Inspection Report

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

Watford General Hospital

Vicarage Road, Watford, WD18 0HB

Tel: 01923244366

Date of Inspection: 17 December 2013

Date of Publication: January 2014

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

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Cleanliness and infection control	✗ Action needed
Staffing	✗ Action needed
Assessing and monitoring the quality of service provision	✗ Action needed
Records	✗ Action needed

Details about this location

Registered Provider	West Hertfordshire Hospitals NHS Trust
Overview of the service	Watford General Hospital is one of three locations operated by West Hertfordshire Hospitals NHS Trust. It is an acute hospital in Watford with an A&E department. Watford General Hospital provides general and medical, surgical, outpatient and maternity care. It has Approximately 600 beds and serves a population of 500,000 people and employs approximately 4,000 members of staff.
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 Management of supply of blood and blood derived products Maternity and midwifery services Nursing care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 17 December 2013, observed how people were being cared for and talked with people who use the service. We talked with staff, reviewed information given to us by the provider, reviewed information sent to us by other regulators or the Department of Health and talked with other regulators or the Department of Health. We were accompanied by a specialist advisor.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

We visited the emergency department, acute admissions unit (AAU,) a surgical ward, a medical ward, the stroke ward, a dementia ward, an orthopaedic ward and reviewed the governance services. We spoke to 29 patients who used service, 40 members of staff and members of the executive team.

People were mostly satisfied with the care they received. In most cases people were complimentary about the attitude of staff. We found that the trust had responded to concerns around mortality at the trust. Overall mortality rates at the trust had improved.

We found concerns with cleanliness and infection control across four departments visited. We found blood stains on the floor in one area that has not been cleaned. We noted it had dried to the floor at the time of being seen, therefore had been there for some time.

On the AAU we found areas of concern around staffing that were not consistent with our findings in the other areas visited. We were told by the executive team that the day of our visit was one of the busiest days for admissions.

We found that the governance and quality monitoring services were not effective. Concerns were identified about whether appropriate action in relation to risk management had been taken by the trust.

We found that the organisation was well led. The Executive team had responded well to areas of concern. Whilst reactive improvements were noted, long term sustainability will be monitored by the Commission.

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

What we have told the provider to do

We have asked the provider to send us a report by 01 February 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

In most cases we observed that people's privacy, dignity and independence were respected. People who use the service were given appropriate information and support regarding their care or treatment.

Reasons for our judgement

In general people were very satisfied with the care and treatment they had received and in most cases were very complimentary about the attention and attitude of staff towards them. Comments included, "The staff are wonderful," "Staff are brilliant, I couldn't fault them." "It's constantly busy but nothing is too much trouble for them."

We observed that although the wards were busy staff remained calm and spoke with people in a courteous manner. We saw that men and women were accommodated in separate bays and curtains were drawn to maintain people's privacy and dignity so far as possible. We observed a doctors ward round. The provider may find it useful to note that although curtains were drawn around the bed when the doctors were talking to the person, we could hear conversations that were of a confidential nature taking place. This meant that people's privacy could be compromised.

There were instances brought to our attention where maintaining people's dignity may have been compromised. For example we observed a staff member walk over to a patient in a bay. They proceeded to provide a treatment to them without drawing the curtains and we also observed that they did not speak to them or explain the treatment being provided. The provider may find it useful to note that we raised our concerns around this patient being treated with dignity and respect to the Director of Nursing who assured us that the matter would be addressed.

We examined a 'Do Not Attempt Resuscitation' (DNAR) order that had been written for one patient. There was evidence in the person's records that a discussion had taken place with the person and their relative. These discussions surrounded what treatment would be given should their health deteriorate and what was in the person's best interests. This meant that the person and their relative were involved in important decisions surrounding treatment and care.

We spoke with one person who told us, "They have been really good. I was very frightened when I came in. They have explained everything in a way I can understand." Another person told us, "They provided me with lots of information, and I have seen the doctor a few times." We viewed the boards at the entrance of each ward and department which provided information about the ward, the service and where to ask questions should the patient wish to talk to a staff member. This meant that people who used the service were given appropriate information and support regarding their care or treatment.

We used the Short Observational Framework for Inspection (SOFI) to observed care on Croxley, Sarratt, Ridge Ward and the AAU. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. Overall we observed that most people were treated kindly, with dignity and with respect. For the majority of the observation periods we observed positive interactions between people and the staff. In one example we observed a nurse patiently explain to a person where they were as they comforted them because they were upset. We saw several members of staff kneel or squat so that they were level with the person in their bed or chair before they spoke with them.

We saw a form used to record observations of people who were confused and were recorded as likely to forget where they were. The form was entitled, 'Wanderer Watch.' One member of staff explained that they provided one to one support to a person with dementia. They told us, that the person was a, "Wanderer and is at risk of falling so has to have someone here all the time." The provider may find it useful to note that although awareness was raised with regard to people who required extra observation, the use of the phrase 'Wanderer' is a practice that may lead to people being 'Objectified' and risks the loss of their individuality and identity.

The 'White Suite' is a 16 bedded ward that provided care for people with dementia. It opened at the beginning of December 2013. We saw that people were cared for in an environment that was suitable to their needs. For example the door frames were painted a different colour to support easier identification for a person with dementia. During our time on the ward we observed staff engage in activities with people. In three care plans we examined we saw, 'This is me' booklets which contained personal information about people. This enabled the staff to talk to people about the person's life and their family to support, comfort and orientate them. We observed them speaking with people in a kind manner which people responded well too. The ward had its own multi-disciplinary team in place. A senior member of staff told us that they worked very closely with the care of the eldery consultants, psychiatrists and social workers. The work undertaken on this ward and the interactions observed evidenced that people's diversity, values and human rights were respected.

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.

People's care and treatment on the stroke unit and on the fractured neck of femur pathway reflected relevant research and guidance. However care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare. The arrangements in place to deal with foreseeable emergencies did not ensure that equipment had been checked as safe to use.

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

Reasons for our judgement

For part of this inspection we focused on the fracture neck of femur (NOF) pathway. The fractured neck of femur pathway is a system used within a trust to provide and monitor a specific course of treatment and surgery for a person admitted with a fractured femur. Prior to our inspection we were aware that the trust had a higher than expected mortality rate for patients who had received surgery to repair their injury. We were also informed that the Medical Director for the trust had implemented changes to improve care and reduce mortality in this area.

We were supported by a specialist advisor for our inspection who was an experienced registered nurse with understanding of orthopaedics. We found that by December 2013 the Trust had decreased mortality from 12% to 6%. This is now below the national average of 8% and is a positive improvement. We examined the records of 41 patients during this inspection. We identified 17 patients that had been admitted in the previous week with a fractured neck of femur, of which four had recently received surgery. In all cases the care received was clearly documented and it had been fully assessed that the patients were safe to return to the ward after surgery. This demonstrated that the trust had responded to the concerns with the pathway by implementing measures to reduce the risk of harm to people.

We spoke with four nurses, the orthopaedic nurse responsible for fractured neck of femur care, the modern matron, consultant in orthopaedics and the Medical Director about the pathway. We found that changes implemented included the employment of a nurse specialist in fractured neck of femur, patients remaining in recovery for a longer period after surgery and that the outreach team from intensive care were also consulted in the patients post-surgery care. We also found that the service had changed its operating policy. This meant that surgery for fractured neck of femur would only be performed by a consultant surgeon with the anaesthetic provided by a consultant anaesthetist.

We found that the pathway tool used in orthopaedics was not a standard tool for use in patient care. This meant that orthopaedic patients, who had been admitted for example to a medical ward, may be placed at risk of harm. This was because staff on non-orthopaedic wards did not use the fracture neck of femur pathway; five staff we spoke to in a non-orthopaedic ward were unaware of the pathway. Overall the risk to patients with a fractured neck of femur had reduced but sustained improvements were needed and sharing of knowledge on non-orthopaedic wards was required to ensure that patient care on the pathway is safe.

We visited the stroke unit during this inspection to ask about the stroke pathway for new admissions. The Stroke Unit is a specialist unit which accepted direct referrals through the emergency department and ensured people were rapidly assessed and treated according to their particular needs on the stroke unit. Overall we found that people were treated in line with national guidelines and best practice. All patients were placed on a 'stroke pathway' to maximise opportunities to reach the best outcome for their condition.

We spoke with three staff on the AAU unit. The staff told us that patient transfer time from the emergency department must be completed within 30minutes. We were told that this can result in the need to stop a medication round in order to move the patient within the time due to pressure of bed availability within the hospital. We were told by one member of staff that tests can be delayed until the person is on the ward because the bed in AAU needs to vacated for the next admission. This meant that the pressures of bed management may place people at risk of unsafe care or treatment by delaying them in receiving the tests and treatment required.

On AAU we found that the care had been assessed, planned and delivered appropriately. Risk assessments had been undertaken where required. For example, one set of records contained the person's risk of venous thromboembolism (VTE) and risk of developing pressure ulcers had been considered and recorded on appropriate scoring tools. We saw that a system used to identify if a person was deteriorating, National Early Warning System (NEWS) had been scored and completed correctly where required. We saw that there was a traffic light system in place which was used as a trigger for when treatment needed to be escalated to a higher level. However, in six cases we found that people's pain scores had not been completed. One person told us that they had been in some minor pain all night. Therefore we were not assured that pain management was appropriately monitored or managed.

We examined two resuscitation trollies that would have been used if there had been an emergency, for example if someone stopped breathing suddenly. Both trollies had folders with a checklist that had been signed to evidence that it had been checked each day, as required by the UK resuscitation council guidance. We checked a sample of medicines and found them all to be within recommended dates. However we found on one that the oxygen cylinder had not been checked and was out of date, both trollies were dusty and the checklist had not been completed thoroughly as the expiry dates of the equipment was not recorded. This meant that were not assured that equipment in place to deal with foreseeable emergencies was always in date and safe to use.

Cleanliness and infection control ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected from the risk of infection because appropriate guidance had not always been followed. People were cared for in an environment that was not clean, we found an area that had not been cleaned in line with trust policy. We were not assured that staff adhered the trust uniform policy in relation to jewellery worn, which can increase the risk and spread of infection.

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

Reasons for our judgement

We saw hand gel dispensers on the end of each bed, by the entrances to bays, in all treatment areas and outside each department. Outside each department there was a movement sensor which activated a message reminding all to apply hand gel. This meant that staff and visitors were reminded and encouraged to cleanse their hands regularly in order to ensure that risk and spread of infection was minimised.

We spoke with the lead nurse for infection and prevention and control who provided us with information and an action plan on reducing the risk of healthcare acquired infections. The action plan was comprehensive and covered existing guidance that the trust was required to adhere to. The action plan also referenced the implementation of new protocols issued by the department of health, for example the early detection, management and control of carbapenemase-producing Enterobacteriaceae. We were assured by the understanding of infection control that the action plan to reduce infection risks in the trust would be effective.

In the emergency department we observed a member of staff make a bed that had been vacated. We observed another staff member wipe the mattress, bed frame, the chair and the bed table with a chlorine based solution. The staff told us that each area is cleaned after each patient. The staff member informed us that they had to turn the bed to clean but was unable to do this on their own so they wiped, "As much as I can." On another ward we asked a staff member how the mattress was cleaned, we were told that the mattress was wiped over. When we asked if the inside of the mattress cover was checked we were told that they were not. We viewed a mattress cleaning procedure displayed on one ward which said that inside mattress cover checks were required when visible damage to the surface of the mattress cover was observed. We checked inside the covers of three mattresses in the hospital and found that all were in good condition. However we were not assured that the mattress cleaning protocols were sufficient in terms of minimising the risk

of infection. We raised our concerns regarding the mattress protocols to the lead nurse for infection control. They told us that staff should be checking inside mattress covers. They assured us that they would look at the protocols on the wards.

We noted that an arm chair in an A&E cubicle had a tear in it; we raised this to the staff member who told us that they, "Could not do anything about it." They also told us that they were aware that it should not be there. We also observed a pillow on a bed which was marked with large stains. The staff member told us that the department had run out of appropriate pillow cases. We then noted that the staff member wrapped a plastic bag around the pillow. We also observed in the corridor between A&E and fracture clinic that there was a blood stain on the floor. This was dried on the floor. We raised our concerns regarding the blood stain and the pillow to the manager within A&E who immediately placed that pillow in the bin and replaced it with a new pillow. They also ensured that the floor corridor was cleaned.

On Aldenham Ward we examined a cubicle that was waiting for a new admission to arrive. We asked the staff if this bed area had been fully cleaned prior to the arrival of the new patient. We were informed that it had been cleaned. We found the cubicle to be dusty at high levels, behind and bed and under the side table. We found a used plaster, a straw and orange fruit on the floor under the bed. When we examined inside the cover of the chair's seat cushion we found a large dark stain. We inspected the commodes and patient equipment and found them to be clean and fit for purpose.

On Langley Ward we found that the curtains that were placed around people's beds had not been dated. Therefore we were not assured of when the curtains had been cleaned. We found two pillows in the linen cupboard that had been torn. We raised our concerns to the ward sister who immediately disposed of the pillows. We inspected the toilets and commodes and found the commodes to be clean but one toilet had a blood stain on the wall. We raised this to the sister in charge who requested for the room to be cleaned.

We observed several staff during our visits washing their hands. The hand washing techniques observed demonstrated that staff knew and understood the correct hand washing technique. The trust undertook regular audits on hand washing and the results were displayed on the notice boards at the entrance to each department. We observed three nurses in one bay of six patients carry out tasks which involved contact with the patient. All were wearing gloves. However, at the end of the task only one nurse washed or sanitised their hands. We discussed this with the matron who agreed it was an error and spoke to the nurses involved.

Across all departments during our inspection we observed if staff on duty had adhered to the trust uniform policy. The uniform policy stated that staff can wear only one set of earrings, no necklaces, no watches and a plain ring or wedding band. We observed that a majority of nursing staff had adhered to the policy, however we observed a couple of nurses and several doctors in the trust wearing watches, necklaces and rings with jewels in. Therefore we were not assured that the uniform policy was working effectively to minimise the risk or spread of infection. This was because the policy had not been monitored or enforced.

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.

There were not enough qualified, skilled and experienced staff to meet people's needs on the AAU. The Trust had not provided one to one clinical supervisions to staff and there is a low ratio of appraisals for doctors. Therefore the trust cannot evidence that that they have enough qualified, skilled and experienced doctors to meet people's needs.

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

Reasons for our judgement

At our last inspection we identified concerns in relation to staffing in the maternity service. We viewed the staffing recruitment and action plan for the service. We also viewed the rotas for the service. We found that the trust had sufficient recruited staff and had appropriate numbers of people on shift. This meant that there was now enough qualified, skilled and experienced staff to meet people's needs.

On the AAU in the green, six bedded, bay we observed that medication rounds were not protected to enable the nurse to concentrate on that important task alone, due to insufficient staffing levels on the day of our inspection. Medication protocols were for the items to be given at set times and times noted on the patients charts. Within the AAU Green bay we observed the staff being called away during a medication round to assist with care. We were told that in Green bay that they were short of staff due to sickness, the rota had been changed to ensure all bays were covered however the unit was extremely busy. We spoke with three people in the green bay who told us that staff were called away in between giving medication. This meant that medication administration was delayed due to the unavailability of staff. We spoke with the Director of Nursing about the green bay who assured us they had the staff numbers, but the responsibilities on the unit may not have been prioritised appropriately.

We were shown an induction programme for a recently appointed member of staff. This included a general orientation to the ward in order to learn more about how patients were cared for and supported. We found on the AAU that new staff shadow an experienced staff member for three weeks and undertake four night shifts. These supernumerary shadow shifts include understanding paperwork and how to undertake medication rounds. This meant that new staff on duty were able to provide care, upon commencement of active duty, with sufficient skills to meet people's needs.

We noted in the afternoon that there were two beds in the corridor outside triage in the

emergency department. We were told that these were only allowed in the corridor for a maximum of 1 hour and only if a bed was becoming available. When these beds were used the triage area had an additional nurse supplied to support people's needs. The senior nurse on duty told us that they had enough staff in triage, medication round was protected because there was always enough staff and staff were able to take breaks.

We spoke with 40 members of staff during our inspection. We asked 22 if they had received appraisals or supervision. Most told us that they had received an appraisal, however all told us that they had not received a formal one to one supervision. They all told us that they felt like to they could go to their manger and discuss any concerns that they may have when they needed to. We asked the Chief Nurse about this who confirmed that people had appraisals but was unable to evidence that people had clinical supervisions. We viewed the appraisal data for the trust which showed a high ratio of annual appraisals completed. However we were not assured that staff skills, qualifications and experience were sufficiently monitored to ensure that safe care was provided to people who used the service.

For medical staff we found that there was a low number of doctors who had been appraised. We spoke with three doctors who told us that they had an appraisal but could not recall when. Not having an appraisal formally documented can affect the revalidation of doctor's registration with the General Medical Council (GMC.) The Medical Director provided us with information and an action plan to demonstrate that they would get doctors appraisals completed. This meant that there is a risk to the professional practice of doctors currently. Without appraisals the trust cannot evidence that that they have enough qualified, skilled and experienced doctors to meet people's needs.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system in place to regularly assess and monitor the quality of service that people receive.

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

Reasons for our judgement

We were aware prior to our inspection that at a risk summit held, concerns were raised about the governance processes within the trust. For this inspection we spoke with members of the executive team and the new associate director for governance. We found that the governance department was significantly understaffed to be able to effectively monitor and report on the risks within the organisation. We were informed that there was a recruitment process in place to increase support to the governance department.

The trust is required to report incidents through the 'National Reporting and Learning Scheme' (NRLS) on a regular basis. They are also required to report serious incidents through the Strategic Executive Information System (STEIS) when the incident is identified. We were aware, prior to our inspection, that some concerns relating to the identification and reporting of serious incidents had been raised about the trust.

We found that there was a policy in place for reporting serious incidents which included responsibility for decision making. We found that the trust had trained incident investigators however serious incident investigations were not always completed by trained investigators. We viewed one investigation and found that the root cause had not been assessed; the lessons learnt did not include sharing information outside of the department or division. We discussed this with the governance lead who told us that there was no system in place to regularly share learning from incidents, complaints, PALS and surveys etc. across the divisions, but that this will be implemented in the new governance arrangements. Therefore we were not assured of the quality of serious incident investigations nor that learning from incidents was implemented.

Because we were aware of concerns related to reporting we looked at the trust's records of incidents reported from 01 April 2013 to 31 October 2013. We found that there was no monitoring system in place to ensure all incidents that were classified as 'serious' were identified and responded to correctly. This is because the governance structure and support system in place did not support the auditing of incidents to identify any potential

serious incidents. This meant that we could not rely on the accuracy of the reports from the trust around serious incidents submitted prior to December 2013, or see how the trust had assessed whether or not specific incidents had affected the quality of the service provided to people.

The governance lead informed us that they had implemented, within the two weeks prior to our visit, that a new process had been drafted for deciding whether incidents reported were serious incidents and to ensure appropriate action had been taken.. This meant that when implemented the trust will be responding appropriately to serious incidents however incidents that occurred over the past 12 months may not have been identified, reported or learnt from.

We viewed a governance action plan which identified how compliance with essential standards would be achieved. We found that the current incident system computer server was at maximum capacity and was at risk of failing to provide the service required to report incidents. We also found that that the trust risk register had not been updated for an extensive period of time and was out of date. We examined the risk register and found items which had been added from 2005 that had not been resolved. We were not fully assured that the current organisational risks were prioritised effectively to reduce the risks to the service and people who used the service.

There were a number of other national reporting agencies that the trust had to submit their data to. There was information available to show that the trust was working to understand and analyse reasons for higher than expected deaths. We viewed a report into the mortality levels within the trust completed by the medical director. We saw that the trust had improved and decreased its overall mortality over the past six months to below the expected level for an organisation of this size, which was a positive improvement.

The trust had undertaken an audit into the mortality concerns within this pathway which is how the actions were identified. We spoke with five members of staff on the orthopaedic ward about the audit, the results and the pathway changes. All five were unaware of the results and why the care had recently changed. This meant that staff were working with the changes implemented but were not aware of the audit results or why changes to patient care was required. Therefore we were not assured that the conclusions of clinical audits were shared in learning and the outcomes fully recognised.

People had their comments and complaints listened to and acted on. Staff told us they knew how to support people who made comment or complained about the service. We saw that complaints were reported and responded to in appropriate timescale. Complaint summaries and trends were examined by managers and reported back to staff with any required action points. Most people told us they knew how to make a complaint, we saw that information leaflets and posters were widely available in most areas.

We saw that the trust had systems to regularly seek the views and experiences of people using the services. The trust received 1164 surveys responses in October 2013. The trust reported that people who used the service had good experiences of care. However the service had received a lower than expected number of responses to their surveys. Given the potential volume of people that the trust served it was not clear how they were going to increase survey completion.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not 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, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

During this inspection we examined the records of 41 people who used the service. We found that records of care provided to people who used the service were not well maintained and were not fit for purpose. In two cases we saw that papers in the records related to other people. For example we found blood test results and a request for a scan in the records that were not for the person whose records were being examined.

We found in the case of four people, each person had been given a malnutrition screening assessment rating (MUST) score of 0 which meant they were at low or no risk of malnutrition risks. However we found that vital information had not been included as part of the assessment, for example the person's height and weight. We saw that each person had been given a body mass index (BMI) score but their height and weight had not been recorded. All four patients had a food and fluid chart in place to monitor their nutritional intake despite being assessed as not being at risk of malnutrition or dehydration. These records of assessment did not support the treatment in place.

One patient had been visited by the intensive care (ITU) outreach team who recorded that the person's fluid balance had not been maintained. The patient had also been referred to the dietician because their appetite had dropped. The dietician reported that it was difficult to complete an assessment because there was a lack of information on the food record chart and fluid balance chart. Our examination of the records supported what was recorded by the dietician. The food chart for this patient indicated that they ate very little over a period of days. We found that information was not always recorded. 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.

The fractured neck of femur pathway paperwork had been developed by the trust but was not in a secure format. The papers were stored loosely in a file and could easily be misplaced. For seven of the 17 records we examined for people on the fractured neck of femur pathway, the paperwork had not been fully completed. We found that data entries were missing, pages were incomplete and information relating to the person's care was

missing. Therefore we were not assured that the records format chosen for the recording of the pathway maintained the security of the documents and was not fit for purpose.

We viewed the internal audit on fractured neck of femur and pressure ulcer management. The recording of care and quality of records was raised as a concern in both audits. We spoke with members of the executive team during feedback who acknowledged and recognised that the records were currently of a poor quality and required improvement.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Diagnostic and screening procedures Nursing care Surgical procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Regulation 9 (1)(b)(i) and (b)(ii) the planning and delivery of care did not always meet the individual needs of the service user and did not always ensure their welfare or safety.
Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: Regulation 12(1)(c) people were not protected from the risks of acquiring an infection arising from the carrying on of the regulated activity.
Regulated activities	Regulation
Diagnostic and screening	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010**

This section is primarily information for the provider

procedures Nursing care Surgical procedures Treatment of disease, disorder or injury	**Staffing**
	How the regulation was not being met: Regulation 22 the trust could not evidence that that they have enough qualified, skilled and experienced doctors to meet people's needs through clinical supervisions and medical appraisals. There was insufficient staffing arrangements identified on AAU.
Regulated activities	Regulation
Diagnostic and screening procedures Nursing care Surgical procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: Regulation 10 (1)(a) and (b), 10 (2)(c)(i) and (ii) and 10(e) The provider had not taken account of audit and incident learning outcomes. The provider was not clear on the priorities of risk within the organisation. The governance structure and system is not sufficient or effective to identify and report on organisational risk. Provider surveys are lower than expected in terms of the number of people sharing their views and experience of care. The serious incident reporting, monitoring and investigation process was not appropriately monitored.
Regulated activities	Regulation
Diagnostic and screening procedures Nursing care Surgical procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Regulation 20 (1) (a) an accurate record in respect of care and treatment provided to service users was not always accurate. Data entries were missing and some paper work was incomplete. Regulation 20 (2)(a) Records were stored loosely in files and some items were being misplaced in other service

This section is primarily information for the provider

	user's records therefore records were not kept securely.

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

The provider's report should be sent to us by 01 February 2014.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of 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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