Inspection Report

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

Arrowe Park Hospital

Arrowe Park Hospital, Arrowe Park Road, Upton, Wirral, CH49 5PE

Tel: 01516785111

Date of Inspections: 23 January 2013
22 January 2013

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

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Wirral University Teaching Hospital NHS Foundation Trust
Overview of the service	Arrowe Park Hospital is situated in the Upton area of Birkenhead, on the Wirral peninsula. It is one location of Wirral University Teaching Hospitals NHS Foundation Trust and is one of the biggest and busiest acute trusts in the North West, serving patients across the Wirral peninsula and surrounding areas. They provide a full range of 'acute' health services for adults and children, an Accident & Emergency (A&E) unit, a Maternity Unit and a Walk-In Centre.
Type of services	Acute services with overnight beds Community healthcare service Diagnostic and/or screening service Hospice services Long term conditions services Rehabilitation services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Nursing care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We reviewed all the information we have gathered about Arrowe Park Hospital, looked at the personal care or treatment records of people who use the service, reviewed information sent to us by the provider and reviewed information sent to us by other organisations. We carried out a visit on 22 January 2013 and 23 January 2013, observed how people were being cared for, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with carers and / or family members and talked with staff.

We were accompanied on this inspection by a pharmacy inspector and a midwifery specialist advisor.

What people told us and what we found

This was a scheduled inspection of Arrowe Park Hospital location. We focussed the visit on two areas of the hospital where concerns had been raised. We visited the Women's and Children's unit and medical unit. People we spoke with were mainly very positive about their experience at Arrowe Park Hospital. Patients and relatives told us:
"We are really well looked after, they are excellent with my baby as well as looking after me",
"They can't do enough for you, the care is excellent",
"It's been absolutely excellent – the whole journey".

Patients and relatives told us they were treated well and with dignity and respect. They told us they received plenty of information regarding their care and treatment; however some patients on the maternity unit told us they would have liked more information and support with feeding their baby.

We found in the areas we visited there were suitable levels of qualified, knowledgeable and experienced staff.

Patients on the maternity unit told us their pain was managed well and that staff always checked with them on a regular basis how comfortable they were or if they were experiencing pain.

We found that the trust had suitable systems in place for monitoring the quality of services and learning and improving from audits, accidents, incidents, feedback and complaints.

We found improvements were needed in relation to accuracy of records and record keeping on the maternity unit.

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 13 March 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

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

During our inspection we spoke with patients and relatives on the maternity and labour wards, ward 32 (a medical ward) and the linked coronary care unit (CCU). Patients and relatives on both units told us they were treated well and with dignity and respect. Everyone spoke positively about their experience at the hospital.

On the medical wards patients told us and we observed that screens were always pulled around beds when treatment was provided in bays in order to preserve dignity; we noted that there was a reminder on the screens for staff to be aware of privacy issues. Staff acknowledged that whilst CCU was a 'mixed sex' unit due to the nature of the treatment provided, where possible they tried to make sure that patients of the same sex were accommodated next to each other, or in a position that was satisfactory for them, however this was not always possible.
One member of staff said, "We think about mixing sexes and try to put people where they will feel more at ease. There are separate identified toilet facilities". One relative told us: "They treat him with privacy and dignity". They also said, "On this ward it has been absolutely brilliant and I cannot fault them".
We saw that male and female patients were provided with separate wash cubicles in the main ward with access to separate toilet and shower facilities to ensure their privacy and dignity was promoted and maintained.

On the maternity unit (labour ward and maternity ward) we noted most patients were cared for in single rooms which had window blinds on the doors for privacy. We observed staff knocked and waited for a response before they entered a room. Patients and relatives told us they preferred to have single rooms as it afforded the privacy that they wanted. However there was no communal area for patients to sit and chat with others. This was commented on by a patient who said they would have liked the opportunity "to share experiences and have a chat". There was a six bedded bay where patients who needed closer observation would stay; this had screens that we observed were used to promote privacy. We saw evidence that the trust monitored its compliance with 'same sex' hospital

accommodation and updated on action plans where appropriate.

There were systems in place to gain feedback about services provided. This included questionnaires, patient experience group meetings, local LINK involvement (Local Involvement Networks are made up of individuals and community groups, working together to improve health and social care services) and review of complaints, incidents and claims. We were told the Patient Advice and Liaison Service (PALS) visited the wards daily to gain views on the patient's experience.

We found that patients were mostly given appropriate information and support regarding their care or treatment. Patients understood the care and treatment choices available to them. Patients and relatives confirmed that the medical and nursing staff always explained what they were doing, what they had found (where appropriate) and what the treatment options were, including the risks and benefits. Staff in both areas visited told us they tried to involve patients and families as much as possible and keep them fully informed of what was happening to them or their relatives. They told us consent was obtained when caring or treating patients. Consent would be obtained formally for invasive procedures and informally or verbally in other cases. Examples were given of informing and communicating with patients and relatives in differing situations. Staff we spoke with told us about the 'Language Line' telephone interpreting facility available when necessary and an interpreter was available if this was appropriate, particularly when obtaining consent to treatment. Written information was available in different languages and formats.

Patients spoken with confirmed they were mostly given plenty of information and involved in their care and treatment options. On the maternity unit, we saw evidence of written information available. A booklet containing a wide range of pregnancy information was given to all patients; those we spoke with confirmed having received this. However one person who was bottle feeding told us they would have liked to have received more information regarding the artificial feeds, they told us there was a DVD they could watch and we saw there was specific written information available; however they would have liked more personal support.

During our visit, discussions we had with staff demonstrated they had a clear understanding of the need to respect and value the people they supported. Staff on the wards were able to give us examples of steps they had taken to meet the needs of patients and their relatives in relation to disability, religion and belief and age. We were told about the multi faith / prayer room that was available and a hospital chaplain would enable people with varying faiths / religions to access suitable facilities and services.

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

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 the two areas of the hospital we visited as we had concerns raised in respect of care and welfare in the maternity unit and CCU.

We found that generally patients received safe and effective care on these two units. We spoke to patients, relatives and staff to gain their views and experiences of care and treatment. People we spoke with were mainly positive about their experience at Arrowe Park Hospital. They told us the care they received was very good and they were always treated with dignity and respect. They told us:
"Its absolutely excellent, the whole journey",
"Staff are amazing, they go above and beyond",
"I am really well looked after, they couldn't do enough for me on the labour ward".

Overall patients told us they were aware of their care or treatment plan and felt they had received adequate information to understand their condition and treatment. On the maternity unit patients told us they were generally satisfied with their overall care however one person told us they had been told about their care but had not been offered choices. We found that on the maternity unit support for feeding the baby varied. Some people told us they had great support with staff having given them plenty of information and assisted them to feed their baby by whatever methods they preferred, however we were told by one person that support for breast feeding had not been useful. This person had experienced difficulties breastfeeding and had subsequently received conflicting advice which resulted in them being offered artificial feeds. This had left the person unsure of how to progress and with which choice of feeding method.

Patients we spoke with on the medical unit told us that staff were excellent, their needs were met and that they were included in decisions about their care and treatment.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We looked at the care records for ten patients across the two units. The care plans were personalised and provided guidance about how patient's needs should be met. Risk assessments were incorporated within the care records. These identified risks to patients and provided guidance on how staff should support patients to manage the risk of harm. Guidance information was seen in the form of standard operating procedures and guidelines. For example, guidelines for breast feeding, support for parents

and babies reluctant to feed, were used on the maternity unit. Information was held electronically and paper based. Care records were integrated and demonstrated people had been looked after by a multi-disciplinary team. We saw evidence patients had access to consultants, various levels of doctors, physiotherapists, occupational therapists, pharmacists, nursing, midwifery and care staff. The content of the care plans was audited as part of the ongoing quality assurance process which took place each month, and action was taken to address any issues identified during the audits.

People's needs were assessed and care and treatment was planned and mostly delivered in line with their individual care plan. Each patient's individual needs had been assessed on admission and areas such as religious and cultural needs, where identified, had been taken into consideration in the records we looked at on the CCU. We noted there were some gaps in religious and cultural information recording in records on the maternity unit. The care plans and risk assessments were reviewed on a daily basis by the staff to ensure they were current and relevant to the needs of the patient. We found there were inaccuracies in record keeping in the records we looked at on the maternity unit. This will be discussed later in the report under outcome 21.

We found there was a risk management system in place that included reflecting on practice, learning from adverse events, incidents and near misses and taking in account findings from national reviews and recommendations from safety and risk alerts. We found on the maternity unit that although the single rooms had nurse call systems, visibility of patients from outside their room was limited if the blinds were closed. There was no piped oxygen available in individual rooms; staff relied on portable oxygen and emergency equipment stored at a designated point. Comfort checks were undertaken on CCU every two hours as per trust policy. Inspection of the records highlighted that these were not completed accurately in some cases on the maternity unit. However patients we spoke with all told us that staff were always visible and frequently checked upon the health and welfare of themselves and their babies. They said staff always attended quickly in the event of them using the nurse call system.

We found evidence of relevant national guidance implemented, for example, in the maternity unit National Institute for Health and Clinical Excellence (NICE) guidelines for induction of labour were used. There was evidence of audit and review of the use of national guidelines across the trust.

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

People who used 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. During our visit, we observed staff treated patients respectfully and with dignity. Patients we spoke with told us they were really well looked after and care given was excellent. None of the people we spoke with during our visit raised any concerns about the care or support provided at Arrowe Park Hospital. People told us that if they did have any concerns, they felt able to raise them with ward staff.

Staff were able to tell us how they would raise any concerns in relation to safeguarding. Staff gave examples of where safeguarding alerts had been triggered and how these had been dealt with appropriately. Ward staff we spoke with were knowledgeable about the actions they needed to take should they have any concerns for the safety or welfare of patients. This involved making a referral to social services as part of the discharge planning process. Some staff we spoke with were aware of the action to take if a referral required urgent action and were able to give examples of where this had occurred. Staff were able to describe the various types of abuse that could occur and the signs they should look for. They were familiar with the term whistle blowing and expressed confidence in raising issues with current managers. Safeguarding training, at different levels, formed part of the trust's mandatory training and was included in the induction programme for new starters at the trust. We saw evidence that all staff had received level one (basic) training in safeguarding; training plans identified which staff required which level of safeguard training they should have. The safeguarding team told us they and ward managers monitored staff training. We found that some staff had received mental capacity and deprivation of liberties training. We found they could make a basic assessment of people's needs and we saw that this was included in assessment documentation. We were told that ward staff would alert the safeguarding team who would deal with any patients regarding lack of mental capacity.

During our visit we spent time with the trust's safeguarding adults and children's leads, who were able to describe the policies and procedures in place to protect patients from the risk of abuse. The provider had named nurses for adult and child protection in place. Mostly we found the provider responded appropriately to any concerns or allegation of abuse. We found evidence of reporting and communication with the local authority

safeguarding team, however we found that not all safeguarding concerns or incidents had been appropriately notified to CQC. The provider may find it useful to note we found from talking to staff and from observation that the safeguarding team were not readily available on the wards and departments for information, guidance or advice, nor did they communicate effectively with ward based staff. There was little feedback received on the wards from the safeguarding team regarding incidents that had been reported or actions that had been taken. We saw examples of safeguarding incidents where action had been taken to identify and prevent abuse from happening. We looked at safeguarding documentation, in particular the three day parenting assessments, on the maternity ward. This had been completed as requested and stored within patient notes, however there was no evidence to indicate the assessments had been reviewed by the safeguarding team or social services prior to discharge of the patient. There was no documented formal review of the assessments carried out to ensure they were consistent, none judgemental and fit for purpose.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

We looked at how medicines were handled and administered on the maternity ward. We spoke with four patients on the maternity unit about their medicines and how they were managed. Comments included:
''Staff have explained my medicines and treatment to me, I fully understand what is happening''.

We found patients were protected against the risks associated with medicines because the trust had appropriate arrangements in place to safely manage them.

We saw appropriate procedures for medicines prescribing and administering. Stocks of medicines were well organised and systems were in place for promptly obtaining supplies of medicines including those to take home. We saw a strong presence from medical and pharmacy staff that helped make sure medicines were safely prescribed.

We saw appropriate arrangements for the storage and disposal of medicines that helped make sure they were safely kept. Regular checks of medicines storage areas were made and these were monitored by trust managers in all areas of the hospital. Results from medicines storage audits showed a positive trend of improvement that showed the trust was taking action in high risk areas to help make sure medicines were safely kept.

Midwives administered all medicines to patients and we saw they were handled in an organised way. Appropriate procedures were in place for prescribing and administering specialist medicines used in midwifery. We saw detailed guidance and policies to support the use of these specialist medicines and evidence of on going staff training to help make sure safe practice was followed.

We looked at the information provided to patients about their medicines. The trust had made recent improvements in response to patient feedback. We saw information provided in different formats and patients we spoke with told us they had been kept well informed about their treatment and their medicines.

We looked at how medicines were recorded and found prescriptions charts to be usually accurate and complete. We looked in more detail at how pain was managed and found improvements had recently been made. Patients were regularly asked about their level of

pain and we saw good evidence of patient's pain being managed properly. The trust might find it useful to note that the arrangements for assessing patient's pain prior to administering medicines might lead to an inconsistent approach because the paperwork and guidance to support this were not clear. This means there was a risk that patients might not receive the most appropriate treatment.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

We assessed this outcome due to concerns being raised regarding staffing levels and staff skills on the maternity unit and CCU. CCU had recently undergone a redesign of the unit to incorporate it fully into the medical unit including redesign of the surrounding and linked medical wards. We judged that the two units we visited had sufficient suitably qualified and experienced staff at the time of the inspection.

All of the patients we spoke with across the two units told us they were satisfied with the level of care and the speed of attendance when they called for assistance. All of the patients spoken with told us they were provided with the care required. They said that staff reacted quickly to call bells and they were not left waiting for care or treatment. One relative on the medical unit said: "The staff look after him well. We are very satisfied with this ward. Staff are welcoming. They let me come when I want because of his condition and they are very helpful".
We spoke to the lead nurse for the medical unit who explained the work they had undertaken and initiatives implemented to fully review and revise staffing within the department. There had been changes since the merger of CCU and ward 32 with new staff employed. This had meant a delay in being fully established but there was confidence that once all new starters were in place the medical unit including CCU would be fully complimented with appropriately skilled, experienced and qualified staff. The changes had caused concern for some members of staff, however a review had taken place and gave assurance this model of working would benefit patient care and staff. Staff working on the unit told us that the changes and the reasons for the changes had been fully explained with meetings held to discuss. We were told they felt it had been a fair process. We were also told that staff morale on the medical unit was good and in part attributed to a recent increase in staffing. Staffing levels were continuously monitored (on a daily basis) and amended according to guidelines for staffing coronary care units and dependency of patients. Staff cover was organised using bank staff or in serious shortages beds would be closed if they did not have suitable cover.

On the maternity unit concerns had been raised and evidence seen of low staff morale caused in part by leadership of the unit. Discussion with staff demonstrated that actions taken recently had resulted in staff morale improvement. It was apparent the unit had undergone considerable change. There had been investment and upgrade of facilities, however staff told us the changes had not always been communicated effectively.

The provider may find it useful to note that we found there were few midwives who were qualified to undertake the primary examination of the newborn assessment. This meant that health care assistants had to run regular "baby clinics" in a designated room on the ward for paediatricians to undertake this important examination of babies. This was not efficient use of staff.

The annual audit of supervision of midwives document (2012) highlighted that currently there was a ratio of 1 supervisor to 28 midwives (the national standard is 1:15) The provider may find it useful to note this may impact on the effective support and development of midwives within the unit. The report does however comment that there was an action plan in place which would improve the ratios.

Staffing levels on the maternity unit were calculated using the birth-rate plus tool. We noted the unit was busy, however on talking to a supervisor of midwives, it was clear that the decision to close the unit to labouring mothers had not needed to be taken due to staff shortages. We were told by one supervisor of midwives:
"All mothers receive one to one care throughout labour"; This was confirmed by two postnatal mothers whom we spoke with.

Assessing and monitoring the quality of service provision ✓ Met this standard

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 meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.
The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

We looked at how the trust monitored quality at ward, department and board level. We gathered evidence by talking with staff, patients/relatives and reviewing documentation. We found that patients, relatives, the public and staff were regularly asked for their views regarding their experience. These comments were acted on. We saw the systems the trust had in place for gaining patients views and experiences. We were told about and saw the Learning with Patients Questionnaire used to record views about their hospital stay. We saw evidence of results displayed on wards and actions implemented in response to comments made. Positive results were seen for the wards we visited. We were told about the electronic kiosk feedback system that was also used to obtain views. The kiosks were rotated around wards/departments regularly. Each area was informed of their results and staff confirmed their discussion at meetings.

We saw evidence of various methods of monitoring quality and safety. The quality account report for 2011/12 demonstrated the wide range of activities undertaken related to service and patient experience improvements and quality. Priority areas for 2012/13 were seen including a focus on patient experience. Clinical audit involves improving the quality of patient care by looking at current practice and measuring compliance with standards. We saw the clinical audit plan and programme for the trust. Audits were prioritised according to policy. The audit plan took into account the need to undertake audits based on national reviews, mortality reviews, National Institute for Health and Clinical Excellence (NICE) guidance, education/training, patient/public involvement as examples. Nursing and Midwifery audits were undertaken following the audit plan. Resources were available to support the audit programme across the trust. We looked at the annual audit report for 2011/12 which demonstrated various audits undertaken, results, outcomes and changes in practice made. The analysis of the information was shared with the ward managers and staff and examples of changes to practice were seen. We were told about the ward sisters daily walkabout and checks of the ward areas, matrons also undertook similar audits as part of the trust's quality assurance processes. These audits included for example, infection control, record keeping, patient comfort checks and medicines management amongst others. We saw that the results of these audits were discussed with staff at meetings. We saw evidence of action planning and implementation of changes as a result

of audit information.

We saw information displayed on the wards that demonstrated performance data and analysis of audits and incidents. Ward level data was then reported on in the 'safety thermometer' and ward 'dashboards'. Evidence was seen of quarterly ward health and safety inspections having taken place and discussed at ward meetings.

The trust had a corporate risk management structure, risk management strategy and policy. These detailed the committees and groups which had responsibility for the management of risk throughout the trust. We saw the newly implemented governance and assurance structure which demonstrated how quality and safety was scrutinised and assured throughout the trust from ward level to the board. Risk registers, risk assessments and risk management was seen to feature as standing agenda items on all board meetings. We saw information that demonstrated key information relating to patient safety and quality were discussed at all levels from ward to trust board. Each clinical area, and at corporate level, had a risk register. A risk register is used across ward, department and at corporate level to keep managers informed of key risks in each area and to action these. We were told by staff how patient safety alerts were disseminated for action.

We saw and were told about the accident, incident and near miss reporting policy and procedures in place. Trust wide an incident/near miss reporting form for clinical and non clinical incidents was used; in the maternity unit a care improvement form (CIF) was used. All staff could complete the form; senior staff would assist completion of the risk scoring tool using the trust methodology for risk assessment and management. It was demonstrated that senior staff received training in risk assessment and management. We saw data and dashboards demonstrating incident reporting and analysis in the two areas we visited. Root cause analysis was undertaken and there was evidence that learning from incidents/investigations took place and appropriate changes were implemented. Evidence was seen in staff meeting minutes and discussed with staff at our visit. Quality and safety committees and groups also disseminated incident and risk data information across the trust. Actions planned and implemented were evident and examples of resulting improvements were seen. The trust produced a newsletter 'Sharing the Lessons'. This communicated information about managing risks and good practice in quality and safety. The women and children's department produced their own newsletter which included a summary of serious incidents and root cause analyses.

The trust undertook quarterly reviews of their internal monitoring of compliance with the Care Quality Commissions (CQC) Regulations. We saw reports with actions planned and implemented. Evidence was seen of the trust responses to external and national enquiries which had influenced and promoted changes for improvement. The trust had a policy for dissemination and implementation of NICE guidance; examples of their monthly NICE assurance reports were seen. We saw evidence of quarterly reports of complaints, claims and patient experience.

We were told about the whistle blowing policy. Staff felt confident in raising their concerns. They said they would not hesitate to speak with their line manager or another manager to raise concerns should the need arise.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not adequately protected from the risks of unsafe or inappropriate care and treatment due to inadequate care records.

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 introduced this outcome at inspection due to issues we found during the visit with accuracy of record keeping within the maternity unit.

Within the seven records looked at on the maternity unit we found inaccuracies with the majority. We found that most of the records we looked at had discrepancies in that signatures were missing, and assessments and checks were not recorded as fully as they should have been.

Identification stamps were used in records to identify the name and title of the person completing the record. In addition these must always be signed by the person; however in some cases where the stamps were used accompanying signatures were missing. Patient identification labels were not always evident on individual pages on the person's notes. We also found that the care records contained medical jargon and use of abbreviations.

We found that the quality of record keeping varied between wards. The trust used standardised care plans and staff could document any additional information, evaluation of care and variances to care which would support staff in meeting patients' specific individual needs. Trust wide various formal assessment tools were used; these included early warning of deteriorating health, risk of venous thromboembolism, risk of pressure sores, risk of falls and assessment of comfort including pain relief. On the medical unit we found that records were well organised, well maintained and accurate with assessments, reviews and signatures all complete in those records we looked at. There was evidence of comfort checks being completed on a two hourly basis and recorded appropriately. However, on the maternity unit staff signatures, designation and dates were not always completed in line with the trust's policies and procedures. We found gaps in the completion of the comfort check charts, assessments such as skin integrity and moving and handling and within record keeping in general. There was poor documentation of communication between patients, medical and midwifery staff. Whilst most patient records were paper based, some were stored on an electronic system (including a number of key risk assessments). We found, and staff commented, that using this electronic system could

sometimes prove challenging with a lack of computer availability and skills in using the technology.

Trust wide we saw evidence of various quality monitoring systems such as monthly nursing and midwifery audits and trust wide clinical record keeping audits. These included assessing against standards for record keeping, completion of documented assessments and discharge planning. Results and reports from departments across the trust for the first half of 2012/13 were seen. These indicated a common theme of poorly completed documentation had been identified in particular in respect of staff signatures and identification of designation. Where scores in these audits had been identified as lower than the set standard the issue would be referred to the risk register corporately and at department/division level for further action. The trust failed the health record keeping standard when they applied for the National Health Service Litigation Authority (UK) (NHSLA) level two accreditation in July 2012. The standard not met included accuracy in recording time, date, signatures and printing of name, use of black ink, annotations and communication with patients. Action plans were implemented and we saw evidence of various methods of communication and initiatives implemented to improve record keeping. More recent re audits have shown improvements had been made with record keeping within the maternity unit and across other departments, however, as detailed, the audits demonstrate areas for improvement are needed in relation to record keeping throughout the trust.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Maternity and midwifery services	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Records of patient's care and treatment were not always accurately completed. Regulation 20 (a)

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 13 March 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:

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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