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

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**Dorset County Hospital**

Williams Avenue, Dorchester, DT1 2JY

Tel: 01305251150

Date of Inspections: 15 November 2012, 14 November 2012, 13 November 2012

Date of Publication: January 2013

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

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<td>Safeguarding people who use services from abuse</td>
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<th>Dorset County Hospital NHS Foundation Trust</th>
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<td>Overview of the service</td>
<td>Dorset County Hospital is a district general hospital providing acute inpatient and outpatient services. It has approximately 430 inpatient beds, 10 operating theatres, and provides specialist services, including oncology and renal. It has a maternity unit delivering approximately 2000 babies/year. It has an Emergency Department which has a Trauma Unit which forms part of a trauma network in the Wessex region set up to improve emergency care for patients who suffer life-threatening injuries.</td>
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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'.

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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 13 November 2012, 14 November 2012 and 15 November 2012, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

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 by a Pharmacy Inspector for management of medicines.

What people told us and what we found

We spoke with inpatients and outpatients who told us that care, treatment and support options had been discussed with them. One patient said "I signed a consent form when I saw my consultant in another hospital. He explained everything in simple terms so I understood."

One member of staff told us "There is no time to talk to patients". A patient remarked "I think the staff have been cut quite a bit. The staff appear rushed" whilst another told us "My needs have been responded to promptly".

Patients told us they felt safe in the hospital. When we spoke with staff we found that not all staff were clear on how and to whom they could report suspected or actual abuse of a patient.

Medicines were being stored securely but there were some instances when this did not happen.

We spoke with patients about the staff. One patient we spoke with said "The staff are brilliant you couldn't wish for better" another said "On the whole I find the staff very good".

We saw a system in place to report, analyse and review incidents but this was not always used to improve services. Patients and visitors were able to provide feedback of their experience of hospital services. During the inspection visit we saw several ways that feedback was gathered by the organisation from staff, patients and their relatives which was used to influence and change practice.
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 12 February 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

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<th>Consent to care and treatment</th>
<th>Met this standard</th>
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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 patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where patients did not have the capacity to consent, the provider acted in accordance with the legal requirements.

Reasons for our judgement

Patients told us their consent had been obtained prior to any care or treatment being given. They told us their consent was given verbally but when it involved an invasive procedure they had signed a consent form.

We witnessed staff explaining clinical procedures to patients and obtaining their consent. This included a patient asking staff about a procedure they were booked to have which was then fully explained. We heard a member of staff ask a patient's consent before removing a urinary catheter.

Patients told us that the doctors explained their medical condition and the proposed treatment including the risks and benefits. Patients we spoke with also told us that they knew they were able to change their mind or decline treatment if they wished to and what the risks were if they did. They said that the nurses also spoke with them about what the doctor had told them to ensure they understood what had been said. One patient told us "I trust the doctors and what they are saying."

We reviewed consent forms in several patient files on the wards and departments we visited. These detailed the procedure to be undertaken, the benefits and risks. The consent forms were signed by the individual and consent was confirmed and remained valid at the time of the procedure. The provider may wish to note that some consent forms we looked at were either not dated and/or did not have the name of the medical professional printed.

We spoke with four patients who were waiting in the theatre department for surgery. They all said they had signed a consent form. One patient said "I signed a consent form when I saw my consultant in another hospital. He was wonderful; he made sure I understood everything, including the risks and benefits. He explained everything in simple terms so I understood." This person went on to say "When I got to Dorset he went through it again."
We spoke with seven clinical staff who told us that consent for surgical procedures would only be taken by staff that were able to perform the procedure themselves.

Staff we spoke with in the theatre department ensured that when a patient lacked capacity to consent to treatment, a best interest meeting was held. We saw a patient with severe learning disabilities waiting to have surgery. We spoke with staff who said a best interest meeting had been held with the person’s representative and a best interest decision had been made on the patient's behalf. The consent form was appropriately signed.

Clear procedures were in place for identification of who has parental responsibility in circumstances where a child is unable to give consent. Staff in the emergency department told us that when a child attended they always asked the child, if old enough "Who is this with you?" to establish from them who the person is accompanying them. Then they check with the adult accompanying the child if they have parental responsibility.

We saw that one member of staff in the theatre department waiting area had taken steps to help patients review and re-confirm their consent decision. They had obtained a magnifying glass to assist patients who needed glasses to read what they had written when reviewing their consent immediately prior to their operation. The member of staff said "They come to theatre without their glasses and struggle to check their consent. I thought it was a good idea so they can read and check it is their signature."
Care and welfare of people who use services  

**Met this standard**

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

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### Our judgement

The provider was meeting this standard.

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

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### Reasons for our judgement

The hospital had a serious surgical safety incident, called a never event, that had occurred in theatre during March 2012. We therefore spent time observing the safety checks performed in the operating theatres. We saw that the World Health Organisation (WHO) surgical safety checklist was being used by staff. All members of the theatre team were engaged in the safety checking process. We were shown a draft WHO surgical safety checklist policy and we were told by the theatre manager that the trust planned to implement the policy in all main and day surgery theatres. We were told that the use of the WHO surgical safety checklist had been re-launched by the medical director in May 2012 and endorsed by the trust board.

The provider may like to note that we saw patient's needs were assessed however care and treatment was not always delivered to meet their needs ensuring their welfare and safety. Many staff in all the wards we visited told us that there were not enough nursing staff. When asked what they were not able to do as a result of this we were told often observations were not done on time and medications were given late. Staff also told us they were unable to spend as much time with patients as they would like. One member of staff told us "There is no time to talk to the patients". Another said "Staffing on nights is dire and I feel the patients' safety is put at risk". One patient remarked "I think the staff have been cut quite a bit. You do not get immediate results and you feel you are not being well looked after. The staff appear rushed." Other patients told us that call bells were answered reasonably quickly. One patient told us "The bells are answered within a minute." Another patient told us "My needs have been responded to promptly".

Staff we spoke with on the wards and departments we visited were able to explain how they ensured a patient's care and medical needs were met. We tracked the care pathway of patients on wards we visited and saw care needs had been identified in care plans. We saw documented a patient had a swallowing problem and weakness in their arms. We observed this patient being assisted to eat a pureed diet.

We observed how staff cared for patients in the wards and areas we visited. Staff were heard and seen to be polite, friendly and respectful.

We spoke with one relative who told us they could not fault the care provided to their relative. Another relative told us there were not enough nurses to meet the care needs of their relative. Their concern was particularly with regard to ensuring fluid and dietary
needs were met and they told us they ensured a family member was there at each meal time to assist with eating and drinking.

Staff were able to quickly recognise if a patient's condition deteriorated and responded appropriately. We looked at a sample of two or three patient records on each of the nine wards or departments we visited. The patients' care was recorded using a combination of paper and electronic records. We saw nursing staff carried a palm-sized electronic device for recording the patients' vital signs. Staff told us that the device identified if a patient's condition had deteriorated sending an alert which escalated the concern to a senior colleague. All staff including medical staff had access to a larger screened electronic device to view all the vital signs of patients on a particular ward together with their x-ray and test results. The devices can be accessed at any point in the hospital and were monitored by clinicians in the Intensive Care Unit and by site managers. There were systems in place to back-up the data which could also be printed if required. Staff told us that the electronic devices were simple to use and had made the recording of patient's vital signs easier.

There was effective communication between all those who provided care ensuring continuity of care. Staff we spoke with told us that all shift handovers started with a safety briefing highlighting any significant safety issues. This included patients at risk of falling, infection control issues and patients identified as at risk of pressure areas. We spoke with nursing staff on each ward we visited who told us that at the handover of patients at each shift change, they used a patient information handover document. This ensured that important comprehensive information was communicated about each patient. We saw that staff had a patient information handover sheet for the patients they were looking after.

At our last inspection in October 2011 we had concerns regarding protocols for dealing with people with a learning disability or with dementia that had to be treated in the emergency department (ED). The hospital now had trained dementia and learning disability champions allocated to each ward and department who would be called to provide care and support when required.

At our last inspection we also identified that patients being assessed and treated on trolleys in the corridor of the ED. We did not see any patients on trolleys in the corridors of ED during this inspection, and staff told us that this practice had now ceased. However, staff also told us that ambulances were now queuing to handover patients. Sometimes patients had to wait for up to 90 minutes in an ambulance and there could be up to three ambulances queuing at a time. We were told that the ambulance crew sometimes brought patients into the ED on ambulance trolleys and stayed with them whilst waiting for a hospital trolley and a cubicle space to become available. The executive directors are aware of this situation. The director of nursing told us that a meeting had recently been held with partner organisations across Dorset to agree some solutions to improve the management of emergency care across all agencies.
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.

People 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

Patients we spoke with told us they felt safe in the hospital. In one ward we observed a patient who was distressed and shouting loudly which one patient told us made them feel anxious but they were confident that the staff were able to keep them safe.

The hospital had a safeguarding policy, issued in January 2010. We were told by the safeguarding adults lead that the policy is currently being reviewed and will remain aligned to Dorset, Bournemouth and Poole safeguarding adults policy and procedures.

Staff we spoke with were able to explain what they would do if they suspected that a patient was being abused, or was at risk of abuse. Staff we spoke with in the emergency department (ED) told us that all children presenting in ED had a child protection indicators of concern matrix placed in their file prior to assessment and examination. We saw this document which we were told by a member of staff acts as a guide for raising or reducing child protection concerns.

We spoke with the safeguarding adults lead who told us that if staff suspected or witnessed abuse, they were required to complete a cause for concern form which was faxed to the hospital social work team. Initial enquiries were then made and a decision taken as to whether the concern needed to be raised with the local authority safeguarding team. In the last 12 months we were told by the safeguarding adults lead that there were 71 cause for concern forms submitted by staff, of which 11 were sent to the local authority safeguarding team. We saw a completed cause for concern form on a ward we visited regarding suspected financial abuse of a patient by a relative. Staff we spoke with on the ward told us the hospital safeguarding team were investigating the allegations.

Staff told us that they had received safeguarding training at induction and that it was covered on mandatory annual updates. However, some staff were not clear whether they had received specific training and to whom and how they could report suspected or actual abuse. It was noted in the safeguarding adults annual report dated November 2012 that to date 78% of staff across all staff groups had received safeguarding training and suitable plans were in place to ensure all staff received training.

Speaking with staff we heard that they not all received appropriate training in relation to the Mental Capacity Act 2005 MCA and the Deprivation of Liberty Safeguards (DoLS).
Some staff told us that DoLS and MCA awareness was covered at induction and mandatory training days. Senior nursing staff we spoke with told us they had not received enhanced DoLS training to make DoLS applications. We were told by the director of nursing that to improve the level of training provided, in relation to the MCA and DoLS, further training had been set up, staff had been identified and dates provided.

The safeguarding adults lead told us that a service level agreement with a local mental health trust was in place to provide MCA training for clinical site managers. This training had not yet taken place but was being arranged. We saw a guidance document for staff on mental capacity and consent and although this did not identify the training available for groups of staff, it was explained to us that the newly developed guidance does, and is currently progressing through the trust ratification process.

Staff we spoke with were either not aware of, or did not understand the hospital's whistle blowing policy which was in place. The provider may wish to note that some staff we spoke with did not have a good understanding of current local safeguarding procedures, DoLS, MCA and whistle blowing, and this should be in place.

The Deprivation of Liberty Safeguards are part of the Mental Capacity Act (2005). They aim to protect patients from being inappropriately deprived of their liberty. The safeguards have been put in place to make sure that a hospital only restricts someone's liberty safely and correctly, and that this is done when there is no other way to take care of that person safely.

We saw that there was a process in place for implementing local procedures for assessing and authorising any necessary deprivation of liberty. The safeguarding adults lead told us that DoLS applications were made by the ward sister (or deputy). We saw that this was also stated in the local DoLS guidance issued in August 2010. The safeguarding adults lead told us that staff were not required to report a risk event on the electronic reporting system when a DoLS application was made. This meant that there was not a contemporaneous overview of patients subject to DoLS because the database of DoLS applications was populated with information provided by the local supervisory authority only once applications had been considered. In the last 12 months the hospital made 25 DoLS applications 12 of which were granted.

At the time of our inspection the safeguarding adults lead and the head of risk told us that no patient was the subject of a DoLS authorisation. This was confirmed with a print out from the DoLS database after the inspection. The provider may wish to note that contemporaneous information on patients subject to DoLS should be available to ensure appropriate action is taken.
Management of medicines

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

Medicines were being stored securely but there were some instances when this did not happen.

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

Reasons for our judgement

We reviewed this standard because we had received information of concern in relation to the management of medicines that related to the prescription charts for chemotherapy and the medicine storage facilities throughout the hospital.

The Cancer Peer Review team carried out a review in June 2012. The review identified a risk due to the number of copies of the chemotherapy prescription charts in use in the hospital. In order to reduce risks around multiple copies being produced in both the chemotherapy unit and pharmacy department a new process for handling chemotherapy prescriptions was agreed by the oncology and pharmacy departments in the hospital. This was implemented in July 2012 and was seen to be in place when we visited.

We looked at the medicines storage and records on four wards and departments and reviewed information supplied to us by the chief pharmacist.

Patients we spoke with were generally complimentary about their treatment and how their medicines were managed. Patients told us they were provided with information about their medicines in a way that was useful to them. Patients also told us they were provided with pain relief when they needed it without delay.

We found in the areas we visited that medicines were not all kept safely. A medicines storage audit carried out in March 2012 identified issues with the safe storage of medicines and an action plan had been produced to address these issues. A further audit was undertaken to ensure that the actions identified had been put in place.

We found that in most instances medicines were being stored securely but that there were some areas that needed improvement. Patients own medicines were kept at the patient’s bedside in a locked cupboard. On the wards we saw medicines were stored in locked cupboards within locked rooms. However, on one ward the intravenous fluids were stored in an unlocked cupboard and it was explained that a programme was being undertaken by estates to ensure all medicine storage areas were fitted with locks.

On a ward we visited we observed a medicine round in progress and saw the medicines...

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trolley open, unlocked and unattended whilst the nurse was administering medication to a patient in a side ward.

On another ward we saw a medicines trolley locked but not secured in a locked room or to a wall. This was discussed with the nurse in charge at the time of our inspection. We saw that this had been addressed the following day and the medicines trolley was locked and secured to a wall when not in use.

We observed that the monitoring and recording of the medicines refrigerator temperature was being done on one ward but was only being done occasionally on other wards. The provider may find it useful to note that the recording of refrigerator temperatures every day will mean that the hospital will be able to ensure that medicines stored in these refrigerators will be fit for use.

The trust was not following its own policy for the self-administration of medicines. The chief pharmacist showed us a policy and procedure, including risk assessment documentation, which was available to support patients who wish to self-administer their own medicines. We talked with four patients who were self-administering some of their medicines. Their medicines were kept on their bedside table as they were medicines that can be needed quickly to relieve symptoms and which would present little risk to other people. One patient’s medication we saw on the bedside table was not labelled with the patients’ name or date the bottle was opened. One patient was administering their own insulin and this was stored in the ward drug refrigerator. We saw no evidence of a documented assessment of the patients’ suitability, their consent nor any monitoring to ensure their safety when self administering medicines whilst in hospital.

We saw that medicines were prescribed and given to people appropriately. We looked at the prescription and administration records in detail for 11 people on three wards. There were clear and detailed records of medicines prescribed and of medicines given to patients. These records showed that medicines were administered as prescribed, there were no gaps on the administration records and any reasons for not giving patients their medicines were recorded. Nursing staff on all the wards we visited told us they received a regular visit from a pharmacist who reviewed medicine charts, ordered newly prescribed medicines, arranged medicines for discharge and provided clinical advice.

We observed pharmacists on the wards we visited providing advice to clinical staff, checking patients’ prescriptions and participating in multi-discipline ward rounds.

Patients were prescribed and administered medicines safely. We saw evidence that when patients were admitted to the hospital, checks were made to ensure that they continued to get the medicines that they were taking at home, where it is appropriate for them to still do so. We saw that these medicine checks were carried out promptly once people had been admitted.

We saw that clear records were kept of medicines given to patients on discharge. Nursing and pharmacy staff told us that there were systems in place to minimise delays to the process of discharging patients. The discharge of patients was not held up due to delays in dispensing medicines. Information provided by the chief pharmacist demonstrated that a pharmacy turn around time for dispensing discharge prescriptions of three hours was met 90% of the time. Patients were provided with information by the nurses about how to take their medicines when they were discharged from the hospital.
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 meeting this standard.

Patients, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

At our previous inspection in October 2011 we had identified that patients were being assessed and treated on trolleys in the corridor of the emergency department (ED). At the time of this inspection we did not see patients being treated on trolleys in the ED corridor. Staff told us there had been improvement and patients were not being treated in the corridors on hospital trolleys.

The areas of the hospital we visited during this inspection we saw were well maintained and protected patient's rights to privacy, dignity and safety.

In a ward which was recently re-opened we saw there was a lack of piped oxygen and suction points in one part of the ward. We saw that there were holes in the wall where piped oxygen and suction should be housed. A patient on this ward who was receiving oxygen told us that during the night they were unable to turn in bed and their ears were sore. This was because they were receiving oxygen via tubing which was connected to a piped oxygen point in the next bed space and this tubing was too short. The patient told us that the day staff had been able to rectify the problem by increasing the length of tubing.

We spoke with a senior nurse on the ward who told us that this was a frequent problem due to the lack of piped oxygen and suction points which were not replaced when the ward was re-opened. We were advised by the director of nursing that the original intention was to use part of this ward for very low risk patients. A capital scheme was in place to add additional oxygen and suction points due to the changing health needs of the patients.
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

We spoke with patients about the staff. One patient we spoke with said "The staff are brilliant, you couldn't wish for better" another said "On the whole I find the staff very good".

Staff received appropriate clinical training, professional development, support and appraisal enabling them to deliver care and treatment to patients safely and to an appropriate standard. We spoke to nursing staff who told us they had received an appraisal in the last 12 months and had a learning and development plan in place. Staff told us they were able to undertake training specific to their role and there were plenty of opportunities to further their skills and knowledge. One staff member told us they were currently studying to become a champion for patients who need care at the end of life. Another staff member told us she had recently received training in removing nose packs. This member of staff told us that they were initially supervised performing the procedure to ensure competence and were now able to do this independently.

A new member of staff told us they had induction training and shadowed another staff member during the first two weeks on the ward. They commented "Everyone was willing to help me and I felt well supported".

Supervision or peer support arrangements were in place. The trust had a clinical supervision policy for all clinical non medical staff. It stated that "Clinical supervision was to take place on average once per calendar month for one hour or as necessary". The provider may find it useful to note that for most nursing staff we spoke with this had not been their experience. Most staff we spoke with told us they did not have formal regular clinical supervision or one to one meetings with their line manager. However, staff told us they felt supported because they knew that management had an open door policy and they were able to discuss any concerns. A senior member of staff told us that supervision was provided on an ongoing basis by working alongside staff. One member of staff, an allied health professional, we spoke with told us they have formal clinical supervision once a month and informal supervision when necessary.
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 and manage risks to the health, safety and welfare of people who use the service and others. However, information obtained was not always analysed and used to learn lessons and improve the service.

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

Reasons for our judgement

We saw evidence that the hospital had learnt lessons from the serious surgical safety incident which had occurred earlier in the year. We saw audits had taken place observing the use of the World Health Organisation (WHO) surgical safety checklist which included observational visits to the operating theatres by senior managers, including the chief executive officer and director of nursing. Staff we spoke with told us the checks had improved communication and teamwork. The draft "surgical safety checklist policy" which we were shown did not identify how implementation of the policy will be monitored, or how often.

The trust had clinical audit plans but we did not see evidence that clinical audits were undertaken as planned, analysed or reported on. The clinical audit lead showed us the trust-wide clinical audit plan 2012/13 which was agreed in March 2012. We noted that there were 160 audits on the annual audit plan and of these eight audits had been completed up to November 2012. We also noted that several audits that we had been made aware of during the inspection did not appear on the annual audit plan, for example the safeguarding adult audits and the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order audit 2012. We were told that action plans were developed following analysis of audit results and these were monitored in the divisions and locally. However we saw no evidence that feedback to staff to facilitate learning and improve the safety of practice is given following analysis of clinical and other audit results.

The trust had a system to report, analyse and review incidents but this was not always used to improve the service. We found that the outcome of risk events reported were not shared with staff providing care, treatment and support. We spoke with staff who told us that they had reported risk events including incidents about inadequate staffing but they had not received any feedback after submitting the report. One member of staff told us that at ward meetings some risk events that had occurred were discussed.

We saw that during the period 1 August to 27 October 2012 there were 45 reported risk events regarding inadequate staffing. We saw in the Health, Safety and Welfare
Committee report dated 7 November 2012 that concerns were raised over the value of information captured in relation to staffing issues. The risk department were asked to evaluate staffing issues to identify any risks to patients or staff.

Medication risk events were being managed appropriately by the pharmacy division. An in-depth review of medication risk events were undertaken monthly by the trust safe medication practice committee. Following the reviews the learning was disseminated across the hospital using a monthly safe medication bulletin distributed to all clinical areas. We saw a copy of the October 2012 safety bulletin on several wards we visited which raised awareness about oxygen prescribing for adults. We also saw the August 2012 safe medication bulletin which was issued following a risk event regarding inappropriately prescribed antibiotics.

Patients and visitors were able to provide feedback of their experience of hospital services. During the inspection visit we saw several ways that feedback was gathered by the organisation from staff, patients and their relatives which was used to influence and change practice. At the entrance to the wards we visited we saw "How are we doing" boards which detailed feedback on patient experience, infection prevention and control, privacy and dignity and food and drinks. The boards also highlighted the weekly patient safety priority. In one ward we saw this was drug awareness on another ward it was completing food charts.

In the emergency department (ED) we saw a suggestion box on the wall with cards for patients to complete. Staff in ED told us that there is also a suggestion box in the staff room. We did not see evidence of how this information was used to change or improve practice.

Since April 2012 every ward had been required to complete five patient experience questionnaires each week and for the same five patients a nursing audit of documentation was completed. The audit results were entered on to an electronic database the quantitative data was captured and provided real time feedback with the results being immediately available. There was also a facility to record qualitative data which was captured in the comments section. This was used by ward staff on the ward notice boards under the section "You said We did". This patient experience was analysed by the nursing care indicators group monthly and feedback given to the ward sister meetings.

We spoke with many staff about the quality assurances processes within the hospital. One staff member said "They do listen; the clinical director is very open and amenable to new ideas". Another said "We get no feedback on anything unless we do something wrong then we hear about it; if we do something right we don't".

We saw that each month, patient experience feedback was the first item on the trust board of directors meeting agenda. Patient feedback, both positive and negative was brought to the meeting and ways of improving the patient experience was discussed. A quality and safety report was also on the agenda of the trust board of directors meeting.

It was noted that the trust's council of governors were actively involved in improving patient experience with quality, safety and performance on their quarterly meeting agenda.
### 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.

Patients were not protected from the risks of unsafe or inappropriate care and treatment because records were not always appropriately maintained and kept securely. Regulation 20(1)(a) and (2)(a)

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

### Reasons for our judgement

We found that some patient records were not well maintained and some did not contain accurate or appropriate information. We reviewed two or three sets of patient records on each of the wards and departments we visited. Some care records were not well maintained and this put patients at risk of inappropriate or unsafe care. For example on three wards we saw several examples where the records were not securely stored in a file but were loose in a brown card folder. Loose documents we saw included a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order which could become separated from the patient's record resulting in inappropriate treatment being given. We also saw that recordings of information on admission were often incomplete, for example patient's preferred name, religious support and specific dietary requirements were not completed.

We saw that not all DNACPR orders were appropriately completed. For example we saw one where it was noted the patient was not included in the decision about the DNACPR order and scribbled next to this was "no capacity". We also saw a DNACPR order which stated the patient lacked capacity but saw no evidence that a mental capacity assessment had been undertaken.

Records were not always appropriately maintained. In the operating theatres we saw that the World Health Organisation (WHO) surgical safety checklist included a verbal checking process of the anaesthetic machines. We looked at three anaesthetic machine log books which had not been signed each day. For example there had been no check done on the day of inspection and there had already been one patient anesthetised that day. We looked at the log books for the previous two weeks and saw gaps in recorded checks. This was fed back to the theatre manager who told us that staff used the anaesthetic chart and WHO surgical safety checks to evidence these checks had been done as well as documenting the check in the anaesthetic machine log book.

Staff in theatres told us that any incidents or near misses that occurred were reported to the theatre co-ordinator who completed an electronic risk event form. We were advised by
the head of risk of a serious incident which had occurred in the operating theatre some months previously. The occurrence of the incident had been highlighted in a complaint and was found to have been documented in the patient's records, but an electronic risk event report had not been completed and the risk event had not been investigated. However the patient concerned had been reviewed and received all appropriate care following the risk event prior to the complaint being received.

Some discarded confidential personal information was not kept securely prior to being destroyed. Staff on wards we visited told us that at the end of each shift they disposed of patient information handover documents into a confidential waste sack kept at the nurses station. We saw that these waste sacks were not secure as they were left open.
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>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Management of medicines</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>Medicines were being stored securely but there were some instances when this did not happen. Regulation 13</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Assessing and monitoring the quality of service provision</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The provider had systems in place to monitor the quality of the service and identify, assess and manage risks to the health, safety and welfare of people who use the service and others. However, information obtained was not always analysed and used to learn lessons and improve the service. Regulation 10(1)(a)(b) and (2)(c)(i)(ii)</td>
</tr>
</tbody>
</table>

Records
### This section is primarily information for the provider

<table>
<thead>
<tr>
<th>Surgical procedures</th>
<th><strong>How the regulation was not being met:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>An accurate record for each patient including appropriate information and documents in relation to the care and treatment provided was not always kept. In addition confidential information was not kept securely. Regulation 20(1)(a) and (2)(a)</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 12 February 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.
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 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.

✔ Met this standard
   This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

✗ Action needed
   This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

✗ Enforcement action taken
   If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. 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.
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.