

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

## Ellesmere Port Hospital

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

**Respecting and involving people who use services** ✓ Met this standard

**Care and welfare of people who use services** ✓ Met this standard

**Safeguarding people who use services from abuse** ✓ Met this standard

**Management of medicines** ✗ Action needed

**Staffing** ✓ Met this standard

**Records** ✗ Action needed

## Details about this location

Registered Provider	Countess of Chester Hospital NHS Foundation Trust
Overview of the service	Ellesmere Port Hospital is a small consultant led community hospital with 88 beds, providing rehabilitation and discharge planning. Emerald Ward has 16 beds specifically for rehabilitation after stroke. Ruby Ward has 26 beds, Diamond Ward has 24 beds and Sapphire Ward has 22 beds, all for general rehabilitation and complex discharge planning after illness or surgery. Sapphire Ward is only open in the winter months.
Type of services	Diagnostic and/or screening service Rehabilitation services
Regulated activities	Diagnostic and screening procedures Treatment of disease, disorder or injury

## Contents

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

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## Summary of this inspection

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### Why we carried out this inspection

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

This was an unannounced inspection.

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### How we carried out this inspection

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We looked at the personal care or treatment records of people who use the service, carried out a visit on 20 November 2012, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

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

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### What people told us and what we found

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We spoke with 24 patients and five relatives of patients who used the service. They commented that they felt comfortable with the service they received and told us that the staff were very helpful and supportive and had put them at ease. They said that the staff responded to call bells promptly and always asked permission before carrying out any examinations or care.

The patients we talked to said that staff had explained to them about their medical condition and that they were encouraged to ask questions if they didn't understand anything. Patients said staff asked them how they wanted to be addressed, were respectful and always maintained their privacy.

All of the patients we talked to said that there were enough staff to meet their needs. We saw that a member of staff went to every patient at least once an hour to check if they were comfortable or needed anything.

The hospital did not have a medicines self-administration policy. This meant that patients could not be supported to self-administer medicines as part of their rehabilitation plan. Nursing records were not always kept up to date, which could result in patients being given inappropriate care.

You can see our judgements on the front page of this report.

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### What we have told the provider to do

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We have asked the provider to send us a report by 29 December 2012, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

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### **More information about the provider**

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

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

## Our judgements for each standard inspected

**Respecting and involving people who use services** ✓ Met this standard

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

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### Our judgement

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The provider was meeting this standard.

Patients' privacy, dignity and independence were respected.

Patients' views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

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### Reasons for our judgement

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We spoke to 24 patients and five relatives of patients who used the service. They commented that they felt comfortable with the service they received and told us that the staff were very helpful and supportive and had put them at ease. They said that the staff responded to call bells promptly, although one said "sometimes they answer the bell and say they'll be back in a minute, but they might be ten minutes". They said that the staff always asked permission before carrying out any examinations or care.

The patients we talked to said that staff had explained to them about their medical condition and that they were encouraged to take part in drawing up a plan of care and also encouraged to ask questions if they didn't understand anything. Patients said staff asked them how they wanted to be addressed, were respectful and always maintained their privacy.

We observed the staff caring for the patients. Call bells were within reach and staff answered them promptly. Staff drew curtains around the beds before carrying out examinations or personal care. We noted that staff smiled and made eye contact with patients and were sensitive to their needs. There was only one exception to this when a member of staff responded to a person asking for the toilet by saying "You only went ten minutes ago!"

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

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**Our judgement**

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The provider was meeting this standard.

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

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**Reasons for our judgement**

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Most of the patients were transferred to Ellesmere Port Hospital from the Countess of Chester Hospital, although some were admitted straight from home.

All of the patients we talked to said their needs were met. We saw that a member of staff went to every patient at least once an hour to check if they were comfortable or needed anything.

We interviewed staff who told us that they always explained to patients about the care that was planned and asked for permission to carry out the care. The ward managers said if the patient did not have mental capacity, they would consult with the family. Multi-disciplinary case conferences were held every week with the patient and/or their relative to discuss discharge planning. There was an outreach team consisting of both hospital and community staff and social services who worked together to facilitate early discharge home with support. The average length of stay in the hospital was three weeks.

Staff identified patients who had dementia and consulted with them and their relatives to complete a booklet developed by the Alzheimers Society called 'This is Me', which provided detailed information about the patient, their life history and important people and events in their lives. This helped the staff to understand the patient better and provide more personalised care.

We observed a staff handover on Diamond Ward. This was very detailed and informed the staff coming on duty what each patient's diagnosis was, what their nursing care needs were and how their health was that day.

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

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## **Our judgement**

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The provider was meeting this standard.

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

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## **Reasons for our judgement**

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We spoke with patients and relatives of patients who used the service. They commented that they felt comfortable with the service they received and told us that the staff were very helpful and supportive and had put them at ease.

We spoke with ten staff who confirmed that there were policies and procedures in place for them to refer to should they have any concerns relating to safeguarding. Staff told us that they had received training in safeguarding adults from abuse and had also received child protection training. We examined records of staff training that confirmed this.

Staff spoken with demonstrated a good understanding of how to identify abuse and what they would do in the event that they had any concerns about the safety of a vulnerable adult or a child. Staff commented that they felt they could raise concerns with their colleagues and managers and that they would receive the support and advice they required to deal with issues of concern.

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

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## Our judgement

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The provider was not meeting this standard.

Patients were protected against the risks associated with medicines whilst in hospital, but were not protected against risk when they went home because policies for supporting safe self-administration in preparation for discharge had not been implemented.

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

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## Reasons for our judgement

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We looked at how medicines were handled and saw appropriate arrangements were in place for their prescribing and recording. A stock of discretionary medicines was available to enable the prompt treatment of minor ailments. We found that medicines were safely stored and controlled drugs were properly recorded and checked. Emergency medicines were available and daily checks were completed to ensure these were in date and available when needed.

We spoke with seven patients about their medicines. Most patients told us they had enough information about their medicines. One person told us they, "they always ask if you want painkillers". A second person confirmed that nurses, "have explained my medicine changes" and "I have the information I need to take my medicines at home". Another person said "The staff are good at managing my pain, they look after me very well indeed."

The seven prescription charts we looked at were clearly presented. Prescription charts were normally looked at by a ward pharmacist but the Sapphire Ward (winter ward) had a reduced pharmacy service compared with the other three wards. This meant that prescription charts sometimes had to be faxed to the pharmacy for a check before any new medicines were dispensed.

On the whole medicines were administered in accordance with the prescriber's directions. We saw that the times medicines were given was recorded to ensure that enough time was left between doses of the same medicine. Arrangements were in place to ensure that people prescribed medicines for Parkinson's disease (where timing is very important) received their medicines at the right times. However, we did note that a bowel chart for one person showed that they had constipation, but records did not demonstrate that the prescribed 'when required' laxatives were offered more frequently. This resulted in another stronger laxative being prescribed after a week.

We looked at the arrangements in place for managing people's medicines on discharge from hospital. Nurses explained that people's medicines needs were considered as part of their discharge plan and checks were made to ensure that, when needed, care packages were in place prior to discharge. Discharge medicines were normally delivered to the hospital mid-afternoon. Where medicines were needed at other times, special transport was arranged. Audits were not carried out to measure how effective current arrangements

were in ensuring there were no delays in obtaining discharge medicines.

One person we spoke with explained that they managed their own medicines at home but were uncertain about the medicines they were having in hospital, because they had changed. The hospital did not have a medicines self-administration policy. This meant that patients could not be supported to self-administer medicines as part of their rehabilitation plan.

## Staffing

✓ Met this standard

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

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### Our judgement

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The provider was meeting this standard.

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

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### Reasons for our judgement

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We looked at staff rotas and discussed staffing levels with staff and patients. Each ward had a minimum of two registered nurses on duty during the day and one at night plus health care support workers. Staff to patient ratios on three of the wards were 1:4 in the morning, 1:6 in the afternoon and evening and 1:10 at night from 9pm. Staffing ratios were higher on Emerald Ward and there was always a senior nurse manager on duty for the site who was supernumerary. Ward managers confirmed that extra staff could be brought in if necessary. In addition, each ward had student nurses, a ward clerk, a housekeeper who served patients with meals and drinks, and domestic staff. The patients we spoke with said they thought staffing levels were adequate. We discussed with one ward manager whether they thought staffing was sufficient at night and they said that the early part of the night could be very busy and they were going to trial having an extra nurse until 11pm. The head of nursing confirmed this and said if it was successful it would be extended to the other wards.

Medical cover was provided in the hospital from 8am to 7pm Monday to Friday and at other times a consultant or registrar was on call from the Countess of Chester hospital.

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

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## Our judgement

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The provider was not meeting this standard.

Patients were not always protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained.

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

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## Reasons for our judgement

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We looked at the nursing and medication records for a number of patients. Some of the nursing records were held on a computer database called Meditech and some charts, including the medication records, were kept in paper form at the end of the bed. Only authorised personnel had access to the database.

We saw that each patient had a full assessment recorded on the database with nursing directions and daily progress notes. Daily progress notes were completed regularly, but we saw that nursing directions weren't always updated promptly. For example, one patient had been seen by the tissue viability nurse specialist and dressings changed to alternate days. The frequency of the dressings had not been updated on the nursing directions, although staff had been told verbally and knew how often they should be changed.

We looked at how individual information within patients' care records on the database supported medicines administration. We found individual information on the medicine charts was not always incorporated into the nursing directions on the database to ensure medicines were given in a person-centred way. One record showed that a patient was regularly refusing a prescribed nutritional supplement. There was no record of this refusal being brought to the attention of the prescriber, or of any advice given about this.

Medication records for another person recorded that medicines should be given with yoghurt to assist with swallowing. This advice from the speech and language therapy team had not been incorporated into their nursing directions to help ensure consistency in approach.

Two staff we spoke with were less confident in using the database than others. There were a number of new staff in the hospital who were new to the electronic records system. The head of nursing confirmed that additional training would be implemented for these staff and that in the future the hospital would be looking to upgrade the electronic records system.

A patient and carer communication record was kept in a folder at the end of each bed for staff to update the patient or their relative on any investigations or changes to care planning. Patients and carers could also record comments or any information they wished to communicate to staff. We saw that staff sometimes used abbreviations and acronyms in these records that patients and relatives may not understand.

This section is primarily information for the provider

✕ Action we have told the provider to take

## Compliance actions

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

Regulated activities	Regulation
Diagnostic and screening procedures	<b>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</b>
Treatment of disease, disorder or injury	<b>Management of medicines</b>
	<b>How the regulation was not being met:</b> Patients were protected against the risks associated with medicines whilst in hospital, but were not protected against risk when they went home because policies for supporting safe self-administration in preparation for discharge had not been implemented.
Regulated activities	Regulation
Diagnostic and screening procedures	<b>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010</b>
Treatment of disease, disorder or injury	<b>Records</b>
	<b>How the regulation was not being met:</b> Patients were not always protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 29 December 2012.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

**This section is primarily information for the provider**

## About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

## How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

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

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

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

## How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

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**Minor impact** – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

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**Moderate impact** – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

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**Major impact** – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

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We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

## Glossary of terms we use in this report

### Essential standard

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

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

### Regulated activity

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

## Glossary of terms we use in this report (continued)

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### **(Registered) Provider**

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

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### **Regulations**

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

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### **Responsive inspection**

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

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### **Routine inspection**

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

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### **Themed inspection**

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

## Contact us

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