Inspection Report

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

Tameside General Hospital

Fountain Street, Ashton Under Lyne, OL6 9RW

Tel: 01613316000

Date of Inspections: 10 January 2014
08 January 2014
07 January 2014
06 January 2014
04 January 2014
03 January 2014

Date of Publication: March 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Respecting and involving people who use services	✖ Action needed
Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✖ Action needed
Cleanliness and infection control	✔ Met this standard
Management of medicines	✔ Met this standard
Staffing	✖ Action needed
Supporting workers	✖ Action needed
Assessing and monitoring the quality of service provision	✔ Met this standard
Complaints	✖ Action needed
Records	✖ Action needed

Details about this location

Registered Provider	Tameside Hospital NHS Foundation Trust
Overview of the service	Tameside General Hospital is an acute general hospital which is eight miles to the east of Manchester and serves a population of approximately 250,000. The hospital has 453 general and acute beds and 50 maternity beds. It provides a number of services including: accident and emergency, medicine, surgery, paediatrics, maternity, intensive care, high dependency and critical care.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Tameside General Hospital had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Consent to care and treatment
- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Cleanliness and infection control
- Management of medicines
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision
- Complaints
- Records

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 3 January 2014, 4 January 2014, 6 January 2014, 7 January 2014, 8 January 2014 and 10 January 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We spoke with one or more advocates for people who use services, talked with people who use the service, talked with carers and / or family members and talked with staff. We reviewed information given to us by the provider, were accompanied by a pharmacist, reviewed information sent to us by commissioners of services and reviewed information sent to us by other regulators or the Department of Health. We reviewed information sent to us by other authorities, reviewed information sent to us by local groups of people in the community or voluntary sector, talked with commissioners of services and talked with other regulators or the Department of Health. We talked with other authorities, talked with local groups of people in the community or voluntary sector, took advice from our specialist advisors and were accompanied by a specialist advisor.

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.

What people told us and what we found

We have found eight breaches of the regulations which would normally lead to enforcement action. This Trust however is in Special Measures and it is the responsibility of the Trust working with Monitor to ensure that any non- compliance is addressed in a timely way. We will report on this following our next inspection.

In the hospital, we talked to over 75 patients, over 20 relatives or carers and over 50 staff,

as well as 24 senior managers. At our listening event held off site, we spoke with twelve people who had used the hospital's services or who cared for someone who had. We also spoke with a range of stakeholders before and during the inspection.

Most patients, relatives, carers and staff spoke positively about the recent changes to the governance of the hospital. Although the systems were not yet fully implemented, we found that the hospital was responsive to concerns raised during the course of the inspection. The hospital had taken reasonable steps to put an effective system in place, given the resources available, and had suitable plans in place to meet the requirements of other regulations. We will be following up to see whether these improvements have been sustained.

Staff said that the culture was now "changing quite quickly" which was challenging for some staff. One senior manager said: "For the first time, I feel like I'm able to be [a senior manager]".

The patients, relatives or carers we spoke with described staff as friendly, patient, caring, hands-on, and courteous, even while reporting concerns about their experience.

One patient said that, because of their previous experience, they had delayed their current admission to hospital, which made their condition worse. They told us that so far they had "brilliant care", "much better" than their previous experience. Another patient said the hospital was "better than it used to be. I still think they need more staff." One patient on the medical assessment and admissions unit (MAAU) said: "[MAAU is] a bit of a madhouse – nurses and staff run off their feet."

One patient said: "I'm fed up of waiting to hear something from a doctor." Another patient said: "I'm frustrated by the lack of information from doctors….They don't seem to talk to each other."

Staff said: "the new processes are working well and improving patient flow." One junior doctor in the emergency department told us the senior cover had improved and there was more support than there used to be, stating: "Things are so much better now." A nurse on an adult medical ward said "we sometimes have to wait quite a while when we have requested a doctor to come to the ward."

Senior managers told us that the hospital's aim was to encourage staff on the wards to "recognise what 'good' looks like."

We found adequate systems in place to manage medicines, to maintain cleanliness, and to control the risk of infections. Generally, we found that people consented to and received appropriate care and treatment in the paediatric and surgical units. Paediatric patients and their relatives or carers were safe and adequately involved.

In the adult medical wards, however, we found that staff did not demonstrate an adequate understanding of the legal processes established by the Mental Health Act 1983 and Mental Capacity Act 2005. Staff disclosed that some patients were restrained without safeguards in place.

We observed that adult medical patients were not protected against the risks of inappropriate or unsafe care and treatment, because staff did not adequately assess their needs. Patients' medical records were inaccurate and incomplete. Care and treatment did not reflect guidance issued by appropriate professional and expert bodies.

We saw that there were not enough staff to meet the needs of patients in the MAAU and some adult medical wards. Supervision of staff, including doctors, was variable, although some staff felt there had been improvements since the change in senior and ward management. Staff spoke positively about their induction and mandatory training. We observed poor staff competencies in other areas, such as caring for patients with dementia.

We observed variation in how staff interacted with adult medical patients, relatives and carers. Some staff did not ensure the dignity and privacy of patients or involve them in their care and treatment. Several people raised concerns about communication with the hospital. Although the hospital had a number of programmes in place to engage with people who used the service, most of the people we asked did not know how to provide feedback or make a complaint.

We saw that the hospital had made improvements to the system for managing complaints; however, the system was not yet effective.

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

What we have told the provider to do

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

We have found breaches of the regulations which would normally lead to enforcement action. This Trust however is in Special Measures and as a result we are drawing specific attention to the breaches to require both the provider and Monitor to give assurance that the non-compliance is being addressed.

People's views and experiences were not taken into account in the way the service was provided and delivered in relation to their care. People's privacy, dignity and independence were not respected.

We have judged that this has a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

At the last inspection in May 2013, we found evidence of non-compliance with this regulation. The systems in place for triaging patients in the emergency department (ED) did not respect patients' privacy and dignity. We judged this to have had a minor impact on people who used the service. The provider sent us an action plan in July 2013 which stated they would develop a standard operating procedure for triaging and handover and monitor patient experience via a kiosk and the 'friends and family test' survey.

At the recent inspection visits in January 2014, we found that the hospital had significantly improved the system for triaging patients. We observed that the new system supported staff to respect patients' privacy and dignity. Two paramedics told us that handovers between the Northwest Ambulance Service and the hospital had greatly improved. They said: "Handovers to nurses/doctors is now done confidentially within a designated cubicle."

We visited a number of wards and units in the hospital and spoke to approximately 75 patients, relatives or carers. The gowns provided to some patients by the hospital looked comfortable and smart; patients told us they preferred them to their own clothes.

The people we spoke with were almost unanimously positive regarding staff attitudes; people described staff as friendly, patient, caring, hands-on, and courteous, even while reporting concerns about their experience. The positive comments about staff included:

"One thing I really appreciate is that the staff call you by name and ask you 'how are you today' – they make you feel like you are someone they are interested in."

"I have nothing but praise for [the hospital]. I received nothing but efficiency. I was told about any delays and was kept informed throughout."

"I give them 10 out of 10! They are all fantastic people and I haven't come across a single person who isn't courteous, friendly and polite. That includes all staff like cleaners and porters."

"All the nurses are very nice and very helpful. I like to do things myself as much as possible and they let me do what I can. They're looking after me very well."

People on the paediatric unit spoke positively about staff. One young person said: "The nurses are dead nice and the doctors are really friendly. There was one moody man in [diagnostics] yesterday, but that was in the adult bit. Everyone in the children's ward has been great." Another young person said: "The nurses are good and I have a good laugh with them. All the doctors are nice. They always tell you who's looking after you." We observed positive interactions between paediatric staff and patients, relatives or carers. One paediatric nurse told us: "a relaxed parent is a relaxed child."

We carefully reviewed the feedback provided by patients, relatives and carers, along with our observations of the wards and units, to identify specific themes. Some patients spoke positively about the information provided by staff: "I know what the problem is and I know what's going to happen tonight and tomorrow. You can't say fairer than that, can you?" We observed that on some wards staff communicated well with each other and with patients, relatives and carers.

We found that most of the concerns reported to us during the inspection were about patients on adult medical wards (such as wards in the Charlesworth or Ladysmith buildings) or about patients who lacked capacity. We also found that people were more likely to report concerns about care or treatment over the weekend or at night. One patient said: "I'm fed up of waiting to hear something from a doctor." Another patient said: "I'm frustrated by the lack of information from doctors. I came in before the weekend and I was left over the weekend with no information at all. Last week someone told me I could go home and then someone else told me I needed a scan so I've got to stay in. They don't seem to talk to each other. Now I'm told I need to see a [specialist doctor] but I don't know when or what's going on."

We observed some positive interactions between staff and patients, relatives or carers. A consultant asked a relative to have a private discussion in the day room, rather than in the open ward. We spoke to this relative later who said the doctor told them they could stay on the ward as their family member did not have long to live. The relative said "can't fault [the staff]". We saw that some staff pulled curtains around patients during care or treatment, to preserve their dignity. During meals, some staff referred to patients by name. One patient said: "I can't fault the staff and they give you privacy when you need it." This meant that the hospital had taken steps to ensure they respected people's dignity and privacy.

However, in Ladysmith wards, domestic staff cleaned around patients while patients were eating. In the emergency department (ED) and medical assessment and admissions unit (MAAU), some patients were uncovered and exposed. We heard some staff talk about patients' care and treatment in front of other patients and visitors. This meant that some

staff did not adequately respect patients' dignity or privacy.

We observed some staff providing care for patients in a depersonalised way. Some staff stood over patients or did not speak to patients while supporting them with eating. Some staff referred to patients as "feeders" at mealtimes. Other staff referred to patients by their gender and ED breach time when staff asked about capacity in the units or wards. 'ED breach time' refers to the time when a patient would exceed the four hour target for being seen, treated, admitted or discharged, if they stayed in the ED any longer.

Records of some patients with confusion or dementia referred to the patient as "wandersome" or "pleasantly confused". One patient had cling-film stuck to their hands and face, because staff had not removed it from the dishes when providing them with their meals. Another patient repeatedly refused assistance from staff, eventually telling the staff member that they did not like it because it was "too fast." We saw a nutritional assessment of a person with dementia that had been started by a nurse at four am but abandoned, stating "not able to assess – patient confused". This meant that staff did not adequately support people in relation to their care or treatment. Some staff did not adequately respect patients' dignity or consider their individual needs when providing care and treatment.

Prior to the inspection, we received concerns about the quality of communication between staff and patients or relatives, especially for those patients who lacked capacity due to physical and mental health conditions. Healthwatch Tameside, in their engagement programme with local people, found that more people felt communication with the hospital needed improvement than people who felt communication was good. During our listening event on 7 January 2014, people told us: "communication is the number one issue" with the hospital.

During the inspection visits in January 2014, we observed good communication with relatives of paediatric patients. Parents told us they were happy that they were kept informed. However, some relatives of adult medical patients had difficulties communicating with staff. People told us that staff were unavailable during visiting hours on some wards and it was a struggle to obtain explanations about care and treatment. One relative said that communication with staff as well as between members of staff was poor and they had found messages had not been passed on. Another relative said "This lack of information is very frustrating!" This meant that staff did not provide people with appropriate information and support in relation to their care and treatment. The senior managers acknowledged that communication with people needed improving. One senior manager said: "Particularly when talking to relatives, we don't always make sure they understand."

One patient said they struggled to get information from qualified staff, but instead was able to get information from a healthcare assistant: "the staff are really good, but communication really does need to improve." We raised concerns with senior managers who told us that some wards were piloting unrestricted visiting hours. Relatives of one poorly patient complained to us that no one had explained anything to them despite them being there most of the day. We discussed this with the nurse in charge who said the patient would be transferred to another hospital the next day, and they had not told the patient's relatives because "I didn't have time."

We spoke with a police officer who told us about recent visits to the hospital where patients were abusive to staff or where visitors were disrupting care and treatment. The hospital had a policy in place to support staff in managing difficult behaviours. We observed that some conflicts between staff and patients or visitors escalated to a point

where staff could no longer manage the situation. The hospital must consider how staff provide information and support to patients and relatives, especially those with challenging behaviours.

Some patients in the hospital lacked capacity and could not communicate their preferences to staff. One relative said they felt positively involved; staff had allowed them on the ward to help with personal care until the patient accepted care from staff. Other relatives of patients who lacked capacity told us that staff did not ask them about the patients' preferences. We observed that there was no information on the patient preferences readily available to staff serving meals or drinks. This meant that people who lacked capacity were not supported to express their preferences.

During the inspection, some patients told us they were happy with the information provided. Others told us they did not know what was going on or when they would be seen by a doctor. We reviewed this feedback carefully and identified that people were more likely to report concerns about lack of communication when specific staff were on duty or when the unit or ward was very busy. This meant that people were not always treated with consideration and respect.

One patient told us that, had they received accurate information regarding their treatment, they would not have proceeded with the treatment. Three patients who had been re-admitted to hospital following recent discharges told us that the lack of information provided at their last discharge from hospital contributed to the latest emergency re-admissions to the hospital. All three people told us that they felt their most recent admission was much better, because staff listened and fully investigated the reasons for their admission. We spoke with senior management at the hospital who acknowledged concerns about poor communication; we saw that the hospital was monitoring re-admissions and had plans to look into potential causes, to develop an appropriate action plan.

We observed that patients on adult medical wards had varied access to media or entertainment, such as televisions or radios. People on wards without individual televisions told us they felt bored. One patient told us: "It's nice to have a chat with you because there's not much else going on." Our observations on the adult medical wards contrasted with our observations in the paediatric unit, where children had access to many forms of entertainment as well as people and staff with whom they could socialise. One young person told us: "They've even got [electronic tablets] for you to use – it's brilliant! You're never bored." Another young person said: "It's great here. It's like a hotel rather than a hospital!" The provider may consider how they prevent the risk of isolation amongst adult patients.

Consent to care and treatment ✖ Action needed

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was not meeting this standard.

We have found breaches of the regulations which would normally lead to enforcement action. This Trust however is in Special Measures and as a result we are drawing specific attention to the breaches to require both the provider and Monitor to give assurance that the non-compliance is being addressed.

People were not asked for their consent before receiving care or treatment. The provider did not act in accordance with people's wishes. Where people did not have the capacity to consent, the provider did not act in accordance with legal requirements.

We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

Before the inspection, we received concerns regarding this regulation.

The Mental Capacity Act (MCA) 2005 states that, if a patient lacks capacity to make a decision, staff should establish whether someone else has lasting power of attorney for the patient's health and welfare. Otherwise, staff should consult with people who may know the preferences of the patient, such as relatives or other professionals, in order to make a decision in the patient's best interest.

We spoke with the relatives of one patient who lacked capacity; they told us that a doctor in the ED had mentioned a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Order to them; they said they told the doctor that they needed to think about it. We saw that this patient had a DNACPR order in place and the order indicated that relatives had been involved in the decision. We confirmed that the patient had no other relatives who may have been involved in the decision to put a DNACPR order in place. The relatives we spoke with were not aware that the doctor had put a DNACPR in place. One relative said that, in the ten days since their family member was admitted to the hospital, they "had not signed any document" and were unsure what would happen if their family member's health deteriorated. This meant that staff did not adequately involve the relatives in the decision or inform them of the existence of the DNACPR.

The hospital's policy on resuscitation reflected the MCA 2005, stating: "Information should not be withheld because the healthcare team find it difficult to convey the decision to patients or advocates. It is preferable for them to be informed of the existence of a DNACPR rather than they find out by chance." and "Clinicians should document the

reason why a patient has not been informed of a DNACPR decision." The staff did not follow this policy, or the MCA 2005, when making decisions about this patient's care and treatment. This meant that before people received the DNACPR order, patients were not asked for their consent. Where patients did not have the capacity to consent, the provider did not act in accordance with legal requirements.

Staff in the adult medical wards did not demonstrate an adequate understanding of capacity and consent. We looked at the notes of two patients on two different wards who staff described as "challenging" and "refusing medication". There was no evidence of capacity assessments regarding the decisions to consent to treatment, although staff told us that they felt the patients were confused and lacked capacity. One patient's records stated on two occasions that the patient had provided verbal consent, even though staff believed this patient lacked capacity. This meant that staff did not act in accordance with legal requirements.

On an adult medical ward, we observed one patient, who appeared agitated while asking to see their partner, verbally refused medication. In response, staff requested support from a doctor on the MAAU to prescribe sedatives for this patient.

On the MAAU, we spoke with staff who told us that staff had given another patient sedative medication as an injection because the patient had refused the medication. We spoke to this patient, who said: "I had an injection but didn't want it." This patient's medical notes stated: ""Patient is at risk to [self] and at risk to other patients. Given IV [sedative medication] – best interests as patient has no capacity." There was no record of a capacity assessment of this patient regarding the decisions to stay in hospital or the decision to take medication. There was no detail regarding how the patient was at risk to themselves and other patients. Staff were unable to explain why this patient was at risk to themselves and others. We spoke with a doctor from the local mental health Trust who said "I have advised staff can use [sedative medication] to manage [the patient] but [the patient] will require monitoring." The hospital's medication policy stated: "a clear distinction should always be made between those patients who have the capacity to refuse medication and whose refusal should be respected, and those who lack this capacity." "Disguising medication … cannot be taken in isolation from the recognition of the rights of the person to give consent." The staff did not follow this policy, or the MCA 2005, when making decisions about this patient's care and treatment. This meant that the provider did not act in accordance with legal requirements.

During the inspection, we found that staff in the paediatrics and surgery units had an adequate understanding of the principles of consent. In the surgery unit, we saw evidence of written consent in patients' medical records. In the paediatrics unit, one nurse told us that they used play specialists to help obtain consent. We observed staff obtaining verbal consent from children, where appropriate, and their parents. Staff provided information to children and relatives in a format which they could understand. One young person said: "The doctors ask me if I understand what they've said to me and ask me to repeat it back. I can remember it better than [my parent]!" One parent disclosed to us that they had been scared they might not understand information about their child's care and treatment. This relative stated "So far, I've understood everything they've said, so that's a big relief." This meant that in the paediatric and surgery units, people were asked for their consent and the provider acted in accordance with their wishes.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

We have found breaches of the regulations which would normally lead to enforcement action. This Trust however is in Special Measures and as a result we are drawing specific attention to the breaches to require both the provider and Monitor to give assurance that the non-compliance is being addressed.

Care and treatment were not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

At the last inspection in May 2013, we found evidence of non-compliance with this regulation. Patients were admitted to or discharged from the hospital with limited information about their needs. Those admitted to escalation areas had variable care and long lengths of stays in hospital. We judged this to have had a minor impact on people who used the service. The provider sent us an action plan in July 2013 which stated they would improve bed management to reduce usage of escalation areas.

At the recent inspection visits in January 2014, we found that the hospital had improved triaging in the emergency department (ED), resulting in better quality and quicker handovers with the local ambulance service. We spoke with two paramedics who said: "You no longer have to go looking to find a member of staff to triage a patient" and "I come here quite a lot and have found the improvements have really helped both patients and us". We observed that sometimes the ED struggled with the number of patients. One patient was alone on a trolley in an ED corridor when we arrived. Another patient in ED told us that they had waited on a trolley in the ED corridor for up to three hours, but was seen "within minutes" by a doctor once they had been moved to a cubicle. One patient who had been admitted to hospital said "there was an excellent doctor in [the ED]. [They] had me sorted in no time."

We saw that children attended the ED through the main entrance, because the paediatric reception was not open. We noted that when the paediatric ED was closed at night, children were quickly triaged and escorted to a private cubicle, to avoid further exposure to other patients in the ED. We observed that both adult and paediatric patients in the ED were assessed in a timely manner and monitored appropriately. This meant that care and treatment were planned and delivered in a way that was intended to ensure people's

safety and welfare. However, we found evidence that one patient had been discharged from the ED, awaiting diagnostic results, and no discharge letter was sent to their community physician. This patient told us their physician was still waiting for diagnostic results when they were re-admitted to the hospital a week later. Senior managers acknowledged that staff were still learning how to use the new electronic system which was implemented in October 2013. We saw that the hospital maintained a register to log and track problems with the electronic system. The provider may consider how they ensure patients are discharged from hospital with the appropriate information to support their care in the community.

Staff in the ED told us that patients with mental health problems who were not in need of immediate physical care were placed in a special cubicle which had two doors, observation windows, a hard-wearing floor, two plastic chairs and no decorations. A nurse told us that there was no routine monitoring of mental health patients waiting to see the psychiatric liaison nurse. During our inspection visit, the observation cubicle was frequently occupied, which meant that other patients with mental health problems waited in seats in the ED within sight of the nursing station. We saw that there were five patients in the ED awaiting assessment by the psychiatric liaison worker, in addition to patients in the medical assessment and admissions unit (MAAU). We heard the liaison worker say that they "need to visit [the ED] first otherwise I will breach". A 'breach' is when workers were not able to assess a patient within a certain time period. The hospital did not use a specific mental health triage tool to adequately assess risk. This meant that staff did not plan and deliver care and treatment in a way that was intended to ensure people's safety and welfare.

One patient with mental health problems was triaged as "v[ery] urgent" by staff and placed in a seat within sight of the nursing station. Twenty minutes later, the patient had left the ED un-noticed. Later in the night, we found this patient lying on the floor of the observation cubicle because they felt tired. The patient did not have a blanket or other means to make themselves comfortable. The patient told us that their experience in the ED "has been absolute [expletive]" and "they didn't know anything about mental health" and that "they admitted it" that "they didn't have a clue." They told us that they did not feel that they received the same attention as other patients because of their mental health problems. This meant that staff did not plan and deliver care and treatment in a way that was intended to ensure people's safety and welfare.

People who used the out-patient service at the hospital told us: "I waited for six months for my appointment – four times my appointment has been cancelled" and "I received three letters to see a diabetic nurse – the day I was going I received a letter cancelling my appointment at the last minute!" Senior managers acknowledged that out-patient clinics were not meeting pathway targets as a result of a backlog caused by implementation of a new electronic records system. This resulted in patients referred to the out-patient clinics experiencing delayed access to care and treatment.

We found that children and their relatives or carers spoke positively about their experiences in the paediatric unit. One carer said: "The nurses here are brilliant. They work closely with all sorts of professionals and have good liaison with teams outside the hospital." Another carer said: "[The patient] is very volatile and needs two supporting workers, but the nurses here are coping very well. It's not easy for them, but they are doing very well." The hospital had a number of programmes in place to engage with children's services in the community. Staff provided care and treatment in a way that met the needs of the patients and their relatives or carers. Parents waiting in the observation and assessment area told us they were happy that their children were being assessed quickly.

We saw that care and treatment for children was planned and delivered in a way that was intended to ensure their safety and welfare.

Senior managers acknowledged that time to theatre for many patients with fractured neck of femur did not meet the target (two days) but that the hospital was able to meet post-operative targets for care and treatment. We spoke with patients who recently underwent surgery, and all but one felt their experiences were good. One patient favourably compared their experience at Tameside General Hospital to a previous operation they had at another local hospital, saying it was a "dream visit to hospital." Another patient said they had "no complaints about how they looked after me."

Staff in the women's health unit told us that gynaecological elective surgery was sometimes cancelled because there were no available beds. This was because the unit was used for escalation of female patients (male patients would stay on the MAAU). We spoke with surgical staff who spoke negatively about the lack of beds for surgical patients; as this meant that they could not proceed with planned surgery. They explained that non-urgent elective in-patient theatre lists had been reduced from 23 December 2013 to 13 January 2014 to free up in-patient beds. They said there had been no explanation from senior managers regarding how the hospital would manage any 'backlog' of surgery cases as a result of this decision. On 7 January 2014, staff told us that six patients had their operations postponed that morning due to bed shortages.

We talked with patients, relatives and carers on the adult medical wards and MAAU. One patient said: "I think I get good care here." A relative of a patient who lacked capacity said care was "quite good, considering [the patient's] behaviour". Three patients were pleased that their current experience of being in hospital was better than their recent other experiences of being in this hospital. All three patients said they had been discharged previously with "no proper diagnosis or treatment" and felt that the doctors, at the time, "dismissed [their] symptoms". One patient said that, because of their previous experience, they had delayed their current admission to hospital, which made their condition worse. They told us that so far they had "brilliant care", "much better" than their previous experience.

We found risk assessments and care plans for people in the MAAU and adult general medical wards did not reflect their individual needs. On the ED, one patient's records stated that the patient was low in mood and had overdosed. This patient had not been assessed for thoughts or risk of self-harm or suicide. The plan was to discharge the patient, with no mention of a referral to mental health services. In an adult medical ward, one patient, admitted due to a fall, had a "quick screening checklist" which did not accurately identify the patient had dementia, a falls history, or a risk of pressure ulcers. The patient had a note on the front of their medical records which said: "please weigh, urinalysis and complete nutritional screen." The nurse in charge said that they had not done this and did not have time to do this.

We visited an adult medical ward in the Ladysmith building and saw that staff did not consistently monitor what these patients ate or drank. We observed one patient ate very little. Their weight chart said they lost over 4 kg between 23 December 2013 and 2 January 2014. The patient did not have a care plan in place to address the poor diet and weight loss, except to say that the patient needed "encouraging." We observed that staff did not speak with or encourage the patient while supporting the patient to eat. Although staff told us they would offer sandwiches to patients who did not eat their meal, we did not see that this patient was offered any other food. This patient's records indicated that the patient did not have a suitable diet. This patient's nutritional screening tool (NST) indicated

the patient was high risk and required a referral to the dietician. The multi-agency discharge plan stated that this patient "requires a referral to the dieticians if not already done due to NST score and recent weight loss." There was no evidence that staff had taken appropriate actions to meet this patient's and another patient's nutritional needs; these patients had not yet been assessed by a dietician, although they had been in hospital for over seven days.

We also saw evidence that this patient, and others, did not have regular monitoring of their glucose levels. Another patient developed diabetic ketoacidosis while in hospital. This meant that staff could not adequately identify diabetic patients' individual needs or provide safe treatment for their diabetes.

Some patients in the MAAU had adequately completed assessments and care plans; we spoke with these patients and they said they had seen a doctor promptly, were aware of what would happen next and had some idea of when they would be discharged. This was in contrast to other patients in the MAAU who had limited information about their care needs in their medical records; staff told us this was because patients were "not clerked in" or were "waiting on assessment by [a specialist doctor]". We spoke with these patients who told us they had been admitted to the MAAU between four and six hours ago and had not yet seen a doctor. They did not know when they would see a doctor, what they were waiting for (other than "tests"), or when they would be discharged from hospital. We saw that some of these people had incomplete assessments or care plans which did not reflect their needs. We raised concerns about one patient with a sustained high blood pressure who did not receive further monitoring or treatment; this patient eventually experienced a transient loss of consciousness before being assessed by a senior doctor and given treatment.

Two patients in the MAAU did not have assessments which reflected guidance for the care and treatment of their head injuries produced by the National Institute for Health and Care Excellence. One patient had attended ED following a collapse and head injury; they received blood tests but no imaging, such as computed topography (CT). They were rapidly assessed and discharged from the ED with instructions on how to monitor for deterioration. When they deteriorated, the patient saw their community doctor, who referred them immediately back to hospital, where they were seen first in the ED and then transferred to the MAAU. We saw that, although it was over six hours since they came to hospital, this patient's medical notes contained little information about their needs or risks and did not mention the recent attendance in ED for a head injury. There was no evidence of neurological observations or a completed Glasgow Coma Scale, although the patient reported confusion, memory loss, more than one episode of nausea/vomiting, and pain. There was no evidence of imaging, such as a CT, and they had not yet been seen by a doctor in the MAAU. This meant that their care and treatment did not reflect the relevant research and guidance.

We observed one patient on an adult medical ward who needed additional monitoring due to deterioration of their condition. The patient told us that they felt very ill and could not breathe. We saw that the patient was not on a monitor and that staff could not provide the level of nursing care this patient needed without neglecting the other patients on the ward. Staff told us that this patient was due to be transferred to another hospital the next day. Senior managers acknowledged concerns regarding the management of deteriorating or poorly patients. Staff described the MAAU as a 'pseudo-HDU' and explained that there was a poor provision of specialist medical input into the MAAU.

We received concerns from staff that patients were transferred to wards without due

consideration for whether the staff in place could meet their needs. However, we saw that the hospital had made improvements to their bed management system since the last inspection, reducing the usage of escalation areas and the number of medical outliers (i.e. medical patients on non-medical wards). Staff told us that the recent appointment of a patient flow manager in September 2013 had made a positive difference. They said: "the escalation process is working really well" and "the new processes are working well and improving patient flow." We met with patients who were medical or surgical outliers. All of these patients had been reviewed by their speciality doctor. The nurses caring for these patients were aware of the patients' needs and care plans; they said that the doctors attended in a timely manner when the nurses called them.

The bed management team told us that, on Saturday 4 January 2014, there were 20 "medically fit" patients who could be discharged but were awaiting packages of care. Staff said this number can go up to 80 patients, which was a significantly high proportion compared to the size of the hospital, as a small acute Trust. The hospital acknowledged concerns regarding discharge planning; we saw evidence of work with the clinical commissioning group to improve discharges from the hospital. We observed that bed management staff followed the hospital's escalation procedure, which included notifying the on-call managers and the local clinical commissioning group, when they identified that the hospital may be short on beds.

When we visited the MAAU, we found one patient walking near the door, asking and attempting to leave. We observed several staff stop the patient from exiting the unit, telling the patient, without further explanation, that "you are not allowed to leave" or "you cannot leave". Staff told us that staff from the local mental health Trust told them that the patient should not be allowed to leave. They acknowledged that there was no legal framework in place to support this, however. We spoke with the patient, who told us: "They said they'd admitted me. I keep trying to escape what's happening. I don't want to be here." and "I don't think I need to be here. I have been a bit forgetful."

We reviewed this patient's medical records and saw a note by clinical staff that this person was admitted as a result of concerns about the patient's weight loss and was not safe to return home. The staff confirmed that the patient had been unlawfully detained in hospital for several days. We asked staff to take action to safeguard this patient.

After consulting with relevant professionals from the local mental health Trust, staff eventually told us that they would detain the patient under Section 5(2) of the Mental Health Act 1983. Section 5(2) allows for the detention of a patient in hospital for no more than 72 hours, by the responsible medical officer in charge of the patient (normally the consultant) The patient must be informed of their rights orally and in writing, as soon as possible and within 24 hours.

The doctor covering the MAAU at that time said they had never detained a patient under section 5(2) of the MHA or made an application under Deprivation of Liberty safeguards (DoLS). When we followed up on this patient the next day, we saw that the patient had not been legally detained. Staff told us that this person had been transferred to the care of another provider. This meant that this patient was deprived of their liberty without authorisation by the Court of Protection or by a Supervisory Body under the DoLS. We found that the hospital did not have an adequate system in place to lawfully keep patients in hospital to receive necessary medical treatment; this resulted in staff depriving people of their liberties without following due process to protect their rights.

Although the hospital was registered to provide assessment or medical treatment for

persons detained under the Mental Health Act 1983, senior managers told us that there were no arrangements in place to receive and scrutinise MHA detention papers. There was no written service level agreement with the local mental health Trust to undertake these functions. Senior managers told us that due to the lack of arrangements, MHA detentions were not undertaken within the Trust and that this was "widely understood" by staff. We spoke with staff, who were unable to demonstrate an adequate understanding of the MHA, the Mental Capacity Act 2005 or the DoLS, even though hospital policies referred to section 5(2) and section 136. One senior manager said that DoLS work had been "put aside" following an external review in 2013, as it was less of a priority. The manager acknowledged a lack of expertise in the hospital regarding the DoLS although they expected this to improve once more of the change programme had been completed.

We saw that there was no patient information available on the wards or the ED about the local mental health services or their rights as detailed by the MHA. We reviewed the medical notes of a patient on the MAAU who was being assessed for detainment under the Mental Health Act (MHA) and saw no evidence of staff explaining to this patient their rights. The hospital's psychiatric liaison team were not sure of the timescales for completing assessments under section 136. They told us that staff did not complete documentation regarding section 136 in the ED: "we don't get involved in rights as they are not our patients."

After identifying concerns with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders for patients on the MAAU, we reviewed the records of all patients on an adult general medical ward and found that, of the ten DNACPR forms in place on that ward, none of them reflected the Resuscitation Guidelines 2010. The Resuscitation Guidelines 2010 recommend that staff maintain accurate records detailing the reason for the DNACPR order and the process for putting the DNACPR order in place. The guidelines also detail the process staff should follow to determine whether a DNACPR order is appropriate; this process reflects the Mental Capacity Act (MCA) 2005. Staff should establish whether someone else has lasting power of attorney for the patient's health and welfare. Otherwise, staff should consult with people who may know the preferences of the patient, such as relatives or other professionals, in order to make a decision in the patient's best interest. Finally, staff completing the DNACPR order should ensure all relevant people involved in this person's care, including relatives, are informed about the DNACPR order and the reasons for it.

Four of the eleven DNACPR orders we reviewed were missing reasons for the DNACPR order. All eleven stated that the timing for the review of the DNACPR was "indefinite." Five of the eleven DNACPR orders had no name or signature for the nurse. None of the DNACPR orders involved the patient in the decision: two of them stated why ("no capacity") and seven had a diagnosis which indicated no capacity. This meant that four patients had DNACPR orders which did not adequately demonstrate that staff had regard for the MCA 2005. Although five DNACPR orders stated that relatives were involved, only one contained information about this conversation in the patient's medical records. We spoke with one family who believed it was their decision to put a DNACPR order in place and was unaware a DNACPR order was already in place. This meant that staff did not adequately involve the relatives in the decision. People's care and treatment did not reflect the relevant research and guidance.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

We have found breaches of the regulations which would normally lead to enforcement action. This Trust however is in Special Measures and as a result we are drawing specific attention to the breaches to require both the provider and Monitor to give assurance that the non-compliance is being addressed.

People who used the service were not protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We have judged that this has a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

Before the inspection, we received evidence of concerns regarding this regulation.

In our out-of-hours visits on the medical assessment and admissions unit (MAAU) and adult medical wards, we observed complex and challenging patients whose behaviour included verbal or physical abuse. We reviewed these patients' medical records and did not see plans for how to keep these patients and other people safe. We observed that staff called security and then the police when the behaviours escalated. In the MAAU, patients said it was a difficult night. One patient on oxygen therapy said it was "a bit scary for me" as they felt they needed help but did not want to call for help because the nurse was so busy with the three complex or challenging patients. One relative said "All in all it was a very noisy and difficult night with alarms going off and people shouting abuse."

We spoke with staff on the paediatric unit who demonstrated an adequate understanding of child protection. We saw evidence that the hospital had an adequate system in place for the safeguarding of children and young people.

We saw evidence of recent improvements to the safeguarding system, including focused work for people with learning disabilities. The hospital had a system in place for safeguarding adults which reflected their safeguarding agreement with the local council. This meant that safeguarding concerns regarding hospital patients were generally investigated by hospital staff appointed as adult safeguarding managers. We noted that the safeguarding referral forms, supplied by the local council, did not support the hospital to collect and report relevant information, such as who raised the concern and when. There was no evidence of audits on whether the hospital was referring concerns in a

timely way to the council.

There was no lead consultant for adult safeguarding. Senior managers raised concerns with us about the difficulties of recruiting doctors who felt safeguarding was "a nursing thing." Although junior nursing staff had an adequate understanding of safeguarding principles, more experienced staff (including those in supervisory roles and those who were trained adult safeguarding managers) did not have an adequate understanding of what constituted a safeguarding concern. These experienced staff members did not articulate the importance of immediately assessing the risk to the patient and putting safeguards in place, or the importance of reporting the concern to the local authority. The majority of staff we spoke to about safeguarding referred to examples of patients who were at risk of abuse or neglect by other people, such as relatives or care homes. Few staff recalled examples which demonstrated an understanding of the risks of abuse or neglect in a hospital setting. One nurse said that safeguarding adults procedures applied only to patients who "did not have capacity." This meant that people who used the service were not protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse.

We saw the hospital had received eight safeguarding referrals between 30 December 2013 and 6 January 2014. Of these eight referrals, five were from the triaging of complaints, one was from the Care Quality Commission, and two were from staff. We reviewed one open complaints investigation which contained safeguarding concerns but did not result in a referral to safeguarding, as the complaint was made before the new triaging system was put in place. A senior manager said that the referral "should be made once the complaints investigation was completed". We reviewed another complaint from a patient regarding a near-miss medication error that could have caused the patient significant harm. There was no evidence that this complaint triggered a safeguarding referral. We asked senior managers how they ensured staff safeguarded this patient or other patients on that ward. Senior managers told us that they did not consider this a safeguarding issue. This meant that people who used the service were not protected from the risk of abuse, because the provider had not taken reasonable steps to prevent abuse from happening.

Prior to the inspection, we found evidence of two incidents which staff did not appropriately identify and report as safeguarding concerns, until we asked for further information about the safeguards in place for these and other patients. In one case, a patient reported being abused by staff during the night. Although this was reported as a serious incident under the National Reporting and Learning System (NRLS), it was not investigated or reported as a safeguarding concern at that time. This meant that the provider did not respond appropriately to allegations of abuse. Senior managers acknowledged that staff needed further training in safeguarding and told us about changes to the incident triaging system, to ensure that safeguarding concerns are adequately identified. We have not been able to test the sustainability of these changes.

We noted that, once identified as a safeguarding concern, recent investigations were generally adequate. We saw 'reflect and review' forms which demonstrated how lessons were identified and discussed at safeguarding managers' meetings. This meant that staff were supported to learn from safeguarding referrals.

However, we found delays in the suspension of staff or in the reporting of staff to professional regulators. Some investigations required prompting and close monitoring by the safeguarding lead to ensure they were completed in a timely way. There was no plan in place for the receipt and triaging of referrals when the safeguarding lead was on leave.

We asked senior managers to consider the risk of having a safeguarding system which was dependent on the presence of the hospital safeguarding lead. Senior managers acknowledged this and told us about their plans to manage this risk. We have not been able to test the sustainability of these plans.

We saw that patients with challenging behaviours, such as refusing or resisting care or treatment, were given sedative medication, in one case covertly. We spoke with staff who did not recognise the provision of sedatives as restraint. It was not clear what safeguards were in place to protect the patients. The patients' records did not demonstrate why the sedation was necessary and proportionate, nor whether it was the least restrictive option. The hospital's policy on 'managing unintentional aggressive patients' contained relevant pro formas for safeguarding patients where restraint is considered; the policy stated that staff should "be aware of procedures before an incident arises". Staff were not aware of these procedures. One staff member on an adult medical ward disclosed that "on a lot of occasions, staff have had to hold the arms and legs" of patients so that doctors could insert a needle. The staff member stated: "It has happened more than once; it's when someone has dementia and they may hit out at you. It doesn't happen often but it does happen. Surely the doctors have to give the lifesaving treatment?" Although the staff member had concerns about holding patients down, they did not demonstrate an adequate understanding of the patient's rights. The staff member said, "The doctors instruct us to help them in this way." This meant that people who use the service were not protected against the risk of unlawful or excessive control or restraint because the provider had not made suitable arrangements. We asked the hospital to take action regarding this disclosure, to safeguard patients.

Cleanliness and infection control ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed. People were cared for in a clean, hygienic environment.

Reasons for our judgement

Before the inspection, we received evidence of concerns regarding this regulation.

As part of the inspection, we visited Tameside General Hospital and looked at a range of wards and units. We spoke about this regulation with the director of infection prevention and control (DIPC), the clinical lead for infection prevention and control (IPC), two ward managers, two nurses, a doctor and a pharmacist. Patients, relatives and carers told us that the wards and units were clean or "always clean".

We found the surgical unit and medical assessment and admissions unit (MAAU) to be clean, tidy and well maintained. Areas such as bathrooms, toilets, utility rooms and sluice rooms were also found to be clean and tidy. We saw that two wards in the Charlesworth building were generally clean but not well maintained. Both these wards were in an older building (approximate 1960's build) and were in need of refurbishment. Across both wards we saw that walls were damaged with holes, exposed plaster and chipped paintwork in the patient areas. The ceiling tiles were stained or damaged in a number of places. We also saw that four patient fans in a store room had visibly dirty fan blades and had not been cleaned.

Within one ward, there was a water leak in the ceiling in the main corridor. A number of ceiling tiles had been removed and a bucket had been placed in the corridor to collect the water. We spoke with a nurse who told us they had contacted the estates team and were awaiting repairs. The nurse told us the estates team were based on site and were contactable by phone.

We saw that cleaning schedules were available in each of the wards we visited. These listed daily and weekly cleaning tasks for the domestic staff. There were systems in place to minimise the risk of Legionella, including the routine flushing of unused water outlets by the ward staff. There was a rapid response team in place which provided out of hours support for ward staff and assistance during deep cleans.

There were schedules in place listing the roles and responsibilities of ward staff in relation to the cleaning and decontamination of equipment. We looked at 13 commodes across the four wards and found these to be cleaned to a good standard. The ward staff we spoke

with told us they cleaned and decontaminated equipment using chlorine-based disinfectant wipes. The hospital had nominated cleaning and decontamination leads in place who were accountable for these processes.

We saw that other equipment such as drip stands, trolleys, benches and hoists were clean and well maintained. The hospital carried out an annual mattress audit during June 2013 which involved checking 253 mattresses, of which 117 were identified as needing replacement. The ward staff we spoke with told us they carried routine checks for mattresses. The hospital had contractual arrangements in place with an external contractor for the sterilisation and decontamination of reusable medical equipment, such as instruments used during surgery. The sterilisation facility was based on site.

The ward staff we spoke with told us where possible they used single use sterile instruments. Across the four adult wards visited, we looked at instruments stored in the clean utility rooms and resuscitation equipment. We found that items such as syringes and airways management tubes were kept in their sterile packaging. The majority of bed pans in use were single use disposable.

We saw that linen was appropriately stored in dedicated linen rooms or cupboards. Ward staff told us that clean linen was supplied on a daily basis. We saw that clinical waste and sharps were suitably stored in the appropriate colour-coded bags and yellow sharps bins that were labelled correctly. The ward staff we spoke with told us they had no concerns relating to the removal of clinical waste or used linen.

During the inspection, we observed staff wearing uniforms in line with "Bare below the elbow" guidelines. The provider may wish to note that we saw two porters in the ward areas that were wearing watches. The majority of staff were observed using disposable gloves and aprons when carrying out their duties. There were a sufficient number of alcohol hand gels and hand wash sinks in the wards we visited.

The ward staff we spoke with told us they monitored infection risks on a daily basis. Any patients identified with an infection were managed in accordance with the hospital's isolation policy. The ward staff told us if there were bed capacity issues, they would escalate their concerns to the bed management team and infection control team in order to transfer patients to an isolation room within the ward or to other wards within the hospital if needed. The ward staff confirmed they sought input from the infection control team on a daily basis and had access to an on-call consultant microbiologist during out-of-hours service.

There was an isolation policy in place, which provided clear instructions for staff on how to manage patients with specific infections. Each ward we visited had a sufficient number of single rooms that could be used to isolate patients to minimise the spread of infection. We saw that appropriate signage and universal safety precautions were in place where single rooms were being used as isolation rooms.

The hospital had a programme of audits in place to monitor key infection prevention and control policies including antimicrobial prescribing, hand hygiene, cannula care, 'Saving Lives' high impact interventions, cleanliness of the environment and cleaning and decontamination of equipment. We looked at a selection of audit records which showed that infection control audits took place on a routine basis and actions were being taken where any concerns were identified.

The hospital carried out annual mandatory training in infection control. The staff we spoke

with confirmed they had received infection control training within the past 12 months.

The IPC clinical lead told us that any identified infection control risks were logged on to the hospital-wide risk register. Specific infection control risks were reviewed and monitored by the IPC team.

The hospital had an antimicrobial prescribing policy in place, which provided instructions for staff on how to manage antimicrobial drugs. The policy was accessible electronically by all staff that prescribed medicines and specified which antimicrobial drugs could be prescribed. We looked at a recent antimicrobial audit report, which showed compliance levels were monitored. The DIPC told us that instances of non-compliance with the policy were identified and fed back to individual doctors.

We spoke with a doctor and a pharmacist, who told us they were aware of the policy and had been given training in antimicrobial prescribing. The pharmacist told us antimicrobial drug prescriptions were monitored by the pharmacy team on a daily basis. They also confirmed that the consultant microbiologist carried out weekly monitoring of antimicrobial prescriptions.

The overall responsibility for infection prevention and control was with the chief nurse, who was also the nominated director of infection prevention and control (DIPC). The DIPC was supported by an infection prevention and control (IPC) team consisting of the clinical lead for infection control, a surveillance nurse, a part-time nurse practitioner, a consultant microbiologist and an additional part-time consultant microbiologist. The IPC team were also supported by a part-time administrator. The IPC team were supported by infection control link staff in each specialty across the hospital.

The DIPC and IPC clinical lead told us they had recently appointed a part-time quality assurance (QA) officer who was responsible for carrying out cleanliness monitoring and audits across the hospital. The IPC clinical lead told us they had also applied for additional funding to recruit an additional infection control nurse to ensure the IPC team was able to support the hospital's needs.

The infection control team and DIPC held routine team meetings and bi-monthly infection control committee meetings. Information relating to infection control was submitted to the quality and clinical governance committee on a monthly basis. The DIPC produced a monthly report that was presented to the hospital's board. We looked at minutes from recent meetings and saw that infection control was a key agenda item.

The hospital had reported that it was failing to meet the annual target for Clostridium Difficile (C.diff) infections post-72 hours of admission. As of 6 January 2014, the hospital had 32 C.diff infections post-72 hours of admission against a year-end target of 31.

The hospital target was zero incidents of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia. The DIPC told us they had identified four cases of MRSA during the current year.

The DIPC and IPC clinical lead told us they carried out root cause analyses (RCA) following each incidence of healthcare acquired infection. We looked at recent RCA records. The investigations included input from nursing and clinical staff. We saw that action plans had been put into place and a number of actions had been taken to minimise reoccurrence. This included the implementation of a patient safety programme with a specific infection control project led by the DIPC aimed at reducing infections and

improving staff compliance with infection control guidance. The DIPC also confirmed they aimed to reduce C.diff infections by monitoring and controlling the use of antimicrobial drugs. Some actions listed in the action plan were still ongoing or had only recently been implemented and had not yet led to a reduction in the number of C.diff and MRSA infections at the hospital.

During the inspection, we visited the pathology and microbiology laboratories. We saw that the environment was clean, safe and well maintained. The laboratory areas were segregated to minimise the risk of cross-contamination. We saw certificates to show that the laboratories had gained Clinical Pathology Accreditation, which meant they operated in accordance with national guidelines. There was an electronic system in place to manage requests to the laboratories and the sending of test results to the rest of the hospital.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Before the inspection, we received evidence of concerns regarding this regulation.

Appropriate arrangements were in place for obtaining medicines. The medical assessment and admissions unit (MAAU) had a large stock of different medicines in case patients did not bring their medicines with them when they were admitted. Medicines were sent with the patient if they were transferred to another ward. Wards had access to a cupboard of medicines when the pharmacy was closed. However we were told that sometimes it was unsafe for a nurse to leave the ward to fetch a medicine. The provider may consider how they support staff to minimise delays in a patient getting the medicine they needed.

Medicines were handled appropriately. The hospital showed us the results of a check (audit) on the handling of medicines that it had carried out across the hospital six months ago. More audits were planned for 2014. The hospital was taking part in the pilot of a national tool to improve medicines safety in hospitals. This showed that the hospital was taking action to improve the use of medicines and patients' safety.

Appropriate arrangements were in place for recording medicines. The hospital had re-designed its prescription chart to reduce the risk of medicine errors. However, we found some shortfalls in the recording of medicine administration.

Medicines were prescribed and given to people appropriately. The chief pharmacist told us that 88% of patients had their medicines checked (reconciled) within 24 hours of admission. This meant that patients continued to receive the medicines they were taking before they came into hospital, unless the doctor stopped them for medical reasons. Pharmacists were present on the wards to check that medicines were prescribed appropriately and safely. A pharmacist was on call 'out of hours'. A doctor told us that the pharmacist on their ward gave an excellent service. This meant that patients were protected from the harmful effects of medicines.

Medicines were safely administered. We watched two nurses giving medicines in different parts of a medical ward in the early evening. Both nurses administered medicines in a safe and friendly way, and respected patients' privacy and dignity. We saw an elderly patient helped to use her inhalers in the right way. Administration records were completed

immediately after each person had taken or been given their medicine. We spoke to three patients on this ward. They all told us that their treatment and medicines were clearly explained to them, and were full of praise for the doctors and ward staff.

The trust has a self-medication policy. We were told that nurses focus on safe storage, continuing patient assessment and clear documentation before a patient 'takes charge' of their own medicines. The provider may consider how and when staff offer patients the choice to self-medicate.

Medicines were kept safely. We looked at medicine storage facilities on one ward and saw that only authorised staff could gain access to medicines and infusion fluids. Controlled drugs (CDs) were securely stored and the CD register was filled in accurately. We saw that the stock of CDs was checked regularly. On another ward we saw that medicines were kept safely during the medicine 'round'. This protects patients from harm caused by taking medicines not prescribed for them and helps prevent mishandling and misuse. The provider should note that we observed one medicine was left on a patient's bedside locker, contrary to the hospital's medicine policy.

Medicines were disposed of appropriately. In the medicines audit in July 2013, the hospital found that medicines no longer in use or time-expired were returned promptly to the pharmacy 81% of the time. This helps prevent medication errors.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

We have found breaches of the regulations which would normally lead to enforcement action. This Trust however is in Special Measures and as a result we are drawing specific attention to the breaches to require both the provider and Monitor to give assurance that the non-compliance is being addressed.

There were not enough qualified, skilled and experienced staff to meet the needs of adult medical patients.

We have judged that this has a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

Prior to the inspection, we received evidence of concerns regarding this regulation.

We observed that the emergency department (ED) had enough staff on duty to meet people's needs. Although the nursing rotas for the last four weeks had a number of initial gaps, these gaps were filled with existing staff, bank nurses or agency nurses. Staff told us that the hospital was recruiting to eleven nurse vacancies in the ED and each shift had a minimum of five agency staff. A junior doctor in the ED said they were satisfied with the locum cover, as the locums were "regularly used" and therefore familiar with the department. The hospital had made a number of changes to staffing in the ED, and staff spoke positively about the changes. One ED nurse said they did not realise how bad staffing levels were until the programme for change came in. An agency ED nurse said that staffing used to be a problem, but that this was no longer the case. This meant that the hospital had taken steps to ensure there were enough qualified, skilled and experienced staff to meet the needs of patients in the ED.

The paediatric unit and surgical unit also had enough staff on duty to meet people's needs. Staff told us that newly qualified staff in the surgical unit were "always supernumerary" while they acquired appropriate skills. One patient in the elective care unit said the hospital was "better than it used to be. I still think they need more staff" and cited a long wait in the ED in December. A manager in the paediatric unit said that staffing in the unit was "satisfactory" but did not meet national guidance. One paediatric doctor mentioned that sometimes there was a shortage of nurses but "medical cover is good." Parents on the paediatric unit said that if they pressed the buzzer, staff came promptly.

One adult medical ward had 'thank you' cards on display. We reviewed these cards which

praised the care and attention of staff.

Some people on the medical assessment and admissions unit (MAAU) and adult medical wards said they thought there were enough staff to meet their needs. Their comments included: "Whenever I pressed my buzzer, someone has come to see me right away", "They come as quick as they can if you need help" and "They seem to have time to help you on this ward. I've been on other wards where the nurses are overworked and you don't get the same help."

Other people on adult medical wards or the MAAU told us that the staff members were good but over-worked. This perception had led some patients to avoid asking for help, as they feared being a burden on the staff. Some patients told us that staff were very busy and more staff were needed. Another patient disclosed that staff had not promptly answered another patient's calls for help. One MAAU patient said the doctors were "all downstairs" in the ED and smiled: "You gotta be a patient patient!" Other comments from patients and relatives included:

"[MAAU is] a bit of a madhouse – nurses and staff run off their feet."

"You keep thinking – maybe something will happen. Maybe we're next on the [doctor's] list."

We found that there were not enough qualified, skilled and experienced staff to meet people's needs on the MAAU and adult medical wards

We observed that on one adult medical ward in the Charlesworth building, one nurse and one healthcare assistant cared for fifteen patients. We saw that this was below the planned staffing level. Staff told us an agency nurse was brought in to help. We observed that a second healthcare assistant came to help on the ward during our inspection visit, as the ward was very busy. Staff told us it was very difficult to care for patients due to the lack of staff. We observed that two patients required frequent attention by the staff; this left the other patients without regular support. We observed that staff appeared low in mood and rushed from task to task. We spoke to staff at midnight who told us they had not had time for a drink since coming on shift earlier that day "never mind a break".

One patient said they were nervous about being moved from the MAAU to a ward, because they had been recently on a ward where most people had dementia; they felt that did not get the attention they needed as a result. On an adult medical ward in the Ladysmith building, we saw that the hospital planned to have four nurses and 3 healthcare assistants on duty to care for the 24 patients. We observed that only three nurses and two healthcare assistants were on duty. We asked if they had made attempts to secure agency staff and one nurse said "I think so."

We spoke with an agency nurse who told us they had been moved several times that night to provide support to wards and that this was a normal occurrence. They said they felt like they were doing "the job of four nurses" and raised concerns about their lack of familiarity with the patients.

We asked for the rotas of nurses and health care assistants on the MAAU and adult medical wards. We found that the ratios of nurses to patients did not reflect guidance produced by the Royal College of Nursing, especially on those wards with a high proportion of complex patients. We observed that staffing levels did not responsively

increase when the acuity of patients increased. Senior managers and staff acknowledged that the hospital used a high number of bank, agency or locum staff as a result of a high level of vacancies. One staff member said "the skills mix is not great at the moment" due to the large number of new staff.

We observed that the MAAU was very busy during our inspection: staff struggled to complete tasks; records were rushed and poorly completed; doctor assessments were delayed. One staff member confirmed their shift should have ended earlier in the day, but their replacement (an agency nurse) had not yet arrived. The staff member told us that it was less than 12 hours before the start of their next shift at the hospital.

We overheard a nurse responsible for bed management state that one ward was "desperate" because of "really poorly patients". They asked a health care assistant to move to this ward to assist. We observed that staff on this ward appeared overwhelmed and flustered, rushing to complete tasks. We raised concerns with senior managers who acknowledged this ward was under-staffed and said they planned to allocate an additional healthcare assistant to the rotas for this ward. We have not been able to test the sustainability of these changes, but staff on this ward later told us: "staffing on this ward has improved since [the Commission] came here on Friday".

Staff on an adult medical ward in the Charlesworth building said "we sometimes have to wait quite a while when we have requested a doctor to come to the ward." We spoke with a patient on this ward who said "doctors do not appear to come round on a regular basis" and "the consultant came around on Monday but I was told I had missed [them] because I was sat in the day room watching television!" Another patient on this ward said they had been in hospital for four days and had only seen a doctor once. We asked for the rotas for doctors, covering the MAAU and adult medical wards, but the rotas provided by the hospital did not include two adult medical wards in the Charlesworth building. During our inspection visit, we observed that staff on one of these adult medical wards could not get a doctor to promptly review one of their patients who was in need of treatment, because the doctor was busy on the MAAU. We asked a senior manager which doctors were responsible for these two wards. The senior manager acknowledged that, although a consultant was in place, there were current vacancies for middle-grade doctors covering these two wards.

Senior managers acknowledged that the hospital, like many other healthcare organisations, has struggled to attract appropriately skilled people to substantive posts. We saw evidence that the hospital was aware of this risk and had a number of plans in place to meet the needs of the organisation, such as going abroad for recruitment of nurses and doctors. The hospital had recently recruited some nurses to improve staffing ratios on the MAAU and adult medical wards. However, staff raised concerns with us that the nurses being assigned to the MAAU were newly qualified and therefore not sufficiently skilled.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

We have found breaches of the regulations which would normally lead to enforcement action. This Trust however is in Special Measures and as a result we are drawing specific attention to the breaches to require both the provider and Monitor to give assurance that the non-compliance is being addressed.

People were cared for by staff who were not supported to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

Prior to the inspection, we received evidence of concerns regarding this regulation.

Staff spoke positively about induction and mandatory training, which included infection control and manual handling. Staff in the emergency department (ED) told us about additional training they had in conflict resolution. Senior managers told us that the hospital's aim was to encourage staff on the wards to "recognise what 'good' looks like." One senior manager said "We've got lots of potential re: education or training [of doctors]. We are determined to get it right."

Although staff said they had completed online training in safeguarding or attended the adult safeguarding managers' course, some were not able to demonstrate an adequate understanding of how to safeguard patients. We observed poor staff competencies in caring for people with dementia, caring for people with mental health needs, or protecting people's rights (such as the Deprivation of Liberty Safeguards). We confirmed that most staff did not have training in the Mental Capacity Act 2005 or in caring for people with dementia. Senior managers acknowledged that access to training was increasingly difficult because of pressures on staffing levels. This meant that staff could not meet the needs of patients because they did not receive appropriate professional development.

Many staff had not had recent supervision meetings, although they had had appraisals. Nurses and healthcare assistants said they felt able to go to their ward managers for support. Staff across the hospital spoke about regular multi-disciplinary team meetings. One staff member said "This is a great opportunity to discuss any issues patients may have or any observations we make."

One junior doctor in the ED told us the senior cover had improved and there was more support than there used to be, stating: "Things are so much better now."

The medical assessment and admissions unit (MAAU) staff were concerned that they did not have time to provide supervision to junior staff. This was in contrast to the emergency department (ED), where staff felt they did have time to provide supervision to junior staff. Staff of all levels agreed that some staff were better at supervising than others.

Staff reported that locums were of variable quality. Some managers told us they "try to get the most reliable" locums but this was not always possible. We observed that supervision of locum staff was inconsistent.

Some staff had been suspended or dismissed, following investigations into their capability or conduct. Other staff had their performance managed, until their competencies improved. One senior manager spoke positively about the interim chief executive officer (CEO), stating that the interim CEO "holds people to account due to performance rather than authority". This meant that the hospital had taken steps to support staff to deliver care and treatment to an appropriate standard. Although the hospital conducted investigations into a number of concerns regarding staff, we found that the hospital had not taken appropriate action where staff failed to appropriately raise or act on safeguarding concerns.

Prior to the inspection, we received concerns regarding the supervision of doctors. We saw that the hospital put a number of new systems in place to support and engage with junior doctors, in response to concerns raised by junior doctors and local health educators. Senior managers acknowledged that the local health educators still had concerns. One senior manager said "If junior doctors don't feel supported at all times, we can't say we have confidence in the medical system." We did not see similar systems in place to support other doctors, however. One consultant told us that there was not enough time to adequately supervise other doctors and that this was a "work in progress". Senior managers acknowledged concerns regarding the poor supervision of staff and inconsistencies in the quality of supervision.

During the inspection, a whistle-blower raised concerns to us about how consultants worked together; they stated that doctors were afraid to come forward about bullying or harassment. We asked the provider to consider how they supported staff to raise concerns about other staff. Senior managers told us about their plans for developing management skills in middle-grade doctors and consultants. We saw that the hospital had a system in place for supervising senior management, as well as a well-being strategy, resilience training and plans to develop senior managers and governors. Staff told us they felt positive about the changes.

Although the hospital has an escalation plan in place, we found evidence that staff do not always seek support from senior staff when necessary. During the inspection, we reviewed the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Orders of eleven adult medical patients. The hospital's "Guidance on decisions relating to cardiopulmonary resuscitation" stated that "chief executives should ensure that: …appropriate supervision arrangements are in place to review resuscitation decisions." The hospital guidance also states: "The responsibility for making the decision rests with the most senior clinician currently in charge of the patient's care. Where possible the decision should be agreed by the whole healthcare team." We found that, of the six DNACPR orders which were not completed by the consultant in charge of the patient's care, only two had been subsequently reviewed by a consultant. That meant that four DNACPR orders did not

adequately reflect the Resuscitation Guidelines 2010, which recommended that the DNACPR order is made by the most senior clinician and that, if a senior clinician is not available, the DNACPR should be reviewed by the senior clinician at the earliest possible time. We found that the DNACPR orders completed by trainee doctors contained more errors, indicating the need for greater supervision. There was no explanation on the form or in the patients' records why the senior clinicians were not consulted.

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

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Prior to the inspection, we received evidence of concerns regarding this regulation.

At the last inspection on May 2013, we found evidence of non-compliance with this regulation. Feedback to staff regarding incidents and other significant events was inconsistent and the system in place did not support staff to report and learn from incidents. We judged this to have had a moderate impact on people who used the service. The provider sent us an action plan in July 2013 which stated they would review the divisional governance structures to ensure they were fit for purpose.

Since the hospital registered with the Care Quality Commission under the Health and Social Care Act 2008, the hospital has been under scrutiny of Monitor, the licensing body for Foundation Trusts. Monitor placed the hospital in "special measures" in August 2013. This meant the hospital had its leadership reviewed and was given support to make improvements, which it reported monthly in an improvement plan. An improvement director was appointed to oversee the hospital while it was in "special measures".

In July 2013, the chief executive officer (CEO) resigned and the medical director stepped down. The current CEO and medical director joined the hospital under interim arrangements made with the hospital's "buddy Trust": University Hospitals of South Manchester NHS FT. Staff at Tameside General Hospital told us they felt positive about the change in management, although they had concerns about the stability of the hospital once the interim arrangement finished.

We saw evidence that the hospital was putting a new structure in place based on recommendations following an external review. This had already resulted in the appointment of staff to this new structure. This appeared to have had a positive effect on staff and has resulted in improvements with this regulation. The management of complaints, incidents, and safeguarding were now integrated under a single director. The size of these teams had increased, which, along with the development of new processes, had improved the responsiveness of the hospital to concerns. We saw evidence that task forces were created in response to concerns. This had helped the hospital to see more

improvement actions through.

After receiving concerns that the improvement plan was not progressing at sufficient pace, the hospital appointed a number of staff to lead on the change programme. These staff members were recruited specifically because their skills matched the needs of the organisation. We saw evidence of considerable work into improving how change was managed in the hospital.

The hospital recognised that they needed to improve communication with people who used the service. We saw they had programmes in place to listen and respond to patient feedback, such as: a social media campaign, senior managers speaking with patients on wards, members meetings, and 'Friends and Family Test' surveys. We saw that several quality improvement groups included representatives from the local Healthwatch. This meant that people who used the service and their representatives were asked for their views about their care and treatment.

A doctor in the emergency department (ED) said that patient questionnaires were "sometimes given out" but not when staff were busy. The doctor was not sure who audited the results, which were passed on to another department. We asked a sample of 54 people during our inspection visits and only one person was aware how to provide feedback to the hospital. The hospital reported in November 2013 that they surveyed 25 patients, and 20% did not agree that they were as involved as they wanted to be. This is in contrast to the paediatric unit, where a group of 30 young people contributed to service development.

A recent hospital presentation on patient experience stated: "Improving the patient's experience is 'everybody's business'". We spoke with staff about the changes in governance of the hospital, but staff, including senior managers, rarely mentioned learning from or involving patients without prompting. We asked the hospital to consider how they ensured staff communication was person-centred.

We spoke with patients who had visited or been in the hospital more than once within the last year and all told us that they had noticed improvements in the hospital and felt positive about the new management.

We looked at how quality was assessed and reported on the wards. On an adult medical ward, we saw an 'audit board' outside the ward manager's office. The board covered a range of clinical indicators, such as in-patient stay, falls, safety thermometer, and risk register. The board showed that these indicators were audited on a monthly basis. We saw that other wards reported on other clinical indicators, such as infection control and nutrition. We spoke with staff on these wards who demonstrated adequate understanding of the quality improvement systems in place. One staff member said the clinical indicators "are important to know what we are good at or not so good at. We want to improve." This meant that staff received feedback regarding the quality of service that people received in their ward or unit.

We reviewed how incidents were investigated since the last inspection. There was evidence of increasingly robust investigations, which resulted in a number of actions. Some staff raised concerns to us that they did not receive feedback after they reported incidents. One staff member felt that, although senior management was aware of their concerns, nothing was being done. Although senior staff demonstrated their familiarity with the change programme, junior staff were less aware. We observed that consultants had varied levels of engagement in and understanding of the change programme. The provider

may consider how they engage with staff at all levels to share learning and promote quality improvements.

Senior managers described how information should be cascaded down the organisation structure. We noted that the senior managers and other staff had raised concerns with us about the variation in management skills across the hospital. We asked the senior managers to consider how this variation in management skill may impact engagement with staff. Senior managers noted our concerns and told us about their plans for engaging with staff, which included investing in the communications team.

The hospital acknowledged the need to develop staff competencies in identifying and reporting incidents and had already taken some action, such as distributing trigger lists as a guide to staff. The hospital was in the process of implementing a new electronic system for the reporting of incidents and believed this would improve the reporting rates. It will take time to embed this new system into practice. While many staff felt supported to report incidents, some staff raised concerns with us that other staff members were not reporting incidents because they felt it was futile. The hospital may consider how ensure all staff are adequately supported to report concerns.

Staff members and senior managers disclosed to us that they had general concerns about the conduct and capability of consultants in the hospital; when we asked what plans were in place to address these concerns, staff said that the interim medical director was aware of the concerns and was in the process of developing a plan. A senior manager said "trust nothing" and "get assurance" were the first steps to addressing their concerns about staff. Senior managers explained how the hospital's previous culture had a negative impact on doctors: the hospital had relied excessively on payments to ensure doctors took on quality improvement responsibilities and doctors had needed permission to attend or speak at clinical meetings relevant to their fields. Staff told us that they had felt "isolated" by that "very restrictive" culture. Senior managers told us how doctors' reactions to the external reviews in 2013 varied from confusion or embarrassment to those doctors who welcomed more leadership and support. They said that the culture was now "changing quite quickly" which was challenging for some staff. One senior manager said: "For the first time, I feel like I'm able to be [a senior manager]".

We saw that doctors were becoming more involved in quality improvements, such as peer reviewing mortality cases. We spoke with two newly appointed clinical directors, who explained the changes to their clinical areas and how they planned to engage with staff and people who use the service to improve the quality and safety of care. We saw that the clinical directors had already taken action regarding concerns we raised during the inspection. This meant that the hospital had taken steps to address concerns raised by staff.

The council of governors work to ensure that people have a say in shaping the hospital. Governors, which are elected to represent constituencies or other key stakeholders, also hold the board to account and appoint non-executive directors. We saw that the governors had been adequately involved in the recent recruitment of non-executive directors. Some of the governors, however, did not adequately understand their role and responsibility. The hospital acknowledged our concerns regarding the effectiveness of the governors; we saw evidence that the governors were offered training. The company secretary was looking into other ways to develop the capabilities of the governors so that they could robustly challenge the hospital when needed.

During our inspection visit, we identified concerns with a number of regulations. The

hospital was aware of most of these concerns and had a suitable plan in place to make improvements. It will take time to embed these changes into practice. We noted that the existing system did not adequately identify concerns relating to consent or deprivation of liberty. We saw that the hospital completed annual audits of do not attempt cardio-pulmonary resuscitation (DNACPR) orders. The last completed audit in early 2013 identified short-comings in the completion of the orders, yet the action plan stipulated a re-audit in a year's time. This meant that the hospital had not adequately identified and responded to concerns regarding the completion of the DNACPR orders. We spoke with senior managers about the DNACPR audit. A senior manager responsible for governance shared our concerns about the audit. They said that when they saw the audit report, they immediately identified problems and asked their team: "how did this happen then and how can we stop it now?" The senior manager explained that the DNACPR audit in 2013 did not have any corporate oversight. They said: "This won't happen now" as all clinical audits will be monitored by the new committee.

The senior managers acknowledged that the previous clinical audit programme was not adequate. We saw evidence that the hospital had commissioned an external review, which resulted in a number of recommendations for clinical audits. At the time of the inspection, the hospital was in the process of implementing these changes. This included reviewing the action plans of previous clinical audits and asking divisions to improve them. The clinical audit team, managed under the new governance structure, provided support to clinicians to make their audits more robust and to align the audit work with hospital priorities. Senior managers told us that they were starting to see the positive impact of these changes. A clinical audit facilitator recently reported improvements in the engagement of staff in the paediatric unit. It will take time to embed the changes into practice.

Although the systems in place were not yet fully implemented, we found that the hospital was responsive to concerns raised during the course of the inspection. The hospital had taken reasonable steps to put an effective system in place, given the resources available, and had suitable plans in place to meet the requirements of other regulations. We will be following up to see whether these improvements have been sustained.

Complaints ✖ Action needed

People should have their complaints listened to and acted on properly

Our judgement

The provider was not meeting this standard.

We have found breaches of the regulations which would normally lead to enforcement action. This Trust however is in Special Measures and as a result we are drawing specific attention to the breaches to require both the provider and Monitor to give assurance that the non-compliance is being addressed.

There was not an effective complaints system available. Comments and complaints people made were not responded to appropriately.

We have judged that this has a minor impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

Prior to the inspection, we received evidence of concerns regarding this regulation.

During the recent inspection visits in January 2014, we found that the hospital was in the process of putting a new system in place, which meant that complaints were triaged to identify reportable incidents and safeguarding concerns.

We saw leaflets around the hospital explaining the role of the Patient Liaison Service (PALS) and how to make complaints or comments. We also saw cards and collection boxes advertising the 'Friends and Family Test' in the emergency department (ED) and medical assessment and admissions unit (MAAU). We spoke with over fifty patients and visitors about providing feedback to the hospital. Only one person could explain how to make a complaint; they told us they were surprised they needed to go "downstairs" to the "citizen's advice bureau" in the hospital. The hospital's complaint procedure states that people should speak with someone in the ward, unit or department first, to see if the concern can be resolved locally. One relative told us that they had been unhappy because their family member's clothes had gone missing and staff did not appear to be taking action regarding their complaint. Eventually, staff agreed that the relative could bring a receipt in for new clothes and the hospital would reimburse it. This relative told us they did not know how to make a complaint, but they were satisfied that their problem would be resolved. As people could not explain how to make a complaint, we asked the provider to take action to ensure people were made aware of the complaints system.

The hospital's complaint leaflet detailed different ways people can receive support to make a complaint. We saw examples of people meeting with staff, including the chief executive officer or director of nursing, to discuss their concerns. The complaints procedure also stated that the hospital would agree a timeline for the investigation of the complaint with

the complainants. According to their monthly summary of PALS, complaints and claims , 67% of complaints received in November 2013 were managed within the agreed timelines. The summary states: "The return of timely complaint responses and action plans remains a concern for the Complaints Department." The hospital acknowledged that this was not adequate and believed they would see further improvements following the very recent recruitment of additional staff, in particular a complaints manager.

We reviewed a sample of recent complaints. Each record had a triage form and evidence of the complaints team prompting divisional staff for their responses. The hospital was able to demonstrate actions taken to satisfy complainants. This included consulting external assessors, making referrals to professional regulators, and completing further investigations. Although the complaints records showed improvements in the management of complaints, we saw that the hospital's responses did not always satisfy the complainants. Some of these people approached the Care Quality Commission and other organisations to complain about the management of their complaints. The provider may consider how they support people to understand the role of the ombudsman in investigating complaints, where people are not satisfied with the hospital's response.

We spoke with people who made recent complaints. They said staff treated them like they were "trouble" for raising concerns. One relative told us they felt making a complaint had negatively impacted on the care and treatment staff provided. Another person said that they had to fight to have their comments and complaints listened to and acted on. We saw that the hospital provided an apology to complainants and an explanation of what happened. In some cases, the hospital did not share what actions they had taken to learn from the incident or what actions they had taken to prevent further incidents. The hospital detailed some of their plans to improve the way feedback was provided to complainants and staff.

We saw evidence that some staff were better than others at handling complaints. We asked senior managers how they intended to develop staff skills in this area. The hospital acknowledged the need to develop the competencies of staff in responding to complaints. A senior manager talked about training they held in 2013. We asked the provider to consider how they supported staff to proactively identify and respond to people's concerns before they became formally investigated complaints. Senior managers told us that 91 front line managers had attended training in handling complaints; they said that more training was planned for the future.

We noted that some of the complaints people shared with us included complaints about other providers. We asked the provider to consider how they worked with local organisations to improve patient experience across the health economy. Senior managers told us about upcoming work with the local clinical commissioning group. We saw that the "Everyone Matters" steering group, which monitored the delivery of local actions in response to the patient experience intelligence, included representatives from other healthcare providers and the local Healthwatch. This meant that the hospital took steps to work with other organisations to learn from patient experience.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

We have found breaches of the regulations which would normally lead to enforcement action. This Trust however is in Special Measures and as a result we are drawing specific attention to the breaches to require both the provider and Monitor to give assurance that the non-compliance is being addressed.

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

We have judged that this has a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

Prior to the inspection, we received evidence of concerns regarding this regulation.

On the recent inspection visits in January 2014, we reviewed patients' medical records in the surgical units and found they were accurate and fit for purpose. In the paediatric unit, we found that the play specialists wrote entries in the nursing notes, which meant that other staff were made aware of their activities or concerns. We noted that the paediatric records included notes written on scraps of paper or post-it notes, and there were a number of loose pages. The provider may consider how they ensure paediatric records are secure.

Senior managers explained that an electronic system for managing patient records, such as pathology tests or discharge letters, had recently been implemented. The hospital's risk register indicated that their biggest risk to patient experience and information governance was the management and implementation of the new electronic system. This was reiterated to us by senior managers, who explained the increased delays in out-patient clinics.

We asked several staff members to show us how they accessed and used information stored on the electronic system. We observed the staff members struggled to find and provide the information we requested. One staff member commented that some information was not stored in the correct area. This meant that electronic records could not be located promptly when needed.

On the medical assessment and admissions unit (MAAU) and adult medical wards, we observed that patient records were usually stored in lockable trolleys. Two adult medical

wards had medical records stored in unsecure locations easily accessible to patients and visitors. Some staff struggled to print results from their electronic records system and were not always sure where patient information went, when printed.

We observed in adult medical wards that staff sometimes struggled to access people's records, because other staff had the records or sections of them. We saw evidence that two staff simultaneously completed falls risk assessments for one patient, neither of which had been completed accurately. The provider may consider how records are located promptly when needed.

In the MAAU and adult medical wards, we found that most medical records were inaccurate or incomplete. Falls risk assessments did not reflect someone's history of falls or confusion, even when they were admitted as a result of a fall and their primary complaint was confusion. Some patients with dementia were not assessed as needing the dementia care plan. A patient with limited mobility and swollen feet had not been not assessed as being at risk of pressure ulcers or needing a tissue viability care plan. Care plans for venous cannulas were incomplete. This meant that people were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

We looked at records on the surgical unit and noted that although most of the records were completed accurately, some of the checks had not been marked as completed for some patients: "ward checks," "pre-operative marking verification by ward," and "check completed by…". We also saw that the operation registers in two theatres were incomplete.

We looked at records on the paediatric unit and noted that staff did not complete the medication records fully, such as the signature log or pin numbers. We looked at a total of nineteen patients' prescriptions charts on three wards. There were nine 'gaps' in medicine administration records. This meant that other staff looking at the chart could not tell whether the patient had been given the medicine. In another five instances the reason why a medicine had been omitted was not written in the appropriate space on the chart. If patients do not receive important medicines their health or well-being could be affected.

Several wards and units kept confidential patient information on boards which were accessible to, and modifiable by, other patients and the public. The ED tracked patients and their presenting complaint on a white board, as the electronic records system did not yet support tracking patient transfers from the ED. The MAAU sometimes displayed information on whether the patient was to be admitted to cardiology or to trauma unit. On one adult medical ward, the large board at the entrance of the ward contained information on whether patients had a do not attempt cardiopulmonary resuscitation (DNACPR) order in place (signified by a black magnet) or was diabetic (signified by the words 'diabetic'). We saw that this information was not correct for some patients. Some staff on the ward could not explain what the black magnet meant; it was not clear whether staff used this information to make decisions about whether to attempt resuscitation. When we raised concerns with the senior managers, they were unaware that the ward was displaying information about people's DNACPR orders.

We spoke with two staff who told us that the "paperwork was appalling." One staff member said they were trying to look after the patients but felt "when [they] go home and look back that it's just not good enough." One staff member said this kept them up at night, worrying about what they might have missed.

Some records relating to the management of the service were not completed accurately. A form for section 5(2) under the Mental Health Act 1983 did not include the date, which is essential for monitoring the length of the detainment. The safeguarding forms, supplied by the local authority, did not include important information, such as who raised the alert and when. The hospital told us they would take action to ensure these forms were fit for purpose and that staff completed them appropriately.

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 other services less often. 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.

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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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