## Review of compliance

**East Sussex Healthcare NHS Trust**  
**Eastbourne District General Hospital**

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<tr>
<th>Region:</th>
<th>South East</th>
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| Location address: | Kings Drive  
          Eastbourne  
          East Sussex  
          BN21 2UD |
| Type of service: | Acute Services  
          Treatment of disease, disorder or injury  
          Assessment or medical treatment of persons  
          detained under the Mental Health Act 1983  
          Surgical procedures  
          Diagnostic or screening procedures  
          Maternity and midwifery services  
          Termination of pregnancies |
| Date the review was completed: | September 2011 |
### Overview of the service:

Eastbourne District General Hospital is located on the outskirts of Eastbourne town centre on one of the main thoroughfares into Eastbourne. The Hospital has commanding views of the town and its rural locality.

The hospital provides a comprehensive range of acute surgery and medicine, for all ages. This includes:

- Coronary Care Unit (CCU)
- Chaplaincy Centre
- Children's Unit - Friston Children's Unit
- Cancer Care Centre
- Day hospital for the Elderly
- Day Surgery
- Delivery Suite
- Diagnostic laboratories and services
- Dietetics and Special Therapy Services
- Emergency Department
- Endoscopy Suite
- Gynaecology Ward
- High Dependency Unit
- Hydrotherapy Pool
- Intensive Care Unit (ICU)
- Maternity Unit
- Early Pregnancy Unit
- Medical Assessment Unit
- Medical and Elderly Unit
- Occupational and Physiotherapy Services
- Operating Theatres
- Outpatients Departments
- Private patients unit
- Radiology - MRI and CT suites
- Special Care Baby Unit (SCBU)
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<td></td>
<td>Urology investigation suite</td>
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<td>Wards - medical and surgical</td>
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Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Eastbourne District General Hospital was not meeting one or more essential standards. We are taking further action to protect the safety and welfare of people who use services.

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

Why we carried out this review

We carried out this review to check whether Eastbourne District General Hospital had made improvements in relation to:

- Outcome 01 - Respecting and involving people who use services
- Outcome 02 – Consent to Care & Treatment
- Outcome 04 - Care and welfare of people who use services
- Outcome 07 - Safeguarding people who use services from abuse
- Outcome 08 – Cleanliness and Infection Control
- Outcome 10 – Safety & Suitability of Premises
- Outcome 13 - Staffing
- Outcome 14 – Supporting Staff
- Outcome 16 - Assessing and monitoring the quality of service provision
- Outcome 21 – Records

How we carried out this review

In September 2011 we reviewed all the information we hold about this provider, checked the provider’s records, 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

We visited the Accident and Emergency Department (A&E), Jevington, Seaford 3, Cuckmere, Medical Assessment Unit, and Hailsham 3 wards and spoke with patients in all these areas.
The majority of patients we spoke with told us that they felt well informed about their care and treatment, and had been involved in decision making around this.

Patients said that all staff were actively maintaining their privacy and dignity by pulling curtains around, and lowering their voices when sensitive information was being passed over.

Patients, who were able to make decisions for themselves, told us that consent was routinely verbally sought by staff for everyday care and treatment activities.

Overall, patients told us that the care they had received had been good. They also thought that nursing staff had an understanding of their needs.

The majority of patients spoken with indicated that there were enough staff on duty, and thought call bells were generally answered in a reasonably short time.

However, some patients on Seaford 3, Jevington and Cuckmere wards did raise concerns about staff responses to call bells. Two patients spoken with expressed dissatisfaction with the lack of consultation with them in respect of their treatment or preferences.

In discussion, all the patients spoken with thought that the general standard of cleanliness was good. They said that cleaning was always happening, and that staff were always washing their hands, and using the alcohol based hand gels.

**What we found about the standards we reviewed and how well Eastbourne District General Hospital 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**

The majority of patients or their nominated relatives felt well informed about their care and treatment options, and were able to make choices in respect of this. Patients had their privacy and dignity respected.

Eastbourne District General Hospital was found to be compliant in respect of the essential standards of quality and safety relating to this outcome.

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

The majority of patients and some relatives spoken with confirmed that they had given verbal consent for routine nursing interventions and that signed consent had been sought for other treatments or operations.
However, there was a lack of evidence that patients with reduced mental capacity had access to advocacy or that best interest meetings had taken decisions on their behalf.

Eastbourne District General Hospital was found to be non-compliant in respect of the essential standards of quality and safety relating to this outcome.

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

Since our last inspection, there had been an improvement in the consistency of documentation used across wards and departments with the introduction of the integrated care plan. However, there were marked inconsistencies across wards in the quality and completion of patients' notes and integrated care plans. There was no evidence in some care plans that concerns were followed through for some patients, this was particularly true for those with a degree of diminished mental capacity. Risk assessments were not always completed nor used to inform the care plan. Discharge planning was not well documented.

The trust has stated that it does not anticipate being compliant with this outcome before 31 March 2012. Systems and processes for monitoring the quality and safety of services are not robust and the trust risk register does not reflect the level of current risk to patients.

Eastbourne District General Hospital was found to be non-compliant in respect of the essential standards of quality and safety relating to this outcome.

In view of the major concerns the Commission has with the trust’s continued non-compliance with this outcome, further enforcement action will be considered.

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

There was an improved awareness, understanding and use amongst staff of safeguarding, mental capacity and deprivation of liberty procedures. Important documentation was not robustly or consistently completed to the same standard across all wards. It remained unclear how decisions around consent were being obtained for people with limited capacity.

Systems and processes for monitoring the quality and safety of services were not robust and the trust risk register did not reflect the level of current risk to patients.

Eastbourne District General Hospital was found to be non-compliant in respect of the essential standards of quality and safety relating to this outcome.
Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

While staff were observed carrying out infection control procedures there were some areas where improvements need to be made to ensure that patients were not placed at risk.

Further actions need to be taken in respect of the management of infected patients in side wards.

Eastbourne District General Hospital was found to be compliant in respect of the essential standards of quality and safety relating to this outcome.

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

Significant improvements to the layout of the environment in the Accident and Emergency Department had contributed appreciably to increased patient flow and the maintenance of the privacy and dignity of patients nursed in this area.

Eastbourne District General Hospital was found to be compliant in respect of the essential standards of quality and safety relating to this outcome.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The trust had substantially increased its front line staffing of qualified and unqualified nurses and midwives, with a positive impact on outcomes for people and a raising of staff morale.

Recruitment of middle grade doctors and consultants remained an issue with high dependency on locum doctors to supplement core medical staffing. There were insufficient allied healthcare professionals in post to fully support the rehabilitation needs of patients.

Eastbourne District General Hospital was found to be compliant in respect of the essential standards of quality and safety relating to this outcome.

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

Staff were provided with an appropriate range of mandatory training opportunities. Improved core staff numbers had led to staffing more readily being released to fulfil booked training commitments. There was a staff appraisal system in place.
There were inconsistencies in the training available to support the introduction and continued usage of the integrated care plan.

Eastbourne District General Hospital was found to be compliant in respect of the essential standards of quality and safety relating to this outcome.

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

We found that the trust was working towards future compliance with this outcome by commissioning a clinical governance review, implementing corresponding recommendations and taking a range of short and long term actions to ensure the safety and quality of services to patients.

However, the effectiveness and efficiency of monitoring and audit arrangements as well as their usefulness in monitoring and changing the quality of the service being provided was inadequate.

The trust has stated that they did not anticipate being compliant with the essential standards relating to outcome 16 before 31 March 2012. Systems and processes for monitoring the quality and safety of services were not robust and the trust risk register did not reflect the level of current risk to patients.

We found that Eastbourne District General Hospital was not meeting this essential standard. We are taking enforcement action against East Sussex Healthcare NHS Trust to protect the safety and welfare of people who use services.

**Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential**

Whilst there were improvements across those areas visited in the range of documentation used, the completion of required assessments and risk information remained inconsistent and directly impacted on staff knowledge of patients’ day to day well being.

Eastbourne District General Hospital was found to be compliant in respect of the essential standards of quality and safety.

**Action we have asked the service to take**
We have asked the provider to send us a report within 14 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.

We are taking further action to protect the safety and welfare of people who use services. 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. Any regulatory decision that CQC takes 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 review 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 1: 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

The provider was compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us

We spoke with four patients in each area. We visited and spoke with any relatives who were available to speak with.

Patients told us that staff had been good at explaining what to expect, when to expect things and why it was necessary. This included both doctors and nurses.

One patient told us that, whilst they had not discussed their care and treatment with doctors, they had given permission for their daughter to make decisions on their behalf.

Another patient said that they were fully aware of their plan of care and treatment and that this had been fully discussed with them.
One relative spoke positively about the doctor who had gone to great lengths to explain care and treatment to be provided to their relative.

Another patient reported “yes, always kept me informed and involved. Also kindly kept my wife involved”.

All patients spoken with said that they felt their privacy and dignity had been respected whilst they had been on the Accident & Emergency department and on the wards.

On the Medical Assessment Unit (MAU), one patient told us that, during their stay, they had observed a patient get up to find a staff member to attend to another patient who was in urgent need. They also said that “it is always busy at mealtimes and again you can wait longer to be attended to then”.

On Jevington ward, a patient told us that doctors had not discussed treatment with them and they were unaware of what was happening next.

On Seaford 3 ward a patient told us that some staff did not call her by her name but always referred to her as ‘dear’, ‘darling’, or ‘love’ and that she did not feel that her dignity was upheld.

On Cuckmere ward, a patient told us that they had not understood some of the medical staff who had come to speak with them about their illness. They were worried and anxious about what was going to happen. They had reported their concerns to nursing staff and, as a result, the consultant had come back to reassure them and make clear the course of treatment.

Other evidence

On the Accident and Emergency (A&E) department and at ward level we saw that patients were generally treated with dignity and respect. Staff were observed ensuring that patients were covered appropriately. Curtains were drawn during the delivery of care. In some instances, we saw staff prompting patients to maintain their dignity.

The environmental changes to the Accident and Emergency Department and Clinical Decision unit had helped to ensure that the privacy and dignity of patients was respected and promoted. (This is further addressed in outcome 10 of this report).

We saw that the smoother and faster admissions procedure coupled with the environmental improvements to the department protected patients from being seen by other people in the waiting areas.

In the A&E department, we observed staff ensuring that all care delivered, including the taking of blood samples, was undertaken behind the curtains. In some areas the
curtains overlapped allowing further privacy and a logo on the curtains reminded staff to respect privacy and of the date to replace the curtains. We saw that curtains were closed around a male patient when he had an Electrocardiogram completed.

There was a separate waiting area for children and a treatment room off this area to help with effective management of distressed children.

In the Clinical Decision Unit (CDU), we noted that there were two single sex bays.

Overall, we saw that people were appropriately dressed either in their own clothes or in nightwear. Where possible patients were encouraged and supported to use the shower room and toilets rather than being washed by the bedside.

Staff on wards confirmed that they had received training on privacy and dignity and that this subject had been discussed at staff meetings. Those spoken with were able to give examples of how they ensured that privacy and dignity were promoted.

One staff member gave an example of how they were caring for an individual where there was a language barrier, and described the measures put in place to ensure that the patient understood the plan of care to be provided. A staff member reported how diversity issues might impact on care delivery and how this could be addressed in a satisfactory way for the patient concerned.

Most of the wards we visited had single sex bays and these could be flexible, dependent on the gender of people being admitted. Some patients we spoke with had been moved to a different ward since their admission but understood the reasons for this.

We observed in all areas that healthcare assistants and nursing staff were talking to patients in a kind, friendly and professional manner. We overheard medical staff introducing themselves to patients and asking them about their illness. Housekeeping staff were heard asking patients what they would like to drink and giving them choices of the drinks available.

An agency staff member commented that they had seen a marked improvement in the way medical and nursing staff were protecting patients’ dignity, by ensuring curtains were closed and imparting information sensitively.

**Our judgement**

The majority of patients or their nominated relatives felt well informed about their care and treatment options, and were able to make choices in respect of this. Patients had their privacy and dignity respected.

Eastbourne District General Hospital was found to be compliant in respect of the essential standards of quality and safety relating to this outcome.
Outcome 2: 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 minor concerns with Outcome 02: Consent to care and treatment

Our findings

What people who use the service experienced and told us

Overall patients able to express a view reported that nursing staff were seeking verbal consent for routine activities, for example, blood samples, observations and personal care.

Some patients told us that relatives had signed consent for their care and treatment. Patients told us that staff always asked them before providing care and they asked what help they needed. One patient said “we are encouraged to do what we can for ourselves by the nursing staff. As I get better I am re-gaining my independence”.

A relative on Seaford 3 ward told us that doctors had explained in detail about their father’s operation and the options that were available for him.

Three patients told us that they had signed consent for their operations and that the anaesthetist had explained about their operation in detail with them.

However, one patient on Jevington ward told us “I have not agreed to anything and I
do not know what is happening. Nurses tell me what they are going to do to me and ask me if that is alright.”

Other evidence

Concerns about the quality and safety of consent to care and treatment had been identified in the last compliance visit undertaken by CQC in February 2011.

The trust completed an audit of consent to treatment and had supplied us with the findings. This consent to treatment audit was approved as part of the trust’s clinical audit forward plan for 2011-2012 and surveys were sent out to junior doctors on 13 June 2011. However, the survey also included an audit of staff awareness and knowledge of consent and the Mental Capacity Act and included a sample of doctors, consultants, nursing staff, allied health care professionals and midwifery staff. The audit showed significant improvement in consent practices across the trust in comparison with a smaller audit that was conducted in 2010.

In-patient documentation we saw across all areas visited showed there was some evidence that consent was sought before taking blood samples, and other tests. There was also evidence in the nursing documentation that staff sought consent daily for delivering nurse-led procedures, such as personal care and dressing.

In some wards we visited, there was evidence within patient notes of signed consent for their operations.

Staff spoken with confirmed that they always tried to seek consent for care, before undertaking any support or personal care for patients. This included contacting relatives or care workers from care home placements. We observed staff seeking verbal consent from patients to undertake their routine nursing activities. Staff said that they explained to patients what they were going to do. If a patient was unable to verbally respond they would look for body language, or signs, to check that the patient was happy for this to happen.

Some staff spoken with said that although they had not had formal training regarding obtaining consent, it had been talked through during ward meetings. Staff told us that they were aware of other agencies that could be involved if the patient was unable to give consent, and that advocates could be arranged. Staff also demonstrated an awareness of deprivation of liberty assessments and involving the psychiatric team in some instances.

Some staff spoken with demonstrated an awareness of action they should take if someone were to refuse personal care. Records we saw indicated that patients occasionally refused personal care or observations. This was clearly documented by staff.

In some documentation we saw, we found evidence of recorded actions taken by
staff, to encourage patients to accept a lower level of support.

In the A & E department, it was noted that no mental capacity assessments were completed by staff when this would seem to have been appropriate.

Overall, we found that for patients lacking capacity, refusals of care and treatment although recorded by staff, did not always make clear actions taken by them to offer a lower level of support or to re-offer support at all. This was a particular concern in relation to refusal of food and fluids, as there was no clear indication that staff had repeated offers of drink or food at a later time.

On Cuckmere ward, we looked at documentation for a patient with advanced dementia. A relative was present and confirmed that the patient could be difficult to manage. They reported that although some staff were able to do this well, the patient was more receptive to male staff, and could refuse personal care on occasion. Although refusals were recorded in the patient notes, no information was recorded as to whether support was re-offered.

On Hailsham 3 ward, we noted that documentation did not always evidence consent to treatment especially if the person was suffering from confusion or a dementia type illness. A blanket statement was noted on the records of these patients which read “patient consented”.

For one patient on Seaford 3 ward who had some short term memory loss, there was no evidence that consent had been sought in respect of this patient’s examination, care, treatment and support.

Across all wards visited, we looked at the clinical notes for patients with significantly diminished capacity. We found that staff were routinely recording that patients had given consent to personal care, routine observations, and some other invasive procedures. We found no reference to best interest meetings, or relatives having given approval for these activities.

Across all wards we visited, we noted a proportion of ‘Do Not Attempt to Resuscitate’ (DNAR) forms for those people who were elderly and/or with a level of diminished mental capacity. The forms had been signed by medical staff. In some cases we viewed, we found no evidence of advance decisions being in place, or that approval had been gained via a best interest discussion to ensure this was an appropriate decision.

Bed rail assessments were in place for some patients we case tracked but these were signed by the medical or nursing staff and not by the individual patient or their relative as well.

Not all staff had completed training on the Mental Capacity Act or Deprivation of Liberty Safeguards. However, there was evidence of bookings for such training with
preference for training slots given to qualified staff.

Our judgement
The majority of patients and some relatives spoken with confirmed that they had given verbal consent for routine nursing interventions and that signed consent had been sought for other treatments or operations.

However, there was a lack of evidence that patients with reduced mental capacity had access to advocacy or that best interest meetings had taken decisions on their behalf.

Eastbourne District General Hospital was found to be non-compliant in respect of the essential standards of quality and safety relating to this outcome.
### Outcome 4: 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

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<thead>
<tr>
<th>Our judgement</th>
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<td>There are major concerns with Outcome 04: Care and welfare of people who use services.</td>
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<tr>
<th>Our findings</th>
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<tbody>
<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
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In general patients spoken with confirmed that they were satisfied with the care, treatment and support they had received. Some patients said they found staff to be kind and attentive.

One patient said that the doctors had spoken with them about their treatment plan and they were happy with this.

Patients said that all staff had been kind and considerate. They made comments such as “the care on this ward has been wonderful,” “the staff here are very nice and they put you at ease by laughing and joking with you,” “the staff on this ward are outstanding”, and ”I cannot praise the staff too highly; they have done an excellent job.”

The wife of a patient told us that staff were “marvellous” with their husband, and sat him with staff at the nurses’ station if he was unsettled.

In general, patients we spoke with said that they thought there were enough staff on
duty although they were always busy.

Two relatives said that they had been informed promptly of their relatives’ admission and kept informed of progress.

Some patients on the Medical Assessment Unit told us that call bell responses changed dependent on how busy staff were attending to new arrivals. In those cases waits could be unduly long.

Two patients on Seaford 3 ward said that “call bells are going all the time” and “staff are rushed off their feet”.

A patient reported that on three occasions that they had been left waiting at least 15 minutes for their call bell to be answered. This was followed by a further wait on each occasion whilst staff dealt with their request. In one instance, the patient reported that staff had taken a total of 40 minutes to respond to the bell and then provide pain relief.

Other evidence

Shortfalls were identified at two previous inspections by CQC undertaken in February and April 2011 respectively and had been the subject of enforcement action taken against the trust on both occasions.

The trust had written to us on the 6 September 2011 outlining the seriousness of the view that the board took in their responsibilities to comply with the regulations. The trust told us a number of steps had been taken to enable the board to form a view of the current level of compliance. There remained areas of patient care and delivery within this outcome that required further development and improvement. The trust board’s expressed view was that actions had been taken to ensure patient safety and provide a basis for ongoing improvement. However, at the present time the trust acknowledged that it was not fully compliant with this outcome.

The trust had provided evidence of improvements made since CQC’s last inspections stating that:

- ‘Inconsistent documentation used in care planning had been addressed and all areas now used the new integrated care plan.

- Spot checks and weekly audits had been implemented since July 2011 on all sites.

- Action had been taken where any gaps in compliance had been identified’.

The trust had advised that at ward and departmental level, training by practice development nurses, clinical matrons and ward/department managers had been
provided to staff in the use of the new care planning documentation. A guide to the new care planning tool had also been developed which had been disseminated to all staff via clinical matrons and ward managers.

The trust acknowledged that there remained areas of patient care and delivery within this outcome that required further development and improvement.

The trust board view was that whilst actions had been taken to ensure patient safety and provide a basis for ongoing improvement, at the end of July 2011 the trust was not fully compliant with this outcome.

Concern at the lack of person centred care planning specifically in relation to nutrition had also been highlighted within the last two CQC inspections and also during a more recent dignity and nutrition inspection (DANI) review. The trust had provided CQC with a detailed action plan to inform remedial action in this respect.

The trust told us that consistency in the recording of personal preferences for patients had also been addressed with staff as it formed a key part of completion of the integrated care plan. The summary of standards for patient care had been used as a prompt for discussion by staff of individual preferences with patients.

In each area we visited, we spoke with a minimum of four patients, and any relatives that might be with them. We looked at the clinical notes and bedside notes linked to each of the patients we spoke with or met.

We found that integrated care plans were in use in all the areas we visited, and were being completed to varying degrees by medical and nursing staff. In general, clinical assessments within these were completed but with some omissions. Nursing assessments were also completed and identified risks which were mostly reflected in the bedside notes with monitoring sheets in place.

There was improved linkage between the nursing assessments conducted, and the risk monitoring information found in the bedside notes. Notes kept at the end of beds were generally completed appropriately.

Nursing assessments included risk assessments for nutrition, moving and handling and pressure sore development which also recorded the air mattress used if required. Any highlighted risks were mirrored by the use of risk monitoring assessments in the bedside notes, for example, pressure sore monitoring, falls risk assessments, food and fluid intakes recording. Falls assessment information was in place where this was identified as a risk and in some instances was being reviewed regularly. There was evidence that patients deemed to be at a high risk of developing pressure sores were sometimes flagged for regular checking by staff.

Healthcare assistants were, in the main, clear about their responsibilities in relation to completing monitoring charts in bedside notes. They reported that, as part of their induction, they received training about the completion of charts used to monitor
care. They demonstrated an awareness of their responsibilities when needs changed and that this could trigger the need for a monitoring chart.

Notes we saw provided evidence of occupational therapists’ and physiotherapists’ involvement with patients.

Staff spoken with told us that all patients when they first came onto the ward had an assessment undertaken by a member of the nursing staff. A staff member said that it helped to get to know the patient and determined the level of care they needed. They recognised that this could change on a daily basis and this was taken into consideration each day. Staff said they actively encouraged patients to be as independent as possible.

Staff on the MAU stated that an assessment was completed for all new patients. There was an admission pack and also transfer information available for them. Most patients were weighed but not if confined to bed or if needing two staff to assist them. Staff reported that weights were normally taken so that the malnutrition universal screening tool (MUST) score could be completed.

On Cuckmere ward, we viewed the notes for four patients. For one patient we noted that fluid monitoring was generally well recorded and there was evidence of supplements being used. This was not so for the other three patients where there were omissions in recording.

In the A & E department, relatives were observed coming into the bays and were involved in discussions about care and treatment as appropriate. Although there was no plan of care in place for these patients this did not detract from the care provided. It must be noted that they had only been in hospital for up to 12 hours. In one patient’s notes it clearly stated that he had been admitted at 3am, and after initial treatment had been allowed to sleep and therefore not all documentation had yet been completed. Another patient was admitted at 0900 hours and was immediately put on the stroke pathway, and transferred to an appropriate ward within two hours.

On the A & E department we observed that the medicine charts indicated that patients had received their medication. However, we found examples that medicine record keeping could be more accurate to ensure safety.

On Seaford 3 ward, staff informed us that multi-disciplinary meetings were held weekly and that an allocated nurse liaised daily with all professionals and relatives regarding discharge.

On Hailsham 3 ward, we found that care documentation for short term planned admissions was completed and clear. We were told by staff that the documentation on the ward was being improved. Staff reported that they were aware that more new documentation was to be introduced.
The practice seen on this ward was to separate the risk assessment tools from the care plan booklet. This practice served to compromise the integrated nature of the care plan. These were then seen to be placed on the end of the patient’s bed. We were told that this was so that nurses and healthcare assistants could access them and update them as necessary.

Detailed handover sheets were noted in use and available to staff on Cuckmere ward and the MAU.

On the MAU, a healthcare assistant was observed talking with a patient who had a degree of diminished mental capacity, and needed prompting to eat. The staff member was observed to support the patient to eat their lunch.

On Cuckmere ward, a member of the nursing staff reported that the ward had access to a range of equipment. For some patients who might be confused and getting out of bed, they would use pressure alarm pads. These warned staff when a patient was getting out of bed and helped staff to manage patients prone to wandering, or the minimise the potential for accidents.

However, across the wards we visited, we found that there were still marked inconsistencies in recording and completion of integrated care plans and risk information. There was a general lack of personalisation of care plans to inform staff about how to support individual’s specific needs.

On the MAU, we noted that doctors had asked for regular blood glucose monitoring for a patient but did not specify a timescale for this to continue.

We spoke with another patient with a partial hearing loss in one ear. This was recorded on the nursing assessment. However, no other information was provided as to how this impacted on the individual and how best to communicate with them, for example whether a hearing aid was used. The same patient told us that they had been without food or drink since 7:00pm the previous evening as they were due to have a procedure under sedation. The clinical notes clearly stated that the patient could be given clear liquid up until midnight, but this information had not been conveyed to the patient.

We checked the notes of another patient with diminished capacity. We found that, except for the resuscitation section, the nursing assessment had not been completed. The resuscitation section was unsigned.

We were informed that the patient was incontinent and wore pads but bedside notes made no reference as to how this was being managed, and whether a toileting programme was in place. The discharge plan was not started. The patient had a visual impairment in one eye and had noted communication difficulties. The care plan and bedside notes provided no personalised information for staff around these needs to help them support the patient appropriately. Some omissions were noted in respect of recording repositioning for this patient to reduce the possibility of
On Cuckmere ward, we viewed the notes for four patients. In two cases, we found that where fluid charts had been in use, these were not always recording outputs for each day or balanced. It was unclear what information could be gained from incomplete records to improve outcomes for the patients concerned.

In one case, we noted that a patient who had been assessed using the nutritional malnutrition universal screening tool (MUST) risk assessment tool was assessed as high risk and had lost 10kgs in weight since admission. There was evidence of a dietician referral but this was undated. Food and fluid monitoring had been implemented but food monitoring charts indicated a very poor intake. We found no reference within the integrated care plan or bedside notes of whether the patient was receiving staff support to eat. Omissions were noted in the repositioning chart records.

In one record we viewed, we noted that the patient had had a fall during the first day on the ward. We found that no body map was completed for this and there was no accident report on file, although a note of the fall was recorded in the clinical notes.

In the records for another patient with dementia and with a degree of challenging behaviour, we found no evidence of how staff were managing their behaviour. The patient’s wife stated that some staff managed the behaviour better than others, but what worked well was not recorded for other staff to work to and provide consistency for the patient.

One patient we spoke with stated that they did not like dairy products as this exacerbated their condition. They had not eaten breakfast for five days since admission because much of this was dairy type products. They told us that a member of the nursing staff had only sat down that morning to go over likes and dislikes. The patient was now more confident that they would be receiving appropriate food choices for breakfast.

On the MAU, food intake for one patient was confusing with records stating the patient consumed all and refused all under the same date. Where refusals had occurred there was no evidence of actions taken by staff to re-offer drinks or food at a later stage.

We noted that several patients with reduced capacity had incomplete clinical and nursing assessments within their integrated care plans. In one case, the patient plan had the resuscitation section completed confirming ‘not for resuscitation’. However, no cognitive function test had been completed within the clinical assessment to confirm level of capacity. It was recorded that the patient had dementia.

A staff member on the MAU commented that all elderly patients were considered by some staff as needing incontinence pads when in fact this was not the case. Another staff member reported that, where possible, patients would be encouraged
and prompted to use the toilet. They commented that getting appropriate sized incontinence pads was a problem and they would encourage patients to bring their own in.

We found that across wards we visited, risk assessments were not always seen in relation to the use of bed rails, and it was noted that bed rails did not have bumper protection.

In the A & E Department, there was evidence that a new form, a check list of initial care, had been introduced. This covered areas of health and safety. However, we found that, although the checklist was a useful tool for staff to use, this was not consistently signed or fully completed.

On Hailsham 3 ward, we viewed five care plans and found that the integrated care plans were only partially completed. Care plans for patients on the ward for longer periods were not easy to follow and did not cover all the identified areas reflecting the individual patient. Medical history, for example diabetes, that impacted on the patient’s treatment and care was omitted on one patient’s care plan. Daily notes were seen to be task based and gave limited evidence of the patients’ emotional and mental well being.

Food and fluid charts were not fully completed and there was no total or fluid balance being monitored. This did not cross reference with the integrated care plan.

Generic care plans were in place and did not reflect how the patient would, for example, use the call bell for assistance. There was limited evidence that patients were supported to be independent with personal care, or how staff promoted independence.

One patient had been on the ward for one month and did not realise that there was a shower near their room. They had been washing in a sink. The discharge form was seen to have been commenced with the intended date of discharge stated but this had not been completed. We found that body maps had not all been updated and had not been linked to the patient’s care plan. Results obtained for urinalysis did not then trigger the need for fluid monitoring. There was confusion in the main notes amongst professionals about the person’s mental capacity.

We noted that on Jevington ward a patient, who was reportedly confused on admission, had no known relatives and had not been provided with an advocate. There was no evidence that attempts had been made to seek one. We also noted that this patient’s integrated documentation had not been completed as thoroughly as for other patients. Within the patient’s integrated documentation, on the daily notes from 12 September 2011 to 20 September 2011, there were continuous written comments, ‘still requesting verbal consent to personal care,’ but nothing to say how these consents were going to be obtained.

For another patient on Jevington Ward we noted that, on the bedside notes, the
weight chart on the day of admittance, on 3 September 2011, recorded the patient’s weight at 52.6 kilograms. On the 16 September 2011, another weighing had taken place and the patient then weighed 49 kilograms. This represented a weight loss of nearly 3 kilograms over a period of 13 days. We found no evidence that action had been taken to monitor this patient’s weight more closely or to take any action. On this patient’s nursing assessment, we noticed on the 5 September 2011, a note stating that the patient should have been given oxygen for the next three days and then re-assessed. On the daily notes for 5 September 2011, the patient was not given oxygen because there was no stocks of nose canulae on Jevington Ward.

On Seaford 3 ward we looked at three patients’ bed notes and their hip fracture integrated care pathway. We noted that the multi-disciplinary discharge planner had not been completed for these patients. Sections of the hip fracture integrated care pathway had not been completed, for example, falls risk assessments for two patients had not been completed; despite these patients being admitted to hospital because they had sustained fractures due to falling.

Record keeping showed that multi-disciplinary discharge planning had not been completed for any of the patients’ notes we saw.

One patient said that their doctor was trying to arrange for them to be discharged the following day. This was discussed with staff on the ward as there was no information on the discharge planner. Staff advised that this was a particularly complex discharge and could only be documented once arrangements were in place as it involved a transfer to another hospital. However, the patient had been advised that it would be the next day and had made arrangements with their family based on the advice received.

We found evidence in the hip fracture integrated care pathways that occupational and physiotherapists had been involved with patients after their operations had taken place. These lacked a person centred approach and were more task orientated.

Trained staff stated that no specific training had been provided by the trust in relation to care planning despite the introduction of the new integrated care plan.

Whilst there were clear improvements in the completion of risk assessments and the manner in which they were used to inform more personalised care planning, it was apparent that there were marked differences in the quality of such assessments and in recording from ward to ward.

Following our inspection visit in September 2011, a meeting was held at the trust on 21 November 2011 to discuss the findings of our inspection. At that meeting, the trust told us that their expectation was that the trust would not be compliant with Regulation 9 (outcome 4) before 31 March 2012.

It was also acknowledged by the trust at that meeting that the current system for
identifying risks to patients did not reflect the level of current risk to the patients. We were told the trust did have action plans in place to address this situation.

Our judgement

Since our last inspection, there had been an improvement in the consistency of documentation used across wards and departments with the introduction of the integrated care plan. However, there were marked inconsistencies across wards in the quality and completion of patients’ notes and integrated care plans. There was no evidence in some care plans that concerns were followed through for some patients, this was particularly true for those with a degree of diminished mental capacity. Risk assessments were not always completed nor used to inform the care plan. Discharge planning was not well documented.

The trust has stated that it does not anticipate being compliant with this outcome before 31 March 2012. Systems and processes for monitoring the quality and safety of services are not robust and the trust risk register does not reflect the level of current risk to patients.

Eastbourne District General Hospital was found to be non-compliant in respect of the essential standards of quality and safety relating to this outcome.

In view of the major concerns the Commission has with the trust’s continued non-compliance with this outcome, further enforcement action will be considered.
Outcome 7:
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 moderate concerns with outcome 07: Safeguarding people who use services from abuse.

Our findings

What people who use the service experienced and told us

Patients we spoke with and some of their relatives raised no concerns about their care or safety within the hospital. They told us that they were consulted about their care, and asked to consent to care and treatment. They reported that they felt there were enough staff, but acknowledged staff were busy.

Other evidence

Concerns were raised in June 2011 by the East Sussex safeguarding team at the increased number of Safeguarding Adults at Risk (SAAR) alerts raised over a short period of time in respect of patients cared for at Eastbourne District General Hospital (DGH). Whilst it was noted that the alerts differed in nature to each other, a common theme identified was that many involved older people who had a degree of diminished mental capacity.

Given this common factor, the decision was taken that running concurrently alongside the individual SAAR investigations, the East Sussex Local Authority adult social care team at the hospital would lead a separate multi-disciplinary ‘practice review’. The review would look at current practices at Eastbourne District General Hospital, and would seek to identify any underlying causes for the spike in SAAR
referrals for this group of patients.

The overarching review of care practice at the hospital agreed the review would look at four areas, these being care provision, Deprivation of Liberty Safeguards (DOLS), use of medication and service user experience. Ten wards were identified to be reviewed and 18 patients were case tracked. The findings of the review were analysed and a detailed report produced to inform the case conference held on 11 October 2011.

Of the initial seven alerts which were included in this wider investigation, five investigations substantiated neglectful care practice, one of physical abuse and in a further case the finding was inconclusive. Though the findings of the overarching investigation into institutional abuse were inconclusive, the resulting report noted that the ‘appropriate identification of care planning, risk identification and risk management was of particular concern as the prevention of harm could have resulted in alternative outcomes for all cases. The ward review focused specifically on the elderly and especially vulnerable people, and raised concerns in a number of differing areas (i.e. monitoring of nutrition, lack of clarity regarding best interest meetings, how to manage challenging behaviour/falls). In all but one of the reviews, the investigators concluded that there were weaknesses and/or failings in the records they had looked at’. This was reflective of our findings also as detailed in this report under outcome 4.

Some staff spoken with during our inspection demonstrated an understanding and awareness of safeguarding procedures, Deprivation of Liberty Safeguards (DOLS) legislation and procedures and also mental capacity assessments. They confirmed that they had attended training for this on the wards. Some staff also understood the role of advocates for patients without capacity.

On Cuckmere ward, we were advised that the system for referring safeguarding concerns had been simplified and that the ward had recently made two referrals for patients they were concerned about.

A patient record we saw highlighted that the ward had been proactive in liaising with relatives to take into safekeeping jewellery belonging to a patient with a confusional state.

Observations we made of care during our inspection evidenced that some medical and nursing staff were actively consulting and involving people in their treatment decisions. However this was inconsistent as was the recording of such discussions.

There were signs of improvement in documentation and better linkage between nursing assessments and bedside documentation to address highlighted risks.

We found across the wards visited that it was not always clear how decisions had been arrived at in respect of patients without capacity. Evidence was lacking that best interest meetings had informed decision making, or that a multi-disciplinary discussion had taken place including representation on behalf of the patient.
Pathway tracking of patients highlighted in general that bed rail assessments were in place. However, consent for bedrails was not always signed for by patients with capacity, or the representatives of those people lacking capacity. Bed rails could be viewed as a form of restraint but, there was no evidence that DOLS applications or best interest meetings had been held to support their use.

At a meeting with the trust on 21 November 2011 it was stated that the current system for identifying risks to patients did not reflect the level of current risk to the patients. We were told the trust did have action plans in place to address this situation.

**Our judgement**

There was an improved awareness, understanding and use amongst staff of safeguarding, mental capacity and deprivation of liberty procedures. Important documentation was not robustly or consistently completed to the same standard across all wards. It remained unclear how decisions around consent were being obtained for people with limited capacity.

Systems and processes for monitoring the quality and safety of services were not robust and the trust risk register did not reflect the level of current risk to patients.

Eastbourne District General Hospital was found to be non-compliant in respect of the essential standards of quality and safety relating to this outcome.
Outcome 8:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

There provider was compliant with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us

Patients spoken with confirmed that all staff were good at washing hands regularly and then applying alcohol gel. They said that the wards were kept clean on a daily basis with some patients reporting that they had seen curtain rails being cleaned.

No-one spoken with raised any concerns in this area, indicating a general satisfaction with infection control procedures carried out by the staff.

The patients spoke about nurses wearing protective clothing when carrying out personal hygiene care and examination.

One patient said they had seen a cleaner wiping down a piece of equipment used with patients. Another said they could not fault the cleanliness of the ward, they reported that cleaning staff pulled beds away from walls.

Other evidence

Moderate concerns were identified against this outcome following the compliance visit undertaken by us in February 2011.
It was noted that there was appropriate access to hand washing facilities on all wards and units and we saw that these were used effectively. In all areas we visited, hand gel, gloves and aprons were strategically placed, and we observed staff using them appropriately.

Staff demonstrated an awareness of isolation protocols and good practice was generally observed in the use of protective clothing and the closure of side room doors. Staff appeared knowledgeable about the expectation on them to ensure they washed their hands between tasks and patients.

Areas we visited had an infection control lead and most staff spoken with knew who this was. On one ward there was an infection control lead nurse and also a Health Care Assistant (HCA) responsible for infection control.

Information regarding infection control was passed down from the infection control leads during ward meetings. Any new products used to clean equipment and the wards generally were explained and demonstrated to staff on duty, who were then responsible for passing this information onto staff who came to work on later shifts.

The majority of permanent staff spoken with at the hospital had undertaken infection control training.

We noted posters on the management of soiled linen for staff guidance and also infection control information for visitors. Clean linen was stored separately from soiled linen.

In all areas we observed infection control notice boards, with guidance for staff on infection control and up to date infection control audit data outcomes. In general these showed positive results for maintaining infection control.

We saw staff cleaning the mattress and surrounding furniture of a recently vacated bed with wipes, ready for the next patient.

In the A&E Department, new flooring had been provided to the resuscitation area and paper curtains were in place in all areas to improve infection control measures. Housekeeping staff were observed replacing some curtains.

There were notifications on display advising visitors of measures to be undertaken to reduce cross-contamination.

However on Hailsham 3 ward we found that there appeared to be some storage issues. The shower room had trolleys stored inside, which had clean towels and generic creams and personal cleaning fluids, for example mouthwash, and shampoo. The floor cleaner was also stored in there. The curtain was broken and the shower room was not in constant use. The ward sister told us that the trolleys were removed if a patient wanted to use the shower. Not all able patients knew that
there was a shower room available for their use.

In the A & E Department, paper curtains were not all dated and signed but once this was identified to the senior Registered Nurse on duty she raised this matter with the housekeeping team to address.

In zone one it was noted that a vacated trolley was not cleaned by the nursing staff and the ambulance crew cleaned the top surface before transferring a new patient onto this trolley.

On Cuckmere ward we observed one side room door open and a relative was sitting with the patient without protective clothing. A staff member reported this had been offered, but the relative had declined this and left the door open. Staff were unable to enforce the infection control arrangements with visitors.

We walked around Jevington Ward and noted in one storeroom that there was a hoist with a written label that said, ‘Infection Control do not use until further notice. This was dated 25 July 2011. There was no other written explanation. This hoist was stored with other mobilising equipment in this storeroom.

We noted a trolley in a side corridor with dirty linen and one of the bags had not been tied. We noticed an alcove with a curtain in front of it and six discoloured pillows stored in the corner. In the ward kitchen we noted that the toaster was not clean. One of the side ward, doors were open despite there being a notice stating, ‘Infection Control, please consult with a nurse before entering this room.’ We spoke with a nurse who told us that the patient had an infection but it was not airborne.

On Seaford 3 ward, we walked around the ward and found that infection control procedures were appropriately managed. However, we observed that one side ward had a notice on the door stating, ‘Infection Control, please consult with a nurse before entering this room.’ We noted that during visiting time the bedroom door was left open. We asked a nurse why the door had been left open and she replied that the patient had an infection and went promptly to shut the door. No other explanation was given by the nurse.

The staff spoken with on both wards knew where policies and procedures could be located and knew how to report any faults in equipment noted.

In the majority of areas we visited staff reported that there were dedicated housekeeping staff who undertook cleaning duties. Staff reported that if they needed extra cleaning they could ring support services.

All staff spoken with confirmed that they received annual training on infection control and that the lead for infection control on each ward provided regular updates throughout the year.
Our judgement

While staff were observed carrying out infection control procedures there were some areas where improvements need to be made to ensure that patients were not placed at risk.

Further actions need to be taken in respect of the management of infected patients in side wards.

Eastbourne District General Hospital was found to be compliant in respect of the essential standards of quality and safety relating to this outcome.
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

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<tr>
<th>Our judgement</th>
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</thead>
<tbody>
<tr>
<td>The provider was compliant with Outcome 10: Safety and suitability of premises</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>What people who use the service experienced and told us</td>
</tr>
</tbody>
</table>

People we spoke with raised no concerns about the environment.

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<tr>
<th>Other evidence</th>
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Moderate concerns were identified against this outcome following the compliance visit undertaken by CQC in February 2011.

During our latest inspection, we observed that there had been a range of environmental improvements to the Accident and Emergency department. These had contributed significantly to increased patient flow and the maintenance of the privacy and dignity of patients nursed in this area.

In the resuscitation area, we found that screening was now provided by curtaining that offered a higher level of privacy. In the major and minor areas (renamed zone 1 and zone 2) cubicles now had permanent partition walls with curtains.

In the Clinical Decision Unit (CDU) consisting of two single sex bays, partition walls had been installed to separate the bays from each other and the corridor areas.
On the Medical Assessment Unit we noted that a shower door in the men’s shower room had come off and was standing inside the shower. A staff member informed us that this had been reported and we observed evidence of a job number recorded on the whiteboard within the unit.

**Our judgement**

Significant improvements to the layout of the environment in the Accident and Emergency Department had contributed appreciably to increased patient flow and the maintenance of the privacy and dignity of patients nursed in this area.

Eastbourne District General Hospital was found to be compliant in respect of the essential standards of quality and safety relating to this outcome.
Outcome 13: Staffing

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 sufficient numbers of appropriate staff.

What we found

Our judgement

The provider was compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us

In general people we spoke with felt there were enough staff on their particular ward although some commented about how busy staff were all the time and how on some wards call bells were ringing constantly.

However, patients on the Medical Assessment Unit (MAU) told us that staff responses to call bells were dependent on what else they had to do. Patients indicated that it took longer for staff to respond when new patients had been admitted.

A patient on Cuckmere ward told us they had been kept waiting on more than one occasion for more than 30 minutes for staff to take action following a response to a call bell.

Other evidence

In our compliance review in February 2011, we found that there were insufficient staffing numbers in place across the trust as well as staff having the right knowledge, experience, qualifications and skills to support people.

Since that time, the trust has taken steps to recruit multiple qualified and unqualified nursing staff both locally and internationally with a positive effect on staffing.
numbers. In addition the trust had employed a significant number of newly graduated nurses.

The increase in front line nursing staffing had impacted positively on improving outcomes for people, which was reflected in the general comments of patients. During interviews, staff stated that they felt less pressurised. They were moved from ward to ward much less often and there were sufficient numbers to ensure that training was now cancelled infrequently due to lack of staff. The positive impact on staff morale was clearly stated by those that were spoken to.

In the 15 weeks from 5 June 2011, the trust had provided evidence to us of a decreasing reliance on bank staff and limited use of overtime and agency staffing. This was in line with the significant increase of core front line staffing levels. However, it was still the case that the bank which was the preferable choice for filling in for absent staff, was not always able to meet the demand placed on it. Over this same period, more than 19% of shift requests for cover were unable to be met from this source.

The trust’s ‘High Level Risk Report’ dated 10 May 2011 highlighted ‘ongoing concern relating to the safety and clinical outcomes for mothers and babies whilst the current configuration of maternity services remained. This was due to

1. concerns over the sustainability of the Middle Grade rota and subsequent high level of agency/locum usage
2. Midwifery staffing below recommended staffing levels according to Birthrate Plus.
3. Midwives staffing theatres (in hours) on the Conquest Hospital site. Booking risk assessments delayed/missed, referrals missed. Women going for scans not consented. Frequent diverts. Complete closures. Reduced capacity for labour care, increased serious incident potential, in some cases unable to monitor properly or administer pain relief etc., as required. Minimal post natal input (no breast feeding support), neonatal screening (delayed/missed) reduced capacity to staff theatre on Conquest site. Delayed category 1 caesarean sections, potential delayed discharges, bed blocks etc., already experiencing increased complaints. Human Resource implications relating to sickness etc;’

The entry above was first highlighted on the trust’s risk register on the 9 April 2010 and the narrative updated in May 2011. The trust reported that it had worked to form a contingency action plan to release midwifery resources and this was in place. However, its impact on the service remained unclear. The trust had commissioned an independent review of the current midwifery configuration with options for future improvement. No decision had been made at time of this report on what options the trust was considering.

We found that recruitment had taken place towards ensuring that there were sufficient numbers of midwives with the right level of experience and seniority across the midwifery service although the trust still did not meet Birthrate Plus guidelines.
The trust had continued to struggle to have sufficient middle grade doctors in post to deliver a safe service. This was particularly the case in emergency care and in the maternity department but also extended to other departments. As a result, there remained a high dependency on the use of locum doctors for all clinical directorates. Although the trust stated that it had continued to take steps to ensure that preference was given to using locums who were familiar with the trust and its departments and wards, this was not always possible and there were continued risks to the continuity and safety of care and treatment of patients as a result.

The trust stated that it had taken what steps it could to address this ongoing recruitment problem and to minimise the inherent risks. There was a limited local recruitment market place in East Sussex and middle grade doctors needed to be gaining wide experience to inform their skills development and future careers. However, the trust had stated their intention in their evidence submission that they were continuing to find new ways of intensifying recruitment outcomes in this area.

There were also continued vacancies at consultant level. However, the trust had been able to successfully recruit to a number of posts.

Staff spoken with confirmed that incident forms were being completed where there had been issues in the staffing provided on or to support the ward.

A staff member on MAU reported that there were not always enough staff on the ward to feed patients, and food could therefore sometimes go cold and this needed to be improved.

Our judgement

The trust had substantially increased its front line staffing of qualified and unqualified nurses and midwives, with a positive impact on outcomes for people and a raising of staff morale.

Recruitment of middle grade doctors and consultants remained an issue with high dependency on locum doctors to supplement core medical staffing. There were insufficient allied healthcare professionals in post to fully support the rehabilitation needs of patients.

Eastbourne District General Hospital was found to be compliant in respect of the essential standards of quality and safety relating to this outcome.
Outcome 14: Supporting workers

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 was compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us

Overall patients told us that the care they had received had been good. They also thought that nursing staff had an understanding of their needs.

Other evidence

In our compliance review in February 2011, we found that there were inadequate arrangements in place for staff supervision and annual appraisals. There was inadequate provision of mandatory training and staff morale was poor.

During our latest inspection, staff demonstrated awareness of the Mental Capacity Act and safeguarding vulnerable adults procedures, and in some instances were able to evidence recent referrals they had made to the safeguarding team.

A programme of training was underway for safeguarding and Deprivation Of Liberty Safeguards (DOLS). Staff told us that this was being provided in house, and a number of staff spoken with had completed this training. We saw evidence that other staff had been booked onto this training.

Healthcare assistants (HCAs) told us that they received training as part of their induction on how to complete charts used to monitor care. One HCA on the MAU
reported that they had not received Mental Capacity Act training but had seen the policy on the ward. They said that the nursing staff would deal with problems regarding mental capacity and arranging advocates. The same staff member reported they had undertaken a refresher course on dignity.

A new staff member on the MAU told us that they had not had safeguarding training but understood the different types of abuse to watch out for and would report any concerns to the staff nurse or ward manager.

An agency staff member told us that, although most of their training was provided through their agency, they were also able to make use of training that occurred at the hospital. They reported that they had not undertaken safeguarding training.

Although not all staff spoken with confirmed that they had received infection control training updates, the majority indicated that they received updates through ward meetings, cascaded through the infection control lead for the ward.

All staff spoken to had completed their mandatory training day which included a range of training opportunities such as moving and handling, health and safety and infection control. Staff stated that now that there were increased core staff in post training was cancelled less frequently.

Some staff stated that the training in support of the implementation of the integrated care plan was inadequate. As we have reported earlier, we saw that there were significant inconsistencies in the completion and functional use of the care plan format from ward to ward.

We found that the profile of gaining consent and routinely involving patients in everyday care and treatment decisions had been raised. Also the profile of maintaining the privacy and dignity of patients had been raised and supported with training. There was evidence that this had impacted positively in corresponding outcomes for people.

Most of the qualified nursing and midwifery staff interviewed stated that they did receive regular supervision meetings but that these were not always properly recorded. Unqualified staff did not have the same level of access. All staff spoken to stated that they had either had a recent annual appraisal with a personal support plan in place or had dates for this to take place.

During interviews with us, staff stated that they had welcomed the increased staffing numbers. However, they were aware that the trust was in financial turnaround and expressed their concern about the tenure of their jobs. On the day of our inspection visit, staff had become aware of proposed ward closures or reconfigurations. Staff told us that this was impacting on staff morale.

In a weekly message sent to staff from the Chief Executive Officer, he outlined
further spending controls which include:-

- Additional controls on the use of bank and agency staffing
- When they are required they will only be allowed after stringent checks to ensure that the additional costs cannot be avoided.

Our judgement

Staff were provided with an appropriate range of mandatory training opportunities. Improved core staff numbers had led to staffing more readily being released to fulfil booked training commitments. There was a staff appraisal system in place.

There were inconsistencies in the training available to support the introduction and continued usage of the integrated care plan.

Eastbourne District General Hospital was found to be compliant in respect of the essential standards of quality and safety relating to this outcome.
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

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<tr>
<th>Our judgement</th>
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<tr>
<td>There are major concerns with Outcome 16: Assessing and monitoring the quality of service provision</td>
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<th>Our findings</th>
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What people who use the service experienced and told us

We did not speak to people using the service about their views in respect of this outcome so we cannot report what they said.

Other evidence

In our compliance review in February 2011, we found inadequacies in the effectiveness and efficiency of monitoring and audit arrangements as well as their usefulness in monitoring and changing the quality of the services being provided.

We wrote to the trust on 15 July 2011 requesting information in respect of actions being taken to address compliance with Regulation 10(3) (outcome 16) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. In its response, the trust provided information about the actions being taken to deliver long term and sustainable improvements in patient care. It was acknowledged that ensuring that the trust and the trust board was able to assess and monitor the quality of care provided to patients and identify where there were risks that may impact on the trust’s ability to deliver consistently good outcomes for patients would ‘require the delivery of a significant and planned programme of change’. The trust further acknowledged that delivering long term change ‘would require not only the development of robust systems and processes, but also a change to the culture of
The trust also acknowledged that considerable further work was required to become compliant and maintain compliance against this outcome.

In our compliance review of February 2011, we identified a range of concerns against multiple regulations impacting negatively on outcomes for people using the services of the trust. A series of action plans were submitted by the trust and updated as appropriate. However, it was not always clear what impact these various actions would have on improving outcomes for people. Not all of these action points had been fully implemented.

We found that the trust had continued to develop a strategic and multi-faceted approach that took into account all of the services of the trust which now also included a range of community health services.

In particular the trust had continued to develop in the following areas:-

- An overarching clinical strategy.
- The implementation of an organisational development programme inclusive of organisational redesign.
- Commissioning of an external complete review of clinical governance arrangements.
- A refocusing of the trust’s relationships with external stakeholders.
- Delivering improved productivity and efficiency through the implementation of an in-year Cash Releasing Efficiency Savings.
- Ensuring that quality improvements drive change by establishing a structured approach within a Quality Transformation Plan.

The Chairman of the Board stated in a letter to us on 6 September 2011 that recommendations from the clinical governance review would also be used to inform a board development programme. This would enable the Chair to ensure that the board was consistently able to fulfil its responsibilities in respect of assurance of compliance and strategic leadership. Further work was being done by externally commissioned bodies to review in detail the clinical governance arrangements.

The trust advised us that the revised arrangements would be in place from 1 October 2011 with changes in board reporting delivered by January 2012.

Since our visit in February 2011, the trust had gone into financial turnaround and had been working on the development and delivery of a detailed cost improvement plan employing the services of an external body. The savings target for the year was £30million. Risks to the delivery had been identified as follows:-

- current vacancies not being held to offset other pay areas
- not being able to deliver growth at marginal cost
- release of 50% demand management reductions
- £30million target not yet fully identified
- transformation costs,
- income risks on demand management and fines.
The baseline risks were estimated at being £11.0 million. The trust acknowledged that financial constraints could compromise many of the plans and ambitions the trust had for further improvements.

In a letter to us from the Chief Executive Officer dated 29 July 2011 it was stated that the board was aware that the governance and reporting arrangements currently in place were not sufficiently robust to provide full assurance to the board that the quality of services provided on every ward was meeting the needs of patients and that patients were being protected against the risks of inappropriate or unsafe care. However, a series of short term actions had been put into place to ensure that ward to board monitoring arrangements were in place. This was whilst longer term plans were developed and implemented.

The trust had acknowledged that whilst they had put a range of detailed actions into place they were not at this time fully compliant with this outcome. It was not clear exactly when full compliance would be achieved.

Subsequent to our inspection visit and during the drafting of this report, a meeting was held at the trust on 21 November 2011. At this meeting, the trust told us it would not be compliant with Regulation 10 (outcome 16) before 31 March 2012 as the robustness of the systems for monitoring and assessing the quality and safety of care and treatment may not be sufficiently adequate to identify risk to inform timely remedial actions to be taken.

The trust also acknowledged that the current risk register did not reflect the level of current risk to the patients but asserted that it did have action plans in place to address this situation.

Our judgement

We found that the trust was working towards future compliance with this outcome by commissioning a clinical governance review, implementing corresponding recommendations and taking a range of short and long term actions to ensure the safety and quality of services to patients.

However, the effectiveness and efficiency of monitoring and audit arrangements as well as their usefulness in monitoring and changing the quality of the service being provided was inadequate.

The trust has stated that they did not anticipate being compliant with the essential standards relating to outcome 16 before 31 March 2012. Systems and processes for monitoring the quality and safety of services were not robust and the trust risk register did not reflect the level of current risk to patients.

We found that Eastbourne District General Hospital was not meeting this essential standard. We are taking enforcement action against East Sussex Healthcare NHS Trust to protect the safety and welfare of people who use services.
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

The provider was compliant with Outcome 21: Records

Our findings

What people who use the service experienced and told us

People who use services that we spoke with made no comment about their records specifically so we cannot report what they said.

Other evidence
Staff told us that there was a greater emphasis on clear and accurate recording.

Our review of documentation during our inspection highlighted a move to an integrated care planning framework which included an appropriate portfolio of risk assessments and an improved recording framework for care planning. However a consistency in the quality of recording had yet to be achieved throughout all wards and units.

Overall, our review of documentation highlighted an improvement in the consistency of documentation used and its completion. However, there remained concerns in regard to those records for people identified as elderly frail or with limited capacity. We found that there was inconsistency across wards with regards to the routine monitoring and recording of food and fluid intake, continence management, behaviour management and pressure area care. All of these were vital to the wellbeing of the patient and to ensuring positive outcomes from their stay in hospital.
Our judgement

Whilst there were improvements across those areas visited in the range of documentation used, the completion of required assessments and risk information remained inconsistent and directly impacted on staff knowledge of patients’ day to day well being.

Eastbourne District General Hospital was found to be compliant in respect of the essential standards of quality and safety.
**Improvement actions**
The table below shows where improvements should be made so that the service provider maintains compliance with the essential standards of quality and safety.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 12 HSCA 2008 (Regulated Activities)</td>
<td>Outcome 08 Cleanliness and infection control</td>
</tr>
<tr>
<td>Assessment or medical treatment of persons detained under the Mental Health Act 1983</td>
<td>Regulations 2010</td>
<td></td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
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<tr>
<td>Diagnostic or screening procedures</td>
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<tr>
<td>Maternity and midwifery services</td>
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<tr>
<td>Termination of pregnancies</td>
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<tr>
<td><strong>Acute Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 23 HSCA 2008 (Regulated Activities)</td>
<td>Outcome 14 Supporting staff</td>
</tr>
</tbody>
</table>

**How the regulation is not being met:**
While staff were observed carrying out infection control procedures there were some areas where improvements need to be made to ensure that patients were not placed at risk.

Further actions need to be taken in respect of the management of infected patients in side wards.

Eastbourne District General Hospital was found to be compliant in respect of the essential standards of quality and safety relating to this outcome.
<table>
<thead>
<tr>
<th>Injury</th>
<th>Regulations 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment or medical treatment of persons detained under the Mental Health Act 1983</td>
<td><strong>How the regulation is not being met:</strong></td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Staff were provided with an appropriate range of mandatory training opportunities. Improved core staff numbers had led to staffing more readily being released to fulfil booked training commitments. There was a staff appraisal system in place.</td>
</tr>
<tr>
<td>Diagnostic or screening procedures</td>
<td>There were inconsistencies in the training available to support the introduction and continued usage of the integrated care plan.</td>
</tr>
<tr>
<td>Maternity and midwifery services</td>
<td>Eastbourne District General Hospital was found to be compliant in respect of the essential standards of quality and safety relating to this outcome.</td>
</tr>
<tr>
<td>Termination of pregnancies</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acute Services</th>
<th>Regulation 20 HSCA 2008 (Regulated Activities)</th>
<th>Outcome 21 Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulations 2010</td>
<td></td>
</tr>
<tr>
<td>Assessment or medical treatment of persons detained under the Mental Health Act 1983</td>
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<tr>
<td>Maternity and midwifery</td>
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</tbody>
</table>

Whilst there were improvements across those areas visited in the range of documentation used, the completion of required assessments and risk information remained inconsistent and directly impacted on staff knowledge of patients’ day to day well being.

Eastbourne District General Hospital was found to be compliant in respect of the essential standards of quality and safety.
| services | Termination of pregnancies |

The provider must send CQC a report about how they are going to maintain 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 within 14 days of this report being received.

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

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Services</td>
<td>Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 2 Consent to care and treatment</td>
</tr>
</tbody>
</table>

**How the regulation is not being met:**

The majority of patients and some relatives spoken with confirmed that they had given verbal consent for routine nursing interventions and that signed consent had been sought for other treatments or operations.

However, there was a lack of evidence that patients with reduced mental capacity had access to advocacy or that best interest meetings had taken decisions on their behalf.

Eastbourne District General Hospital was found to be non-compliant in respect of the essential standards of quality and safety relating to this outcome.

| Acute Services | Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 | Outcome 7 Safeguarding people who use services from abuse |

**How the regulation is not being met:**

There was an improved awareness, understanding and use amongst staff of safeguarding, mental capacity and deprivation of liberty procedures. Important documentation was not robustly or
The Mental Health Act 1983

- Surgical procedures
- Diagnostic or screening procedures
- Maternity and midwifery services
- Termination of pregnancies

Consistently completed to the same standard across all wards. It remained unclear how decisions around consent were being obtained for people with limited capacity.

Systems and processes for monitoring the quality and safety of services were not robust and the trust risk register did not reflect the level of current risk to patients.

Eastbourne District General Hospital was found to be non-compliant in respect of the essential standards of quality and safety relating to this outcome.

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 14 days of this report being received.

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 Adult 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

<table>
<thead>
<tr>
<th><strong>Document purpose</strong></th>
<th>Review of compliance report</th>
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</thead>
<tbody>
<tr>
<td><strong>Author</strong></td>
<td>Care Quality Commission</td>
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<tr>
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<td>The general public</td>
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<tbody>
<tr>
<td><strong>Telephone</strong></td>
<td>03000 616161</td>
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<td><strong>Email address</strong></td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
</tr>
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