHO) surgical safety checklists in theatres. All three stages of the form had been completed to some degree, although there were inconsistencies. Some forms had extra written details and some without every box checked. Staff gave us conflicting information about who was the lead on the surgical safety checklist. Everybody asked stated that the WHO surgical safety checklist does happen for every case. However, the notes we looked at suggested that the sign out process was not always completed on the form.

In recovery we looked at Venous Thromboembolic Assessment forms (VTE), drug charts, care-plans, swab instrument and needle count charts and WHO safe surgery checklists. We found that the swab instrument and needle count charts were completed and remained in the patient notes and the WHO checklists. We looked at 10 count charts which were acceptable.

Team briefings had been introduced at the start of each day so that the surgeries planned for the day could be discussed. The aim of these briefings was to prevent errors and ensure that all staff were clear on issues such as who was being operated on, what the operation was and the surgical site. Staff said that there were several team briefings during the day including theatre and unit briefings. We reviewed team briefing record forms that were used at the start and end of the surgical list. We observed a de-brief at the end of an ophthalmic surgical list and reviewed the record which showed that there was a systematic approach. Audits showed that problems had been identified by team briefings.
before causing any problems or harm. Staff said that team briefs occurred 98% of the time. Emergency situations dictated that sometimes it was not possible to have a team briefing.

We saw evidence that the trust had focused on improving the systems to ensure surgery was safe. We noted that there had not been any surgical never events at Whipps Cross University Hospital in 2013, which was a significant improvement. However, the trust should note that we identified some shortfalls in the documentation which suggests that further work is needed to improve safety.

We were concerned about theatre list arrangements. There were various versions of the trauma list available which could increase the chance of incorrect site surgery and incorrect patient surgery. Standard acceptable practice was that an operating theatre should have one version of an operating list with copies kept in theatre, the theatre preparation room, anaesthetic room, recovery room and centrally for the coordinator to know what was happening. The nature of trauma and emergency surgery lists sometimes dictated changes to lists. However, there was a lack of standard operating procedures to address such incidents. We were told that if a list was split (when a person is moved into another theatre from the intended theatre), a team brief did not happen in addition to list changes. This could also increase the risk of errors.

We were concerned about communication failures in sending for patients for theatre. Normally the patient is accompanied to theatre with ward staff who should know exactly which anaesthetic room/theatre they are going to as going into the wrong anaesthetic room could possibly result in wrong patient surgery. In theatres five to eight our inspection team witnessed a patient walking into theatre with a staff member who did not know which theatre the person was being sent to. Theatre staff intervened and directed them to the correct theatre. The team brief produced as part of the hospital's productive operating theatre improvement programme that showed patients were sometimes sent to the wrong theatre.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan most of the time. We spoke to two people in theatres and they told us that they felt that staff were caring and had explained their care to them. They confirmed that staff had told them what to expect after the operation.

People's pain was assessed post operatively. However, where specialist input was needed there was sometimes a delay due to staff shortages. Staff we spoke with said that the pain management team was not operating to optimal standards due to staff shortages. Senior staff told us they were aware of this and planned to recruit appropriate staff. This sometimes resulted in delays to specialist pain management advice and review of people who used the service.

On Sage and Sycamore wards, we found that care was planned on admission. However, care was not always reassessed or individual. We found that some post-operative care plans were blank and had been left in people’s bedside folders. Other records such as fluid balance charts risk assessments and the hourly intentional rounding (this is when nurses went checking on how people were) were up to date.

Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare. There were some concerns raised by staff regarding the lack of Paediatric Intermediate Life Support (PILS) skilled staff in the paediatric theatre.
Staff on Plane Tree day surgery ward told us they conducted risk assessments on people before they operated. All the patients knew when they would be discharged later on in the day and were told what to expect after the operation. Staff had introduced themselves to them by their names and people knew what roles they had on the ward. Staff were there straight away if patients became ill suddenly. They all felt safe on the ward and said they could speak to staff on the ward straight away with no long wait.

There was a lack of available beds on the wards. This meant that patients spent too long in recovery areas after surgery. We found that patients could wait several hours in recovery and, on occasions, overnight. On the day of the inspection we found some patients had been waiting in recovery for several hours due to the lack of beds on the wards. Although we were assured that people were kept safe, this was not the most appropriate place for them once they had recovered.

People's care and treatment reflected relevant research and guidance. There were procedures in place for people with diabetes and they were usually the first people on the list to have operations. This was also the case for those with latex allergies. Staff described the enhanced recovery plan for post-operative pain relief and the type and frequency of observations.

There were arrangements in place to deal with foreseeable emergencies. Theatre nursing staff had yearly training in medical emergencies and were aware of what to do in the event of an emergency. Staff told us that anaesthetists were supportive to recovery and stayed with patients in recovery when needed. In the anaesthetic room the majority of the equipment had been checked and medication and medical gases were within their expiry date. It would, however, be useful for the trust to note that in the ophthalmic theatres the resuscitation trolley had not been checked at the start of the shift.

Ward staff were able to tell us the individual needs of the people that they were looking after. Staff were able to demonstrate the procedure in an emergency. Staff were able to tell us about changes implemented following serious clinical incidents. Post-operative care handovers and patient checks in recovery by ward staff on Sage and Sycamore had been changed in order to promote patient safety following an incident that had occurred.
Cleanliness and infection control

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

Our judgement

The provider was not meeting this standard.

People were not protected from the risk of infection because appropriate guidance had not been followed.
People were not always cared for in a clean, hygienic environment.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Maternity services

There were ineffective systems in place to reduce the risk and spread of infection. The maternity services department was, in places, unclean. Staff were not following the trust's hand hygiene policy. This placed new born babies, women giving birth and staff at risk of infection. All of our findings were confirmed in the trust's audit of the cleanliness of Mulberry ward in May 2013. We did not see any evidence during the inspection that the shortfalls around cleanliness and infection control practice identified in the trust's audit had been rectified.

Staff had been trained in infection control. Staff told us this and the training and were able to clearly explain how they would minimise the spread of infection. However, we found many instances where infection control practice was poor.

On the labour ward, there were stainless steel bowls on stands in some delivery rooms. We saw a blood stained bowl in a delivery room which was described as a room ready for use. We found another room that a midwife had said was ready for use had stains on the disposable curtains.

In the high dependency room on the labour ward we found that a Vygan Leader Catheter had been taped up inappropriately with Micropore tape. Staff could not be assured that the sealed bag in which the catheter was stored to keep it sterile had not been compromised.

On the labour wards, we observed that the theatre sluice pipe had previously leaked onto the floor. We saw visible dried stains on that sluice pipe and floor. In addition, we saw that the edges of the drain cover located in the theatre sluice room was taped over with tape that was visibly dirty.
In the neonatal resuscitation trolley room on the labour ward, we found that there was a high level of dust on top of the resuscitation equipment. We observed that the work surface in the neonatal resuscitation trolley room had been cleaned and had a sticker was affixed which stated that it had been cleaned. However, there were visible dirty marks on the work surface which were removed when we lightly wiped them.

We observed that a trolley stored in the corridor outside the theatres and theatres sluice on the labour ward had high levels of dust on the base of the trolley and visible blood stains. We reviewed the weekly sanitary checklist for cleaning the shower room affixed to the wall on the labour ward and found it incomplete. We found no evidence that the system in place to check for cleanliness was used appropriately.

In the antenatal clinic we saw staff entering the antenatal clinic without using hand sanitizer. During one appointment we observed that one staff member did not use any hand sanitizer before applying the heart monitor to a woman. We saw that a urine sample was taken and the bottle left on a desk wrapped in tissue. The same woman had their blood pressure taken, but at no time was it seen that the midwife used the hand sanitizer after touching the table near the urine sample on numerous occasions and on entering the room. This did not adhere to the trust’s hand hygiene policy which said that hands must be decontaminated before and after contact with patients, and on entering and leaving a ward.

On the antenatal clinic we tested and found that the hand gel at the entrance to the treatment rooms at the back of the clinic did not work. We raised this with the matron and they asked the midwifery team to attend to this. They were still not working when we checked later in the day. This was escalated to the midwife in charge who instructed staff to change the hand gel. This was resolved by the time we had left the clinic. We also saw other instances of poor hand hygiene.

We saw one doctor (who refused to provide their name when asked) provide care to a baby in the transitional ward of Mulberry ward. We observed Staff member G leave the bay with the same gloves they had just used and did not change them or sanitise their hands. This placed babies at risk of infection.

We spoke to two midwifery assistants on Mulberry ward who were cleaning a bay. We observed them change bed linen, wipe the TV, call bell, lamp and furniture using Clinell wipes. They told us they wrote in the communication book that they had cleaned the room. We looked in the communication book and found that the checklist had not been completed.

When we observed some vacant rooms and communal bays on Mulberry ward we saw that they had not been cleaned properly. We saw that there was dust behind the furniture in the rooms, blood stains on the disposable curtains and bodily fluid stains on the walls near the beds. We were told that the disposable curtains are changed every six months or sooner if they had stains on them. The curtains in the rooms had last been changed on the 26 March 2013 and had visible stains on them.

We also noted on Mulberry ward that clinical and domestic waste had not been emptied when the room had been cleaned. We saw in some rooms that offensive waste was overflowing from the bin. We raised this at 16.35pm and were told that the bins would be emptied between 17.00 and 18.00 pm. After this time they had been emptied.

The sluice room on Mulberry ward contained correctly assembled and labelled sharps
bins. We looked in sluice cupboards and found one micropore tape had hair on it. Toilets on Mulberry ward had bins overflowing and one woman told us that there was offensive waste in the corner of the toilet. We looked at some toilets on the postnatal side of Mulberry ward and saw used paper towels on the floor. There were, however, timetables for the cleaning of toilets.
Safety and suitability of premises

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who use the service, staff and visitors were not protected against the risks of unsuitable premises.

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

Maternity services

The trust had not taken steps to provide care in an environment that is suitably designed and adequately maintained. The premises were poorly maintained. What appeared to be long-standing cosmetic and other damage to the premises had either not been repaired or had been subject to temporary repairs. This potentially placed people at risk.

The labour ward premises were in need of repair and the décor was not being adequately maintained. The shower room on the labour ward had loose floor lino which had the potential to be a trip hazard. In three rooms on the labour ward, we found that ceiling tiles were ill-fitting. In places, paint was peeling from walls, was damaged or heavily scuffed. There was mould around some of the sinks used for handwashing. Parts of the flooring on the labour ward was damaged. In one room where women give birth, we found a damaged wall with loose plaster.

We were advised that the labour wards would be replaced by new premises in June or July 2013. We visited the new labour ward. The new premises were clean, light and airy. However, in one room, the en suite toilet could not be closed without the use of force as it was catching on the floor.

The ante natal and postnatal wards were in a poor state of repair and the décor was not being adequately maintained. In some rooms on Mulberry ward, the paint on the radiators and walls was peeling. The wooden sink and vanity units in the single rooms were chipped.

Toilets on the ante natal ward smelt of damp which was unsuitable as the ward also had women and babies receiving transitional care. This posed a potential health risk.

On the post natal ward we found a broken showerhead. No evidence was available to show that this fault had been reported. On the day of the inspection we also had to ask a
midwife to ask the external cleaning company to clean the shower room floor after it had flooded as this posed a slip risk for women using the facility. A toilet was marked out of use although there was no record of when or whether it was reported. This system in place to report and address maintenance issues on an ongoing basis is inadequate.

There were appropriate security arrangements in place at the entrance to the maternity ward and there was a clear visitor policy for all people who were entering the ward to adhere to. The trust may find it useful to note that there were a number of siblings on Mulberry ward who were not always with their families and were in the corridors. This posed a potential risk as it was left to staff to bring siblings back to their respective families.

Signage for wards in the maternity department were adequate, although we noted there was no signage for Lilac ward.

Surgical services.

The surgical department was adequately maintained. However, the layout of the wards did not support the safe delivery of care. The treatment room at the entrance of Sycamore ward was a considerable distance from the main bay areas. This meant that nurses were spending a lot of time walking backwards and forwards to the treatment room to check controlled drugs before they could administer pain relief. This resulted in unnecessary delays to care. We were told a risk assessment for this had been completed. In addition, the way the ward was configured near the nurses’ station posed an infection control risk and potentially compromised patients’ confidentiality.
Our judgement

The provider was not meeting this standard.

People were not protected from unsafe or unsuitable equipment.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Maternity services

The trust has failed to ensure that suitable arrangements were in place to protect people who used the service from the risk of the use of unsafe equipment. Staff were not able to verify whether resuscitation equipment had been checked. This did not follow the guidelines "Resuscitation Guidelines UK" chapter 9 which states: "Responsibility for checking resuscitation equipment rests with the department where the equipment is held and checking should be audited regularly. The frequency of checking will depend on local circumstances but should ideally be daily." The systems in place to record and report faulty equipment were not working effectively. This potentially placed new born babies at risk.

We observed the handover from the day to the night staff on labour ward. A member of the night staff coming on duty asked the labour ward co-ordinator if the emergency neonatal resuscitation equipment that had not been working properly the previous night had been repaired. The labour ward co-ordinator said she did not know. We asked for and were shown a book where staff were supposed to write details of equipment requiring repair and there was no record. The room remained in use despite the neonatal resuscitation equipment not having oxygen supply.

We found that resuscitation equipment had not been checked on the labour ward. On checking the emergency neo-natal resuscitation unit (affixed to the wall) in three rooms, we found essential equipment had not been checked as required. A checklist, affixed to the front of the unit and clearly visible to staff before the table was lowered before use, stated that the equipment should be checked after every shift. In one room we found that the essential emergency equipment inside the unit was not suitable for use. The laryngoscope blade and yankauer suction tip should be contained within a sealed bag to minimise the risk of infection. The laryngoscope blade and yankauer suction tip were contained in an open bag in one room. Staff could not be assured that this equipment was safe to use.

We reviewed the checklist for the labour ward's neonatal resuscitation equipment, which
was located in a specific room on the ward. The checklist stated: "Minimum: check all units after each shift change and after use". We spoke to a midwife who was checking the equipment at the time. She confirmed that the equipment should be checked after each shift change and after use. On checking the checklists, we found that staff could not be assured that the equipment had been checked on several dates.

The Paediatric Emergency Trolley in the high dependency room on the labour ward had a log book with a notice on the front which stated "Please check daily". The major haemorrhage trolley had a log book for checking the equipment. On checking the entries for the previous month in the log books, we found that entries had not been recorded daily on several dates for checking the equipment. Staff were not able to tell us if either of the trolleys had been checked. It was best practice to record each time the equipment was checked as outlined in section 10.1.5 of the trust's patient connected medical equipment policy that states, "Regular visual inspection, recording and reporting any misuse or damage" is required.

On Mulberry ward there was a broken electric bed control in use. It had been taped together with micropore tape. There was no record of this being reported in the maintenance log book and this was against the trust patient connected medical equipment policy which states in Section 6.2 that staff should "ensure all defects and malfunctions are immediately reported to department/ward manager and/or medical engineering and the equipment in question is immediately withdrawn. This must be clearly marked as being unfit for patient use and an equipment repair form must be completed."

On Mulberry ward and labour ward, faulty equipment did not have appropriate notification labels and they were not always withdrawn from use in accordance with the patient connected medical equipment policy which stated in Section 10.1.2 that "Users must ensure that equipment is functioning safely. Any equipment found to be malfunctioning must be withdrawn immediately."
**Staffing**

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

**Action needed**

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### Our judgement

The provider was not meeting this standard.

There were not always enough qualified, skilled and experienced staff to meet people's needs within the antenatal scan reception area, orthopaedic surgical wards and on the labour ward triage department.

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.

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### Reasons for our judgement

**Maternity services**

There were enough qualified, skilled and experienced staff to meet people's needs most of the time. At the time of the inspection the hospital's midwife to mother ratio was 1:33.

When we questioned senior staff about this we were advised this is the ratio in relation to the establishment not the midwives in post. We were told that the Whipps Cross maternity service had met the Clinical Negligence Scheme for Trusts (CNST) level one which meant that they were assessed every two years and were able to demonstrate that annual audits, business plans and contingency plans to address on going and short term staffing shortfalls. Senior midwives were aiming to achieve 1:32 ratio for midwives, although this was still above the London and national averages. At the time of the inspection, there were 14 vacancies (about 8-9%). Midwives were being interviewed for the vacant posts on the day of the inspection.

Up to 40 women were seen on the antenatal unit each day. There were 12 consultants. Each consultant had their own high risk antenatal specialist clinic. Staff told us there were three midwives, four midwifery assistants (MA) and three students on duty. The usual number of MA's was six. However, sickness and annual leave was not covered unless the MA's number fell to three or below. Sickness levels had reduced. We reviewed midwifery staff rotas and consultant rotas and found that staffing ratios were maintained most of the time. There was a consultant obstetrician physically present on labour ward from 08.00hr to 22.00 hrs Monday to Friday, in line with "Safer Childbirth" guidelines written by Royal College of Gynaecologists (RCOG2007).

Staff had mixed views about whether absences due to sickness were covered. Staff told us that sometimes they struggled to cover sick leave despite escalating to the pathway coordinator. We looked at rotas between April and June 2013 and found that shifts were covered most of the time. However the trust failed to provide sufficient information within the deadline and the agency cover information we did receive was in hours and not in total...
number of shifts. This information could not provide us with assurance that staffing levels were being maintained at all times. Other midwives thought staffing only became a problem if workload increased due to high-risk women who needed one to one care. It would be useful for the trust to also note that skills mix could be reviewed further to ensure that newly qualified midwives were not left to work in demanding areas without enough experienced staff cover.

We found inadequate staffing in the antenatal clinic reception area and the triage section of the labour ward. We observed that there was no receptionist in the scan waiting room. A couple in the clinic had been waiting for half an hour and were not aware if anyone knew that they were there. There were no staff available to ask. There was a problem with access to doctors in the triage section of the labour ward. Triage had access to the same doctor as the labour ward. However, the labour ward took priority and therefore women had to wait longer before they were seen by a doctor. Sometimes women waited for up to four hours at times when they need a doctor to assess whether or not they should be admitted. The management team were aware of the problem of access to a doctor in this department. However, nothing had been introduced at the time of the inspection to alleviate the problem.

Surgical services
On Sage and Sycamore ward, there were not enough staff on duty to meet the levels of dependency that people had. This led to people experiencing unacceptable levels of care. Elderly and frail people's needs were not being met and their safety was being compromised.

During our visit, staff did not have time to check on people in side rooms unless they rang the bell. We observed care in two female bays and found that after spending a minimum of 45 minutes in each bay, the two staff allocated to each bay could not meet the demands of other people. Patients were frail, confused and calling out for help most of the time. In one bay a person was constantly trying to get out of bed and needed someone to be with them in order to prevent falls whilst another staff member was answering call bells. In another bay, the nurse spent time looking round for another nurse to check controlled drugs in order to give pain relief whilst the support staff tried to toilet patients. It took 10 minutes before the nurse came back with pain relief. By this time another patient also requested for pain relief. Another patient who was blind was crying out for a drink. We had to intervene to help them have a drink. Another person wet the bed because staff could not get to them on time.

There was adequate doctor cover during the week and at weekends. Eight consultants covered Sage and Sycamore ward. Junior doctor cover at weekends had also been increased to two staff. One doctor covered the wards and the other covered the emergency department. There was also an orthogeriatrician to support the care of people on Sage and Sycamore wards in addition to the fracture neck of femur nurse.

On Rowan ward, two people told us staff were meeting their needs. However, they both thought staffing could be improved. We were concerned that on this ward there was one full time staff member on shift with three agency staff on the night shift.

There were enough qualified, skilled and experienced staff to meet people's needs in theatres, although the trust may wish to note our findings. The managers told us that there was no problem with recruitment and retention and were happy with the staffing levels and mix. However, some doctors and nursing staff told us that there was a shortage of nursing staff. "We are generally short of staff (nursing) and operate on a knife edge" and "we do
struggle on the nursing side.” One staff member said there should be six recovery nurses, but they usually had four or five nurses. Another told us that there was a shortage of scrub nurses. Usually staff do overtime to cover shortages, but sometimes agency staff covered shifts which could cause delays because they are not familiar with the area they are working in. We looked at nursing rotas which verified the above happened on some occasions.

Senior medical staff felt that there was enough staff to support them in practice. According to senior staff, the deanery had no concerns about anaesthetist supervision. We were told of a positive result of a recent General Medical Council (GMC) assessment of staffing in relation to being an approved practice setting for training doctors. Any shortfall in staff numbers of anaesthetists were normally made up of staff anaesthetists working shifts in their free time.

We looked at rotas and the allocation whiteboards in the theatre which indicated that the Association for Perioperative Practice (AFPP) standard staffing was being met (which was two qualified scrub practitioners, one theatre support staff member, one anaesthetic practitioner and at least one recovery practitioner per theatre). We were told that sometimes they are very busy, but generally staffing levels in recovery were satisfactory. New staff were supported by the practice development nurse and an induction pack.

We spoke with the lead for the productive operating theatre improvement programme (and looked at staff survey reports that appeared on the whole quite positive but there was a question of concern about the ‘I am given opportunity to raise concerns’ result.

On the wards, day surgery and theatres, we found that staff had up to date mandatory training or were scheduled to attend mandatory training. Mandatory training covered areas such as safeguarding, dementia, CPR and infection control. We were told that vascular assessments were in the process of being made mandatory following a serious incident.
Supporting workers

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Maternity services

Senior staff and newly qualified midwives received appropriate professional development. Staff were able, from time to time, to obtain further relevant qualifications. Several staff were on the Neuro Behavioural Physiological Assessment of the Newborn (NBPAN) course while others were waiting to start leadership and mentorship courses.

Most midwives had received an annual appraisal in the antenatal clinic and on Mulberry ward. However, on the labour ward it was unclear when all band six midwives had last had an appraisal, although they all had a review date. We were informed that some appraisals were delayed due to a change in new appraisal documentation and the delivery of the training on the new document. There were plans in place for carrying out appraisals of all midwifery staff in 2013/2014.

It would be useful for the trust to note that not all midwifery assistants (MA) had been appraised. It was also unclear whether midwifery assistants on Mulberry ward had attended mandatory training.

The midwives we spoke to knew their named supervisor, whose role is to ensure staff were up to date with their practice and support staff. Midwife statutory supervisors were currently 1:19 whilst the recommended ratio was 1:15. However, four staff were being trained to be supervisors and there was a supervisor on call every day.

Staff thought they worked well together as a team, received sufficient educational support from mandatory training and the practice educator. However, some staff felt they only met management when something had gone wrong. Other staff felt the merger had been very stressful and unsettling, mainly due to the lack of information. This had a negative impact on staff morale.

Matron's meetings and team meetings were held regularly whilst whole team meetings were held three times a year. There were brief daily team meetings held on antenatal clinic before the clinic started to discuss work issues. For staff who could not attend meetings, minutes were sometimes made available.
Assessing and monitoring the quality of service provision

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 had a system in place to identify, assess the risks to the health, safety and welfare of people who use the service and others. However, not all identified risks were managed effectively.

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

Maternity services

We found that the aspects of the system to manage risks and ensure patients health, safety and welfare were inadequate.

On occasions there were not enough beds available for women and they needed to be redirected to other London hospitals to give birth.

The system to ensure that the maternity wards were clean and that staff followed infection control good practice had failed. An audit had been carried out in May 2013 and issues around cleanliness and infection control practice had been identified. However, no effective action had been taken by the time of our inspection.

The maternity wards had not been maintained effectively and in places were in need of repair.

Equipment was not always maintained effectively. The systems to ensure that essential equipment was repaired when faulty did not always work.

Surgical services

Surgical theatre practice audit was carried out and that five records were audited in each location monthly. We looked at the audit list of 20 most frequent problems in December 2012. The two most common issues were changing lists and consent not carried out by the wards. Changes had been made so that the lists were now looked at for the whole week rather than on a daily basis. With regard to consent this was now more embedded and patients were not taken from the wards without consent forms signed.
Staff described regular audits such as recovery room, tissue viability and swab counts. They felt that actions were implemented following audits such as the improvements in swab counts and briefing and debriefings taking place. Audit information was shared with them via emails and noticeboards. On Rowan ward we saw a schedule in the ward manager's office with a "CQC Audit" schedules for 2013-2014. Audits had been scheduled according to the essential standards such as infection control, medication and patient safety.

There was evidence that Plane Tree day surgery collated data and compared it to other services by specialism. This data was used on a weekly basis to compare the quality of the service to ensure the service was meeting its targets.

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. There was information available to people to allow them to make complaints about the service. Staff told us people could complain to the service and this would be handled by the governance team in the hospital.

A customer services facilitator on Sage and Sycamore ward spoke to people who used the service regularly and found that people's main concern was communication. Doctors were coming to see people straight after surgery when people were still slightly disorientated and were not introducing themselves all the time. Due to the client group it was felt doctor's needed to introduce themselves all the time. However, doctors did not always do this on the day of our visit, which resulted in people or relatives calling the nurses later to get the information.

There was evidence that learning from incidents took place and appropriate changes were implemented. The staff we spoke to were aware of the "never" events that had occurred in particular the swab counts and wrong sides and said that these were now stringent. There were frequent swab counting audits carried out by the practice enhancement nurse. We saw a noticeboard in a staff room which had information on "never" events, infection control and staff training.

There was a patient safety committee which was chaired by a consultant and led by a clinical lead and a director of nursing. We spoke to a consultant anaesthetist, who was the patient safety lead with an allocated one day per week. They told us about safety initiatives such as 'pause for the gauze' where by the surgical team actually stop as a pause moment whilst the scrub practitioner counts the swabs (gauze) and instruments in order to eliminate retained swabs.

We reviewed clinical information governance minutes of meetings held, where any serious incidents, complaints and planned audits were discussed. There was a plan to audit wound infections that had happened over the last two years. Management of people, post fractured hips in order to prevent pressure sores was also monitored. Audits which compared the average length of stay across surgical specialities at Whipps cross to those of 11 other NHS Trusts across the country, found that between September 2012 and March 2013 most surgical specialties recorded an average length of stay lower than or equal to the CHKS (an organisation providing performance improvement services in the healthcare sector) peer group average.
Records

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

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained. On surgical wards people’s information was not secure as it was displayed electronically on big screens at the nurses station.

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

Maternity services

People's personal records including medical records were not always accurate and fit for purpose. We looked at completed labour ward notes and post natal booklets. Whipps Cross maternity notes were still in use at the same time as the national standardised notes.

Staff told us they followed the Nursing and Midwifery Council's (NMC) and the trust's guidance. Most notes were detailed and clear although signatures were not always legible. However, some of the notes we reviewed were inaccurate, poorly written or disorganised. One set of notes recorded a second degree tear of the perineum. Elsewhere in the notes an episiotomy had twice been recorded. We alerted the labour ward co-ordinator and were told the notes would be corrected to reflect the procedure that had actually been undertaken.

Another set of notes had loose paperwork. The wrong baby notes were in another mother's notes. We found two sets of labour ward notes that did not conform to section 2 of the trust's management of maternity records policy which states that "entries made in the maternity notes must never be erased, overwritten or inked out. Errors should be scored out with a single line, signed, dated and timed." In one set of notes we saw overwritten entries where dates had been changed.

In another set of notes we saw inaccurate and overwritten entries. At one point there was a gap of three days between entries. We saw two entries that were dated in advance. The mother and baby's dates of birth had also been mixed up.

Staff records and other records relevant to the management of the services were not always accurate and fit for purpose. Maintenance records did not show that all faulty
equipment had been logged or staff were unable to locate them during the inspection. Cleaning schedules did not show who had cleaned what and when cleaning had taken place. Routine checks on essential equipment were not always recorded so the trust could not be assured that equipment was safe to use.

Medical records were kept securely and could be located promptly when needed. All electronic records were password protected. Some electronic information such as blood results and scans were restricted to specific members of staff. Records of observations were kept at the bedside where the women and staff could monitor who had access to these records.

On the antenatal clinic, all filing was neat and accessible. There was a system in place to archive women’s files.

Records were kept for the appropriate period of time and then destroyed securely.

Surgical services

Records were not always kept securely. We were concerned that people's information, such as name, hospital number and date of birth, were displayed on big screens at the front of the nurses' station on Sycamore and Rowan wards.

In theatres, we reviewed 10 sets of notes and found inconsistencies (particularly in ophthalmic) with the printing of the theatre practitioners name alongside their signature and position (which is required by Nursing and Midwifery Council and Health and Care Professions Council). On Sage and Sycamore wards, we found that six out of ten surgical safety checklists did not have the “sign out” part completed. This made it difficult to verify if the sign out process had taken place correctly.
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.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
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<tbody>
<tr>
<td>Maternity and midwifery services</td>
<td>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010</td>
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<tr>
<td></td>
<td>Respecting and involving people who use services</td>
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<tr>
<td></td>
<td>How the regulation was not being met:</td>
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<tr>
<td></td>
<td>The registered person must, so far as reasonably practicable, make suitable arrangements to ensure - (a) the dignity, privacy and independence of service users. 1. (1) (a)</td>
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<tr>
<td>Maternity and midwifery services</td>
<td>Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Care and welfare of people who use services</td>
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<tr>
<td></td>
<td>How the regulation was not being met:</td>
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<tr>
<td></td>
<td>The registered person did not take proper steps to ensure that each person using the service was protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of planning and delivering of care and, where appropriate, treatment in such a way as to ensure the welfare and safety of the person using the service. Regulation 9 (1) (b) (ii).</td>
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<tr>
<td>Regulated activities</td>
<td>How the regulation was not being met:</td>
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<tr>
<td>Surgical procedures</td>
<td>The registered person did not ensure that people using the service and others having access to premises where a regulated activity is carried on are protected against the risks with unsuitable premises by means of design and layout and adequate maintenance. 15 (1) (a) (c)</td>
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<tr>
<td>Treatment of disease, disorder or injury</td>
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<td>How the regulation was not being met:</td>
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<td>How the regulation was not being met:</td>
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<td>In order to safeguard the health, safety and welfare of people who use the service, the registered person did not always take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22.</td>
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In order to safeguard the health, safety and welfare of people who used the service, the registered person did not always take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22.

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<td>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</td>
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<td>Assessing and monitoring the quality of service provision</td>
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<td>How the regulation was not being met:</td>
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<td>The provider did not protect people who used the service, against the</td>
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<td>risks of inappropriate or unsafe care and treatment, by means of an</td>
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<td>effective operation of systems designed to enable the provider to manage</td>
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<td>service and others who may be at risk from the carrying on of the</td>
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<td>regulated activity. Regulation 10 (1) (b).</td>
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<tr>
<td>Surgical procedures</td>
<td>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010</td>
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<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Records</td>
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<td>How the regulation was not being met:</td>
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<td>The registered person did not ensure that people were protected against</td>
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<td>the risks of unsafe or inappropriate care and treatment arising from</td>
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<td>a lack of proper information about them by means of the maintenance of</td>
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<td>accurate records in respect of each person. The provider did not ensure</td>
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<td>that electronic records were kept securely on surgical wards.</td>
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<td>Regulation 20.(1)(a) &amp;(2)(a)</td>
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<td></td>
<td>Records</td>
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</tbody>
</table>
How the regulation was not being met:

The registered person did not ensure that women were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of accurate records in respect of each mother and baby.

Regulation 20.(1)(a) (b)(ii).

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 10 August 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.
### Enforcement action we have taken to protect the health, safety and welfare of people using this service

**Enforcement actions we have taken**

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation or section of the Act</th>
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<tbody>
<tr>
<td>Maternity and midwifery services</td>
<td><strong>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010</strong></td>
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<td></td>
<td><strong>Cleanliness and infection control</strong></td>
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<td></td>
<td><strong>How the regulation was not being met:</strong></td>
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<tr>
<td></td>
<td>The registered person must, so far as reasonably practicable ensure that -the maintenance of appropriated standards of cleanliness and hygiene in relation to - the premises occupied for the purpose of carrying on the regulated activity, equipment and reusable medical devices used for the purpose of carrying on the regulated activity. 12 (1) (i)(ii)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation or section of the Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity and midwifery services</td>
<td><strong>Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Safety, availability and suitability of equipment</strong></td>
</tr>
<tr>
<td></td>
<td><strong>How the regulation was not being met:</strong></td>
</tr>
<tr>
<td></td>
<td>The registered person did not make make suitable arrangements to protect people who used the service and others who may be at</td>
</tr>
</tbody>
</table>
risk from the use of unsafe equipment by ensuring that equipment including medical devices provided for the purposes of the carrying on of a regulated activity was properly maintained and suitable for its purpose. Regulation 16 (1) (a)(4)(a)(b).

For more information about the enforcement action we can take, please see our Enforcement policy on our website.
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.

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>Met this standard</td>
<td>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.</td>
</tr>
<tr>
<td>✗</td>
<td>Action needed</td>
<td>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.</td>
</tr>
<tr>
<td>✗</td>
<td>Enforcement action taken</td>
<td>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.</td>
</tr>
</tbody>
</table>
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:

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

**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.