Review of compliance

Nottingham University Hospitals NHS Trust Queen's Medical Centre	
Region:	East Midlands
Location address:	Derby Road Nottingham Nottinghamshire NG7 2UH
Type of service:	Acute services with overnight beds Rehabilitation services Diagnostic and/or screening service
Date of Publication:	December 2011
Overview of the service:	Nottingham University Hospitals NHS Trust provides services on three locations. At this location, the Trust is registered to provide the regulated activities 'assessment or medical treatment for persons detained under the Mental

	Health Act 1983', 'family planning', 'maternity and midwifery services', 'surgical procedures', 'termination of pregnancies', 'treatment of disease, disorder or injury' and 'diagnostic and screening procedures'.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Queen's Medical Centre was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 02 - Consent to care and treatment
Outcome 04 - Care and welfare of people who use services
Outcome 06 - Cooperating with other providers
Outcome 07 - Safeguarding people who use services from abuse
Outcome 10 - Safety and suitability of premises
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 27 October 2011, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

Most patients told us that they understood the care and treatment choices available to them. One patient said, "I've been given literature about my condition and treatment each step of the way to help me take it all in and help me reflect, I know I'm in the driving seat." However, one patient told us that they had not been given enough information to enable them to make an informed choice about treatment.

Patients told us that they could express their views and were involved in making decisions about their care and treatment. One patient said, "I'm in control, they give me the information I need and I make my own decisions." Patients told us their privacy and dignity was respected.

Patients told us that they were able to give consent to the care and treatment that they received. They also told us that they understood and knew how to change any decisions about care and treatment that had been previously agreed.

One patient told us they were very satisfied with the way their individual care needs had been assessed and managed. Another patient said, "I've had ultrasounds and x-rays, and other procedures in other departments and they've all been brilliant." Some patients had experienced delay in the implementation of their assessment and treatment plans. Two patients expressed their frustration that they had not been told about delays to their planned procedures. Neither patient had been told to anticipate delays nor were they given an explanation of the reason for the delay and what was being done to address the problems.

One patient told us that the food was fine but said, "Then again, I'd eat anything, it's not always that hot but I don't mind that." One patient said, "[The food was] absolutely diabolical, even the sandwiches are old, pre-packed, dry and awful." Another patient said, "The food is very poor, lukewarm at best."

One patient thought the liaison between services was, "excellent." Another patient told us that there had been very good communication between departments and that information had been shared with them so that they knew what was happening and planned for them. However, three patients we spoke with in the discharge lounge had experienced significant delays waiting for their prescriptions to be filled by the hospital pharmacy and for transport to take them home.

Patients told us that they felt safe and they knew who to speak to if they had any concerns. Patients told us that they were happy with the premises.

Patients told us that their needs were met by competent staff. They also told us that staff were well trained and worked hard. Most patients knew where their records were kept and were happy they were available for staff to use but kept secure enough so as to be safe and confidential.

What we found about the standards we reviewed and how well Queen's Medical Centre was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Patients understood their care and treatment choices and were involved in making decisions about them. However, patients did not always have their privacy and dignity respected.

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

On the whole, patients were able to give valid consent to the care and treatment that they received. They understood and knew how to change any decision about their care and treatment that had previously been agreed. However, patients could not be confident that there were effective systems in place to ensure that assessments of capacity were undertaken when appropriate and to ensure that decisions were being made in the best interests of those patients who had been assessed as lacking capacity to make a specific decision.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

Patients did not always experience effective, safe and appropriate care, treatment and support that met their needs and protected their rights as documentation to support the safe delivery of care was not always accurately completed.

Outcome 05: Food and drink should meet people's individual dietary needs

Patients were not always appropriately supported to have adequate and appropriate nutrition and hydration as their assessed needs did not always reflect the diet and assistance given.

Outcome 06: People should get safe and coordinated care when they move between different services

Most patients received safe and coordinated care, treatment and support where more than one provider was involved, or they were moved between services. However, some patients experienced significant delays when waiting for medication to be dispensed or for transport to arrive to take them home or to another service.

Outcome 07: People should be protected from abuse and staff should respect their human rights

Patients were protected from abuse, or the risk of abuse and their human rights were respected and upheld. However, the amount of staff who had attended safeguarding training needed to be increased to ensure that all staff could recognise when there was a risk of abuse and knew what actions to take to address any risks of abuse.

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

Patients were generally cared for in safe, accessible surroundings that promoted their wellbeing. However, improvements were needed to the shower and bathing facilities on one ward, the discharge lounge and the facilities on one older people's ward to ensure that all patients were cared for in an environment that promoted their wellbeing.

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

Patients did have their needs met by competent staff as staff were properly trained, supervised and appraised.

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

Patients benefited from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

Outcome 21: People's personal records, including medical records, should be

accurate and kept safe and confidential

Patients could not be confident that their personal records, including medical records were held securely and remained confidential. Patients could also not be confident that their medical records were always accurate and fit for purpose.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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

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

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

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

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are minor concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
Most patients told us that they understood the care and treatment choices available to them. One patient said, "I've been given literature about my condition and treatment each step of the way to help me take it all in and help me reflect, I know I'm in the driving seat." Another patient said, "Everything they said would happen, has happened, I'm very confident that they know what they're doing." However, one patient told us that they had not been given enough information to enable them to make an informed choice about treatment.

Patients told us that they could express their views and were involved in making decisions about their care and treatment. One patient said, "I made my own decisions, I had three choices, I was told the options and I made my choice, but I was guided by them." Another patient said, "I'm in control, they give me the information I need and I make my own decisions."

Patients told us their privacy and dignity was respected. One patient said, "I was asked what name I wanted them to use, the curtains are always pulled round and they do as much as they can [to preserve privacy and dignity] in bay accommodation." Another patient said, "[Staff] communicate very well with me, I'm not patronised, I'm kept informed and I'm respected."

Other evidence
Before our visit, we contacted a number of key partners involved with the service. All partners that replied to the Care Quality Commission (CQC) reported that they had no concerns regarding this outcome.

We also reviewed the information we hold regarding the provider and found no issues of concern regarding this outcome.

On all wards visited apart from one, we observed staff taking steps to protect patients' privacy and dignity through the use of screening around the beds and by speaking quietly and respectfully when asking for permission to undertake care procedures. We also saw staff giving patients opportunities to express their views on the care that they were receiving.

On one ward, we heard part of a conversation between a member of the medical team, a patient and one of their representatives. The doctor was heard carefully explaining the patient's current medical diagnosis and proposed treatment. The doctor responded to questions confidently and with sensitivity. The doctor showed them literature about their condition and asked for their views.

However, on one ward we saw three staff help a patient with their personal care and replace their mattress with a pressure relieving mattress. The patient was heard to say that this process had caused pain. However, the staff were heard to refute this and when the patient called out for help again the staff were heard to inform the patient that they were receiving more attention than others on the ward. A conversation was heard to continue amongst a member of staff and another patient as to how long the patient would take before calling out again.

We immediately informed the ward manager and matron of the incident we had observed. We also raised the issue with senior management at the service. The service took action to review the care of the patient who had been observed above. They also made changes to the management of the ward and started an investigation into the conduct of staff involved in the incident. The service has also updated us since the visit on additional actions they have taken to address the identified concerns. A programme of training has been started for all staff on the ward, regular unannounced observations are taking place and competencies for staff have been reviewed.

We also saw on this ward, one patient lying in a bed near the corridor who was regularly adjusting their night gown and bedclothes, which meant that their dignity was not always protected. The staff were not able to observe them closely enough to respond in a timely way to ensure they were appropriately covered. We immediately raised this issue with the ward manager and matron who took action to ensure that the dignity of the patient was preserved.

We looked at patients' care records and found no issues of concern regarding this outcome.

Staff told us that patients received information about their treatment before coming into the hospital where possible. If a patient's admission to the hospital was not planned then they would be given information as soon as possible after arriving.

They told us that they received privacy and dignity training and were able to explain potential privacy and dignity issues. Staff told us that there had been a strong focus on privacy and dignity issues at the service. One member of staff talked about, "Making people feel guilty about barging through the curtains."

Staff also told us that they could access interpreting services if a patient needed support and that they could also get advice from a learning disability liaison nurse if a patient with a learning disability needed support when communicating with staff.

Our judgement
Patients understood their care and treatment choices and were involved in making decisions about them. However, patients did not always have their privacy and dignity respected.

Outcome 02:
Consent to care and treatment

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are moderate concerns with Outcome 02: Consent to care and treatment

Our findings

What people who use the service experienced and told us
Patients told us that they were able to give consent to the care and treatment that they received. One patient said, "I've signed to give my consent to treatment and the staff ask for my consent every time they come to do a procedure." Another patient said, "They explain everything very clearly and ask for consent to carry on."

Patients told us that they understood and knew how to change any decisions about care and treatment that had been previously agreed. One patient told us they preferred their close family members to be involved in this process and they confirmed that this had been respected by staff.

We observed staff appropriately asking patients for consent before carrying out care.

Other evidence
We inspected this outcome as we had received information that raised concerns about the care and treatment that patients were receiving. This information concerned a series of 'never events' that had taken place at both the Nottingham City Hospital and the Queen's Medical Centre locations. A never event is a serious, preventable patient safety incident that should not occur if the available preventative measures are implemented.

Before our visit, we contacted a number of key partners involved with the service. Partners that replied to Care Quality Commission (CQC) reported that they had no concerns regarding this outcome with the exception of the 'never events'.

We also reviewed the information we hold regarding the provider and found no issues of concern regarding this outcome except for the 'never events'.

We looked at patients' care records. We saw consent forms had been fully completed by staff and had been signed by the patient consenting to the care and treatment. However, the required two stage test of capacity under the Mental Capacity Act (MCA) 2005 was not being consistently used to protect the rights of patients who had been assumed to lack capacity.

The MCA protects patients who lack capacity to make a decision for themselves because of permanent or temporary problems such as mental illness, brain injury or learning disability. If a patient lacks the capacity to make a decision for themselves, staff can make a decision in their best interests. The MCA sets out care providers' responsibilities, including a two stage test of the patient's capacity to make particular decisions.

In two cases, staff told us there were concerns that a patient lacked capacity. There was no evidence of a two stage test of capacity in either record.

We did however; see examples of completed two stage tests. We saw one well completed form but another was not fully completed. We saw that sections of the form that would assist the staff to make the most appropriate decision, and which could be evidenced as being in their best interests, had not been completed. For example, the significance of the patient's life history, culture and diversity had not been taken into account.

Staff were able to explain the consent process. Staff told us that doctors would speak to patients regarding consent for procedures and nurses would speak to patients regarding consent for any nursing care being provided. Healthcare assistants told us that they would also speak to patients regarding consent when carrying out care.

Some staff spoken with had received MCA training and some had not. Some staff were able to discuss issues of capacity and showed understanding of the MCA; other staff were not able to. MCA training is important to support staff when making decisions regarding consent and a patient's capacity to consent.

Our judgement
On the whole, patients were able to give valid consent to the care and treatment that they received. They understood and knew how to change any decision about their care and treatment that had previously been agreed. However, patients could not be confident that there were effective systems in place to ensure that assessments of capacity were undertaken when appropriate and to ensure that decisions were being made in the best interests of those patients who had been assessed as lacking capacity to make a specific decision.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
One patient told us they were very satisfied with the way their individual care needs had been assessed and managed. Another patient said, "I've had ultrasounds and x-rays, and other procedures in other departments and they've all been brilliant."

Some patients had experienced delay in the implementation of their assessment and treatment plans. Two patients said they didn't particularly mind the delays. One patient said, "I'm left waiting a little but it's not their fault, they're always busy." Two patients expressed their frustration that they had not been told about delays to their planned procedures. In one case, the patient had been in hospital for two days. They had not received their scan, which had been planned for the previous day and then did not have a blood test at a prescribed time the previous evening. Another patient told us that there had been delays to their exploratory examinations and treatment. Neither patient had been told to anticipate delays nor were they given an explanation of the reason for the delay and what was being done to address the problems.

Other evidence
We inspected this outcome as we had received information that raised concerns about the care and treatment that patients were receiving. This information concerned a series of 'never events' that had taken place at both the Nottingham City Hospital and the Queen's Medical Centre locations. A never event is a serious, preventable patient safety incident that should not occur if the available preventative measures are implemented.

Before our visit, we contacted a number of key partners involved with the service. Partners that replied to CQC reported that they had no concerns regarding this outcome with the exception of the 'never events'. Partners described some national targets that the provider was not meeting but also provided details of the work that the provider is carrying out to meet those targets in the future.

We also reviewed the information we hold regarding the provider and found no issues of concern regarding this outcome except for the 'never events'.

Most of the never events took place in the operating theatres at both the Nottingham City Hospital and the Queen's Medical Centre locations. As a result, we commissioned a specialist theatre inspector to visit and inspect the operating theatres at both locations.

The specialist theatre inspector visited two wards and six theatres at the Queen's Medical Centre. They talked to staff, observed theatre practices and looked at records.

Nottingham University Hospitals use a modified version of the World Health Organisation (WHO) surgical safety check list, as recommended by the National Patient Safety Agency (NPSA).

We saw many good examples of patients being checked on the ward, in the theatre reception area, anaesthetic rooms and operating theatres and handover to recovery staff.

However, at one sign in check, the surgeon made a mistake in the proposed position on the operating table. This was swiftly corrected by the anaesthetist. At another sign in check, the anaesthetic form was blank. The form had been completed by the anaesthetist at the preoperative visit but had not been attached to the notes taken to the theatre area so a blank form was placed with the notes by the theatre staff. The completed form was attached to the notes by the anaesthetist at the first check.

During a time out check, in another theatre, there was a CD player playing extremely loud music. Staff had to read the checks very loudly to overcome the noise. Halfway through the checks, a member of nursing staff noticed what was happening and turned the music down.

Towards the end of an operation and after the final swab and instruments count, the scrub nurse informed the operating surgeon that the final count was correct. However the surgeon failed to acknowledge hearing this important information.

We spoke with staff who were visiting from a care home which was one patient's permanent residence. They told us they had provided the hospital with information and guidance about the patient's preferences and individual characteristics. They said the staff had managed the patient's care needs well. The care home staff had been involved in the patient's assessment and had been able to provide other useful information about the patient's learning disability and communication preferences.

We observed appropriate care taking place on most wards, however, on one ward we saw that while the qualified staff were professional and respectful, the manner in which some healthcare assistants delivered services did not ensure a patient's individual

needs were met (see outcome 1).

We checked a number of patients' records. The records all contained evidence of care needs assessments. The records also contained a range of completed risk assessments including those for nutrition, falls and tissue viability. However, in one record, a patient's original falls risk assessment had not been fully completed and the follow up assessment asked whether the patient had a visual impairment. The answer given was 'No'. We looked at the patient's original assessment, which stated that the patient was 'blind or partially sighted'. Risk assessments must be accurately completed to ensure that risks to a patient's wellbeing are identified and managed appropriately.

Standardised care plans were used to manage risks. For example, if a patient was assessed as being at risk of falling, a standard care plan was placed in their records to provide a set of instructions to staff about how to manage the care and reduce the risk. The care plan for one patient who was at risk of falls stated that they should have an assessment for the use of bed rails and be positioned close to a toilet. Neither of these instructions had been acted upon. Where necessary, standard care plans should be amended to reflect both individual needs and the limitations presented by the environment. For example, if there are no bed spaces near to the toilet, the care plan should be amended to reflect how the patient who is at risk of falls will be supported to access these facilities.

Some patients' care records included 'Do not attempt resuscitation' (DNAR) directives. Significant decisions concerning whether to attempt resuscitation or not had been taken, but the documents used to support these important decisions, were not fully completed and did not always contain sufficient information given the seriousness of the potential outcome of the decision.

Staff told us that patients' needs were identified through the assessment and care planning process. Observations were taken regularly and changes made to care plans where necessary. Patients' changing needs were also discussed at ward rounds and in team meetings.

Our judgement
Patients did not always experience effective, safe and appropriate care, treatment and support that met their needs and protected their rights as documentation to support the safe delivery of care was not always accurately completed.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are moderate concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
One patient told us that the food was fine but said, "Then again, I'd eat anything, it's not always that hot but I don't mind that." One patient said, "[The food was] absolutely diabolical, even the sandwiches are old, pre-packed, dry and awful." Another patient said, "The food is very poor, lukewarm at best."

Other evidence
Before our visit, we contacted a number of key partners involved with the service. All partners that replied to the Care Quality Commission (CQC) reported that they had no concerns regarding this outcome.

We also reviewed the information we hold regarding the provider and found no issues of concern regarding this outcome.

We looked at this outcome following comments made by patients during our inspection. We did not inspect this outcome in full and as a result have reported only on those parts of the outcome that we did inspect.

We observed lunchtime on one ward and saw patients being appropriately supported to eat their meal. However, on another ward, one patient was noted to require pureed food and thickened fluids. The lunchtime options were meat and potato pie or cheese and pickle sandwich. We saw a member of staff attempting to support the patient to eat a cheese and pickle sandwich. The patient was also given a cup of tea which had not been thickened.

One patient's records included a risk assessment that stated that the patient was nutritionally at risk and recommended that a soft diet be provided on a red tray scheme. The red tray scheme supports staff to identify when vulnerable adults require additional assistance to receive adequate nutrition. This risk assessment also stated that a referral to a dietician should be made; however, this referral had not been made. The patient's care plans recommended that a food chart be used and that they were to have full assistance with eating and drinking. However, the patient's records above the bed stated they should have a 'normal' diet. We shared our observations with the staff and the over bed instruction was amended to reflect the accurate assessment of need. A diet sheet had been completed and listed the foods that they had eaten and those that had been refused.

Another patient had been readmitted following a fall at home. During their previous stay they had been assessed by the hospital speech and language therapy team who had recommended a modified diet because of swallowing problems. The information from the previous recent admission had not been used to inform care practice on the current admission and the patient was offered a normal diet, which they experienced problems with.

Another patient's care records did not include a full assessment of their nutritional needs. It also incorrectly stated that the patient did not require assistance with eating and drinking. The patient had been kept 'Nil by Mouth' but for fluids, for a prolonged period of time and when we visited we saw that food was gradually being reintroduced. However, the food and fluid care plan still stated 'Nil by mouth at present'.

The risk assessment identified that the patient was at risk of malnutrition. Records above the patient's bed reminded the staff that the risk assessment must be repeated after a week. The care records showed the staff had had limited success in supporting the patient to eat and drink. We discussed this with the person in charge who confirmed this would usually prompt an earlier repeat of the nutritional risk assessment and a referral for a full nutritional assessment, which is a more detailed, specific and in depth evaluation of a patient's nutritional needs. The person in charge confirmed they would review what had happened and initiate an earlier review of the nutritional risk assessment.

Our judgement
Patients were not always appropriately supported to have adequate and appropriate nutrition and hydration as their assessed needs did not always reflect the diet and assistance given.

Outcome 06:
Cooperating with other providers

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are minor concerns with Outcome 06: Cooperating with other providers

Our findings

What people who use the service experienced and told us
One patient thought the liaison between services was, "excellent." Another patient told us that there had been very good communication between departments and that information had been shared with them so that they knew what was happening and planned for them.

However, three patients we spoke with in the discharge lounge had experienced significant delays waiting for their prescriptions to be filled by the hospital pharmacy and for transport to take them home.

Other evidence
Before our visit, we contacted a number of key partners involved with the service. All partners that replied to the Care Quality Commission (CQC) reported that they had no concerns regarding this outcome.

We also reviewed the information we hold regarding the provider and found no issues of concern regarding this outcome.

During our visit we spoke to staff from a care home who had been accompanying a patient to hospital. They said that staff had followed their advice and as far as they were able to tell were providing good care to, and support for, the patient.

We discussed our findings following observations in the discharge lounge with the management team. The management team provided evidence to us that they had

raised the transport issue regularly with the commissioners buying the transport service from another provider for them. They also provided evidence that they were monitoring the situation and would continue to raise issues with the commissioners if they re-occurred.

We also discussed the medication issue observed in the discharge lounge with the management team. We were informed that a new e-pharmacy system, which was being piloted, had brought about some improvements. However, the system was not yet fully understood by all staff and had led to patients being given incorrect information that raised expectations, which were then not met.

We saw areas of good practice between different departments and teams.

We saw that one patient's admission to hospital revealed a breakdown in their care arrangements at home and showed them to be highly vulnerable to the risk of abuse. The admission presented an opportunity to review the care arrangements and establish additional safeguards prior to their discharge. The care records showed there was very good and proactive interagency working to ensure the full risks were known. It was also recommended the patient should not be discharged home until there had been an interagency case review. The records showed there were multiple agencies involved. They also showed that referrals had been made to relevant disciplines to help assess and manage the patient's ongoing health and social care needs.

In other patients' records we saw appropriate and timely referrals to physiotherapy and to the speech and language therapy team.

Staff told us that a number of other professionals from other providers were involved in the care of patients. The other professionals wrote in the medical notes and attended reviews of care and ward meetings as appropriate. On one ward, we were told that staff from other departments visited the ward to check whether there were any patients that could be transferred to their departments.

Staff also told us that there was a much improved relationship with the local primary care trust and this was leading to much better coordination of services.

However, staff also told us that they were concerned about the long waits some patients experienced before an ambulance arrived to transport them home or to the other hospital for tests. We were shown two examples of long waits suffered by patients using the service. One ambulance (for an 82 year old patient) was booked at 2.30pm but did not arrive until 5.10am. Another ambulance (for an 89 year old patient with dementia) was booked at 6pm and did not arrive until 5.30am. We were told that the wait should be four hours.

Our judgement
Most patients received safe and coordinated care, treatment and support where more than one provider was involved, or they were moved between services. However, some patients experienced significant delays when waiting for medication to be dispensed or for transport to arrive to take them home or to another service.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are minor concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
Patients told us that they felt safe and they knew who to speak to if they had any concerns.

Other evidence
Before our visit, we contacted a number of key partners involved with the service. All partners that replied to the Care Quality Commission (CQC) reported that they had no concerns regarding this outcome.

We also reviewed the information we hold regarding the provider and found no issues of concern regarding this outcome.

However, we did observe one incident of concern involving a patient. We saw a visitor speaking to a patient lying in bed on one of the wards. We approached and asked if we could speak with the visitor about their experience of the ward. They told us they weren't visiting the patient but had approached because the patient was calling out. The visitor had been observed helping the patient re-position themselves and pulling them up the bed. A member of staff working in the area had seen this, stopped what they were doing and walked away, we assumed to get another member of staff. The member of staff didn't return.

The patient had been assessed as being at risk of pressure sores and was being nursed on pressure relieving equipment. Re-positioning patients who are at risk of pressure sores by pulling them up the bed can damage the skin. Staff had not

challenged the visitor pulling the patient up the bed, and as a result, the patient had not been protected from the risk of harm.

We looked at the provider's training report. Attendance records for the end of August 2011 showed that the provider was around 50-70% against its training targets to be achieved by the end of August for safeguarding children levels 1 and 2 and safeguarding vulnerable adults training.

Most staff told us that they had received safeguarding training; however, not all staff were able to explain what actions they would take if they had any safeguarding concerns. We discussed this issue with the management team who provided us with evidence that plans were in place to ensure that all staff received safeguarding children and safeguarding adults training. The provider also agreed that safeguarding procedures and telephone numbers would be displayed on the noticeboards of each ward to provide further support for staff when considering safeguarding issues.

We also checked the service's records of safeguarding referrals. There was clear evidence of appropriate referrals from the service and all investigations and outcomes were logged.

One patient's records showed that they were at risk of abuse as a vulnerable adult at home. Appropriate referrals using safeguarding adults' protocols had been made and there was evidence of positive interagency cooperation to help keep the patient safe from future risk of abuse. We spoke with staff who were very well informed about the risks the patient faced and the plan to ensure they are protected in the future.

Our judgement
Patients were protected from abuse, or the risk of abuse and their human rights were respected and upheld. However, the amount of staff who had attended safeguarding training needed to be increased to ensure that all staff could recognise when there was a risk of abuse and knew what actions to take to address any risks of abuse.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are minor concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
Most patients told us that they were happy with the premises. One patient said, "It's clean and tidy." However, on one ward, a patient told us there were no hooks or rails to hang clothing in the showers and therefore they had to put their clothing and belongings on the floor of the shower.

Other evidence
Before our visit, we contacted a number of key partners involved with the service. All partners that replied to the Care Quality Commission (CQC) reported that they had no concerns regarding this outcome.

We also reviewed the information we hold regarding the provider and found no issues of concern regarding this outcome.

We looked at eight different areas where patients were being cared for. We visited the discharge lounge and seven wards.

The discharge lounge was small and felt cramped. Building work was taking place and the lounge was not a pleasant environment for patients to wait in. There was no nurse call system in the discharge lounge toilets.

The wards were all well organised, with no noxious smells and quite well maintained although some of the cupboards and surfaces in cleaning and treatment rooms were dated and had started to deteriorate. The windows for some of the wards were quite dirty which meant it was difficult to see out and there was less natural light coming in.

The design and layout of the wards were mostly suitable for providing care; however, there was one ward where there was only one shower and no bath for up to 28 patients. One ward for older people, where the length of stay could be quite long, did not offer any activities. The ward also did not have an activities coordinator, day room, visitors' room or dining room. It did not have any appropriate space for end of life care.

Staff told us that they knew who to report concerns to and most staff felt that issues were usually dealt with quickly though it depended on the type of work that was required. Staff were generally content with the environment but the lack of facilities on the older people's ward and the condition of the discharge lounge were raised with us as issues.

Our judgement
Patients were generally cared for in safe, accessible surroundings that promoted their wellbeing. However, improvements were needed to the shower and bathing facilities on one ward, the discharge lounge and the facilities on one older people's ward to ensure that all patients were cared for in an environment that promoted their wellbeing.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
Patients told us that their needs were met by competent staff. Patients also told us that staff were well trained and worked hard. Some patients felt that staff had very little time to manage unplanned events.

Other evidence
Before our visit, we contacted a number of key partners involved with the service. Most partners that replied to the Care Quality Commission (CQC) reported that they had no concerns regarding this outcome. One partner told us that while access to clinical supervision was not always easy; the provider's service was, "A rich training environment."

We also reviewed the information we hold regarding the provider and found some concerns within the staff survey results regarding the level of job relevant training, quality of job design and pressure to work when sick. However, levels of work related stress, percentage of staff experiencing physical violence or bullying and harassment from relatives of patients were much better than equivalent providers.

All staff told us that they had received a corporate induction and almost all staff had received a ward based induction. Staff told us that they had received lots of training, both mandatory and non-mandatory.

We were told by the managers on two wards that formal clinical supervision was not taking place at present. However, other staff on those wards told us that they did receive appropriate clinical supervision. All staff told us that they received appraisals.

Most staff felt well supported but staff felt that there were not enough healthcare assistants on the ward. We discussed this issue with the management team who told us that there had been recent changes in the balance of staffing on the wards. They told us that the changes had led to a higher proportion of nurses compared with healthcare assistants. The management team told us that they were continuing to work on this issue to ensure that work was better shared between nurses and healthcare assistants.

Our judgement
Patients did have their needs met by competent staff as staff were properly trained, supervised and appraised.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
Patients knew how to make a complaint but most told us that they had not been offered the opportunity to provide formal feedback on their experiences at the service.

Other evidence
Before our visit, we contacted a number of key partners involved with the service. All partners that replied to the Care Quality Commission (CQC) reported that they had no concerns regarding this outcome and one partner stated that the provider had very robust incident reporting procedures.

We also reviewed the information that we hold regarding the provider and found no issues of concern regarding this outcome.

Staff told us that there were lots of audits taking place. Wards were audited on a monthly basis by another ward regarding a wide range of issues including falls, medication safety, pressure ulcers and respect and dignity. Weekly infection control audits also took place. There were also spot checks carried out by the ward manager and matrons regarding documentation, complaints and incidents forms.

Staff told us that they were confident reporting incidents and that they also attended team meetings where they could raise concerns and discuss any learning from incidents. Learning from audits and incidents was also e-mailed to staff and displayed on staff noticeboards.

We discussed the provider's arrangements for monitoring the quality of its service. Comprehensive structures were in place to ensure that effective monitoring took place and appropriate actions were taken in response to any concerns identified from that monitoring.

Our judgement
Patients benefited from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are moderate concerns with Outcome 21: Records

Our findings

What people who use the service experienced and told us
Most patients knew where their records were kept and were happy they were available for staff to use, but kept secure enough so as to be safe and confidential.

The comments we received did not support the outcome and we saw a number of examples of information not being stored securely.

Other evidence
Before our visit, we contacted a number of key partners involved with the service. All partners that replied to Care Quality Commission (CQC) reported that they had no concerns regarding this outcome.

We also reviewed the information that we hold regarding the provider and found no issues of concern regarding this outcome.

However, on a couple of the areas that we visited, whiteboards with patients' names could easily be read by any visitors. Computers with patients' information showing were not being correctly secured by staff before leaving them unattended. We saw patients' notes that had been left unattended. We also saw that a member of the medical team had written a personal message in a patient's medical records which said, "Thanks [Member of staff], congratulations on consultant job."

We checked a number of patients' records. Documentation was not always fully completed. Some nursing records seen were only partly completed and did not give a full and clear picture of the patient's assessed needs nor include sufficient information in the care plans to guide staff in the way they should manage and support patients with significant and complex needs associated with a cognitive impairment or behaviours that challenge them. We discussed these issues with staff. We were told that new documentation had only just been introduced and wards were evaluating the documentation to see how effective it was in supporting staff to meet patients' needs.

Staff told us that they were aware of issues of confidentiality and that records should be kept in locked trolleys. Some staff told us that doctors sometimes left the notes out of the trolleys. One member of staff said, "I think sometimes notes are left out and we are a little lax."

We asked the provider to give us information regarding the amount of staff who had attended information governance (IG) training. At the end of September 2011 - 45% of all of the provider's staff had completed their IG training.

The provider has achieved a satisfactory rating on the NHS Information Governance toolkit. The Information Governance Toolkit is a performance tool produced by the Department of Health. It draws together the legal rules and central guidance and presents them in one place as a set of information governance requirements. The provider is required to carry out self-assessments of their compliance against the IG requirements.

Our judgement
Patients could not be confident that their personal records, including medical records were held securely and remained confidential. Patients could also not be confident that their medical records were always accurate and fit for purpose.

Action
we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: Patients understood their care and treatment choices and were involved in making decisions about them. However, patients did not always have their privacy and dignity respected.	
Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: Patients understood their care and treatment choices and were involved in making decisions about them. However, patients did not always have their privacy and dignity respected.	
Family planning	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: Patients understood their care and treatment choices and were involved in making decisions about them. However, patients did not always have their privacy and dignity	

	respected.	
Maternity and midwifery services	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: Patients understood their care and treatment choices and were involved in making decisions about them. However, patients did not always have their privacy and dignity respected.	
Surgical procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: Patients understood their care and treatment choices and were involved in making decisions about them. However, patients did not always have their privacy and dignity respected.	
Termination of pregnancies	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: Patients understood their care and treatment choices and were involved in making decisions about them. However, patients did not always have their privacy and dignity respected.	
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: Patients understood their care and treatment choices and were involved in making decisions about them. However, patients did	

	not always have their privacy and dignity respected.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	How the regulation is not being met: On the whole, patients were able to give valid consent to the care and treatment that they received. They understood and knew how to change any decision about their care and treatment that had previously been agreed. However, patients could not be confident that there were effective systems in place to ensure that assessments of capacity were undertaken when appropriate and to ensure that decisions were being made in the best interests of those patients who had been assessed as lacking capacity to make a specific decision.	
Diagnostic and screening procedures	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	How the regulation is not being met: On the whole, patients were able to give valid consent to the care and treatment that they received. They understood and knew how to change any decision about their care and treatment that had previously been agreed. However, patients could not be confident that there were effective systems in place to ensure that assessments of capacity were undertaken when appropriate and to ensure that decisions were being made in the best interests of those patients who had been assessed as lacking capacity to make a specific decision.	
Family planning	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment

	How the regulation is not being met: On the whole, patients were able to give valid consent to the care and treatment that they received. They understood and knew how to change any decision about their care and treatment that had previously been agreed. However, patients could not be confident that there were effective systems in place to ensure that assessments of capacity were undertaken when appropriate and to ensure that decisions were being made in the best interests of those patients who had been assessed as lacking capacity to make a specific decision.	
Maternity and midwifery services	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	How the regulation is not being met: On the whole, patients were able to give valid consent to the care and treatment that they received. They understood and knew how to change any decision about their care and treatment that had previously been agreed. However, patients could not be confident that there were effective systems in place to ensure that assessments of capacity were undertaken when appropriate and to ensure that decisions were being made in the best interests of those patients who had been assessed as lacking capacity to make a specific decision.	
Surgical procedures	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	How the regulation is not being met: On the whole, patients were able to give valid consent to the care and treatment that they received. They understood and knew how to change any decision about their care and treatment that had previously been agreed. However, patients could not be confident that there were effective systems in place to	

	ensure that assessments of capacity were undertaken when appropriate and to ensure that decisions were being made in the best interests of those patients who had been assessed as lacking capacity to make a specific decision.	
Termination of pregnancies	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	How the regulation is not being met: On the whole, patients were able to give valid consent to the care and treatment that they received. They understood and knew how to change any decision about their care and treatment that had previously been agreed. However, patients could not be confident that there were effective systems in place to ensure that assessments of capacity were undertaken when appropriate and to ensure that decisions were being made in the best interests of those patients who had been assessed as lacking capacity to make a specific decision.	
Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	How the regulation is not being met: On the whole, patients were able to give valid consent to the care and treatment that they received. They understood and knew how to change any decision about their care and treatment that had previously been agreed. However, patients could not be confident that there were effective systems in place to ensure that assessments of capacity were undertaken when appropriate and to ensure that decisions were being made in the best interests of those patients who had been assessed as lacking capacity to make a specific decision.	
Assessment or medical treatment for persons detained under the Mental	Regulation 9 HSCA 2008 (Regulated	Outcome 04: Care and welfare of people who

Health Act 1983	Activities) Regulations 2010	use services
	How the regulation is not being met: Patients did not always experience effective, safe and appropriate care, treatment and support that met their needs and protected their rights as documentation to support the safe delivery of care was not always accurately completed.	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Patients did not always experience effective, safe and appropriate care, treatment and support that met their needs and protected their rights as documentation to support the safe delivery of care was not always accurately completed.	
Family planning	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Patients did not always experience effective, safe and appropriate care, treatment and support that met their needs and protected their rights as documentation to support the safe delivery of care was not always accurately completed.	
Maternity and midwifery services	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Patients did not always experience effective, safe and appropriate care, treatment and support that met their needs and protected their rights as documentation to support the safe delivery of care was not always accurately completed.	
Surgical procedures	Regulation 9 HSCA	Outcome 04: Care and

	2008 (Regulated Activities) Regulations 2010	welfare of people who use services
	How the regulation is not being met: Patients did not always experience effective, safe and appropriate care, treatment and support that met their needs and protected their rights as documentation to support the safe delivery of care was not always accurately completed.	
Termination of pregnancies	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Patients did not always experience effective, safe and appropriate care, treatment and support that met their needs and protected their rights as documentation to support the safe delivery of care was not always accurately completed.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Patients did not always experience effective, safe and appropriate care, treatment and support that met their needs and protected their rights as documentation to support the safe delivery of care was not always accurately completed.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: Patients were not always appropriately supported to have adequate and appropriate nutrition and hydration as their assessed needs did not always reflect the diet and assistance given.	

Diagnostic and screening procedures	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: Patients were not always appropriately supported to have adequate and appropriate nutrition and hydration as their assessed needs did not always reflect the diet and assistance given.	
Family planning	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: Patients were not always appropriately supported to have adequate and appropriate nutrition and hydration as their assessed needs did not always reflect the diet and assistance given.	
Maternity and midwifery services	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: Patients were not always appropriately supported to have adequate and appropriate nutrition and hydration as their assessed needs did not always reflect the diet and assistance given.	
Surgical procedures	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
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Termination of pregnancies	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: Patients were not always appropriately supported to have adequate and appropriate nutrition and hydration as their assessed needs did not always reflect the diet and assistance given.	
Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: Patients were not always appropriately supported to have adequate and appropriate nutrition and hydration as their assessed needs did not always reflect the diet and assistance given.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 06: Cooperating with other providers
	How the regulation is not being met: Most patients received safe and coordinated care, treatment and support where more than one provider was involved, or they were moved between services. However, some patients experienced significant delays when waiting for medication to be dispensed or for transport to arrive to take them home or to another service.	
Diagnostic and screening procedures	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 06: Cooperating with other providers
	How the regulation is not being met: Most patients received safe and coordinated care, treatment and support where more than	

	one provider was involved, or they were moved between services. However, some patients experienced significant delays when waiting for medication to be dispensed or for transport to arrive to take them home or to another service.	
Family planning	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 06: Cooperating with other providers
	How the regulation is not being met: Most patients received safe and coordinated care, treatment and support where more than one provider was involved, or they were moved between services. However, some patients experienced significant delays when waiting for medication to be dispensed or for transport to arrive to take them home or to another service.	
Maternity and midwifery services	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 06: Cooperating with other providers
	How the regulation is not being met: Most patients received safe and coordinated care, treatment and support where more than one provider was involved, or they were moved between services. However, some patients experienced significant delays when waiting for medication to be dispensed or for transport to arrive to take them home or to another service.	
Surgical procedures	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 06: Cooperating with other providers
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	waiting for medication to be dispensed or for transport to arrive to take them home or to another service.	
Termination of pregnancies	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 06: Cooperating with other providers
	How the regulation is not being met: Most patients received safe and coordinated care, treatment and support where more than one provider was involved, or they were moved between services. However, some patients experienced significant delays when waiting for medication to be dispensed or for transport to arrive to take them home or to another service.	
Treatment of disease, disorder or injury	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 06: Cooperating with other providers
	How the regulation is not being met: Most patients received safe and coordinated care, treatment and support where more than one provider was involved, or they were moved between services. However, some patients experienced significant delays when waiting for medication to be dispensed or for transport to arrive to take them home or to another service.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: Patients were protected from abuse, or the risk of abuse and their human rights were respected and upheld. However, the amount of staff who had attended safeguarding training needed to be increased to ensure that all staff could recognise when there was a risk of abuse and knew what actions to take to address any risks of abuse.	

Diagnostic and screening procedures	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: Patients were protected from abuse, or the risk of abuse and their human rights were respected and upheld. However, the amount of staff who had attended safeguarding training needed to be increased to ensure that all staff could recognise when there was a risk of abuse and knew what actions to take to address any risks of abuse.	
Family planning	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: Patients were protected from abuse, or the risk of abuse and their human rights were respected and upheld. However, the amount of staff who had attended safeguarding training needed to be increased to ensure that all staff could recognise when there was a risk of abuse and knew what actions to take to address any risks of abuse.	
Maternity and midwifery services	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: Patients were protected from abuse, or the risk of abuse and their human rights were respected and upheld. However, the amount of staff who had attended safeguarding training needed to be increased to ensure that all staff could recognise when there was a risk of abuse and knew what actions to take to address any risks of abuse.	
Surgical procedures	Regulation 11 HSCA 2008 (Regulated	Outcome 07: Safeguarding people who use services from

	Activities) Regulations 2010	abuse
	How the regulation is not being met: Patients were protected from abuse, or the risk of abuse and their human rights were respected and upheld. However, the amount of staff who had attended safeguarding training needed to be increased to ensure that all staff could recognise when there was a risk of abuse and knew what actions to take to address any risks of abuse.	
Termination of pregnancies	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: Patients were protected from abuse, or the risk of abuse and their human rights were respected and upheld. However, the amount of staff who had attended safeguarding training needed to be increased to ensure that all staff could recognise when there was a risk of abuse and knew what actions to take to address any risks of abuse.	
Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: Patients were protected from abuse, or the risk of abuse and their human rights were respected and upheld. However, the amount of staff who had attended safeguarding training needed to be increased to ensure that all staff could recognise when there was a risk of abuse and knew what actions to take to address any risks of abuse.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises

	How the regulation is not being met: Patients were generally cared for in safe, accessible surroundings that promoted their wellbeing. However, improvements were needed to the shower and bathing facilities on one ward, the discharge lounge and the facilities on one older people's ward to ensure that all patients were cared for in an environment that promoted their wellbeing.	
Diagnostic and screening procedures	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: Patients were generally cared for in safe, accessible surroundings that promoted their wellbeing. However, improvements were needed to the shower and bathing facilities on one ward, the discharge lounge and the facilities on one older people's ward to ensure that all patients were cared for in an environment that promoted their wellbeing.	
Family planning	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: Patients were generally cared for in safe, accessible surroundings that promoted their wellbeing. However, improvements were needed to the shower and bathing facilities on one ward, the discharge lounge and the facilities on one older people's ward to ensure that all patients were cared for in an environment that promoted their wellbeing.	
Maternity and midwifery services	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: Patients were generally cared for in safe,	

	accessible surroundings that promoted their wellbeing. However, improvements were needed to the shower and bathing facilities on one ward, the discharge lounge and the facilities on one older people's ward to ensure that all patients were cared for in an environment that promoted their wellbeing.	
Surgical procedures	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
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Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: Patients were generally cared for in safe, accessible surroundings that promoted their wellbeing. However, improvements were needed to the shower and bathing facilities	

	on one ward, the discharge lounge and the facilities on one older people's ward to ensure that all patients were cared for in an environment that promoted their wellbeing.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: Patients could not be confident that their personal records, including medical records were held securely and remained confidential. Patients could also not be confident that their medical records were always accurate and fit for purpose.	
Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: Patients could not be confident that their personal records, including medical records were held securely and remained confidential. Patients could also not be confident that their medical records were always accurate and fit for purpose.	
Family planning	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: Patients could not be confident that their personal records, including medical records were held securely and remained confidential. Patients could also not be confident that their medical records were always accurate and fit for purpose.	
Maternity and midwifery services	Regulation 20 HSCA 2008 (Regulated Activities)	Outcome 21: Records

	Regulations 2010	
	How the regulation is not being met: Patients could not be confident that their personal records, including medical records were held securely and remained confidential. Patients could also not be confident that their medical records were always accurate and fit for purpose.	
Surgical procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: Patients could not be confident that their personal records, including medical records were held securely and remained confidential. Patients could also not be confident that their medical records were always accurate and fit for purpose.	
Termination of pregnancies	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: Patients could not be confident that their personal records, including medical records were held securely and remained confidential. Patients could also not be confident that their medical records were always accurate and fit for purpose.	
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: Patients could not be confident that their personal records, including medical records were held securely and remained confidential. Patients could also not be confident that their medical records were always accurate and fit for purpose.	

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

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

The provider's report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

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

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

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

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

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

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

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

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

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

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

Information for the reader

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