Inspection Report

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

Queen's Medical Centre

Derby Road, Nottingham, NG7 2UH

Tel: 01159249944

Date of Inspections: 28 September 2012
27 September 2012

Date of Publication: October 2012

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

Respecting and involving people who use services	✓ Met this standard
Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Safety and suitability of premises	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Nottingham University Hospitals NHS Trust
Overview of the service	Nottingham University Hospitals NHS Trust is one of the largest trusts in England and it provides services on three locations. This report focuses on one of these locations, Queen's Medical Centre, which provides a range of acute and specialist services to the local population of Nottingham as well as across the wider East Midlands area.
Type of services	Acute services with overnight beds Diagnostic and/or screening service Rehabilitation services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Queen's Medical Centre had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Consent to care and treatment
- Care and welfare of people who use services
- Meeting nutritional needs
- Cooperating with other providers
- Safeguarding people who use services from abuse
- Safety and suitability of premises
- Records

This was an unannounced inspection.

How we carried out this inspection

We reviewed all the information we have gathered about Queen's Medical Centre, looked at the personal care or treatment records of people who use the service, carried out a visit on 27 September 2012 and 28 September 2012 and observed how people were being cared for. We checked how people were cared for at each stage of their treatment and care, talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

Patients told us their privacy and dignity were respected and they were asked for their consent before they received any care or treatment. Patients told us they were happy with the care and treatment they received and felt safe. They knew who to speak to if they had concerns. Patients told us they had no concerns about the environment or the confidentiality of their records.

We found that patients' privacy and dignity were respected and staff obtained consent before carrying our treatment. Patients received appropriate care and treatment and received appropriate nutrition and hydration. The provider worked effectively with other providers and there were arrangements in place to ensure the safety of patients. The premises were appropriate and records were kept securely. However, records were not always accurate and fit for purpose.

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

What we have told the provider to do

We have asked the provider to send us a report by 21 November 2012, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Patients' privacy, dignity and independence were respected.

Reasons for our judgement

Patients' privacy, dignity and independence were respected.

Our inspection in September 2011 found that patients did not always have their privacy and dignity respected. The provider wrote to us and told us that staff involved had received further training, staff competencies had been reviewed and regular unannounced observations were taking place.

We spoke with 11 patients. Patients told us their privacy and dignity was respected. One patient said, "Yes, this has been one of the highlights of my care." Another patient said, "The staff are very respectful. I've not been on the ward for long but was made to feel welcome and they explained how things work. Privacy is always respected, the curtains are drawn so no-one can see what's happening."

We visited six wards. We saw on one occasion a patient's dignity was compromised due to staff talking loudly so that everyone else in the bay could hear what was being said. We also saw another patient's dignity was compromised as they had taken off their blankets as they were trying to get out of bed. This was not recognised and responded to and consequently the patient remained like this for half an hour before they received support and assistance from staff. During the rest of our observations on this ward, we saw patients' privacy and dignity were respected. On all other wards we visited, we saw patients being cared for appropriately and their privacy and dignity were respected.

On one ward we heard a ward manager reassure a patient who was upset. The nurse responded to the patient's embarrassment in a kind and sensitive manner.

We saw two members of staff assisting a patient to walk to the bathroom. The staff had tried to persuade the patient to wear a dressing gown, but the patient refused. We saw the staff maintained the patient's dignity by holding their gown together whilst they were walking.

On a ward for older people, we saw a doctor treating patients with dignity and respect. The doctor spoke to patients in a kind and sensitive manner and knelt beside them to ensure

they were not talking over them.

We spoke with one relative. They said, "My relative is treated with respect on this ward. The staff are very polite and respectful. Privacy is always respected, the curtain is drawn when needed."

We spoke with seven members of staff about the information that patients received when they first entered hospital. All of them were able to discuss the information they provided to patients. They told us they thought the information was sufficient to ensure patients were involved in their care and any decision making. One member of staff said, "Patients are seen and clerked by a junior doctor, they are told everything. It is probably a repetition of what they may have been already told but it's to make sure we don't miss anything." Another member of staff said, "We give the family a 'This is me sheet' to fill out. It is so we can get to know them and their history. We give patients verbal information and sit and have a chat with them and ask them if there is anything they want to know."

They also told us if they had any problems communicating with patients that specialist services such as interpreters were available for them to access. One member of staff said, "We have picture boards and liaise with the family and they may leave us with basic words we can use on a clipboard. We also have interpreters available." Another member of staff said, "We have a traffic light system for patients with learning disabilities so we can communicate effectively. We can also use an interpreting service, they are always very prompt."

Eight out of nine members of staff confirmed they had received training in respect of maintaining patients' privacy and dignity. All staff were able to discuss how they did this in practice when supporting patients with their needs to ensure their privacy and dignity were maintained. One member of staff said, "We always ask people if they want a chaperon when being examined." Another member of staff said, "It is a mixed ward, therefore we try to make sure people's privacy and dignity are maintained. We make sure patients are in a dignified state of dress as much as possible and if people wander into different parts of the ward, we guide them back."

Consent to care and treatment ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where patients did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where patients did not have the capacity to consent, the provider acted in accordance with legal requirements.

Our inspection in September 2011 found that 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. The provider wrote to us and told us that Mental Capacity Act 2005 (MCA) and consent training were to be improved and attendance levels increased. Consent audits would continue with outcomes being shared with staff.

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.

We spoke with 11 patients. Patients told us that they were asked for their consent before they received any care or treatment. A patient said, "Staff will make sure I understand before doing something. I always give consent and feel I understand what's happening. They will come and explain a while before doing something." Another patient said, "Yes, they always explain what's happening and make sure I'm ok with it. I know I could say no if I wasn't comfortable with something."

We saw a member of staff asking for a patient's consent prior to taking a sample of blood from them. Good interactions were maintained and the staff member offered appropriate explanations to the patient. We also saw on all wards with the exception of one that staff were kind and caring and asked for patients' consent where necessary prior to carrying out any task.

On one ward we saw that staff did not always ask for patients' consent and we observed on three occasions where staff simply told a patient what to do rather than asking them

their choices and preference. Nevertheless, we also saw on the same ward that staff then spent time with a patient when they were reluctant to have their observations carried out. The staff member spent 15 minutes offering explanations and reassurance until the patient was happy to consent and proceed with the procedure.

We spoke with one relative. They said, "Staff will always explain what they're doing to me and my relative (even though they may not understand). They would not do anything without consent."

During our tour of the wards, we saw that MCA information was displayed on walls and care records contained further information as a reminder for staff. Staff also carried MCA information on a credit card sized reminder card.

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. We also saw in nursing records that consent was obtained before carrying out any procedures.

We also looked at whether assessments of capacity were taking place where appropriate. We looked at seven care records and saw that issues of capacity had been considered in all records. Formal assessments of capacity had not taken place in two of these records where it had been indicated that it may be necessary. Both of these records were for patients who had been on the ward for less than 24 hours; however, trust management confirmed that this assessment should be made at the time of admission. We did not see any evidence of adverse impact to the patients as a result of this omission. The other five records included completed assessments of capacity where necessary.

Eight out of nine members of staff told us they had received training on the MCA. The member of staff who told us they had not undertaken training in this area told us they had carried out research so they were fully aware of their obligations in respect of this act.

All staff demonstrated a good understanding of the MCA and how and when they would need to use this in their everyday practice to ensure patients' rights and choices were maintained. One member of staff said, "We are very focused on capacity due to the nature of people's diagnosis. We would document everything, whether people have given verbal or implied consent or whether we need to act in a person's best interest. This would be documented in a care plan." Another member of staff said, "We would carry out a first stage assessment if we had concerns and then a second stage if the person lacked the capacity to make decisions. We would discuss this with the relatives, the doctors and consultants. Best interest decision making is used well on this ward definitely."

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

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

Our inspection in September 2011 found that 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. The provider wrote to us and told us that communication and documentation training were to be improved and documentation audits would continue to take place with outcomes shared with staff.

Some of the concerns we identified at our previous inspection took place in the operating theatres at the hospital. As a result, we commissioned a specialist theatre inspector to visit and inspect the operating theatres.

The specialist theatre inspector talked to staff, observed theatre practices and looked at records. They concluded that our previous concerns had been addressed by the provider.

We spoke with 11 patients. Patients told us that they were happy with the care and treatment that they received. One patient said, "The care is perfect, no problems at all. I am getting better." Another patient said, "I've not been here long, but the care has been brilliant so far, I can't fault them." Another patient said, "All the staff in this hospital are fantastic, we are very lucky."

We saw that staff supported patients as needed and in line with their individual plan of care. We saw staff carrying out assessments of patients' needs and discussing and gaining their past medical history and social situation to ensure this information was considered within their plan of care and treatment.

On one ward we saw one patient had challenging behaviour and staff told us they needed constant supervision and support. However we saw on two occasions that staff were not fully supportive of their needs and anxieties. They were brusque in their attitude and this resulted in the patient remaining agitated. However we saw two other members of staff support this patient effectively by offering them time, support, explanations and reassurance. This resulted in the patient being more settled for a period of time which

enabled them to eat their lunch.

During our visit, two patients on the Coronary Care Unit had become very unwell and emergency procedures had to be instigated. One patient said, "When the patient's heart stopped the staff responded immediately, they were amazing, they were so controlled and efficient." The patient also told us that despite dealing with an emergency situation, staff took the time to go to each of the other patients on the ward and check they understood what was happening and reassured them.

On a ward that cared for older people we observed a patient who was confused and kept calling out. We saw some very good practice by the nursing and therapy staff caring for this patient but not all staff appeared as confident to manage the situation. A staff member who we observed was confident told us they had received training in caring for patients with dementia and this had really helped them understand how to communicate with and care for patients who had dementia or delirium.

We spoke with one relative. They said, "I am very happy with the care they've given on this ward. They are very responsive to anything I raise."

All eight members of staff told us they would ensure they communicated any delays in treatment to patients to ensure they were kept fully informed of events. They all felt that any delays were communicated effectively to patients.

Four members of staff who were involved in the implementation of care plans told us there had been recent changes in the standardised care plans in use to ensure patients' individual needs and preferences were met. One member of staff said, "Care plans are better than they used to be, they are more informative." Another member of staff said, "Care plans are more standardised, but we personalise them to the patient."

All members of staff were able to discuss how they made sure that patients' individual needs were met in line with their plan of care. One member of staff said, "We follow plans of care, there is invaluable information in them, knowing about them and their needs and preferences."

All eight members of staff spoken with were able to discuss the assessment processes that patients undertake when they are admitted to the hospital. They told us that a range of assessments such as maintaining healthy skin, falls risk assessments and nutritional assessments were undertaken. They were able to discuss how these assessments were then used to ensure that patients' individual needs were met.

We discussed 'do not resuscitate' policies with seven members of staff. All of them were able to demonstrate a good understanding of how and when these polices were used to ensure that appropriate care and support were given to patients in an emergency. One member of staff said, "When people are admitted if they had an old form this would not stand, we would need to get a consultant to review this. We would involve the family where possible." Another member of staff said, "We always check. The consultant would assess or sometimes the patient will say. We have to check to see if someone has power of attorney as they can make these types of decisions."

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

Patients were protected from the risks of inadequate nutrition and hydration.

Reasons for our judgement

Patients were supported to be able to eat and drink sufficient amounts to meet their needs.

Our inspection in September 2011 found that 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. The provider wrote to us and told us that nutrition and hydration training would be improved and documentation audits and observations would continue to take place with outcomes shared with staff.

We spoke with 11 patients. One patient told us the food wasn't good. However, another patient said, "The food is nice and always served warm. There is a choice, its fine for me. I don't have any special requirement. I can have drinks any time I want and the water is always kept topped up. Meal time is respected and I am left to get on with it, but I can feed myself. Nurses do help some of the other people." Another patient said, "The food was ok and it met my specific cultural needs. There is a choice and plenty of drinks and water. I don't have any difficulties with feeding myself and haven't seen anybody's dignity compromised." Another patient said, "I had the breakfast this morning, haven't tried a lunch yet. The breakfast was fine, there was plenty of choice. Yes, there was enough and plenty to drink."

We observed lunchtime on two wards. Appropriate food and drink was available for patients at all times. Patients were supported to eat and drink. The provider may find it useful to note that we observed two staff standing over a patient while supporting them to eat. This does not maintain a patient's dignity. However, on other wards we saw staff sitting beside the patient and supporting them correctly.

We spoke with one relative, they said, "My relative is nil by mouth as of yesterday and all of the staff know this, it's also written on the board. They had eaten the food before this and seemed to enjoy it. I can see that there is a choice of meals and people always seem to have plenty to drink."

We spoke with seven members of staff about the nutritional assessments that may be undertaken for patients. All of them demonstrated a good understanding of the assessments in use and how these may trigger the need for monitoring of someone's intake or a referral to a specialist practitioner such as the dietician. One member of staff said, "There have been a lot of measures put into place since the last visit, such as a link nurse and the red tray scheme. We monitor people's intake on admission to make sure

their needs are met. This would trigger if we needed to make any referrals to the dietician." Another member of staff said, "If someone scored a four or more on the MUST assessment (a tool used to assess someone's nutritional needs) or I felt there was a change in their appetite I would always refer them to the dietician."

All members of staff said they would look at a patient's past medical records to ensure that any medical history in respect of their nutritional needs was fully assessed and appropriate support such as input from the dietician gained as needed to ensure continuity of care.

All members of staff demonstrated a good understanding of the 'red tray' scheme (a red tray is used when someone needs assistance with eating, or monitoring of their dietary intake), when this would be used and the assistance and support they may provide to patients to ensure their nutritional needs were met.

Cooperating with other providers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Patients' health, safety and welfare were protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

Patients' health, safety and welfare were protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Our inspection in September 2011 found that 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. The provider wrote to us and told us that a new non-emergency patient transport service had commenced, pharmacists had been designated for each ward and discharge lounge practices had been improved.

We spoke with 11 patients. One patient said, "The move to this ward went well. There were no delays, they just told me I was moving and off I went." Another patient said, "I came up here from A and E. It went well, they came along to explain I was moving and took me straight up. I'm not sure, but I think my notes came up with me. The staff here knew I was coming anyway." Another patient said, "My move to this ward was fine, not stressful at all."

We observed one patient being admitted to the medical admissions ward accompanied by a transfer nurse. The nurse ensured the patient knew where the toilet was and provided them with the nurse call bell and showed them how to use it.

We spoke with one relative. They said, "The transfer between wards seemed to go well. The staff on this ward knew we were coming and the notes came across too. There were no delays in the transfer."

We saw within one plan of care there was evidence of discharge planning with other professionals and the patient's relatives to ensure the patient's discharge was as coordinated as possible.

We checked the discharge lounge co-ordinator's records and they showed that patients were having short stays in the discharge lounge and a quick response from the ambulance service.

All members of staff spoken with told us that communication within each department was good which ensured coordinated practices and therefore continuity of patients' care. One member of staff said that communication with other departments could be "Hit and miss." However, the other six members of staff told us that communication with other departments was good.

All staff spoken with told us that more emphasis had been placed on discharge planning to make sure this was more coordinated and waiting time reduced. Although a minority of staff said that further developments were needed, they all felt that the discharge process had improved.

All seven members of staff told us that the 'e pharmacy system' had greatly improved the service that patients received and this had helped to reduce the waiting times that patients experienced when they go home. One member of staff told us there was a transfer team which helped to manage transfers in the emergency department and two of the main admitting wards. They told us that this team was effective in releasing ward staff time for caring for patients. Staff on two wards told us that patient transport times still required improvement; however, there were no concerns on the other wards we visited.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

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

Our inspection in September 2011 found that 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 know what actions to take to address any risks of abuse. The provider wrote to us and told us that safeguarding procedures and telephone numbers were to be displayed on each ward; the number of staff attending safeguarding training was to be improved through better release of staff to attend training and through additional support and advice from safeguarding champions with protected time. The provider also told us that a review of safeguarding training and its impact assessment would be carried out.

We spoke with 11 patients. All patients told us they felt safe and they knew who to speak to if they had any concerns. One patient said, "Oh yes, I feel very safe in here." Another patient said, "Yes I do feel safe, I have no concerns about anyone. I would be happy if I had to stay here a bit longer. I would speak to the ward manager if there was a problem."

We observed care on six wards and saw no concerns regarding this standard.

We spoke with one relative. They said, "I feel my relative is safe here. Some of the other patients can wander but I see the staff do their best to divert people and keep people occupied. I would speak with the sister in charge that day if I had a problem. I am sure they would deal with anything I raise."

During our tour of the wards, we saw that safeguarding procedures and telephone numbers were clearly displayed on the noticeboards of each ward. Each care record contained safeguarding information as a further reminder for staff. Staff also carried safeguarding information on a credit card sized reminder card.

The provider's training figures showed that 79% of staff had received safeguarding vulnerable adults training and 76% of staff had received safeguarding children and

younger adults training as at 31 July 2012.

Eight out of nine members of staff told us they had received safeguarding vulnerable adults training. The one member of staff who had not received training told us they had carried out research to ensure they were aware of their roles and responsibilities. All nine members of staff were able to demonstrate a good understanding of keeping patients safe and what may constitute abuse. They were also aware of the whistleblowing procedures they may follow to report concerns if they felt the need to.

Safety and suitability of premises ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Patients who use the service, staff and visitors were protected against the risks of unsafe and unsuitable premises.

Reasons for our judgement

The provider has taken steps to provide care in an environment that is suitably designed and adequately maintained.

Our inspection in September 2011 found that improvements were needed to the shower and bathing facilities on one ward and the discharge lounge to ensure that all patients were cared for in an environment that promoted their wellbeing. The provider wrote to us and told us that work had been carried out on the ward to improve the shower and bathing facilities and the discharge lounge had been moved to a new part of the hospital and facilities had been improved.

We spoke with 11 patients. One patient said, "It was quite difficult to sleep last night. It was noisy." However, all patients told us they had no concerns about the environment. One patient said, "The ward seems to be well looked after. I've not spotted anything amiss." Another patient said, "The environment seems alright, it's clean and fairly spacious. The facilities are exactly what I'd expect."

We observed care on six wards and saw no concerns regarding this standard.

During our tour of the wards, we saw that two new bathrooms had been provided on one ward and that the discharge lounge had been moved to a different part of the hospital and discharge facilities had been improved with further refurbishment to take place. We saw no concerns regarding the environment on any of the six wards that we visited.

We spoke with one relative. They said, "The environment seems suitable for the type of patient. It feels well looked after and always clean. "

Six out of seven members of staff outlined how they would report any maintenance issues. All six of these told us that maintenance issues were addressed quite quickly and they did not have any issues with waiting times. One member of staff told us that it did depend on what the issue was and things were prioritised, but they did not have any concerns.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Patients' personal records, including medical records, were kept securely. However, patients were not fully protected from the risks of unsafe or inappropriate care because accurate and appropriate records were not always maintained.

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

Reasons for our judgement

Our inspection in September 2011 found that 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 wrote to us and told us that notices would be displayed on the ward regarding confidentiality of records, staff would be reminded of the importance of patient confidentiality and staff attendance of information governance training would be improved. They also told us that communication and documentation training were to be improved and documentation audits would continue to take place with outcomes shared with staff.

Records were kept securely and could be located promptly when needed.

We spoke with 11 patients. All patients told us they had no concerns regarding the confidentiality of their records. One patient said, "I believe my records are looked after properly, I've not seen anything left out. Another patient said, "I've not seen any records lying around, they always use the trolley for that."

We spoke with one relative. They said, "I have no worries about confidentiality of records. The notes are always in the trolley, I've not seen any lying around."

During our tour of the wards, we saw that on all wards except one that records were kept confidential and when not in use they were placed in a locked cabinet or a locked room. The provider may find it useful to note that on one ward we saw that records had been left on a desk at the nurses' station. Staff were in the area, however the records were left unsupervised for short times. This meant that patients could not be fully assured that their records were kept confidential at all times.

During our tour of the wards, we saw that information was kept securely. Unattended computers were locked and we saw no examples of records being left unsupervised. Whiteboards did not contain any confidential patient information. There were notices

displayed on all wards reminding staff of the importance of keeping patient information confidential.

The provider's training figures showed that 71% of staff had received information governance training as at 31 July 2012.

All seven members of staff told us there had been improvements in ensuring patients' records were kept confidential. They were also able to outline how they made sure that patients' records were accurate and fit for purpose.

Patients' personal records including medical records were not always accurate.

We saw that Do Not Attempt Resuscitation forms were correctly completed. Admission booklets including risk assessments were generally well completed and reviewed where appropriate. Care plans were in place when risks had been identified and also were reviewed where appropriate. Daily records were also generally well completed. However, although we did not see that patients' welfare had been negatively affected as a result, we did see examples where documentation was incomplete or inaccurate.

On two patients' care records we saw that food monitoring charts had not been fully completed where required. This meant that there was a greater risk that patients' nutrition was not being monitored appropriately with the risk that appropriate action to address nutrition concerns would not be taken.

On three patients' care records we saw that tissue viability risk assessment had stated that three hourly turns were required, however turn chart documentation had not been fully completed to demonstrate that the turns were taking place at the required frequency. This meant that there was a greater risk that patients' pressure care needs were not being met.

On one patient's care record we saw that they had been admitted to the ward in part because they had recently fallen twice. The assessment identified that a care plan to manage the risk of falls needed to be in place but the care plan was not in place until 12 days after the patient had been transferred to the ward. This meant that staff did not have all the relevant information available to them to fully support the patient.

Within another patient's records we saw that a plan of care had not been implemented in respect of a medical intervention that had taken place. This meant that staff did not have all the relevant information available to them to fully support the patient. We spoke with a member of staff about this and they acknowledged that a plan of care should have been put into place.

We found on one ward that a patient had been on the ward for over three hours. A pressure area care assessment and the patient's observations of blood pressure, pulse and temperature were recorded when they first arrived on the ward but there were no other nursing records available for this patient. We spoke with a member of staff about this and they told us they had been exceptionally busy that morning and they had not had the opportunity to complete the necessary records. We saw this patient was very uncomfortable and they were trying to get out of bed. The patient had been assessed as being at high risk of developing a pressure sore but there was no documentary evidence to demonstrate they had been given any pressure area care since their arrival on the ward. This meant there was a risk that the patient may not have received the appropriate care, treatment and support they needed.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Patients were not fully protected from the risks of unsafe or inappropriate care because accurate and appropriate records were not always maintained. 20(1)(a)

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

The provider's report should be sent to us by 21 November 2012.

CQC should be informed when compliance actions are complete.

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

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.

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