Review of compliance

Basildon & Thurrock University Hospitals Foundation Trust

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<td>Type of service:</td>
<td>Acute Hospital Services</td>
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<td>Date the review was completed:</td>
<td>08/12/2010</td>
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<td>Overview of the service:</td>
<td>Basildon Hospital was one of the first 10 NHS Foundation Trusts in the country and are an associate teaching hospital. Providing an extensive range of acute medical services at Basildon University Hospital and Orsett Hospital, they primarily serve the 310,000 population of Basildon and Thurrock in South West Essex, plus some residents of the neighbouring districts of Brentwood (for whom they are the main provider of cardiology services) and Castle Point. More than £60 million has been invested in the last few years</td>
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expanding and modernising Basildon University Hospital. With a budget last year of £168 million, the Trust treated more than 58,000 inpatients and day cases, provided nearly 260,000 outpatient consultations and attended to nearly 105,000 Accident and Emergency (A&E) patients. The Essex Cardiothoracic Centre based at Basildon University Hospital opened in July 2007. Amongst the most modern centres of its kind in the country, The Essex Cardiothoracic Centre provides specialist diagnosis and treatment for people with cardiovascular (heart) and respiratory (lung) diseases, and boasts the latest state-of-the-art equipment and technology.
Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Basildon and Thurrock University Hospitals NHS Foundation trusts was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews looking at.

- Respecting and involving people who use services
- Consent to care and treatment
- Care and welfare of people who use services
- Meeting nutritional needs
- Cooperating with other providers
- Safeguarding people who use services from abuse
- Cleanliness and infection control
- Management of medicines
- Safety and suitability of premises
- Safety, availability and suitability of equipment
- Requirements relating to workers
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision
- Complaints
- Records
How we carried out this review

We reviewed all the information we hold about this provider and contacted care homes, general practitioners and people who use services for their views. We then carried out visits on 6, 7 and 8 December 2010 in which we observed how people were being cared for, spoke with more than 60 people using services and more than 150 staff, checked the provider’s records, and looked at records of people who use services. As part of these site visits we used a formal observation tool so as to enable us to directly observe and report on the quality of care experienced by patients at Basildon Hospital. The tool enables us to tune into the patient's experience by observing their general level of well-being and engagement and to assess how those providing care support and interact with patients. Whilst the tool can highlight and evidence poor practice, it also helps to recognise positive practice and helps to drive service improvement.

What people told us

More than 60 patients, carers and relatives were spoken with or interviewed over the three days of inspection and most of them (across six clinical areas) did not identify any privacy and dignity issues. They noted that information provision, especially around complaints, needs improvement in some areas although the information on medical conditions, such as stroke, was noted as good and freely available. Two patients recovering from a stroke were positive about the care and treatment available on the stroke rehabilitation ward, but both felt they would progress more quickly if there was physiotherapy available at weekends.

Overall patients felt well informed by medical staff when being asked for their consent; they stated that they had been given a full explanation of what was happening and their treatment. Maternity patients were very positive about the care and treatment that they had received, including breast feeding support, free visiting for fathers, cleanliness, hand hygiene and security of their belongings but were less positive about sleeping facilities for fathers and storage facilities. There were no complaints regarding levels of staff in the departments.

Patient feedback about their care and treatment across Basildon Hospital was generally positive and that the response to call bells is usually prompt, although there was some criticism of occasional slow response to call bells during handover.

Patients in the Elective Admissions Unit expressed positive feedback about the unit and the staff. However, a patient interviewed in the elective admissions unit reported that during a recent admission to Elsdon Ward they had experienced some difficulties due to their physical disability. They stated that their care and wellbeing had been compromised due to the lack of a fully accessible shower and other adaptations to maintain their welfare in getting in and out of bed and their sense of security whilst in bed. Another patient felt their needs had not been fully understood by staff on Kingswood ward, as they had been admitted to a surgical ward although they had a medical condition.
We spoke with eight patients about the quality of meals provided. In general terms all were complimentary about the quality of meals provided and advised they had no complaints. The only negative comment was in relation to one male patient who found the quantity of meals provided to be inadequate and not satisfying enough. Patients said that overall the food had improved since the new catering system had been introduced. They said that there was more choice, food was hot, its presentation was good and that if they had a meal late it was still edible. They also said that drinks were available and they could ask for a hot drink at any time.

Patients were positive about cleanliness and hand hygiene across all areas visited. They felt the wards were clean and that the staff worked hard on this, especially in busy areas such as the Acute Medical Unit [AMU]. Patients also observed and commented that staff washed their hands a lot and wore gloves and aprons when required.

We discussed medication practices with six people. One patient reported that one intravenous dose of antibiotics had been administered four and half hours late and only after repeated prompting from the patient. Five of the patients said that they had received enough information about their medicines and that they would ask the nurses if they needed further medicines information.

Patients consistently expressed positive feedback about the hospital environment. On the stroke rehabilitation ward patients spoke very positively about having easy access to facilities to help them with their rehabilitation programmes. Patients on maternity noted there is 24-hour visiting for partners and a partner said they were impressed by security, as staff always checked who they were before allowing them in.

Issues were raised by some patients where they said that they had been on the AMU for several days, up to five, as there was not a bed available on a ward. They said the unit was very busy and described a day when there was a 'sea of people' in the corridors. They also said that the unit was very busy at night and that staff were noisy at the nurses’ station. They were also unhappy because there was no proper call bell system available and just a light went on, which they reported staff could turn off at the desk and that this did happen at night when you wanted something. One patient told us that staff are fast and efficient but found that, “paperwork comes first and the patient second; there is an impersonal feel and staff have little time to talk to you.”

Numerous people made comments that staff were knowledgeable, and included them in discussion about their care and treatment and that they treated patients with respect. Patients reported that staff were doing a very good job. One patient said that their painkillers always arrived on time and that after being in and out of hospital for most of her life she felt that staff on Mary Seacole Ward were the best she had ever experienced.

We spoke to a member of the patients’ panel, who spoke positively about the Trust and the role of the panel. They felt that everywhere was not perfect, there remains a lot to be done but that the Trust is being proactive about it. They felt that they were given the information that they needed, they were listened to and, although the panel is in its early stages, having had only three meetings, the Trust has already taken
suggestions on board and actioned them. The panel member was able to show us examples of work completed, such as the admission and discharge letters on the ward. The panel member felt it was an open forum and that, if required, they could raise any issues and dissatisfactions comfortably. One concern raised by the forum was about the lack of improvement in dementia care and care of the elderly, which was borne out by the inspectors’ observations during the visit. The trust did report its plans, including a proposed project which brings the national dementia strategy together with the ‘Who Cares’ for Carers?’ project, which remains in pilot form on the Trust's older people’s wards. However, it was apparent from talking to staff and observing care in the clinical areas that awareness training needs to be actioned quickly to support staff in this challenging environment, particularly to manage and improve outcomes for patients with dementia.

Patients interviewed said they would feel comfortable in making a complaint if they wished to. However, three patients interviewed on Florence Nightingale ward, which had been admitted as emergency cases, had not been provided with 'Help us get it right' leaflets or information about the Patient Advisory Liaison Service [PALS]. One patient was in the process of making a complaint as they had not received their evening meal until 23.00 hrs the night before. They said they had not been provided with any information about making a complaint or about the PALS. No patients reported concerns about confidentiality or data protection.

Where people were unable to provide a verbal response, for example as a result of limited verbal communication or poor cognitive ability, we noted their non-verbal cues. These indicated that people were relaxed and comfortable and found their experience at the hospital to be positive. Two relatives with whom we spoke confirmed they were happy with their relative's treatment and care at the hospital.

What we found about the standards we reviewed and how well Basildon Hospital was meeting them

**Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run**

Where appropriate and possible, patients have their care, treatment and support explained to them. The care that patients receive maintains their privacy and dignity. We saw few examples of patients’ privacy and dignity being compromised and patient feedback about their care and treatment was generally positive. We also observed examples of good personalised care. Efforts are made to uphold and maintain patient's privacy and dignity.

Whilst the Trust has produced information to patients, such as patient information packs, these are not used consistently by staff in all patient areas. Some patients we spoke to did not have this information and we saw that it was not available by patients’ beds. Patient information was in English and standard format only, throughout all clinical areas visited.

- Overall, we found that Basildon Hospital was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.
Outcome 2: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Information available to the Care Quality Commission prior to our site visit did not highlight or raise any concerns in relation to this outcome. Patients and staff were well informed on consent practices and inspectors saw good examples of staff ensuring that patients, where they were able, gave valid consent to the examination, treatment and support they received.

- Overall, we found that Basildon Hospital was meeting this essential standard.

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

Overall patients are happy with the care, support and treatment received at Basildon Hospital. The majority of patients, with the main exception being those on the Acute Medical Unit (AMU)-East, can be assured of receiving care and treatment in single sex accommodation.

Significant improvements have been made to stroke services in the last year, improving outcomes for patients.

The Trust has a dedicated team in place that work on the prevention and management of falls in the hospital. This team has had a positive effect in the last two years on the reduction of falls in the Trust. More proactive work and a more flexible approach could be introduced on assessing patients and having active input into those patients who have experienced falls in the hospital, in order to reduce risk further. Currently the team is only contacted when a patient has fallen three times or more.

There is evidence of a lack of consistent, timely nursing care planning and assessment practice. Key risk assessments for patients, with indicated needs including weight loss, nutritional status and pressure ulcers, were not always in place and documented discharge practices were lacking in some cases. This is a significant concern, as these issues were raised with the hospital as a compliance condition during registration in April 2010 and an improvement action was placed by the Commission in May 2010. A formal meeting will be held with the trust in January 2011 to highlight the key areas of concern and enforcement action will be taken if significant improvements are not now made in a timely manner and then sustained to improve patient care. This will be checked at the next responsive review.

We have concerns that there is an overall lack of understanding and awareness relating to the care and treatment of elderly people who have dementia. It is evident that insufficient training opportunities and knowledge for staff in dementia awareness and challenging behaviour impacts on their ability and confidence to provide good quality outcomes for patients.

CQC recognises the good work and investment the trust has achieved regarding learning disability patients, for example the appointments of a lead nurse and a disability champion who is a service user (or customer) and the development of a
staff resource pack (updated and promoted in June 2010), but it is clear there is work outstanding as staff awareness of the needs of people with learning disabilities and recommended practice is not yet embedded. The percentage of basic staff awareness training was not possible for us to assess due to the lack of central records but the level of intermediate training is positive and needs to continue in order to help improve outcomes for patients.

- Overall, we have moderate concerns in relation to this outcome and improvements are needed.

**Outcome 5: Food and drink should meet people’s individual dietary needs**

Not all patients can be assured that their nutritional needs will be identified or that they can be confident that staff will support them to eat and drink. Where patients have a food chart in place, staff are not consistently recording the individual’s nutritional intake. Identified risks, such as weight loss, are not always being monitored regularly and included in the plan of care to ensure that appropriate actions are taken to ensure people have adequate nutrition. Two care records observed showed patients with significant weight loss, which was unexplained, and a further patient record showed poor nutritional intake with no actions stated to address this.

Patients are generally satisfied with the new catering system and there is a good choice of menu, but it is early days and outcomes could improve further with ongoing review, based on feedback from patients.

- Overall, we have moderate concerns in relation to this outcome and improvements are needed.

- **Outcome 6: People should get safe and coordinated care when they move between different services**

Evidence showed there are systems in place to enable patients to receive coordinated care, treatment and support.

Further developments need to be made to ensure that referrals from wards are forwarded to the relevant social work teams in a timely manner and that discharges from hospital are undertaken over a seven-day period rather than just Monday to Friday.

- Overall, we found that Basildon Hospital was meeting this essential standard.

**Outcome 7: People should be protected from abuse and staff should respect their human rights**

The Trust has a proactive safeguarding lead member of staff in post, who sees the role as wide-ranging and who links in well with other key staff and external agencies
in order to protect patients. Staff, patients and members of the public can contact someone in the hospital at any time for advice on safeguarding matters.

Records of internal investigations undertaken by the team were thorough, objective and outlined areas for action/recommendations. Actions implemented were appropriate.

- Overall, we found that Basildon Hospital was meeting this essential standard.

Outcome 8: People should be cared for in a clean environment and protected from the risk of infection

There is evidence that the trust has taken action to review and improve systems to manage and monitor the prevention and control of infection, following previous inspections by CQC. There was evidence in the clinical areas that the measures put in place are being implemented. The Trust’s infection prevention and control team were widely acknowledged during discussions with clinical staff and all staff were aware of the unannounced ‘spot checks’ that the team undertake.

The Accident and Emergency department was busy at the time of our visit and, in addition, there is major rebuilding work underway, which is set to continue for some time. Despite this, the overall impression was that staff were managing to maintain standards of cleanliness; the isolated issues that were noted during our inspection appeared to be due to the heavy workload at the time of the visit and the focus on patient treatment.

The trust had identified some concerns in the Cardio-Thoracic theatre department regarding infection control, as part of an internal audit undertaken in November 2010. During this inspection some of the issues were still evident. The time limit for proposed actions had not passed at the time of our inspection. There are processes to identify the failings and a process to escalate and monitor improvements; however, the department had recently lost two key managers, the theatre manager and the Head of Nursing, to whom the audit results would usually have been escalated. The concerns identified were being monitored via the trust own existing escalation processes, the cardiothoracic theatre team had taken note of the improvements needed, and this was an issue isolated to this one area. This has resulted in a judgement of 'minor concern'.

The overall impression of the areas visited were that they were clean and there were processes in place to monitor cleanliness and infection control.

- Overall, we found that Basildon hospital was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 9: People should be given the medicines they need when they need them, and in a safe way

People were receiving personalised care through the effective use of medicines and there were effective procedures about medicines handling in place, to manage risk.
Staff could demonstrate that they had relevant qualifications, knowledge, skills and experience to carry out their role in medicine management.

We have concerns that the arrangements for the safe storage and security of medication in some areas may compromise the safety of patients and others and that learning from medicines’ incidents should be cascaded across the whole of the hospital to minimise the risk of repetition.

Following a report of the incorrect disposal of chemotherapy in the day unit, the trust demonstrated that they had investigated the incident and have taken action to reduce the chance of a recurrence. This includes reviewing policies and procedures, reviewing staff competencies and understanding of safe systems of work and the provision of additional guidance for staff. The trust has noted that they are satisfied that no patients or staff have been put at risk as a result of the incident.

- Overall, we found that Basildon hospital was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

**Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare**

Patients consistently expressed positive feedback about the hospital environment and systems are in place to address environmental problems as they occur. Some negative comments were raised by patients regarding inaccessible facilities and lack of storage, but these related to specific wards/units.

Significant concerns were raised by some staff regarding the safety of patients and staff within the Cardio-Thoracic Centre (CTC) and the management of identified risk. These relate to fire safety, the revolving entrance doors, and power failure. The two former issues have been ongoing for some time and, whilst risk assessments are in place and the fire safety plans are satisfactory, planned action remains outstanding for the revolving doors. When considered in conjunction with the theatre infection control issues (see outcome 8) and power failure contingency planning, this raises the level of overall concern to moderate regarding risk management in CTC.

Outcomes for patients on the Acute Medical Unit (AMU) are variable depending on the pressure on beds and availability of single sex accommodation. The assessment unit is a busy place and not ideal for patients to stay for more than 24 hours.

- Overall, we have moderate concerns in relation to this outcome and improvements are needed.

**Outcome 11: People should be safe from harm from unsafe or unsuitable equipment**

Equipment within clinical areas is well maintained and serviced regularly.
However, concerns were raised by patients regarding sufficient quantities of nebulisers in the AMU (East), resulting in them waiting to have their medication. Access to suitable shower and accessible seating facilities was also raised as an issue that does not promote the independence and comfort of service users.

There is a system in place for routinely checking patients’ own electrical equipment for safety.

Checking of resuscitation trolleys in some areas was inconsistent and could impact on patient safety. Systems to ensure that all staff are aware of changes to these trolley contents are not always robust. This has the potential to pose a risk to patients.

- Overall, we have moderate concerns in relation to this outcome and improvements are needed.

**Outcome 12: People should be cared for by staff who are properly qualified and able to do their job**

Full time staff, students, bank and agency staff are recruited appropriately and do not commence work at the trust until all pre-employment checks have been completed satisfactorily, including any necessary immigration checks. The process for the safe recruitment of volunteers is currently not outlined in the recruitment policy, which means staff are uninformed. Integration into the trust and its working practices is reinforced through induction, which, after taking into consideration staff absences, has a high attendance rate of 94.1%.

- Overall, we found that Basildon hospital was meeting this essential standard.

**Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs**

In some areas, patients and staff are generally happy with the level of staffing and skill mix, and the system for covering vacancies and absences. In these areas, staff are usually able to take breaks and recoup any time owing. However, there was a negative experience for some staff and more pressure felt in areas such as maternity and the AMU, which could impact on the delivery of care in those services. The last trust staff skill mix review took place in 2008 and the trust should now consider carrying out a new review to ensure that staffing levels are appropriate, to ensure that people who use the services are safe and their health and welfare needs are met by sufficient numbers of appropriate staff. The trust produced a Nursing and Midwifery Council action plan in response to concerns raised in April 2010 about service provision and demonstrated that the ratio of women receiving one to one care in labour was 98% at the time of the review and remains at this level.

Vacancy rates on the wards are low and agency staff usage is also kept to a minimum. Feedback from most patients with whom we spoke indicated they are satisfied with the care and treatment provided by the hospital.
Some reports were received about there being a ‘negative culture’ at the trust or ‘fear and intimidation’. We took these allegations very seriously and it was a prominent area that we focused on during staff and patient interviews. The vast majority of people interviewed by us were complimentary about the organisation, leadership and culture; however, the ‘middle management’ level was perceived by some staff as lacking leadership and, in some cases, as taking a bullying approach at times.

- Overall, we found that Basildon Hospital was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

**Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills**

Staff are generally supported by the trust through attendance at mandatory training and through the appraisal system. They receive regular one-to-one meetings with their manager including monitoring of ongoing professional development.

The number of staff receiving appraisal is 77% and the trust is pro-actively addressing any shortfalls to increase this percentage.

- Overall, we found that Basildon Hospital was meeting this essential standard.

**Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care**

The trust has developed a quality strategy with support from external specialists, which has recently been ratified by the Board. Numerous staff with whom we spoke were positive about the recent senior management team changes and the planned realignment of the directorates to provide clearer reporting lines for quality and risk management practices.

Principles of Care Audits have been ongoing in 2010. There was good evidence of planned audits for 2011 including re audits of high risk areas. Named responsible persons for actioning audits were in place, which demonstrates a more proactive approach to assurance than in the past reviews in 2010. Good examples were seen of implementing new care practices following incidents and spot audit checks to ensure the new practices are adopted.

The reports going to the Board of Directors now provide a clear combined quarterly report to support the identification, collation and dissemination of learning from complaints, litigation, incidents and Patient Advisory & Liaison Services (PALS). Patient experience reports are also included and include complaints, patient experience of care, PALS interactions, comments cards and plaudits. The report highlights key performance indicators, including trends. Patient feedback mechanisms are in place and the patient forum is being encouraged to get involved in hospital audits. The board of directors receive updates on comments and complaints from patients at regular meetings. Actions from serious incidents and complaints are now reviewed.
In general staff spoke positively about the Chief Executive, Director of Nursing and Board of Directors and, although a lot of the recent initiatives for quality management are not yet embedded, the inspectors were given the impression that the senior management team has now got the systems in place to identify, monitor and manage the risks to people who use, work in or visit the service. At our next review of compliance we will check further that systems are fully embedded in the organisation.

- Overall, we found that Basildon Hospital was meeting this essential standard.

**Outcome 17: People should have their complaints listened to and acted on properly**

Complaints are generally handled, investigated and followed up appropriately. People generally know their complaint will be treated seriously and that they will not be discriminated against for making a complaint. Advice on how to make a complaint, and receive support to do so, is available but this is not always publicised effectively in the hospital and leaves some people uninformed. Complaints’ information on the trust's website is out of date. There is also a high rate of late responses to complainants.

Three complaints were reviewed, which demonstrated appropriate handling, communication, investigation and follow up. Complaints’ handling training is provided to relevant staff groups.

- Overall, we found that Basildon hospital was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

**Outcome 21: People’s personal records, including medical records, should be accurate and kept safe and confidential**

The trust has a clear system of audit for patient records, which highlights any issues and then puts action plans in place to address these. However, whilst there is a clear system, the trust’s Principles of Care audits of clinical records demonstrated basic fundamental omissions, such as the frequency of patient observations, which makes us question how staff learning is addressed and implemented. Information governance has undergone major review and the trust faces a difficult target to train its entire staff in the new system by March 2011.

The Caldicott Guardian role has not been fully covered for a time until the new director of nursing started in September 2010, so many of the functions of that role are only just being picked up again. The trust is aware of these issues and is making considered attempts to make the improvements; however, the results of these will not be apparent until autumn 2011.

The concern noted in relation to Outcome 4, above, together with the findings of the Principles of Care audits indicate that there remains a shortfall in the accuracy of recording of patient information. Taken in conjunction with the evidence included in this Outcome area, we have a moderate concern in relation to this
element of the standard; however, this concern has already been reflected in Outcome 4. Taking into account the audit system that is in place for this standard and the plans in place to address the shortfalls, we tentatively conclude that the trust is meeting Outcome 21. Progress will be tested again during our next responsive review, so the planned improvements will need to be demonstrated at that stage in order not to be found non-compliant against this outcome area.

- Overall, we found that Basildon Hospital was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

**Action we have asked the service to take**

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

**Other information**

In a previous review, we found that improvements were needed for the following essential standards:

**Outcome 14**
Staff in the A&E unit are not being properly trained to manage episodes of violence and aggression appropriately

Trust response: H&SE re-visited the trust in November 2010 and reviewed the current position. Informal comments were positive. The required evidence was submitted by the trust to the Health and Safety Executive on 01 December 2010 and the trust is awaiting a formal response.

**Outcome 4**
There was no consistent system for reporting histopathology results. There is evidence that these inconsistent practices are putting patients at risk and that people are experiencing delays in receiving care that is for serious or significant needs.

Trust response: Action plan developed and submitted to Care Quality Commission December 2010. This will be followed up by us at our next review of compliance of the trust.

**Outcome 16**
The trust is not always fully investigating serious incidents, near misses or adverse events which may impact on patient safety. Learning from these incidents or events is not always identified, and cascaded to staff for implementation

Trust response: Compliance statement submitted 03 December 2010 incorporating actions taken to date. This will be followed up by us at our next review of compliance of the trust.

Please see previous review reports for more information.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*. 
Outcome 1: Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
- Understand the care, treatment and support choices available to them.
- Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
- Have their privacy, dignity and independence respected.
- Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us

Over sixty patients were spoken with or interviewed over the three days of our visit and most of the patients (across six clinical areas) did not identify any privacy and dignity issues. Patient feedback about their care and treatment was generally positive and the response to call bells is generally prompt.

Some of the patients told us they were aware of the care, treatment and support to be provided by the hospital and had been informed what was happening. Some patients received comprehensive information packs prior to admission and were aware of the timings for their surgery and the plan for transfer to another ward. However, others noted they were supposed to get information about the ward but had not seen it and staff seem surprised that they knew to ask for it. Information on medical conditions such as stroke was noted as good and freely available.

Where people were unable to provide a verbal response, for example because of limited verbal communication or poor cognitive ability, we noted their non verbal
cues and these indicated that people were relaxed and comfortable and found their experience at the hospital to be positive. Two relatives with whom we spoke confirmed they were happy with their relatives’ treatment and care at the hospital.

One patient stated they were very happy with their experience at Basildon for the birth of their first baby. They had been admitted to be induced today for second baby. They confirmed that the ‘booking in’ consultant had explained everything to them and that staff had spoken and explained procedures. Staff had allayed their fears about a possible Ceasarian Section. Their partner also stated that staff are polite, friendly and courteous.

Another maternity patient noted the service had been good so far. Nursing staff had explained everything, as had the doctors. They confirmed that their privacy and dignity had been upheld, stating that staff always knock before entering their room. They said that they found staff to be very good and happy to explain things to them. They confirmed that written information had been provided.

Other evidence
What we saw on the wards showed that, in general, patients have their privacy and dignity respected and upheld. On one ward we saw two people receiving assistance, from staff, with their personal care. On both occasions the privacy screens were used to maintain the patient's dignity and privacy. One member of staff was overheard to ask the patient if they were ready to have assistance with their personal care. The member of staff was overheard to empower the patient's choice and independence by asking them to choose their clothing and to assist in some of the personal care tasks. Another member of staff was seen assisting another patient on the same ward. When asked if they were ready to have assistance with their personal care, they told the member of staff that they were waiting to have an assessment of their needs by an Occupational Therapist. The patient was enabled to get their own items from their personal locker by the bed. The patient told us that it was important to them to maintain some level of independence.

On another ward we saw one patient being asked by two healthcare specialists (physiotherapists) if they were ready to have an assessment of their mobility needs carried out. The patient was seen to initially become distressed as they clearly did not want this to happen. Both members of staff were seen to deal with the patient's distress well and to respect the patient's decision to not undertake the assessment. The outcome of this was that the patient's wellbeing was maintained.

Of the ten patients whose care pathways we looked at in detail, only two were seen to have a 'Patient Information' bedside folder. This contained information relating to: your stay in hospital, your care and treatment, life on the ward, help us with good hygiene, safety in hospital, patient support, leaving hospital and PALS. All staff with whom we spoke advised that patients and their representatives can raise concerns/make a complaint through Patients Advisory Liaison Support (PALS). Not one member of staff spoke of the Patient Feedback system in operation at the hospital. Information about Patient Feedback was evident on each ward; however, the posters and information were placed in a corridor and the information was not easily accessible. Not all patients with whom we spoke were aware of its existence.
All clinical areas we visited were pleasant environments and very few issues of privacy or dignity were identified. We saw good examples of personalised care; however, moving patients to wards unrelated to the specialty under which they have been admitted was noted as a concern by a patient interviewed. Staff reported that whilst Elsdon is a female surgical ward it routinely receives patients from other specialties, including breast care, orthopaedics and medicine.

An example of very good personalised care was witnessed, in which an elderly person had been admitted to the elective admissions unit and was distressed that they would probably have to wait several hours for their operation, having expected to go to theatre in the morning. The patient was also distressed that their relative could not wait with them. Staff allowed the relative to return, providing accommodation in one consulting room so that other patients were not compromised. They also arranged for the patient and their relative to visit the restaurant for a light snack. Staff were very supportive and sensitive to this person’s needs throughout.

Cedar ward staff reported that 24 hour fathers’ visiting is being piloted, however staff encourage fathers to return home between midnight and 7am due to the lack of sleeping facilities and to safeguard the privacy and dignity of all patients.

Staff in all areas we visited reported accurately the procedures for the management of patients’ own belongings and valuables that reflected trust policies and procedures. This was also borne out by what patients told us. Through input from the patient panel, ward introduction and discharge letters have been developed but this initiative has not been embraced on the wards and the information was not seen to be available to patients. It was seen in the main corridor rather than at the patients' bedside. One ward manager spoken to said ‘there is no formal information available to patients on admission’.

We saw that leaflets were available on privacy and dignity and a range of medical conditions. Advice was displayed on accessing dementia and learning disability support services. Information was also available around the hospital on accessing safeguarding advice, although some of the information requires work in relation to access, especially regarding PALS information. Work is also needed to ensure information is consistently ‘user friendly’.

**Our judgement**

Where appropriate and possible, patients have their care, treatment and support explained to them. The care that patients receive maintains their privacy and dignity. We saw few examples of patients’ privacy and dignity being compromised and patient feedback about their care and treatment was generally positive. We also saw examples of good personalised care. Efforts are made to uphold and maintain patients privacy and dignity.

Whilst the Trust has produced information for patients, such as patient information packs, these are not used consistently by staff in all patient areas. Some patients with whom we spoke did not have this information and we saw that it was not available by patients’ beds. Patient information was in English and standard format...
only, throughout all clinical areas we visited.
Outcome 2: Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:
- Where they are able, give valid consent to the examination, care, treatment and support they receive.
- Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
- Can be confident that their human rights are respected and taken into account.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
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<tr>
<td><strong>The provider is compliant</strong> with outcome 2: Consent to care and treatment</td>
</tr>
</tbody>
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<tr>
<th>Our findings</th>
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| **What people who use the service experienced and told us**
Three patients on the elective admissions unit felt well informed by medical staff when being asked for their consent. Minimal written information was available within the unit but patients stated that they had received a comprehensive information pack prior to admission. All three patients were aware of the timing for their surgery and the plan for transfer to a (as yet unconfirmed) ward.

As stated in Outcome 1, one patient refused treatment (physiotherapy) and their decision and rights were taken into account. However it is unclear as a result of their diagnosis of dementia/confusion if they fully understood the risks of not having the treatment.

Overall, patients in maternity said that they found the midwives and doctors to be good. They had been seen and had been given a full explanation of what was happening and their treatment.

Other patients with whom we spoke said that their consent was always sought prior to any medical investigation. |
**Other evidence**

Patient records that were looked at in detail showed that consent is sought from patients prior to specific investigation or treatment and that a patient's right to refuse is respected, whilst the duty of care is considered. Surgical patients stated that they felt well informed about their care and treatment and that both doctors and nurses were good at keeping them up to date.

In one patient's case notes there was evidence to show that an assessment of the patient's capacity to make decisions had been undertaken. This referred specifically to them being moved from one ward to another and them not being able to give valid consent and agreement to this course of action.

Not all staff with whom we spoke were aware of information relating to local advocacy services and we only saw information relating to this on one ward (Lionel Cosin Ward).

We saw consent audit documentation and the World Health Organisation surgical safety check list is in place. This monitoring process includes patient consent to procedures and the last audit demonstrated 95% compliance. The check list is also part of the clinical audit programme for 2011.

The trust reported that patient experience questionnaire results, in response to the question about giving patients access to the patient choices website, were positive. The trust has "getting it right leaflets" which explains to patients how they can obtain information about their rights. It also contains information about available advocacy services that can be accessed. In addition to the Mental Capacity Act Policy, patients who require additional support and advice can seek this through referral to an Independent Mental Capacity Advocate (IMCA). The Patient Advice and Liaison Service (PALS) is also a route for patients to obtain independent advocacy.

The trust also has evidence which identifies the process undertaken when a person using the service lacks capacity and the actions taken to ensure that the person has representation and support. The trust's Consent Policy details the process to follow when seeking and obtaining consent from children.

**Our judgement**

No concerns were raised through the Care Quality Commissions quality risk profile or desktop review prior to the visit. Patients and staff with whom we spoke were well informed on consent practices and inspectors observed good examples of staff ensuring that patients, where they were able, gave valid consent to the examination, treatment and support they received.
Outcome 4: Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

Over sixty patients were interviewed or spoken with during the visit. In general, patients told us they were happy with the care, treatment and support they have received at Basildon Hospital with comments such as "my stay has been fine and the nurses are lovely", "oh yes, everything is good, thanks" and "the staff are very caring".

One patient on the Acute Medical Unit (AMU) told us that staff are fast and efficient but finds that, "paperwork comes first and the patient second, there is an impersonal feel and staff have little time to talk to you."

Where people were unable to provide a verbal response or tell us verbally their experiences, for example as a result of limited verbal communication or poor cognitive ability, we noted their non-verbal cues and these indicated that people were relaxed and comfortable and found their experience at the hospital to be positive.

Two relatives with whom we spoke confirmed they were happy with their relative's treatment and care at the hospital. Maternity patients were positive about the care and treatment that they had received, including breast feeding support, open visiting
for fathers, cleanliness, hand hygiene and security of their belongings. They were less positive about sleeping facilities for fathers or about storage facilities. There were no complaints regarding levels of maternity staff in the departments, apart from slow response to call bells during handover between staff arriving for duty and those leaving.

Patients in the elective admissions unit expressed positive feedback about the unit and the staff. However, a patient interviewed in the elective admissions unit reported that during a recent admission to Elsdon Ward they had experienced some difficulties due to their physical disability. They stated that their care and wellbeing had been compromised due to the lack of a fully accessible shower and other adaptations to maintain their welfare in getting in and out of bed and their sense of security whilst in bed.

On a surgical ward, a medical patient, who was waiting for transfer to another ward, reported poor communication regarding their condition. Their diagnosis was confirmed by a nurse and more than 24 hours had elapsed between doctors’ visits on one occasion. One intravenous dose of antibiotics had been administered four and a half hours late and only after repeated prompting by the patient. Staff confirmed that the antibiotics had been administered late “probably because they didn’t have any”. This had not been reported as a clinical incident. In addition, despite a diagnosis of pulmonary embolism, the patient was not offered anti blood clot stockings. When they asked for them they were initially refused by a nurse who stated that “they are only for surgical patients”

Two patients recovering from stroke were positive about the care and treatment available on the stroke rehabilitation ward, but both felt they would progress more quickly if there was physiotherapy available at weekends.

A female post-operative elective surgical patient gave very positive feedback about her care, the information she had received (appropriate and at their pace) and the staff’s approach and conduct. The patient did not have any concerns about privacy, dignity or confidentiality. She reported that response to call bells is generally prompt, pain relief is appropriate and that staff routinely wash their hands.

Several maternity patients were complimentary regarding care and welfare support throughout their stay, with comments such as ‘the lady on the phone was very nice’. They stated that they had been welcomed by the midwife who they found ‘lovely’ and said that “the care was excellent.”

One patient admitted to Edith Cavell ward once every few weeks for ongoing treatment noted: ‘Very well explained. The care is very, very good. I cannot see how anyone can fault them. They always look after me. They are very particular. They always wash their hands, change their gloves. I have no issues whatsoever’.

**Other evidence**
We undertook detailed observation of ten patients in ward areas and noted positive signs of well-being were generally experienced for each patient. Patients were seen to be responsive, comfortable and relaxed. Some patients demonstrated their assertiveness, making independent choices and decisions and showing signs of self respect and positive self esteem. Examples of good personalised care and efficient
systems in place for the screening of maternity patients were noted by us.

Our observations also showed that of those areas visited all patients except those on the Acute Medical Unit (AMU-East), receive care and treatment in single sex accommodation. The unit recognises the concern and additional signage has been purchased for the MAU ward to forewarn patients that this is a mixed ward at times of high demand. Staff strive to provide single sex accommodation where possible within the constraints of availability of facilities and beds.

We spoke with the tissue viability nurse specialist about her role and the incidence of pressure ulcers in the hospital. Overall, there is a clear reporting system in place. However, records and our inspectors' findings indicate that occasionally nurses on the ward omit to report people with pressure ulcers, whether hospital or community acquired. Evidence of support from the tissue viability nurse was apparent and staff told us that there is no problem in the supply of pressure relieving equipment.

We looked at six identified cases where pressure ulcer assessment and/or discharge planning had been reported as poor or non existent by care homes that had raised concerns with the Commission. The review of case notes supported ongoing concerns with poorly documented skin integrity assessment, care planning and discharge practices in some cases, including no reference at all regarding a grade three pressure sore on one patient's discharge to a care home; evidence of this shortcoming was reinforced through further detailed inspection of records on the wards.

We looked at the case notes for a further ten in-patients. These care records were inconsistently completed in most cases. For example, the case notes for two patients showed that since their admission they had sustained a weight loss of between seven and nine kilos. There was no evidence for one of these patients that their care plan was being fully implemented. In addition, there was no information recorded for either person that they were being weighed regularly or that their weight loss was being monitored. Neither record showed how this was being proactively managed. There was also evidence in some case records of the poor completion of food charts to monitor nutritional intake. Of 15 case notes reviewed (including five from AMU) only two had an Adult In-Patient Risk and Assessment document completed in full and one was omitted completely. This is not good practice and the trust has not sustained improvements made previously in response to the compliance condition imposed at the time of its registration in April 2010, which required improvements in assessment and care planning. The hospital's Principles in Care audits in November 2010 highlight that Acute and A&E departments are underperforming in assessment practices such as skin integrity and recording the weight of patients, which again supports this concern.

There was little evidence of social interaction between staff and patients on several wards visited including the Acute Medical Unit, Lister ward and Osler ward. The patients' panel raised concerns in September 2010 that there had not been sufficient improvement over the last two years for patients with dementia and the elderly. Where patients are elderly, have poor cognitive ability and/or a diagnosis of dementia and exhibit agitation or challenging behaviours, we found evidence to show that their care needs may not always be understood or managed appropriately by staff. On one ward staff with whom we spoke told us that on occasions they “feel
a bit helpless” when supporting patients who display agitated and/or challenging behaviours and who have dementia, as they have not received training in either area. From our discussions with the ward sister and supporting evidence, of 31 members of support and nursing staff on the ward, no member of staff had received dementia awareness training and only three members of staff had received challenging behaviour training (conflict resolution). The ward sister confirmed to us that seven members of staff are to have this training between January and March 2011.

A senior sister on a ward primarily caring for male patients with dementia, told us that none of the staff have had training on caring for people living with dementia and only a few had attended conflict resolution training. She said that it can be quite difficult working on an all male ward and dealing with ‘aggressive’ behaviour. On a similar ward caring for females living with dementia, only the ward manager had attended a training course. This is of concern.

The case notes for one confused patient showed that, over an approximate six week period, their care needs had consistently proved a challenge to respond to. Records showed the patient as wandering, disturbing other patients, suffering from agitation and displaying both verbal and physical aggression towards staff. Records showed that the patient was prescribed and administered two medications, which are known to have sedative properties and used for people who are agitated, restless and/or aggressive. The clinical notes detailed that the patient could be at increased risk of falls if both medications were administered and the ward doctor should discontinue their use. It was of concern that the clinical records showed that this advice was disregarded and both medications were administered for a further two days. This concern was even more relevant because the reason for admission of this patient was that injury had been sustained as a result of having had a fall. The hospital had already raised a safeguarding alert for this patient in relation to over-sedation to manage the patient’s challenging behaviour.

Significant improvements have been made in the provision of stroke services during the last year, improving outcomes for patients. Improvements include the establishment of 24/7 thrombolysis and a one-stop clinic (Monday to Friday). Basildon Hospital's stroke services have received positive feedback from the Royal College of Physicians, following peer review, and positive feedback from the Essex Cardiac and Stroke Network in respect of their rehabilitation services. There is one ring-fenced bed retained for acute stroke patients. The one-stop clinic does not run at weekends, due to the limited availability of scanning and some specialist support, such as physiotherapy. 67% of patients who have had a stroke have had a physiotherapy assessment within 48 hours. A senior clinician confirmed that a seven-day therapy service would significantly improve the trust’s performance in this area. The senior management team told us that they are currently reviewing physiotherapy provision within the Trust.

On three wards, we reviewed accident/incident records in relation to patient falls. Overall the records were completed well and showed that staff were recording all types of incidents. We spoke to the falls’ prevention officer, who works with a team of six staff. The trust, overall, has a proactive approach to falls, with staff on the team reviewing, for example, accident and emergency records to track patients. The team also highlights those who have been discharged home to the community
services, to help avoid re-admission. The trust has a 'falls group' that reviews statistics from accident records and plans accordingly. Targets to reduce falls by 10% have been set for the past two years and have been achieved and exceeded. This year the 10% target continues but the team feel that it is becoming difficult to reduce the figures further, due to patients' medical conditions affecting the risk of falls. The trust's falls' statistics show that since April 2010 between 78 and 96 patients have one fall a month. Between 12 and 24 patients have 2 falls in a month and between 2 and 12 patients have 3 or more falls in a month. Due to the number of patients experiencing two falls, it is possible that more proactive work could be done to reduce risk and possibly reduce the number of people ultimately having three or more falls.

We looked at the care of patients with a learning disability who attend the hospital. We spoke with the lead nurse for people with learning disabilities, visited a ward, and reviewed records, including a recent adult safeguarding report.

The trust has put several initiatives in place to raise awareness with staff around the needs of people with learning disabilities that may attend the hospital wards or departments. These include the appointment of a lead nurse, the appointment of a disability champion who is a service user (or customer), the development of a staff resource pack (updated and promoted in June 2010) and a staff training strategy that identifies different levels of training for a range of staff. From visiting the wards it was evident that staff are aware of the need for assessment for one to one nursing. Whilst this was seen to be in place, one to one nursing care was provided from within the standard staffing numbers on the ward, affecting overall staffing numbers and putting people under pressure. Nursing records were basic but did acknowledge the patient's needs with regard to communication and reassurance. Staff on the ward were aware of the input of the learning disability lead nurse and the need to contact her if any patients with those needs are admitted.

One patient was noted to experience a poor level of pre-admission assessment and care planning in relation to day surgery and this resulted in a less than desirable outcome for the patient and a safeguarding investigation for the Trust. This relates to shortfalls in the assessment of need, poor communication and co-ordination of a care pathway and failure to follow trust guidance and policy. The Trust has developed an action plan to help ensure that such issues do not recur, which includes a review of the trust's Policy on Caring for People with a Learning Disability, the Specialist Assessment Form (SAF) and the care pathway for people accessing day surgery and dental services. This action was instigated following direct feedback from family carers, Community Learning Disability Teams and following the occurrence of an incident in day surgery. This incident is being managed through the trust's Serious Incident Policy. From the records, it is clear that there is variable understanding from staff of the potential needs of patients with a learning disability, with wards possibly being more informed and aware than other departments. Whilst the profile of learning disabilities in the trust has increased, there is more work to do to ensure that outcomes for patients with learning disabilities improves.

It was reported that, as from January 2011, Level 1 learning disability training will be part of the induction programme for all staff and records of attendance will be kept. One hundred staff have already attended the Level 2 learning disability or
intermediate training, which is more in depth and lasts an hour. It is also now mandatory for all clinical staff to attend this training. The training strategy was reviewed this year in light of a successful £70,000 innovation bid for the development of elective and emergency care pathways for people with a learning disability, including a toolkit for patients to access services.

Our judgement
Overall patients are happy with the care, support and treatment received at Basildon Hospital. The majority of patients with the exception of those on the Medical Assessment Unit (MAU-East), can be assured of receiving care and treatment in single sex accommodation.

Significant improvements have been made to stroke services in the last year, improving outcomes for patients.

The trust has a dedicated team in place that works on the prevention and management of falls in the hospital. This team has had a positive impact over the last two years on the reduction of falls in the trust. More proactive work and a flexible approach could be introduced on assessing and having active input into those patients who have fallen twice in hospital, in order to reduce risk and potentially reducing the number of people falling three or more times.

There is evidence of a lack of consistent, timely nursing care planning and assessment practices. Key risk assessments for patients with indicated needs, including weight loss, nutritional status and pressure ulcers, were not always in place and documented discharge practices were lacking in some cases. This is a significant concern, as these issues were raised with the hospital as a compliance condition during registration in April 2010 and an improvement action was placed on trust by the Commission in May 2010. A formal meeting will be held with the trust in January 2011 to highlight the key areas of concern and enforcement action will be taken if significant improvements are not now made in a timely manner and sustained in the long term.

We have concerns that there is an overall lack of understanding and awareness relating to the care and treatment of elderly people with dementia. It is evident that there is insufficient training opportunity and deficiencies in staff knowledge in relation to dementia awareness and challenging behaviour, which impacts on their ability and confidence to provide good quality outcomes for patients with this condition.

The Commission recognises the good work and investment the trust has achieved regarding learning disability patients but it is clear there is work outstanding, as staff awareness of learning disability and recommended practice is not yet embedded. We were unable to assess the level of basic staff awareness training due to the lack of central records. The level of intermediate training is positive and needs to continue in order to help improve outcomes for patients.
Outcome 5: Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

What we found

Our judgement

There are moderate concerns with outcome 5: Meeting nutritional needs.

Our findings

What people who use the service experienced and told us
We spoke with eight patients about the quality of meals provided. In general terms all were complimentary about the quality of meals they received and told us they had no complaints. The only negative comment was in relation to one male patient who found the quantity of meals provided to be inadequate and not satisfying enough.

Patients said that overall the food had improved since the new catering system had been introduced. They said that there was more choice, it was hot, the presentation was good and that if they had a meal late it was still edible. They also said that drinks were available and they could ask for a hot drink at any time.

Some patients felt the level of flexibility with the food on offer depended on which staff were on duty and what they were willing to do for patients, for example making toast or offering alternatives.

Other evidence
At the time of the site visit, a new menu and meals system for patients called 'Steam Cuisine' was in the process of being introduced at the hospital. We were told that the 'Steam Cuisine' concept is designed to improve food and service standards for patients within the hospital by providing greater choice and range of menus and
flexibility of times when meals can be provided to individual patients. The menu is in a written format and offers patients the choice of 2 starters, 16 main courses (hot meals), 4 salads, 4 sandwich fillings and 8 desserts. Individual meals are stored within each ward in a refrigerator and microwave ovens are used to cook the food.

One housekeeper with whom we spoke told us that since the 'Steam Cuisine' system had been implemented, they had found comments from patients to be mainly positive. Each of the wards visited were noted to have 'Protected Meal Times', whereby during mealtimes there is reduced activity on the ward so that staff can serve and supervise meals and give assistance to patients who need help to eat and drink. In addition a 'red tray' system is in place whereby any patient who has their meal served on a red tray is deemed to require assistance from staff.

Our observations on the wards showed that, where patients were supported by staff to eat their meal or to have a drink, the support provided was appropriate. Patients were not hurried by staff to eat their meal where they required assistance and some patients were empowered to eat their food and drink as independently as possible. On only two occasions did we see meals placed in front of patients who were either not prompted or assisted to eat their meal by staff in a timely manner.

Records for eight patients showed their nutritional status as having been assessed as either low or high. Where patients were assessed as having a high risk nutritional status, action was seen to be taken to ensure that each patient had a completed nutrition and swallowing assessment and where appropriate they had been referred to a healthcare specialist e.g. dietician or speech and language therapist.

However, it was of concern that where food charts had been commenced, these were inconsistently completed. Records were not completed each day or after each meal or where patients had refused a meal or eaten only small amounts. In addition, there was no evidence to suggest that an alternative meal had been provided or that staff had gone back later to see if the patient wanted to eat. It was difficult in some cases to determine the patient's nutritional intake. For example, the food charts for one patient over a four day period showed minimal food intake and records for the same patient detailed that the rationale for food not taken/provided included “too drowsy to feed”, “patient not able to tolerate food as too drowsy”, “patient asleep”, “patient refused”, “declined” and “too drowsy to eat”. There was no evidence to demonstrate that staff had recognised that this was a concern nor was any actions noted.

Two further patients' records showed that since their admission they had sustained a weight loss of between seven and nine kilos. Records showed that both patients had had their nutritional needs assessed, a swallowing assessment completed, referral to a dietician and an assessment from the speech and language team. For one patient there was evidence that an instruction had been made by the dietician on five separate occasions for the patient to be weighed; however, there was no information recorded for either person that they were being weighed regularly or that their weight loss was being monitored. Neither record showed how this was being proactively managed, which is a significant concern.

Our judgement
Not all patients can be assured that their nutritional needs will be identified or that
they can be confident that staff will support them to eat and drink. Where patients have a food chart in place, staff are not consistently recording the individual’s nutritional intake. Identified risks, such as weight loss, are not always being monitored regularly and included in the plan of care so that appropriate actions are taken to ensure people have adequate nutrition. Observation of two care records showed patients with unexplained and significant weight loss and a further patient record showed poor nutritional intake, with no actions stated to address this.

Patients with whom we spoke were generally satisfied with the new catering system and there is a good choice of menu, but it is early days and outcomes could improve further with ongoing review, based on feedback from patients.
Outcome 6: Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:
• Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

The provider is compliant with outcome 6: Cooperating with other providers.

Our findings

What people who use the service experienced and told us
Two patients, on separate wards, with whom we spoke told us that the only negative comments they had to make related to the amount of time they were waiting to either be seen by the discharge nurse or to be discharged e.g. waiting in the discharge lounge to be transferred home.

Other evidence
Evidence showed there are systems in place so as to enable patients to receive coordinated care, treatment and support.

Following our visit to the trust we spoke with the Fieldwork Service Manager from Thurrock Social Services, who has overall responsibility for the Thurrock Social Work team based at the hospital. The main purpose of this team and the social work team from Essex County Council is to ensure that through joint working with the hospital, local Primary Care Trust and other social care services and providers, patients are discharged in a timely manner and receive the correct level of care, treatment and support so as to ensure their health and wellbeing.

Processes in place to ensure this happens include multi-disciplinary meetings prior to the patient’s discharge, ensuring that the Delegated Transfer of Care Agreement process with the hospital is followed and that joint care packages between social
care and health are created under the Continuing Healthcare Framework.

The Fieldwork Service Manager told us that collaborative working with the hospital has improved over the past 12 months. This has been as a result of the Deputy Chief Executive from the hospital attending provider meetings and through fortnightly Capacity Board meetings. The latter discusses data relating to patient's length of stay in hospital, numbers of admissions and discharges Monday to Friday and over a weekend period.

We were told that, ideally as soon as a patient is admitted, discussions around the patient's future discharge should be commenced, so as to ensure the patient receives the appropriate social care and/or health provision. The Fieldwork Service Manager told us that, whilst there are improvements in collaborative working, further improvements are required so as to ensure that referrals from wards are forwarded to the social work team in a timely manner. In addition, most discharges at the current time are Monday to Friday only. It is recognised by all that in order to meet capacity demand for the future, the discharge process will need to encompass weekends.

From discussion with the lead nurse for complex care discharges, the trust has a good system in place. Patients are referred to the discharge team and the staff in this team assess and arrange the discharge with the teams on the wards and try to ensure that everything, including documentation and communication, is in place. The discharge co-ordinator says that the discharges are very patient centred and patient choice is key.

Our judgement
Evidence showed there are systems in place so as to enable patients to receive coordinated care, treatment and support.

Further developments need to be made to ensure that referrals from wards are forwarded to the relevant social work teams in a timely manner and that discharges from hospital are undertaken over a 7 day period rather than just Monday to Friday.
## Outcome 7: Safeguarding people who use services from abuse

### What the outcome says

This is what people who use services should expect.

People who use services:
- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

### What we found

#### Our judgement

| The provider is compliant with outcome 7: Safeguarding people who use services from abuse |

#### Our findings

**What people who use the service experienced and told us**

We did not speak with any patients regarding safeguarding and being protected from abuse during the visit.

**Other evidence**

Contact information for the safeguarding lead and link/key staff was seen around the hospital. The safeguarding lead plans to change the poster to make it easier for members of the public to contact them.

Medical records showed that doctors considered adult safeguarding and had referred patients/cases appropriately to the safeguarding team for investigation. Discussion with medical staff showed that they were aware of the safeguarding team and they confirmed attendance at training.

The safeguarding lead is suitably qualified and experienced to undertake this role and she knows the hospital and staff well. She views her role as wide ranging and considers mental capacity, deprivation of liberty, clinical need in relation to risk, including increased nursing supervision, as well as concerns about different forms of abuse.
Whilst the service is primarily Monday to Friday, there are on call staff who have been trained to deal with any safeguarding queries or referrals outside of 'core' provision of the service. The hospital team works with other agencies and links in with, for example, social services and the police. Records show that the team take referrals from a range of people, including hospital staff, external agencies and the general public. From discussion, they continue to work on raising their profile and promote a community based helpline as well as their own contact system. Records we reviewed of internal investigations undertaken by the team were thorough, objective and outlined areas for action/recommendations.

**Our judgement**

The trust has a proactive safeguarding lead in post who sees the role as wide ranging and links in well with other key staff and external agencies in order to protect patients. Staff, patients and members of the public can contact someone in the hospital at any time for advice on safeguarding matters.

Records of internal investigations undertaken by the team were thorough, objective and outlined areas for action/recommendations. Actions implemented were appropriate.
Outcome 8: Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

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<th>Our judgement</th>
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<tr>
<td>There are minor concerns with outcome 8: Cleanliness and infection control</td>
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What people who use the service experienced and told us
Patients were positive about cleanliness and hand hygiene across all areas visited. Patients felt the wards were clean and felt that the staff worked hard on this, especially in busy areas such as the Acute Medical Unit (AMU). Patients also noted and commented that staff washed their hands a lot, and wore gloves and aprons when required.

Other evidence
Numerous clinical areas were visited by our team of inspectors over the three days of our visit.

The infection prevention and control team were widely acknowledged during discussions with clinical staff and all staff were aware of the unannounced ‘spot checks’, which the team undertake. Staff were also aware that if their area failed to meet the Infection Prevention Control (IPC) audit target that they would have to produce an action plan to be monitored by the IPC team. The Director for Infection Prevention and Control (DIPC) is supported by a recently seconded Assistant DIPC, who is also the trust lead for decontamination. Progress against the Infection Control programme, including the audit of key policies, is monitored through action plans and key performance indicators by the infection control committee. The DIPC reports on progress against the programme in his annual report.
The trust has implemented the Saving Lives high impact intervention audits in clinical areas and has recently purchased software to facilitate this. There was evidence of audit results covering components of the Saving Lives initiative on notice boards in most of the areas visited.

All staff with whom we spoke had attended the mandatory annual staff training that includes an infection prevention and control (IPC) update. It was clear from the discussions with staff that this training is updated regularly to include any new developments. Most staff were aware of the IPC link practitioners in their areas and were aware of how to obtain IPC advice out of hours. All of the staff with whom we spoke were able to consistently describe how they would be made aware of a service user’s infection status and the correct signage and protective equipment. However, one member of staff that was asked said that they would not inform the IPC team if they were unable to secure necessary isolation for a patient, which is contrary to the trust’s processes.

In maternity services, nursing staff work to a daily job list that includes cleanliness checks, including pulling out and cleaning beds. The four bedded bays in the postnatal area are cramped due to the presence of fathers’ 24 hours visiting and patients’ belongings. Bed curtains remain drawn throughout the day which adds to the confined feel of the ward area.

Staff with whom we spoke during a tour of the cardiac unit do not have any concerns regarding the cleaning on the ward and were positive about staff education provision. When looking at the notice board, the ward had 100% compliance with the Saving Lives audits. There was a concern that there were delays in waiting for the Facilities team to address problems. For example, there had been leaks in the ceiling that had not been fully sorted. This issue has been raised with the Estates Department in the trust. All areas visited were clean, tidy and in a good state of repair. Staff reported that cleaning is high priority and that Aramark-employed cleaning staff are efficient and effective. Bed curtains are changed regularly each month.

The overall impression of the ward areas visited was that they were clean, although several areas appeared cluttered. Lack of storage space was reported as an issue in all areas and all but one of the wards was undergoing some refurbishment of a store room or linen room, temporarily compounding the problem. The Acute Medical Unit (AMU) East is cramped and shabby, in stark contrast to the newly refurbished AMU West. Despite this, and having to work around the refurbishment of a store room, the ward was clean and staff appeared to be managing the cramped and cluttered environment as best they could. In the maternity delivery unit, there is no treatment room so medicines are prepared and drawn up in the same room that is used for staff handovers; this room also contains the phones and computers for staff, which can be distracting. There were adequate hand washing facilities in all areas with plenty of hand gel and posters reminding everyone to wash their hands.

Bathrooms and toilets for patients were generally clean and in good order. There were some isolated incidents where improvements could be made, such as mouldy sealant around a shower tray in the delivery unit, and a used shower room in Florence Nightingale Ward that needed to be cleaned. All staff that were asked were aware of the need to flush unused water outlets to minimise the risk of Legionella.
and that the process is monitored by the estates department.

Checklists for cleaning and equipment decontamination were seen in most areas and were generally up to date. In all ward areas there were clear instructions on correct waste segregation and disposal commode cleaning instructions were visible in all wards visited. The use of tape to indicate that commodes were clean had just been introduced to some areas, although the process was inconsistently applied. All commodes seen in the ward areas were clean.

The A&E Department was extremely busy at the time of the visit and in addition there is major rebuilding work underway, which is set to continue for some time. Overall, the environment was acceptable although there were lapses that appeared to be due to the very heavy workload at the time of the visit; waste bags in the sluice were overflowing and one of the two commodes had tape attached, indicating that it was clean, but it had clearly been recently used and not cleaned. The Associate General Manager present at the time immediately arranged for appropriate action to be taken.

All staff with whom we spoke were aware of the trust's policy on antimicrobial prescribing. One consultant told us that the policy has been well publicised, discussed at ward rounds and instructions and that training and education had been provided for junior doctors. There is access to microbiologists for advice and staff pharmacists monitor compliance with the policy. There were examples given of collaboration between the DIPC and clinical teams to discuss antimicrobial prescribing.

All staff, with the exception of one paediatric doctor, were seen to be observing the trust’s uniform policy and were bare below the elbows (BBE). Staff said that they felt able to challenge any clinical staff who were not complying with the policy.

Wards had proactive systems in place for screening all patients. In the medical assessment unit, records showed that medical staff were actively checking patients with recurring chest infections for legionella. Records showed that a curtain changing rota is in place for wards and patient areas.

In the cardiothoracic theatres, the trust's infection control team had carried out an unannounced audit on 17 November 2010. This showed concerns about the procedures for cleaning and the general infection control measures, including damaged theatre chairs making them difficult to clean and failure to adhere to the trust policy for washing the walls in the cardiothoracic theatres, which requires six-monthly cleaning but had not taken place for at least 18 months. The date for submission of the action plan to address the issues is not until 22 December 2010 and the DIPC agreed that this should be followed up sooner. The theatre department has produced a document for staff to read as a result of the audit; however, some of the issues identified had not yet been addressed at the time of the inspection. The unit is currently without a Theatre Manager and the Head of Nursing has recently retired. The Associate General Manager for the cardiothoracic theatres was not aware of the audit nor of the document produced in response to the results, which stated that the unit ‘shows much improvement’, despite the poor results of the audit.
There is evidence that the trust has taken action to review and improve systems to manage and monitor the prevention and control of infection, following our previous inspections. There was evidence in the clinical areas that the measures put in place are being implemented. The infection prevention and control team were widely acknowledged during discussions with clinical staff and all staff were aware of the unannounced ‘spot checks’ that the team undertake.

The A & E Department was busy at the time of the visit and in addition there is major rebuilding work underway which is set to continue for some time. Despite this, the overall impression was that staff were managing to maintain cleanliness standards, the isolated issues that were noted appeared to be due to the very heavy workload at the time of the visit; the Associate General Manager present at the time immediately arranged for appropriate action to be taken where necessary.

Whilst the cardio thoracic infection control audit identified concerns in theatre, there are processes to identify the failings and a process to escalate and monitor improvements. The fact that the department has recently lost two key managers, the theatre manager and the Head of Nursing, to whom the audit results would usually have been escalated, appears to have contributed to delaying the urgent response that could have been expected but it is also of concern that the absence of the required frequency washing of walls had remained unidentified for so long.

The time limit for the action plan to be provided to the infection control team in order for the improvements to be actioned had not passed at the time of the inspection. This together with the existing escalation processes and evidence that the infection control team were monitoring of the situation, that the wall washing had been rescheduled and that the cardiothoracic theatre team had taken note of the improvements needed, albeit lacking in a sense of urgency, which could be due to the vacancies in the senior team, and the fact that this was an issue isolated to this one area, has resulted in a judgement of ‘minor concern’ for this outcome.

Our judgement

There is evidence that the trust has taken action to review and improve systems to manage and monitor the prevention and control of infection following previous inspections. There was evidence in the clinical areas that the measures put in place are being implemented. The infection prevention and control team were widely acknowledged during discussions with clinical staff and all staff were aware of the unannounced ‘spot checks’ that the team undertake.

The A & E Department was busy at the time of the visit and in addition there is major rebuilding work underway which is set to continue for some time. Despite this, the overall impression was that staff were managing to maintain cleanliness standards, the isolated issues that were noted appeared to be due to the very heavy workload at the time of the visit.

The trust had identified some concerns in the cardio thoracic theatre department regarding infection control during an internal audit in November 2010, one of which highlighted a failure to monitor that intended infection prevention measures had actually taken place. During this inspection some of the issues still remained
evident. The time limit for the action plan to be provided to the infection control team in order for the improvements to be actioned had not passed at the time of the inspection. There are processes to identify the failings and a process to escalate and monitor improvements, This department has recently lost two key managers, the theatre manager and the Head of Nursing, to whom the audit results would usually have been escalated. The trust should ensure that, when key lead staff leave post, responsibilities are delegated appropriately.

The concerns identified were being monitored via the existing escalation processes, the cardiothoracic theatre team had taken note of the improvements needed, and this was an issue isolated to this one area. This has resulted in a judgement of 'minor concern' for this outcome.

The overall impression of the areas visited were that they were clean and there were processes in place to monitor cleanliness and infection control.
Outcome 9: Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:

- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are minor concerns with outcome 9: Management of medicines</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>What people who use the service experienced and told us</td>
</tr>
<tr>
<td>We met with six people who had been admitted to the hospital. Five of them said they were on regular medicines when they came into hospital. Two of the patients had not brought their medicines into hospital with them and this had led to a delay in the administration of medicines for one patient. Another patient reported poor communication regarding their condition; one intravenous dose of antibiotics had been administered four and a half hours late and only after repeated prompting from the patient. Five of the patients said that they had received enough information about their medicines and that they would ask the nurses if they needed further medicines information.</td>
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<tr>
<th>Other evidence</th>
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<td>We looked specifically at the arrangements for medication on four wards at the hospital and met nurses, doctors and people who had been admitted to hospital. We looked at 46 prescription charts and saw that, for the medicines prescribed, a record had been made of all medicines administered, with reasons given for any medicines not given. All medicines prescribed to be given only when required (PRN), had a maximum dose stated. Some of the medicines did not have the reason for administration noted, e.g. paracetamol, but the majority of medicines did. We</td>
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observed the administration of medication on one ward. The actual administration of medication to patients was observed to be positive, with patients receiving their prescribed medication in a timely manner and with due regard to their privacy and dignity.

Nurses and doctors explained how the pharmacist came to the wards twice a day to see if the ward needed any medicines for use on the ward and to check medicines and prescription charts for discharge. They were also available at other times via the bleep system, therefore, as far as possible, prescription charts are always available on the wards so that medicines can be administered at the correct time. Medicines’ advice was available from the pharmacists, as well as from the hospital intranet and reference books on the wards. Nurses knew how to obtain emergency medicines out of normal working hours and how to access the on-call service. Medicines for individual patients were stored in bedside lockers and some medicines that are used as stock across the ward were stored in a medicine trolley and in medicine stock cupboards and controlled drug cupboards within a dedicated room.

All medicines in the bedside lockers were labelled ready for discharge and some of the wards also had ready labelled discharge packs of commonly used items, this is to reduce the amount of time it takes to discharge a patient. Pharmacists were available to discuss medicine issues with both staff and patients. Where appropriate, information was verbally provided by the member of staff to patients about their medication regime.

Medicine administration errors were reported using the hospital incident reporting system. These were discussed at ward level, but it was not apparent that any learning points were disseminated across the trust. There were scoring matrices for medication administration and prescribing incidents, which were used to determine the action that would be taken following an error, e.g. reflective practice, competency assessment and/or re-training. Nurses were assessed on their competency to administer medicines. There was a system in place for the assessment of all new nurses and this is to be extended in the future to existing nursing staff.

An example of a medicine error was described and staff demonstrated appropriate action taken and systems in place for staff development to prevent recurrence. A new member of nursing staff had administered a controlled drug and not signed for it. An investigation and application of the trust drug matrix confirmed that the nurse had development needs and that these were being addressed.

We noted two medication errors. Both records showed no evidence of further investigation and the ward manager, in one case, was very unclear whether an investigation had taken place. Two incident forms identified that a power failure on 01 November 2010 caused temperatures to rise in both the cardio thoracic theatre and catheter lab. The integrity of medication and stents stored in these areas could not be guaranteed and the products had to be destroyed. In theatres this risk was not identified for 48 hours and some medication had been used in the intervening period, clearly posing a risk to patients. From medication errors seen and raised as incidents and notified to the medical team, it is unclear whether further investigation is always undertaken.
We were told that the pharmacists and medication technicians were involved in checking the medication pathway on admission. The quantities of medicines that had been brought into hospital were also noted. The pharmacists talked to patients throughout their stay about their medicines, they counselled patients about specific medicines if they were notified by the nurses, but the nurses also provided medicines information as well. Therefore medicines and medicines' advice were available when they were needed.

There were policies and procedures for the self-administration of medicines by people. There was a risk assessment process to decide if people can self-administer their medicines.

Controlled drugs were stored in appropriate cupboards. There are standard operating procedures in place that were available via the intranet. Nurses interviewed could describe these procedures. The hospital had appointed an Accountable Officer.

Following a report of the incorrect disposal of chemotherapy in the day unit the trust has investigated the incident and has taken action to reduce the chance of a recurrence, this includes reviewing policies and procedures, reviewing staff competencies and understanding of safe systems of work and the trust has also provided additional guidance for staff. The trust has stated that it is satisfied that no patients or staff have been put at risk as a result of the incident.

On one ward we saw that the security of the medication trolley, on three occasions, was not safe. This refers specifically to the medication trolley left outside three patient's rooms, during which time the trolley was unlocked and the medication was easily accessible to others. On the same ward we saw that the dedicated refrigerator for medication that requires cold storage was unlocked and this contained several medications.

On another ward we saw that the medication storage facilities were not locked and the door was kept open. Medication was easily accessible to patients, visitors and staff. Medication was stored on open shelves in most cases. A dedicated refrigerator for medication that requires cold storage was placed outside the medication room. Although this was fitted with a lock, the refrigerator could in fact be opened and medication was seen to be stored in it. We discussed this with the ward manager and they confirmed that this situation had been in place for the past three days as a new medication room was being newly created. The ward manager confirmed that the issues highlighted were not satisfactory but advised that no alternative risk strategy had been considered during this time to ensure that medication was safely stored.

**Our judgement**

We judged that people were receiving personalised care through the effective use of medicines and that there were effective procedures about medicines handling in place, to manage risk. Staff could demonstrate that they had relevant qualifications, knowledge, skills and experience to carry out their role in medicine management.

We have concerns that the arrangements for the safe storage and security of
medication in some areas may compromise the safety of patients and others. We are also concerned that the learning from medicine incidents is not cascaded across the whole of the hospital, thereby reducing the opportunity to minimise repetition of similar incidents.
Outcome 10: Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are in safe, accessible surroundings that promote their wellbeing.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
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<tr>
<td><strong>There are moderate concerns</strong> with outcome 10: Safety and suitability of premises</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Our findings</th>
</tr>
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<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
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<td>Patients consistently expressed positive feedback about the hospital environment. One patient in the elective admissions unit expressed concern about their ability to sit for long periods in an upright armchair (the only provision) for a long period, due to their condition. The same patient reported that during a recent admission to Elsdon Ward she had experienced some difficulties due to her physical disability. She stated that her care and wellbeing had been compromised due to the lack of a disabled shower and other adaptations to maintain her welfare in getting in and out of bed and her sense of security whilst in bed.</td>
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<td>Patients on the stroke rehabilitation ward spoke very positively about having easy access to facilities to help them with their rehabilitation programmes.</td>
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<td>Patients said that they had been on the Medical Assessment Unit for several days, up to five days in one case, as there was not a bed available on a ward. They said the unit was very busy and described one day when there was a 'sea of people' in the corridors. They also said that the unit was very busy at night and the staff were noisy at the nurses station. Patients were also unhappy because there was no proper call bell system available and just a light went on, which staff could turn off at the desk. Patients reported that this actually did happen at night when they wanted something.</td>
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Patients said they found the midwives to be ‘lovely and very supportive’. There is 24 hour visiting for partners, who said they were impressed by security as staff always checked who they were before allowing them in.

**Other evidence**

Many clinical areas visited were clean, tidy and in a good state of repair. The lounge in the Willow Suite is particularly homely and pleasant, as are the two ensuite lounges in the elective admissions unit.

In the postnatal bays the floor space was cramped due to the presence of 24 hour fathers’ visiting and patients’ belongings. Bed curtains remain drawn throughout the day which adds to the confined feel of the ward area. Patients confirmed that storage and fathers’ sleeping facilities are limited and staff reported that 24 hour fathers’ visiting is being piloted; however, staff encourage fathers to return home between midnight and 07.00 hrs, due to the lack of sleeping facilities and to safeguard the privacy and dignity of all patients.

In the Cardio Thoracic Centre (CTC) we discussed general risk management with a number of senior staff, focussing on infection control, fire safety, power failures and revolving doors. A complete tour of CTC is carried out weekly and any issues are identified to estates by facsimile; however, staff stated that response is generally slow.

There has been a problem with smoke seals on fire doors within CTC and across the link bridge from the point of installation. Poorly fitting doors cause the smoke seals to shred (and become less effective) within a week of fitting/replacing. This has been identified on the CTC risk register as a red risk for a number of months.

The issue has been escalated to the trust’s Health and Safety Committee and to the Board, with inference that the level of risk should be lower. Fire doors are checked on a weekly basis and the risk assessment reviewed regularly. Staff stated that within the last year there have been no fires within clinical areas and that no fire incidents have been reported. Risk assessment documents demonstrate that appropriate assessments/action plans are in place and that these are reviewed regularly. However, recommended actions have not yet been completed. There was evidence of continued replacement of door seals. The trust’s fire officer confirmed that the fire doors installed in the CTC meet the legal requirements. The quality of the doors demonstrates good fire stopping/delaying ability; however, confidence levels are decreased with regard to smoke. To reduce the constant frictional breakdown of the seals, and a focus on the general good keeping of the fire doors, the trust is currently looking at wireless magnetic ‘hold-open’ retaining devices linked to the fire alarm system along with motion-sensor doors. The trust has a capital allocation in its Annual Plan for 2011/12 to fund this work.

External advice was sought from Essex fire safety officers, who stated the trust have taken appropriate actions to date and the planned implementation of wireless magnetic "hold open" retaining devices is satisfactory within the time scales noted.

The rotating entrance door to CTC has been the subject of several reported incidents since installation. The most serious incident resulted in a patient fracturing their arm. Following a subsequent incident, the doors were taken out of commission
for three to four months pending inspection and modification by the manufacturer. The doors had been back in use for about a month yet the security adviser has observed the doors in use and concluded that they still pose risk to people with slow mobility, where they could become trapped if they collapse. A risk assessment demonstrates that risks have been identified and some actions taken, however the revolving doors continue to pose a risk to people in respect of emergency situations.

The risk assessment has been updated and is currently in draft, awaiting ratification by the patient safety manager. Health & Safety Steering Group minutes recorded that discussions have taken place regarding the risks of the revolving doors. However, the inspectors viewed this as a slow response to a continuing high risk. The trust’s Chief Executive stated the doors would immediately be taken out of action when we raised this with him during our visit.

Staff confirmed that there is no risk assessment or policy in place for power failure within CTC. A corporate internal incident plan (action card) for electricity failure on wards is general in nature and does not address the issues raised regarding CTC. It does not include any reference to the integrity of medication or that staff should seek pharmacy advice re storage/use of medication. Staff reported that back up generators cut in promptly to provide power. Incident forms have been completed for previous episodes of power failure. Significant work on the power supply has been undertaken and is in progress. Previous power failures have affected only individual clinical areas, rather than the whole unit. Recent power failures have raised a number of issues, including the resultant increase in temperature compromising the integrity of expensive theatre operation packs and theatres being too cold. Two incident forms recorded that a power failure on 01 November 2010 caused temperatures to rise in both the CTC theatre and the catheter laboratory. The integrity of medication and stents stored in these areas could not be guaranteed and had to be destroyed. In theatres this risk was not identified for 48 hours following the incident and some medication had been used in the intervening period, clearly posing risk to patients.

Health and Safety Steering Group minutes of April 2010 recorded that discussions have taken place regarding development of a risk assessment for the loss of power with no emergency power back-up. The minutes state that backup batteries cannot be obtained for all equipment. Submission of a risk assessment was identified as an action for the patient safety manager but there was no evidence that this had been done.

We saw improvements were being made to the Acute Medical Unit (AMU) East, including a new storage room and medication room. Whilst this was in progress, we saw the door of the medication room, stocked with shelves of boxed medicines etc, open for over one hour. We discussed this with the ward manager who said that the unit was very busy and not always were the logistics of the work needed given enough consideration.

The staff on the Acute Medical Unit East work hard to provide a single sex system by the flexible use of bays and ward toilets. The manager said that they do their best but could not always achieve single sex provision. On the day we visited we saw one four bedded bay to be mixed sex patients.
The ward manager on the AMU East told us that the target time for a patient to be in the unit was no more than 24 hrs. On the day we visited we tracked the care of patients who had been in the unit three days, four days and nearly five days respectively. The ward manager said that it was sometimes difficult to find beds for patients aged 78 years or under, who did not ‘qualify’ for a care of the elderly bed. Daily bed meetings are held to inform ward managers of the current bed availability and current pressures.

Facilities in the stroke rehabilitation ward are good and easily accessed for patients, who do not have to travel off the ward to attend physiotherapy, occupational and/or speech therapy.

Our judgement
Patients consistently expressed positive feedback about the hospital environment and systems are in place to address environmental problems as they occur. Some negative comments were raised by patients regarding facilities for disabled persons and lack of storage, but these related to specific wards/units.

Significant concerns were raised by some staff regarding the safety of patients within CTC and the management of identified risk. These relate to fire safety, the revolving entrance doors, and power failure. The two former issues have been ongoing for some time and whilst risk assessments are in place, planned actions remain outstanding for the revolving doors. When considered in conjunction with the theatre infection control issues (see outcome 8) and lack of contingency planning for power failures, this raises the level of overall concern to moderate regarding risk management in CTC.

Outcomes for patients on the Acute Medical Unit are variable depending on the pressure on beds and availability of single sex accommodation. The assessment unit is a busy place and not ideal for patients to stay for more than 24 hours.
Outcome 11: 
Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
- Benefit from equipment that is comfortable and meets their needs.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are moderate concerns with outcome 11: Safety, availability and suitability of equipment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>What people who use the service experienced and told us</td>
</tr>
</tbody>
</table>
The majority of patients raised no issues about access to appropriate equipment.

Patients on the AMU East said that they were short of nebuliser units and they had to wait for one to become available before they could have their medication.

One patient expressed concern that their care and wellbeing had been compromised due to the lack of accessible shower facilities and other adaptations to maintain their welfare in getting in and out of bed and their sense of security whilst in bed.

Other evidence
Equipment within clinical areas is well maintained and serviced regularly. An example was a hoist which was serviced on the morning of the visit; the date it was due to be serviced. All repairs and servicing are carried out or coordinated by [MEMs].

In the delivery suite, the paediatric resuscitaires are checked daily against a
checklist specific to each area. Completion of checks is monitored by the delivery suite coordinator. Evidence of checking and monitoring systems were seen across all areas visited.

Resuscitation trolleys are stored in corridor areas within each ward/unit, and are easily accessible by staff. Resuscitation arrangements throughout the hospital were reviewed in September 2010 and the contents of resuscitation trolleys were revised. There is a signature sheet for staff to acknowledge that they have seen and understood the arrangements; however, completion of this is variable. In a number of clinical areas this sheet was blank or contained very few signatures. In addition a bound log book is maintained for each trolley to record the daily checking of resuscitation equipment in accordance with trust policy. Again, completion of these varied between clinical areas. Only one was complete, the remainder had between 2 and more than 20 gaps. Midwives reported that checking the trolley was often missed due to competing time pressures within a busy department and that in the antenatal clinic this is a shared responsibility with other staff groups.

We checked a further two resuscitation trolleys in general ward areas and staff were seen to be checking these but the records contained staff errors, for example, we noted that a defibrillator had a low battery because it had not been plugged in as part of the checking process. On another ward, the extension lead had been plugged in but not switched on. In addition, staff had requested replacement items from pharmacy, these were taking a few days to get to the wards and staff were having to 'chase' for these items.

Across all clinical areas visited staff demonstrated a good knowledge of reporting equipment faults and reported that issues referred to MEMs are responded to promptly and appropriately. Staff also reported that patients' own equipment is routinely notified to MEMs for testing.

The ward manager on AMU said that they only had three nebuliser machines and these were all away for repair. At the moment they were currently borrowing machines from other wards.

Our judgement
Equipment within clinical areas is well maintained and serviced regularly. However, concerns were raised by patients regarding sufficient quantities of nebulisers in the AMU (East), resulting in them waiting to have their medication, which could impact on patient safety and meeting assessed needs. Also access to suitable shower and seating facilities was also raised as an issue, as this does not promote independence and comfort for service users.

There is a system in place for routinely checking patients’ own electrical equipment for safety.

Checking of resuscitation trolleys in some areas was inconsistent and systems to ensure that all staff are aware of changes to trolley contents are not always robust. This has the potential to pose a risk to patients as equipment may fail, or be absent, when needed in an emergency situation.
Outcome 12: Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:
- Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

The provider is compliant with outcome 12: Requirements relating to workers.

Our findings

What people who use the service experienced and told us
Four patients on two wards (Mary Seacole Ward and Elizabeth Fry Ward) were interviewed. Each patient made comments that staff were knowledgeable, and included them in discussion about their care and treatment. One patient said they had had communication problems on one occasion with a member of staff from overseas but they then spoke to other staff who were able to help. This was an isolated incident.

Other evidence
The trust's operational recruitment and selection procedure sets out the process to follow in identifying, advertising and recruiting to a new or vacant post. The policy was last reviewed in May 2010. It states that all job offers are subject to the satisfactory completion of pre-employment checks and that no offers of appointment can be made unless the checks are carried out. The checks listed are references, criminal records checks (vetting and barring), occupational health, registration, verification of identity and eligibility to work in the United Kingdom. These checks also apply to bank staff. Where agency workers are deployed, the policy states that the personnel department will seek assurance that the same checks are implemented by the agency. The policy does not currently make reference,
however, to the recruitment of students or volunteers. The policy states that attendance at induction for all new staff is mandatory. The Programme Director said that student checks are carried out by the host university under the national education contract, which is overseen by the Strategic Health Authority (SHA). Checks on volunteers are carried out in the same way as for new permanent staff.

The trust's induction policy shows that all new staff, regardless of grade or discipline, will undertake induction to enable them to provide a safe and efficient service. The policy was last reviewed in September 2010. Attendance at induction is currently at 94.1%.

The personnel files of four new staff that had started at the trust since April 2010, were reviewed. These were for a head of nursing, a staff nurse in paediatrics and two clinical support workers. All pre-employment checks had been carried out satisfactorily, including the appropriate immigration checks for the overseas staff nurse. Where relevant, checks with the appropriate licensing authority had been carried out.

Interviews with staff on two wards showed that there were few vacancies but no, or few, agency staff are used to cover these positions. Any shortfalls in nursing staff on those wards are usually filled using their own bank staff. One consultant nephrologist interviewed said that the service was one doctor down at the moment but this was being covered from within the team. Mary Seacole Ward also runs an outpatient foot clinic on Tuesdays and Thursdays, which staff reported has to be staffed from the ward staff and puts pressure on the team at that time, as no funding for extra staff is received. The trust state that this is incorrect. When the diabetic foot clinic was set up, the business case included the nursing provision and was funded and included in the ward establishment as additional staff. This is 0.4 WTE band 5 staff nurse and 0.2 WTE band 2 Clinical Support Worker.

Workforce issues are reported to the Board on a monthly basis, through the performance report. This includes staff vacancies and turnover. Staff vacancies are reviewed on a weekly basis and the trust is following the latest published guidance on the NHS East of England employment framework in respect of advertising positions on the NHS jobs website prior to national advertising, whereby employees placed at risk can apply for positions locally.

**Our judgement**

Full time staff, students, bank and agency staff are recruited appropriately and do not commence work at the trust until all pre-employment checks have been completed satisfactorily, including any necessary immigration checks. The process for the safe recruitment of volunteers is not outlined in the recruitment policy, which means staff are uninformed. Integration into the trust and its working practices is reinforced through induction, which, after taking into consideration staff absences, has a very high attendance rate. Vacancy rates on the wards are low and agency staff usage is also kept to a minimum. Feedback from patients indicate they are satisfied with the care and treatment provided by the hospital.
Outcome 13: Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are minor concerns with outcome 13: Staffing

Our findings

What people who use the service experienced and told us

Four patients on two wards (Mary Seacole Ward and Elizabeth Fry Ward) were interviewed. Each patient made comments that staff were knowledgeable, and included them in discussion about their care and treatment. They felt that staff were doing a very good job. One patient said that their painkillers always arrived on time and often before and that, after being in and out of hospital for most of their life, they felt that staff on Mary Seacole Ward were the best they had ever experienced. Another patient had spent twelve weeks on Mary Seacole Ward and said that since the summer, she felt there was a lack of staff on the ward at night and one patient had fallen off a commode because she was not given support. We raised this with the ward manager who explained that on one occasion they had had a very busy night and that the matter had been reported as an incident and followed up.

Several patients interviewed noted satisfactory staffing levels and competence of maternity staff. The only critical point made was regarding slow response to call bells sometimes during handover between staff leaving and arriving on shift.

Other evidence

Prior to our review of compliance, we received an anonymous letter from some staff
highlighting concerns regarding the ability and attitude of a head of nursing at the trust and a culture of fear and intimidation. During the inspection a potential ‘whistleblower’ also raised concerns highlighting fear and intimidation amongst staff. Other issues included a call taken during inspection from a staff member who expressed concern that their staff had been instructed to be ‘positive’ when we were visiting the area and calls from nurses in outpatients department who talked about a negative culture in the organisation. On the first day of our visit, some individuals contacted the CQC’s management to report that the mobile telephone number of the lead inspector had been put out incorrectly by the trust, meaning they could only contact the inspector on the trust’s own landline number, which they felt reluctant to use. The trust corrected this error the following day.

In contrast, a large number of staff also contacted us during our visit to say how the trust was supportive of them, that there was a ‘no blame’ culture and that the chief executive officer, the director of nursing and the board of directors were generally open and approachable.

In 2008, the trust had a review of nurse bank and agency usage undertaken by the Audit Commission, which benchmarked the trust against the national standard at that time. Following this review, the deputy director of nursing undertook an in-depth skill mix/establishment review triangulating the findings against the Audit Commission, Healthcare Commission and ‘nurse per occupied bed day’ benchmarks. As a result of this work, an additional £2million for staffing was provided by the trust, which has since been successfully recruited into.

Staffing levels in the trust are reviewed with directorates through the annual planning process where activity projections for the next financial year are reviewed alongside budgetary and other constraints. A review of staffing levels in line with the establishment and recruitment activity is undertaken at directorate performance review meetings.

Staffing levels are reviewed regularly at ward level in response to the patient needs. The trust’s Principles of Care document provides tools for nursing staff to determine staffing levels and how these should be reviewed in response to the changing needs of the patient and the need for increased nursing observation/supervision.

Interviews with staff on two wards (Mary Seacole Ward and Elizabeth Fry Ward) showed that there were few vacancies but no, or few, agency staff are used to cover these positions. Any shortfall in nursing staff on those wards are usually filled using their own bank staff. All of the staff with whom we spoke on these wards said that they did manage to take their breaks and any extra time worked was always taken back. However, on the maternity unit, staff reported having difficulty in taking their breaks during the evening when working long days.

Evidence received from staff in five other patient areas reflected the opinion that staffing levels were not generally a problem and shortages were well managed.

We were informed in maternity that the lack of breaks is a problem. Staff have a one hour lunch break and a second half hour break in the evening when working a long day. To ensure they get their break, some staff are taking one and a half hours at lunch time. They are not given time off in lieu or paid for additional hours worked.
Two antenatal midwives reported that one part-time coordinator is insufficient to support the clinic. No agency midwives are used within the antenatal clinic. Staff shortfalls are covered by the clinic’s own staff group and supplemented by some bank clinical support. Staffing was reported as the biggest challenge to delivering the service, particularly due to long term sickness. Difficulties are compounded by two factors. These included a shortage of clinical support workers to deliver screening for Down’s syndrome. The workload for this is unpredictable, with up to 24 women a day presenting for a blood test at 12 weeks pregnant. Secondly, clinic staff are regularly asked to support the colposcopy service for advice and the provision of care support worker chaperones. This service is situated in the antenatal clinic but managed by gynaecology. The trust produced an action plan in April 2010 in response to recommendations made by the Nursing Midwifery Council in December 2009. The Trust wrote to the NMC on 3 March 2010 and on 24 March explaining amongst other actions that the ratio of women receiving one to one care was 98% at the time of the review and remains at this level. These levels of care are reported to the PCT and SHA. The SHA audit of one to one midwifery care in this Trust (February 2010) confirmed that 98% of women received one to one midwifery care.

Staffing levels are maintained across the trust with the use of the clinical areas’ own staff group and some bank use. There is little agency staff use, apart from agency midwives in delivery suite. Regular agency midwives are used and their qualifications etc are checked on their first shift.

All new or bank staff are subject to an induction competency checklist and are assigned to a mentor.

Sickness records and vacancy levels are variable and are monitored as part of the trust's key Performance indicators. This data is displayed on all units. Staff report good access to mandatory training. A nurse practitioner interviewed had undergone a structured development programme to achieve appropriate knowledge and competency. She also reported undertaking a university course every one to two years funded by the Trust.

A senior staff member on AMU said that in the afternoon there are six nursing staff on duty and two care support workers. If they are short of staff and cannot cover with bank staff, the trust is 'very reluctant' to cover with agency staff and they will run short. The staff member stated that the staff on the unit get to a stage where they are 'too tired or burnt out' to cover the unit. One ward manager confirmed that she had two new band six nurses who were going to start on the ward and this would enable her to put a named nurse system in place.

We saw that wards who were providing one to one nursing to patients often had to cover this out of their own staffing complement and this, they felt, made them short of staff. For example, one ward was providing one-to-one nursing for two patients from within their normal staff ratio and the RGN on duty said that they were two staff short.

Our judgement
In some areas, patients and staff are generally happy with the level of staffing and skill mix, and the system for covering vacancies and absences. In these areas staff...
are usually able to take breaks and time owing. However, there was a negative experience for staff and more pressure felt in areas such as maternity and the MAU, which could affect the safe running of those services. The last trust staff skill mix was reviewed in 2008, and the trust would benefit from carrying out a new review to ensure that staffing levels are appropriate to ensure that people who use the services are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

Some reports were received about there being a 'negative culture' at the trust of 'fear and intimidation'. We took these allegations very seriously and it was a prominent area that we focussed on during staff and patient interviews. The vast majority of people interviewed by us were happy and complimentary about the organisation, leadership and culture. The 'middle management' level was perceived by some staff as lacking leadership.
Outcome 14: 
Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:
• Are safe and their health and welfare needs are met by competent staff.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider is compliant with outcome 14: Supporting workers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
</table>
| **What people who use the service experienced and told us**
Patients with whom we spoke felt that staff were knowledgeable, knew what they were doing and that they treated patients with respect. |

**Other evidence**
The trust has an induction policy, a mandatory training policy and a performance appraisal and development policy.

The appraisal policy shows that appraisal should happen every twelve months and this will be monitored by the personnel department, who will provide a report to the board of directors on a quarterly basis. The latest report to the board shows a month-by-month increase in the number of staff receiving appraisal since May 2010. The current total stands at 77%, with a further 2% having an appraisal date confirmed. Weekly discussions are taking place with senior managers to ensure that those employees without a scheduled appraisal date are followed up and dates are confirmed. This is being monitored fortnightly.

The trust's induction policy shows that all new staff will receive induction to the organisation upon starting work with the trust. Local induction is monitored by the board of directors through the quarterly training report. Current figures for new staff attending induction are 94.1%.
The mandatory training policy sets out the minimum level of training that all staff should be expected to receive to enable the trust to comply with legal requirements. The trust has a training needs analysis, which sets out the mandatory training courses that each grade of staff must receive. The mandatory training policy states that non-attendance at mandatory training is not tolerated and that training will only be rearranged on two further occasions. Individuals still not attending the training are referred to senior management where the staff conduct policy may be invoked. Examples were seen where non-attendees had been identified and re-booked on and attended training.

It was reported that, as from January 2011, Level 1 Learning Disability training will be part of the induction programme for all staff and records will be kept. It is also now included in mandatory training updates for all staff. Staff training records seen on the wards show that staff have certificates in place for the one day training, where they can cover up to eight subjects. This seems a lot for one day and links in with the 17-minute level one training for staff on learning disabilities. This approach to training could call into question the quality of the knowledge imparted and its long-term impact on care provision in relation to the ability of individuals to take in such a range of subjects on one day.

There is a policy relating to bullying and harassment available for staff reference. The matter is also covered in staff induction.

Five staff on Elizabeth Fry Ward were interviewed and three staff on Mary Seacole Ward. All staff on Elizabeth Fry Ward had attended mandatory training and said they had regular one-to-one meetings with their manager. Newly-qualified staff undertake support training for six months, with their supervisor signing off their competencies. All staff, except one staff nurse on Elizabeth Fry Ward said they had had an annual appraisal and current Professional Development Plan (PDP).

On Mary Seacole Ward, the ward manager has been in post since September 2009, but there had not been a ward manager on the ward for the previous nine months. As a result of this, appraisals fell behind and staff were not released for training. This is now being addressed and is 'moving in the right direction'. A staff nurse interviewed was undertaking her preceptorship. PDPs are discussed at regular one-to-one meetings. All professional staff interviewed on wards said they were able to keep their skills updated as a requirement of their respective professional registration body.

Our judgement
Staff are generally supported by the trust through attendance at mandatory training and through the appraisal system. They receive regular one-to-one meetings with their manager including monitoring of ongoing professional development.

The number of staff receiving appraisal is reasonably high and the trust is pro-actively addressing any shortfalls to increase the numbers.

The time allotted to cover multiple subject areas within induction raises some questions about the depth of learning that can be imparted and its subsequent
impact on provision of care, which the trust should consider.
Outcome 16: Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
- Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

**Our judgement**

The provider is compliant with outcome 16: Assessing and monitoring the quality of service provision

**Our findings**

**What people who use the service experienced and told us**

We spoke to a member of the patient’s panel who spoke positively about the trust and the role of the panel. They felt that everywhere was not perfect, there is a lot to be done but the trust is being proactive about it. They felt that they were given the information that they needed, they were listened to and although they are in their early stages, having only had three meetings, the trust has already taken suggestions on board and actioned them and was able to show us examples of work completed, such as admission discharge ward letters. The panel member felt it was an open forum and that if required, if they were unhappy, they could raise the issue comfortably.

The vast majority of patients with whom we spoke throughout our visit were positive about care provision within the hospital.

**Other evidence**

The trust has developed a quality strategy with support from external specialists which has recently been ratified by the board. Numerous staff spoken with were
positive about the recent senior management team changes and planned realigning of the directorates to provide clearer reporting lines for quality and risk management practices. Each directorate will have a designated lead for quality; a ‘check and challenge person’. These roles will be responsible to the director of nursing and will cover governance and patient safety.

The assurance structure is outlined and will come fully into force in January 2011 when the director of operations is in post. It was reported that the Governors are ‘fully supportive’ and the board are ‘delighted’. The doctors are ‘buying into it’ and it has been discussed at the clinical directors meeting.

Two senior members of staff with whom we spoke correctly identified the same top five risks in the trust; legionellas, capacity, health care associated infections, clinical issues such as pressure sores and slips, trips and falls, and finance.

Principles of Care audits were maintained throughout 2010. There was good evidence of planned audits for 2011 including re audits of high risk areas. Named responsible persons for actioning audits were in place, which demonstrates a more proactive approach to assurance than we have witnessed in past reviews during 2010. The clinical audit leads for each specialty met with either the specialty risk coordinator, matron or service manager supported by a member of staff from the Clinical Effectiveness Unit to consider the clinical audit programme. Directorate risks, incidents, claims, complaints, patient survey results and audits ready for re-audit were reviewed to identify topics for inclusion in the clinical audit programme for 2010/11. It was agreed that the key themes to focus on were patient safety, patient experience and efficiency and effectiveness. Projects have been categorised under these themes as either new projects or re-audits. The clinical audit strategy incorporates measured outcomes throughout the programme. Examples were seen of implementing new care practices following incidents and spot audit checks to ensure the new practices are adopted, for example hand gel is now provided in reception in the out-patients department following a hand hygiene audit. Nasogastric tube safety posters are in clinical areas to heighten awareness of flushing practices.

The October 2010 Complaints, Litigation, Incident and PALS (CLIPS) report provides a combined quarterly report to support the identification, collation and dissemination of learning from complaints, litigation, incidents and PALS. Patient experience reports are included and include complaints, feedback from patients, PALS interactions, comments cards and plaudits. The report highlights key performance indicators, including trends. The report demonstrates monthly comparison data for complaints and outlines from which directorate the complaint emanated. The board has requested monthly updates on key themes such as staff attitude, communication and care. The top ten reported incidents, trust-wide, highlights slips, trips and falls, and clinical incidents make up over half of reported incidents in the trust currently. Reports are available for each directorate regarding incidents and complaints. Reporting on serious incidents noted the January to October 2010 themes and trends, how many are still under investigation, are being reviewed by the coroner or are with the legal team relating to potential claims.

The report also incorporates Parliamentary Health Service Ombudsman complaints and updates. PALS contacts by directorate are also recorded and litigation claims,
including claims closed, with risk management recommendations and outcomes noted. The CLIP report and the performance report cover the planned actions for improvements. There was good information provision to the committees on the risk management practices throughout the trust. Staff with whom we spoke were aware of the monitoring practices.

The trust has taken action to address the compliance action regarding the management of serious incidents arising out of our September 2010 review of compliance of the trust. The director of nursing has been providing presentations and quizzes through the Clinical Governance Symposium to heighten awareness and understanding regarding the reporting of, investigating and learning from serious untoward incidences. A position statement of compliance in relation to management of serious incidents as at 03 December 2010 has been submitted to the Commission outlining the actions taken to date. This includes a meeting with the Directorate Governance and risk leads, also attended by the chief executive and the medical director, on 16 November and continued on 22 November, to further streamline and standardise the management of serious incidents and clinical incident investigation process. The outcome of this meeting was to develop an incident investigation template which was approved at clinical governance management group on 03 December 2010 and commenced on a trial basis on 06 December. The effectiveness of these actions will be tested by the Commission at our next review of compliance of the trust. We were, however, assured by the actions taken to date that the likelihood of improved management of incidents is now in place.

The director of nursing noted that since last week the medical director and the director of nursing have been checking and reviewing incident reports. In the next year they are looking to move away from the paper-based incident system and use a computerised system (e.g. Datix). They are aware that the outcomes are not fully in place currently, but feel this will happen. There is a need to ensure that information is fully ‘married up’.

We were informed of a recent serious untoward incident where a change in practice was needed. Although the report into the issue had not been finalised it was evident that the change in practice required was immediately communicated to all staff. We were informed this was done by e-mail and hand delivered communication to all staff. The trust did a follow up audit, shortly after the communication, to check all staff were aware of the required change in practice, which found that a small group of staff had been missed.

When we asked a head of nursing to describe any changes in practice that had occurred as a result of the investigation of a serious incident, we were informed it was 'difficult' to identify change and relate it to a serious incident. This head of nursing did, however, go on to tell us of a change required in a letter sent to patients about retinal screening. The trust’s Complaints, Litigation, Incidents and PALs report for October 2010 reports a serious untoward incident related to retinal screening in the period January to October 2010, which was recorded in the serious incident spread sheet.

Key performance indicators, where concerns had been raised through our own risk profiles of the trust and from external agencies, were discussed with the director of
nursing. We looked at National Patient Safety Alerts and key cases of hospital acquired pressure ulcers and poor discharge practices, where assessment and discharge planning had been poor or non existent and care homes had raised concerns with us. The trust has been collecting information on the incidence of pressure ulcers in the hospital since December 2009. Records show that currently the rate for significant pressure ulcers, grades 3 and 4, is six in total. Overall, the incidence of pressure ulcers within the trust has reduced. However, it is recognised by the trust that more work is needed and it was reported that discussions are being held with the Primary Care Trust to look at improving communication and sharing of information with care homes.

The principles in care audits November 2010 highlight that Acute/A&E departments are underperforming in assessment practices and continue to demonstrate below target achievements throughout the year for the standard “Patient has a Falls Management Pathway, if applicable”. This remains a concern, as the annual report of the board of directors highlights falls as a key concern. The trust has a falls action plan and the clinical audit strategy encompasses assessment as a key area for monitoring and development. This was presented at the last board meeting and governors have also viewed this. The trust was able to demonstrate that it is aware of the key risk areas for action and that the board of directors are supportive of developments required.

Patient feedback mechanisms are in place and the patient forum is being encouraged to get involved in hospital audits. The board of directors receive updates on comments and complaints from patients at regular meetings. It was reported that "The Local Information Networks" (LINKS) receive regular updates from the trust and the directors of the Primary Care Trust on their involvement as commissioners. Dementia and care of the elderly has been raised recently as a concern by the patient’s panel and also, during this inspection, by our inspectors in relation to staff awareness, in order that these patients are supported and provided with care in a safe and appropriate manner. The trust did report its plans, including a proposed project which brings the national dementia strategy, together with the ‘Who Cares’ carers’ project, which remains in pilot form on the trust’s older people’s wards. However, it was apparent from talking to staff and observing care in the clinical areas that awareness training needs to be actioned quickly to support staff in this challenging environment to manage and improve outcomes for patients with dementia.

Ward metrics (data about areas of ward performance) displayed in ward areas incorporates information for staff and patients regarding key performance indicators such as number of falls, number of pressure ulcers, MRSA and patient experience tracker.

Currently there is no single committee where all risks are considered, but one member of the executive team, the director for continuous improvement and programme director, is the designated lead for risk management in the trust. The trust maintains one trust-wide risk register, as well as directorate risk registers. The trust is in the process of moving to a new management risk system, with only health and safety having moved to this new system to date. Within the new system, risks identified are judged using a system of inherent risks (when no controls are in place to manage the risk), residual risk (the current level of risk) and mitigating risk.
(the level of risk when controls are in place). The new risk management system in place uses a sliding scale to rate or judge the level of risks, and where an issue is rated above 10 this becomes a corporate risk. This new system of risk management is accessible to trust board members, although it is not possible to ascertain which members of the board are currently accessing the system. There is also a medical patient safety lead who works with the director of nursing on patient safety issues.

In the past year, main theatres at the hospital have adopted the 'Productive Theatre' model. This model considers theatre productivity and utilisation as well as key safety indicators such as adverse incidents. Local reports suggest a 95% compliance with the Safer Surgery Checklist, which is recorded in the patient notes as well as on the electronic theatre system. The completion of the checklist was not witnessed during the visit however evidence of other indicators was widely displayed throughout the department.

One senior doctor spoke very positively about the executive team and stated that he has regular and direct contact with the clinical director, for whom he has great respect. He considers the chief executive and board members to be approachable. This was reinforced by numerous staff throughout the three day visit. Some staff stated that they rely on their monthly ward meetings as a conduit for information exchange with senior trust members. One senior staff member reported a recent increase in the sense of trust in senior staff and attributed that to the new director of nursing who was in post. Ward managers said that the trust's board members do visit the wards. They said that the management of the trust had improved over the last few months and the atmosphere is different.

Capacity management has also improved in the last 6 months, for example when the Primary Care Trust (PCT) rapidly withdrew their discharge team for redeployment, the trust had to quickly form a discharge team. They have also transferred PCT employed physiotherapists to the trust and reviewed the patient pathways. The Programme Monitoring Office is monitoring planned/actual discharge data and bed meetings are held 2 or 3 times a day.

It was reported that non executive directors assure themselves of the quality of services that the trust provides via a range of mechanisms. All incidents have action plans with regular reporting mechanisms for monitoring. Outcome information is recorded on the hub or performance accelerator as appropriate. Maternity data quality has improved since the new director of nursing was appointed. Patient experience has significantly improved. In the last three months feedback suggests that 98% of patients would recommend Basildon Hospital.

**Our judgement**

The trust has developed a quality strategy with support from external specialists which has recently been ratified by the board. Numerous staff with whom we spoke were positive about the recent senior management team changes and planned realignment of the directorates to provide clearer reporting lines for quality and risk management practices.

There was good evidence of planned audits for 2011 including re audits of high risk areas. Named responsible persons for actioning audits were in place, which
demonstrates a more proactive approach to assurance than in the past reviews in 2010. Good examples were seen of implementing new care practices following incidents and spot audit checks to ensure the new practices are adopted.

The reports going to the board of directors now provide a clear combined quarterly report to support the identification, collation and dissemination of learning from complaints, litigation, incidents and PALS. Patient experience reports are also included and include complaints, patient tracker, PALS interactions, comments cards and plaudits. The report highlights key performance indicators including trends.

Patient feedback mechanisms are in place and the patient forum is being encouraged to get involved in hospital audits. The board of directors receives updates on comments and complaints from patients at regular meetings.

In general staff spoke positively about the chief executive, director of nursing, and board of directors and, although a lot of the recent initiatives for quality management are not yet embedded, the senior management team does now appear to have the systems in place to identify, monitor and manage the risks to people who use, work in or visit the service. We will check how well embedded these new systems are at our next review of compliance.
Outcome 17: Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:
- Are sure that their comments and complaints are listened to and acted on effectively.
- Know that they will not be discriminated against for making a complaint.

What we found

**Our judgement**

The provider is compliant with outcome 17: Complaints

**Our findings**

**What people who use the service experienced and told us**
Patients interviewed said they would feel comfortable in making a complaint if they wished to. However, three patients interviewed on Florence Nightingale ward, who had been admitted as emergency cases, had not been provided with 'Help us get it right' leaflets or information about PALS. The 'Help us get it right' leaflets were available at the entrance to ward, but not located where they could easily be seen by patients. One patient was in the process of making a complaint as they had not received their evening meal until 23.00 hrs the night before. They said they had not been provided with any information about making a complaint, nor of PALS. Two ward managers interviewed on separate wards said they do not automatically think to include PALS where a patient has concerns and try to help them themselves. This was reportedly seen as a communication problem by PALS. This lack of inclusion is also not making best use of a trust resource, which is there for the benefit of people with concerns.

**Other evidence**
Complaints information in the hospital for patients and the public is provided by the 'Help us to get it right' leaflet. The leaflet outlines the procedures for making a complaint or voicing concerns. It sets out timescales for responses and how the complaints procedure works. It contains the contact details for the Patient Advice
and Liaison Service (PALS), Independent Complaints Advocacy Service (ICAS) and the Health Service Ombudsman (HSO). It states that the leaflet is available in other formats on request. Although the leaflet is written in plain English, no other language versions were seen, or statements provided in other formats to inform non-English speaking people that the leaflet could be provided in their language. The leaflet does not make it clear that people will not be discriminated against for making a complaint.

The leaflet is available in parts of the hospital, such as outpatients, and other wards but is not always displayed prominently. The adult A&E department has no complaints information displayed at all. Children's A&E has child-friendly feedback forms available but none were on display during the inspection. There is a box for posting the feedback forms. Whilst the PALS office is signposted, there is no publicity information on display in the hospital to show what services PALS have to offer.

Complaints information on the trust's website is provided by the 'How to make comments and suggestions, compliments and complaints' document. It states that it is available in other languages and formats and it contains statements to this effect in various languages. This leaflet clearly states that the trust will not discriminate against you for making a complaint and that your treatment will not be adversely affected. However, it also refers to the Healthcare Commission as part of the complaints procedure, which is no longer accurate, as the Healthcare Commission has not existed since March 2009. The Care Quality Commission does not have a remit to investigate individual complaints.

The complaints policy and procedure for the management of complaints sets out staff roles and responsibilities for the effective management of complaints. It states that in its consideration of complaints the trust must demonstrate openness, honesty and be non-discriminatory. It sets out how the trust will learn any lessons following complaints; that all front line staff will be trained in customer care and the principles of the complaints policy; the reporting and monitoring process for complaints managements.

Staff receive training in complaints handling (called 'patient experience') at induction. Foundation years 1 and 2 doctors also receive training in the legal aspects of complaints. PALS awareness also forms part of induction. Complaints workshops are held for non-front line staff and staff in directorates have root cause analysis (RCA) training to enable them to investigate complaints about their ward or area, as directed by the complaints policy. RCA training sessions were run in April 2010, with 34 multi-disciplinary staff attending, and 33 more staff attending a session in September 2010.

Complaints are received by the Patient Experience Team (PET) and are forwarded to the patient experience and complaints lead (PECL) for each department to which they relate, for investigation by staff in the area, with a given timescale for response. Each directorate has a PECL who provides a link between the directorate and the complaints team. These are usually service managers who take on the role as an extra responsibility. All the ward staff interviewed, except one, said that they were involved and informed about complaints in their area. A central log is kept on the progress of all complaints received by the trust.
Monthly patient experience performance reports are provided to the PECLs and to the board of directors, whilst a wider report on complaints, litigation, incidents and PALS (CLIP) is provided to the board via the clinical governance management group. The performance reports show that 62% of responses sent during October 2010 were 'out of target', i.e. late. The CLIP report shows that the board has been proactive in complaints' management and has requested to receive complaint themes on a monthly basis for attitude, communication, medical care and treatment, nursing care and treatment and all others. These performance reports break down complaints by department and incident. It also provides an update on cases that have been referred to the Health Service Ombudsman (HSO).

Lessons learnt are monitored through a quality improvement plan, which is sent to PECLs for dissemination and action within their directorates. This also covers where more than one directorate is involved. Directorates then update this plan and it is reviewed again at the next PECL meeting and informs the performance report. Feedback on the trust's complaints handling is sought through complaints satisfaction survey and is reviewed by the patient experience team. Independent scrutiny of the trust's handling of concerns is provided at the patient panel meetings, which were started in June 2010 and meet every two months. The meetings are attended by the head of litigation and complaints and minutes show where the panel raises concerns for response.

Three complaints were reviewed which demonstrated appropriate handling, communication, investigation and follow up.

**Our judgement**
Complaints are generally handled, investigated and followed up appropriately. People generally know their complaint will be treated seriously and that they will not be discriminated against for making a complaint. Advice on how to make a complaint, and receive support to do so, is available but is not publicised effectively in the hospital and leave some people uninformed. Complaints information on the trust's website is out of date. There is also a high rate of late responses to complainants.
**Outcome 21: Records**

**What the outcome says**

This is what people who use services should expect.

People who use services can be confident that:
- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

**What we found**

**Our judgement**

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**Our findings**

**What people who use the service experienced and told us**

No patients reported concerns about confidentiality or data protection.

**Other evidence**

All new staff receive training in information governance, record keeping and confidentiality, as part of the induction programme. Ongoing training in information governance is a mandatory annual requirement for all staff and health record keeping is provided on appointment and when required thereafter.

There is a health records policy for staff reference, which includes appropriate completion, storage, transportation, relevant legislation and retention times. The trust's Principles of Care, essential standards document, sets out the expected standards of record keeping. Principles of Care activity is audited and reported to the board in the monthly performance report. Clinical audit plans for each directorate show their audit strategy for the financial year. Although the audit programme is not completed, example audits were provided and copies of action plans showing where these had been completed.

Examples of invoicing were seen to demonstrate safe and appropriate destruction of
The trust uses a computerised patient administration system (PAS) record tracking system, which is designed to show the location of each of the trust's medical records and bookings. An example of a health records service performance report for outpatients was provided, which covers the volume of requests received and the breakdown of missing records each month by directorate and specialty, which is designed to identify those areas which suffer most from the unavailability of notes.

We identified two incidents of the computer on wheels (COW) being left unattended in a ward corridor with patient identifiable information on view. Staff were unaware that this had happened. Some areas have signage reminding doctors to switch off screens when not in use to maintain confidentiality.

With regard to information governance, the director of nursing is the new Caldicott Guardian; however, she has only been in post for a short time. The Caldicott Guardian role had been allowed to flag, to the extent that it was put on the trust's risk register. The director of nursing intends to recommence providing a report to the board on information governance activity on a quarterly basis and generally raising the profile of the role within the trust. The trust has a new information governance toolkit and aims to have all staff completing the new online training module by 31 March 2011, but it will be a challenge to achieve this. The trust has carried out a data mapping exercise and has established that there is no known data flow overseas. The trust is also moving to an electronic-only medical records format and will start to shred paper versions in January/February 2011. The information governance lead provides training to the departmental information governance leads and also provides National Vocational Qualification (NVQ) training to health care assistants.

**Our judgement**

The trust has a clear system of audit for patient records, which highlights any issues and then puts action plans in place to address these. However, whilst there is a clear system, the latest reports for nursing and midwifery records show basic fundamental omissions, such as the frequency of patient observations, which leads us to question how effectively staff learning is addressed. Failings relating to the comprehensiveness and accuracy of recording of patient information can contribute to sub-optimal patient care and needs addressing by the trust. Information governance has undergone major review and the trust faces a difficult target to train all its staff in the new system by March 2011. The Caldicott Guardian role has not been fully covered for a time until the new director of nursing started in September 2010, so many of the functions of that role are only just been picked up again. The trust is aware of these issues and is making considered attempts to make the improvements; however, the results of which will not be apparent until autumn 2011.
**Improvement actions**

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>TDDI; surgical procedures; Diagnostic or screening procedures; Management of supply of blood and blood derived products etc; Maternity and midwifery services; Termination of pregnancies</td>
<td>Regulation_17.</td>
<td>Outcome 1 Respecting and involving people who use the services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Why we have concerns:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Whilst the Trust has produced information to patients, such as patient information packs, these are not used consistently by staff in all patient areas. Some patients we spoke to did not have this information and we saw that it was not available by patients’ beds. Patient information was in English and standard format only, throughout all clinical areas visited.</td>
</tr>
<tr>
<td>TDDI; surgical procedures; Diagnostic or screening procedures; Maternity and midwifery services; Termination of pregnancies</td>
<td>Regulation_12.</td>
<td>Outcome_8 Cleanliness and infection control.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Why we have concerns:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>An audit carried out by the infection control team in the cardiothoracic theatre department identified issues about the procedures for cleaning and the general infection control measures. Some of the issues were slow to be identified and then had not been addressed in a timely manner.</td>
</tr>
<tr>
<td>TDDI; surgical procedures; Diagnostic or screening procedures; Maternity and midwifery services; Termination of pregnancies Management of supply of blood and blood derived products etc;</td>
<td>Regulation_13.</td>
<td>Outcome_9 Management of medicines.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Why we have concerns:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>We have concerns that the arrangements for the safe storage and security of medication in some clinical areas may compromise the safety of patients and others.</td>
</tr>
<tr>
<td>TDDI; surgical procedures; Diagnostic or screening procedures; Maternity and midwifery services; Termination of pregnancies Management of supply of blood and blood derived products etc;</td>
<td>Regulation_19.</td>
<td>Outcome_17.Complaints.</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>Why we have concerns:</strong></td>
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</tr>
<tr>
<td>The information available for people regarding complaints in the hospital and on the trust's website is inconsistent and poorly displayed in some areas. Sixty-two per cent of the trust's responses to complainants are outside the time frame set by the trust.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>TDDI; surgical procedures; Diagnostic or screening procedures; Maternity and midwifery services; Termination of pregnancies Management of supply of blood and blood derived products etc;</th>
<th>Regulation_9.</th>
<th>Outcome_4.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Why we have concerns:</strong></td>
<td></td>
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<tr>
<td>Placing of patients in wards unrelated to the specialty under which they have been admitted can cause patients' care and treatment to be compromised, including if they have a physical disability. The trust is not always ensuring that specific individual needs are fully assessed prior to ward placement.</td>
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</table>

<table>
<thead>
<tr>
<th>TDDI; surgical procedures; Diagnostic or screening procedures; Maternity and midwifery services; Termination of pregnancies Management of supply of blood and blood derived products etc;</th>
<th>Regulation_22.</th>
<th>Outcome_13.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Why we have concerns:</strong></td>
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</tr>
<tr>
<td>There was a negative experience for some staff, and more pressure felt, in areas such as maternity and the MAU regarding staffing numbers and cover for breaks and/or provision of specialist support, which could impact on the delivery of care in those services. The middle management level was perceived by some staff as lacking leadership.</td>
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</table>

<table>
<thead>
<tr>
<th>TDDI; surgical procedures; Diagnostic or screening procedures; Maternity and midwifery services; Termination of pregnancies Management of supply of blood and blood derived products etc;</th>
<th>Regulation_22.</th>
<th>Outcome_21.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Why we have concerns:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The function of the Caldicott Guardian role has not been fully covered for a time and has only just been picked up again. The trust is aware of these issues and is making considered attempts to make the improvements; however, the results of these will not be apparent until autumn 2011.</td>
<td></td>
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</tbody>
</table>

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

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 within 28 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.
## Compliance actions

The table below shows the essential standards of quality and safety that are not being met. Action must be taken to achieve compliance.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>TDDI; surgical procedures; Diagnostic or screening procedures; Maternity and midwifery services; Termination of pregnancies</td>
<td>Regulation_15.</td>
<td>Outcome 10  Safety &amp; suitability of premises.</td>
</tr>
<tr>
<td><strong>How the regulation is not being met:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant concerns were raised with the provider regarding the management of identified risks associated with unsafe premises in the Cardio Thoracic Centre. These relate to the lack of appropriate measures taken to make safe the revolving entrance doors and provide adequate procedures and contingency planning for power failures within the unit and to address a breach of policy in respect of infection control.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TDDI; surgical procedures; Diagnostic or screening procedures; Maternity and midwifery services; Termination of pregnancies</td>
<td>Regulation_9.</td>
<td>Outcome_4.</td>
</tr>
<tr>
<td><strong>How the regulation is not being met:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is evidence of a lack of consistent, timely nursing care planning and assessment practices. Key risk assessments for patients with indicated needs, including weight loss, nutritional status and pressure ulcers, were not always in place and documented discharge practices were lacking in some cases. This is a significant concern as these issues were raised with the hospital as a compliance condition during registration in April 2010 and an improvement action was place on the trust by the Commission in May 2010.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TDDI; surgical procedures; Diagnostic or screening procedures; Maternity and midwifery services; Termination of pregnancies</td>
<td>Regulation_9.</td>
<td>Outcome_4 Care and Welfare.</td>
</tr>
<tr>
<td><strong>How the regulation is not being met:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is an overall lack of understanding and awareness relating to the care and treatment of elderly people who have dementia. It is evident that there are insufficient training opportunities and deficiencies in knowledge for staff relating to dementia awareness and challenging behaviour and that this impacts on their ability and confidence to meet the service user’s individual needs and provide</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### How the regulation is not being met:

Patients cannot always be assured that their nutritional needs will be identified or that they can be confident that staff will support them to eat and drink. Patient's food intake charts are at times inconsistently recorded and identified risks, such as weight loss, are not monitored regularly. Therefore patients may not be protected from the risks of inadequate nutrition.

### How the regulation is not being met:

Concerns were raised by patients regarding sufficient quantities of nebulisers in the MAU (east), which could impact on the safety of service users and meeting their assessed needs. Access to suitable shower and seating facilities was also raised as an issue which could impact on independence and comfort of service users.

Checking of resuscitation trolleys in some areas was inconsistent and systems to ensure that all staff are aware of changes to trolley contents are not always robust. This has the potential to pose a risk to patients in an emergency situation.

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The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

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 within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called Guidance about compliance: Essential standards of quality and safety.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions:** These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action:** These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.
Information for the reader

<table>
<thead>
<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
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<tbody>
<tr>
<td>Author</td>
<td>Care Quality Commission</td>
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<tr>
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<td>The general public</td>
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Care Quality Commission

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<tr>
<td>Telephone</td>
<td>03000 616161</td>
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<tr>
<td>Email address</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
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<tr>
<td>Postal address</td>
<td>Care Quality Commission</td>
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