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

## Mile End Hospital

Bancroft Road, London, E1 4DG  
Tel: 02073777000  
Date of Inspection: 18 February 2013  
Date of Publication: April 2013

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>✔ Met this standard</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>✔ Met this standard</td>
</tr>
<tr>
<td>Meeting nutritional needs</td>
<td>✗ Action needed</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>✔ Met this standard</td>
</tr>
<tr>
<td>Staffing</td>
<td>✗ Action needed</td>
</tr>
<tr>
<td>Supporting workers</td>
<td>✔ Met this standard</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>✔ Met this standard</td>
</tr>
<tr>
<td>Records</td>
<td>✗ Action needed</td>
</tr>
<tr>
<td>Registered Provider</td>
<td>Barts Health NHS Trust</td>
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<tr>
<td>Overview of the service</td>
<td>Mile End Hospital forms a part of Barts Health NHS Trust and is located within the London Borough of Tower Hamlets. It provides a range of inpatient and outpatient services. These include mental health treatment, family planning, termination of pregnancy and rehabilitation services (illness or injury).</td>
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<tr>
<td>Type of services</td>
<td>Acute services with overnight beds</td>
</tr>
<tr>
<td></td>
<td>Community healthcare service</td>
</tr>
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<td></td>
<td>Doctors consultation service</td>
</tr>
<tr>
<td></td>
<td>Community based services for people with a learning disability</td>
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<tr>
<td></td>
<td>Long term conditions services</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
</tr>
<tr>
<td>Regulated activities</td>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
</tr>
<tr>
<td></td>
<td>Diagnostic and screening procedures</td>
</tr>
<tr>
<td></td>
<td>Family planning</td>
</tr>
<tr>
<td></td>
<td>Nursing care</td>
</tr>
<tr>
<td></td>
<td>Surgical procedures</td>
</tr>
<tr>
<td></td>
<td>Termination of pregnancies</td>
</tr>
<tr>
<td></td>
<td>Treatment of disease, disorder or injury</td>
</tr>
</tbody>
</table>
When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of this inspection:</td>
<td></td>
</tr>
<tr>
<td>Why we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>How we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>What people told us and what we found</td>
<td>4</td>
</tr>
<tr>
<td>What we have told the provider to do</td>
<td>5</td>
</tr>
<tr>
<td>More information about the provider</td>
<td>5</td>
</tr>
<tr>
<td>Our judgements for each standard inspected:</td>
<td></td>
</tr>
<tr>
<td>Respecting and involving people who use services</td>
<td>6</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>8</td>
</tr>
<tr>
<td>Meeting nutritional needs</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>12</td>
</tr>
<tr>
<td>Staffing</td>
<td>13</td>
</tr>
<tr>
<td>Supporting workers</td>
<td>15</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>16</td>
</tr>
<tr>
<td>Records</td>
<td>18</td>
</tr>
<tr>
<td>Information primarily for the provider:</td>
<td></td>
</tr>
<tr>
<td>Action we have told the provider to take</td>
<td>20</td>
</tr>
<tr>
<td>About CQC Inspections</td>
<td>22</td>
</tr>
<tr>
<td>How we define our judgements</td>
<td>23</td>
</tr>
<tr>
<td>Glossary of terms we use in this report</td>
<td>25</td>
</tr>
<tr>
<td>Contact us</td>
<td>27</td>
</tr>
</tbody>
</table>
Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 18 February 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information we asked the provider to send to us and took advice from our specialist advisors.

What people told us and what we found

At this inspection we focused on the care of the elderly and rehabilitation service in Jubilee and Gerry Bennett wards.

Patients' privacy and dignity were respected. Patients and relatives said they were treated with respect and given choices. One patient said, "staff are very kind and helpful, nothing is too much trouble and almost all of them are smiling." Another patient commented, "they do their best and I like it here."

Patients' views about the quality of care were mixed but mostly positive. Staff said patients received care that met their basic care needs. Due to limited staffing levels, care was mostly task-based rather than personalised to meet the individual needs of patients.

Patients were not always adequately supported to be able to eat and drink in a way that met their individual needs.

Whilst the trust was in the process of recruiting new staff and reviewing staffing levels, current staff numbers were not always sufficient to meet the needs of patients.

There were a variety of ways in which the trust regularly assessed and monitored the quality of service and gathered the views of patients who used the service.

Patients were not protected from the risks of unsafe or inappropriate care and treatment as records relevant to the management of the service were not accurate and fit for purpose.

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

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

More information about the provider

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

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
## Our judgements for each standard inspected

<table>
<thead>
<tr>
<th>Respecting and involving people who use services</th>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run</td>
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</tbody>
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### Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

### Reasons for our judgement

Patients' privacy, dignity and independence were respected. Most patients and their relatives told us they were treated in a respectful manner and given choices.

The wards each consisted of 24 beds laid out in single sex bays and included single side rooms for people who were nursed in private for clinical reasons. We saw that before delivering care, staff closed the curtains around the beds in the bays and doors were shut in the side rooms. We saw staff knock on doors before entering.

One patient said staff explained things and she was clear about what was happening at every stage. The patient said she felt comfortable and her privacy was always considered.

Most patients said staff were friendly, caring and polite. One patient said, "staff are very kind and helpful, nothing is too much trouble and almost all of them are smiling." Another said, "they do their best and I like it here."

Three patients said their family members had been involved in plans about their care. We saw that other people involved with a patient, a patient's social worker for example, were consulted and involved in planning the patient's care.

Patient choice was respected. For example, people could have food brought in from home, although staff were not allowed to warm food on the wards. One nurse said they encouraged and supported patients who refused care and would try again later. "We can't force them." Another staff member said, "I encourage them. I look at their care plan and listen to the hand over meetings. But mainly I ask the patients what they need."

Sometimes patients were admitted if they were nearing the end of their life who chose to be somewhere quieter than a general hospital ward away from home.

Staff had links with advocacy and interpreting services, and books they could use with patients who had difficulties in language or communication. They could also use the
occupational health department for other communication aids.

The trust encouraged the use of advocates over family members in formal meetings when patients could not speak English. Where there were mental capacity issues the Independent Mental Capacity Advocates (IMCA) had been used to support patients in making decisions.
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 meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

We focused on patient care in Jubilee and Gerry Bennett wards at this inspection. Most patients arrived from care of older people wards from the Royal London or other hospitals, A&E and occasionally referred by their G.P. Patients were transferred to the wards once medically stable to receive rehabilitation services and to gain more independence.

There were some mixed views about the quality of care from patients and their relatives on both wards. Positive comments we received were in relation to the way staff cared for patients. Patient comments included, "the care is pretty good. Nurses look after me as well as they can. I am as comfortable as I can be." And, "nurses help with washing and changing my pad." One patient was particularly complimentary about the doctors and therapists and said, "all the consultants, doctors and therapists have been brilliant."

However patients or their relatives gave examples when they felt that the quality of care was not as good. For example, on Jubilee Ward a relative described a time when their family member received personal care late in the afternoon which resulted in her missing physiotherapy sessions. She said the situation improved after she complained.

On Gerry Bennett Ward, the relative of a patient described an occasion when her family member had waited four hours to be put to bed, after a difference of opinion between the physiotherapist and nurses as to who would do this. They said the quality of care depended on individual staff on duty and that sometimes staff communication could be better.

Some patients said they found it very hard to find the appropriate people at the appropriate time to discuss their progress. Others mentioned that pain control was a problem.

In preparation for a patient's admission, staff identified a suitable 'pathway', which was a plan of action to meet the patient's needs. For example, if there was advance warning of a patient suffering from pressure sores, the ward would ensure the correct aids or equipment, such as a pressure relieving mattress, was in place. This reduced known risks to the patient and ensured continuity of care.
We saw that there had been no recent incidents of pressure sores among patients. Skin assessments were carried out on admission and incidents of pressure sores were reported. A system was in place to record and take action for dealing with pressure sores. This included the involvement of a specialist nurse for Grade 4 and above pressure sores.

All staff attended the daily handover meetings to discuss the patient's plan of care, past and present medical history, social needs and involvement with other professionals. Those involved in the care and rehabilitation of patients included physiotherapy and occupational health services.

We received information from the trust about patients' views collated in the last two months. Whilst the sample of patients was small, the information showed the majority of patients were generally satisfied with their experiences of care.

We were told that comments received from patients were positive and complimentary of the staff, whilst others raised areas for improvement, including staff communication and attitude. We saw evidence that work was ongoing internally in the trust that aimed to address this.

A member of the nursing team said, "we have quite a lot of pressure at times. But the quality of care is really good, I am really proud of my staff."

The majority of patients in both wards were elderly, frail, and incontinent. Staff felt that they needed more time than was currently available to them. They said this would allow them to offer more than basic care and be able to empower and support patients as they aimed to do. Senior nursing staff on both wards said whilst people received the care they needed, care was often task based. There was not always the time for conversations or to fulfil the aim of the ward.

We brought the views of patients, relatives and staff to the attention of the trust senior mangers we spoke with. They acknowledged there were areas where improvements could be made to the quality of care experienced by patients and said they were working to improve this.
Meeting nutritional needs

Food and drink should meet people’s individual dietary needs

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of inadequate nutrition and dehydration because they were not always adequately supported to have their meals and drinks in sufficient amounts to meet their needs.

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

Nursing staff told us patients generally liked the meals. A patient on Jubilee Ward said, "the food is sometimes good and sometimes not, but we do have a choice." This echoed the comments we received from patients in Gerry Bennett Ward.

Another patient said, "the food is alright. I choose meals from the menu...I can raise myself up in the bed to drink water."

We saw a menu displayed on a board in the hallway of Jubilee Ward with a guide to healthy eating and options at the bottom. Meals were varied and patients were offered a choice. These included Halal, Kosher, vegetarian, diabetic and pureed meals.

On Gerry Bennett ward, staff told us that patients who could eat independently received their meals first. Patients who needed support had their meals served on red trays. Staff served them afterwards so that they could sit with patients to assist them, to make sure their meals were served hot and patients had the support they needed.

We spoke with a representative of a patient on Jubilee ward who gave a different account of one patient's experience. They found cold meals left on the side when they visited. They said there was no-one to help the patient with their meals. They said nurses would give the patient two to three spoonfuls and then take the food away. They questioned whether staff had time to feed individual patients if they needed it as, in their friend's experience, the patient ate more if they were given more time to eat.

The same person was concerned about the patient's level of hydration. The person left the patient a straw as they needed, but every day the straw was gone. The representative said they had to speak with staff on numerous occasions about this. They questioned how much water the patient had.

Each patient's nutritional needs were assessed and recorded on admission and on a
weekly basis thereafter. We found records were available of the patient's difficulty with eating and drinking as a result of their medical condition. Records, including nursing plans, did not identify how to support the patient to adequately maintain their nutrition and hydration.

The temperature of the food was an issue raised by two people we spoke with. The relative of a patient said, "they enjoy their food. We always have a family member here to feed them at lunchtime. But the soup from the evening meal is always on the side and is cold." This reflected the views of a few other patients who gave their comments to the trust in the last month, who said the food was not hot enough.

A relative in Gerry Bennett told us of her concern that food was sometimes left for her immobile family member where they could not reach it. The relative added that nurses had given the patient food against the written guidance of the speech and language therapist. They said this was putting the patient at physical risk. They said they wrote a notice to staff listing the foods the patient was not allowed to eat. They said, "it felt like they were giving my relative things when they couldn't have them and not giving my relative things when she could."

Whilst we saw mixed patient views about the food in data provided by the trust, we noted that in the previous month, the majority of patients who commented rated the hospital food as fair, poor or very poor.
Safeguarding people who use services from abuse  ✔  Met this standard

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

Our judgement

The provider was meeting this standard.

Patients who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

The trust had a policy and procedure on safeguarding vulnerable adults. Patients who used the service were protected from the risk of abuse, because the trust had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

The safeguarding team details were displayed on the board in the staff office and noted the lead person responsible for safeguarding in the trust.

A member of the nursing staff said, "if I saw anything bad by another member of staff I would say something, I would escalate it with a manager." They said there were no major complaints and everything was addressed, as management were good at responding to complaints.

Staff told us they had received safeguarding adult training and were aware of the organisation's whistle-blowing policy. Staff could explain their understanding of what was involved in preventing and reporting abuse and about involving the local authority. They said they felt supported and able to speak to the ward manager if they had concerns. This meant that patients were more likely to be protected.

On one ward staff had identified potential abuse, made an alert appropriately and took the required action according to their procedures to make sure patients were safe.

Staff were required to complete accident or injury reports with actions taken by staff. Information from the trust showed that the incidents related to patients' or relatives' complaints or dissatisfaction with care, during times when wards were short of staff. The data provided by the trust showed that patients had not suffered harm when the incidents were reported.
Staffing

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

Our judgement

The provider was not meeting this standard.

Staff numbers were not always sufficient to meet the needs of patients.

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

There were three rehabilitation wards (including Shadwell Ward) that were headed by a manager, who had responsibility to oversee the care of patients in all three wards.

On Jubilee and Gerry Bennett Wards there were 24 patients in each ward who were looked after by three qualified nurses and three healthcare assistants when wards were fully staffed.

This meant there was one nurse and one healthcare assistant to eight patients. Healthcare assistants provided care including personal hygiene, toileting and dressing some wounds.

The wards were fully staffed when we visited. But staff told us they did they did not often have a full complement of staff. Minimum numbers would be two nurses and two healthcare workers for reasons of safety. All staff we spoke with said staffing was an issue and there were often days when there were not enough staff.

The trust had access to a pool of internal ‘bank’ staff and an NHS agency to find staff replacements. Staff and trust members advised us it was not always possible to get extra staff. One senior staff member told us that the agency was not always contacted early enough and so they were often left short staffed.

A senior member of the nursing team said, "staff work hard under a lot of pressure at times but all staff receive their breaks and what they are entitled to." " We encourage staff to take breaks as they need time out too."

We saw incident reports completed since January 2013 that showed five out of seven reports referred to staffing issues or delays in care due to staffing levels on Gerry Bennett Ward. The notes referred to staff being under pressure with low staffing levels.

In the incident reports staff described themselves caring for vulnerable people who had one to one supervision needs. Patients were identified as being at risk of falls and needing
Support, for example, with eating, continence and personal hygiene. The reports underlined the difficulties faced by staff, who indicated that their breaks were insufficient against these pressures.

Staff explained the age of the patients was increasing (two-thirds of the patients were over 85) and they were often sicker. The effect was that nurses were more stretched to care for patients whose needs were greater. Nursing staff told us the ratio of eight patients to one nurse was enough to cover the general nursing tasks of patients but there was not enough time to spend with each individual.

Day to day staffing levels varied as nurses provided occasional cover to the other wards when the wards were short of staff. Additionally, staff were used to escort patients who required services in other parts of the hospital or trust. This had an impact on remaining staff. For example, when one nurse was called away, this could result in another nurse having 12 patients each.

Despite staff being stretched at times, members of the nursing team on both wards thought the care was very good, and did not think that patient care was unsafe or had been compromised. They said staff were able to cope particularly as there was good communication on the wards.

One nurse described the impact as being having less time to speak with patients or patients waiting 10 to 15 minutes longer than usual. This reflected a comment by a patient who said she waited, "probably about 10-15 minutes, but it depends on how busy they are." However on Jubilee Ward one relative described an incident where a patient had been left on a toilet for over 30 minutes. A relative of another patient told of a time when the patient was left lying in urine for an hour.

A member of the nursing team on Gerry Bennett Ward said patients had good care but sometimes when short of staff, there would be a delay getting to the buzzer. They said this could happen once or twice a week.

All relatives and visitors said that they could see that the staff were "rushed off their feet" and the wards often told them they were short-staffed. Friends and relatives appeared to feel that there was warmth among staff but the nursing staff had other things they had to be getting on with. They questioned the level of individual care that could be given to the patients.

The evidence we found showed that staff numbers were not always sufficient for the needs of patients. We discussed this with members of the management team in the trust. We were told the review into staffing levels had been ongoing and staff recruitment had started in order to address some of the issues raised.

Whilst the recruitment process was underway, permanent posts were unlikely to be taken up for some months. Trust members described difficulties in filling vacant posts in the meantime. Despite these difficulties, staffing levels require close monitoring at all times to ensure there is minimum risk of impact to patients and their health, safety and welfare needs are met.
Supporting workers

Met this standard

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

Patients told us that staff treated them well and discussed their care and treatment with them. None of the patients said they had concerns about the skills, approach and competence of staff.

All staff had mandatory induction that involved them shadowing other staff on the ward. They were supported with one to one monthly supervision with the ward sister and there was a buddy system for new staff. Staff employment included a six week probation period.

Staff identified training as being very good and said they were really happy with the level of training and support they received. We saw a training matrix pinned up on the wall in the staff office. It included an assessment of competencies. The matrix showed the training courses that staff had attended. The range of courses were linked to their roles and responsibilities, some of which were compulsory, such as infection control, moving and handling, health and safety and safeguarding adults and children.

Some of the healthcare assistants had National Vocational Qualifications (NVQ) or Access to Nursing. This allowed them to do some nursing observations such as the checking of bloods. All healthcare staff were being sent for training that included an assessment of their competency and skills.

A member of the senior nursing team on Gerry Bennett Ward held the view that there was an adequate skill mix on the ward. They described their main role as supervising and appraising staff, observing their clinical practice and ensuring their training was up to date. They also worked with consultants and had discussions with patients and their relatives.

The senior nurses said they had frequent contact with their manager and felt supported. Staff on both wards gave us positive feedback about their line managers. One nurse described their manager as being, “really good, helpful and supportive and would join us on the ward if we are short of staff,” reflecting comments given by staff. Staff told us they had received or had a date for their annual appraisals.
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

Met this standard

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

The hospital used a variety of ways to assess the quality of care and to gather patient and visitor views. Before being discharged patients were asked to give their feedback about their hospital experience. We saw one nurse talking quietly with a patient asking if they would complete a short questionnaire about their stay in Jubilee Ward.

On Jubilee and Gerry Bennett Wards, 'discovery interviews' were undertaken by a trained patient experience lead with a minimum of three elderly patients each month. The information was collected and discussed with the ward nursing team.

We were told that where comments suggested things could be improved the information was dealt with locally led by the manager and or fed into the Governance Board. We were told that patient views and experiences would also inform the Older People’s Improvement Programme.

Staff also told us that improving communication and staff attitudes had been raised as an issue. In response to this the trust were running reflective sessions with staff to change attitudes and behaviour. Where there were more serious and/or individual staff concerns, these were managed through staff performance management.

Every month the manager visited each ward together with a consultant to do an MRSA (a hospital acquired infection) audit control. This was to check that patient screenings were complete and if patient needs to have their tests repeated.

The ward managers told us about their responsibilities for auditing and monitoring patient care and staff performance on a regular basis. Additionally the ward manager on Gerry Bennett Ward had appointed staff to act as leads in individual aspects of patient care. This included areas such as dignity and nutrition, infection control, dementia and pressure care. In this way staff could be kept up to date with good practises and new developments in patient care.

A member of the nursing team on Gerry Bennett Ward said that communication between ward staff and trust members worked quite well. They cited a time when staff were
concerned about the risk of falls to some patients. The senior management team were informed. The ward was supplied with bed and chair sensors to alert the team of a patient at risk of falling, who was attempting to get out of their bed or chair. This meant staff could respond and attend to them quickly. The staff member said this significantly reduced the rate of falls on the ward.

The trust had begun to implement their plan to deliver 'Excellence in Older People's Care.'
Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment as records relevant to the management and monitoring of their care were not always accurate or fully complete.

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

Patients' files contained a 'daily care record.' Nurses completed this record to show they had undertaken actions at regular and defined intervals with patients. For example, they indicated patients had been offered a drink, been repositioned in their beds and that call bells were checked as being within reach.

We saw a range of assessments and records in each patient's file. These included pre-admission assessments, nursing care plans, observation charts, falls risk assessments, the results of screening tests, for example, for the presence of MRSA and signed consent forms for treatments.

The views of the patient and or their representatives were not so evident in assessments or other records during the care planning process. As we found during our talks with patients and their representatives, this was important to ensure that care was delivered effectively to the individual patient.

We looked at five patient files and found incomplete records in each. This was particularly noticeable in food and drink records where there were gaps in the daily monitoring checks. This meant it was not possible to accurately monitor if a patient's nutritional and hydration needs were being met.

We found multi-professional record sheets in files intended to identify the patient's issues, the goal for action and who would undertake the action. The form was designed to be completed by each of the professionals present at joint meetings to identify their own input, but they were not always fully completed. The actions being undertaken with the patient by staff including other professionals involved with the patient were unclear.

Whilst patient's assessments and nursing plans identified their medical condition, their plans did not always identify how to deliver the person's care in a way that met their individual needs. The effect of this was apparent when patients transferred from one part
of the Trust, such as a hospital or ward to another.

An example was particularly notable in one patient's records. The patient had been admitted from the Royal London Hospital and transferred to Jubilee Ward. The actions taken by staff from the Royal London Hospital to support the patient were substantially different to the actions taken by staff to manage the same issue in the Mile End Hospital. The reason for the way the care was delivered was not identified in any pre-assessment of their needs. And the inconsistency of approach to care subsequently was not reflected in a reassessment of the patients' needs.

As the issue involved the patient's ability to take their medication, there were issues in relation to risk and consent with respect to the patient. We discussed our concerns with the trust in relation to these omissions and lack of clarity about meeting the individual's support needs. Staff had not picked up changes in the way care was provided after the patient's admission or in any subsequent audits.
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 activities</th>
<th>Regulation</th>
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<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Nursing care</td>
<td><strong>Meeting nutritional needs</strong></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td><strong>How the regulation was not being met:</strong></td>
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<th>Regulated activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Nursing care</td>
<td><strong>Staffing</strong></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td><strong>How the regulation was not being met:</strong></td>
</tr>
<tr>
<td></td>
<td>Staff numbers were not always sufficient to meet the needs of patients.</td>
</tr>
</tbody>
</table>

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<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
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</table>
This section is primarily information for the provider

<table>
<thead>
<tr>
<th>screening procedures</th>
<th>Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing care</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>People were not protected from the risks of unsafe or inappropriate care and treatment as records relevant to the management and monitoring of their care were not always accurate or fully complete.</td>
</tr>
</tbody>
</table>

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 23 April 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.
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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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>✔ Met this standard</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<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>✗ 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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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.
Essential standard

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

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

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
### Glossary of terms we use in this report (continued)

**(Registered) Provider**

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

### Regulations

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

### Responsive inspection

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

### Routine inspection

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

### Themed inspection

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