Inspection Report

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

Calderdale Royal Hospital

The Calderdale Royal Hospital, Salterhebble, Halifax, HX3 0PW

Tel: 01422357171

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

Records	✖ Enforcement action taken

Details about this location

Registered Provider	Calderdale and Huddersfield NHS Foundation Trust
Overview of the service	Calderdale Royal Hospital is situated about 1.5 miles south of Halifax town centre. The hospital offers a full range of day case and outpatient services and an accident and emergency department. It is also the specialist centre for planned orthopaedic and general surgery for the residents of Calderdale and Kirklees.
Type of services	Acute services with overnight beds Community healthcare service Diagnostic and/or screening service Community based services for people with mental health needs Rehabilitation services
Regulated activities	Diagnostic and screening procedures Management of supply of blood and blood derived products Maternity and midwifery services Nursing care Surgical procedures Termination of pregnancies Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury

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

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Summary of this inspection

Why we carried out this inspection

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

- 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 20 March 2013, talked with people who use the service and talked with staff.

What people told us and what we found

We spoke with three people who were receiving care on the one ward we visited. They described staff on the ward as" caring and kind", "helpful" and "friendly". They said that staff always came quickly when they used the call bells. All three people told us the experience of their care on the ward was positive.

They said positive things about the food that was provided for them on the ward, describing "a good choice of food" offered to them and "decent sized portions".

One person said that if they had any questions about their care they could ask and receive information in a way that they understood. This person said they had regular contact with their doctor on the ward.

One relative visiting the ward said they had found the staff helpful and had kept their family well informed about care their relative received.

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

What we have told the provider to do

We have taken enforcement action against Calderdale Royal Hospital to protect the health, safety and welfare of people using this service.

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

Records ✖ Enforcement action taken

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 risk of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

At our previous inspection visit on the 23 August 2012, we judged the provider was not meeting this standard because people were not protected from the risk of unsafe or inappropriate care and treatment. We carried out a follow up inspection visit on the 20 March 2013 to see what actions had been taken to achieve compliance with Regulation 20, Outcome 21 records.

During this visit, we spoke with the Deputy Director of Nursing, Lead Matron for Acute Services and two Ward Sisters. They all told us that the trust had monthly audit systems and processes in place for checking the accuracy of people's records at ward level. They also informed us about plans for the introduction of new nursing documentation from May 2013 onwards.

Each person had two separate records, one retained at the bedside and the other for use by the nursing, medical and therapy teams. The provider may wish to note that neither records included a clear index on the documentation to be retained within each file nor within each section of the file; this made the navigation and reading of people's records difficult.

We looked at the care and treatment records for six people using the service. In one record, we saw there were six occasions from the 12 to 19 March 2013, where staff had not signed the medication administration chart to confirm whether they had given this person's insulin. We saw in a second record, that on the 19 March 2013 staff had not signed this person's medication chart to confirm whether they had given them their lunchtime medication.

We saw omissions in people's fluid balance records. For example, on one persons fluid

balance chart dated 16 March 2013, there was no output recorded, on another three charts dated the 12, 13 and 14 March 2013, the only output entries made were at 06:00 hours and on the 11 March 2013 on this chart, only two output entries were recorded. Two of the charts dated on the 11and 13 March 2013 had entries about the person's fluid intake. The fluid balance chart for the 15 March 2013 was not within the records.

In another person's fluid balance records dated 13, 14 and 15 March 2013 only their fluid output was recorded. No fluid charts were available for the 16 and 17 March 2013 and on the charts dated the 18 and 19 March 2013 only the fluid intake had been recorded. This means that an accurate and ongoing assessment of the risks associated with each person's fluid balance could not be assured. We discussed these issues with the staff and they acknowledged the gaps in the records and agreed that appropriate actions would be taken to improve the recording of people's fluid balance.

We saw omissions and inconsistencies in the nutritional records of three people using the service. For example, in one person's records, we saw that following recent weight loss their nutritional risks had been reassessed as being high. However, according to their weight records, they had only been weighed once and that was on admission in January 2013. This person was also receiving nutrition via a PEG feed (percutaneous endoscopic gastrostomy). We looked at their gastrostomy feeding records and saw no entries recorded on the 15 and 17 March 2013. This means that from the records it could not be confirmed whether they had received adequate nutrition on both these days.

We looked at the nutritional records for a second person also assessed at high risk of malnutrition who had lost weight. Their March 2013 food intake records documented that on six days, only breakfast and lunch were recorded, on one day only the evening meal was recorded and there were no records at all for two days. The nutritional records for the third person on 12 March 2013, showed that only the evening meal had been recorded. The records for the 13 March 2013 documented that they had taken porridge for breakfast but no other food intake had been recorded that day. On the 14 March 2013, only the breakfast had been recorded. This means that an accurate and ongoing assessment of the risks associated with each person's nutritional health could not be assured.

We saw from one person's records that they had a pressure sore, which was being dressed. We were unable to find the details recorded about what dressings were being used and any information on the frequency of changing the dressing. We spoke with the staff and they told us the dressing chart should be on file and they looked through the file but could not find the dressing chart.

In another person's records, we saw they had a wound assessment and management plan in place dated 02 February 2013, which detailed the type of wound and described how it had been dressed. No further entries were recorded from this date within the plan. This means that an accurate record in relation to the continuing care and treatment to manage this wound could not be assured.

We saw a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form in place within two of the records we looked at. We looked at the first form dated 20 December 2012 and saw it had been documented that a discussion had not taken place with the person using the service about the decision not to resuscitate and their next of kin was not available to discuss this decision. We looked at the progress notes and saw a record of a discussion with the next of kin dated 20 December 2012 that stated they had been informed of the poor prognosis of their relative but, there was no entry to indicate their agreement to introduce a DNACPR form.

When we looked at the second DNACPR form dated 08 February 2013, we saw documented that the person using the service did not have the capacity to make this decision. We saw documented on the form a discussion had taken place with their relative, however, we were unable to find a record of this discussion entered within the person's notes.

Both forms were discussed with the Sister on the ward who agreed to have these decisions reviewed.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 31 May 2013 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were not protected from the risk of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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