## 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 is registered to provide treatment of disease, disorder or injury, diagnostic and screening procedures, surgical procedures, assessment or...
medical treatment for persons detained under the Mental Health Act 1983, family planning, maternity and midwifery services, termination of pregnancies.
Our current overall judgement

Eastbourne District General Hospital was not meeting one or more essential standards. Action is needed.

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

Why we carried out this review

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

Outcome 01 - Respecting and involving people who use services
Outcome 02 - Consent to care and treatment
Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 07 - Safeguarding people who use services from abuse
Outcome 09 - Management of medicines
Outcome 12 - Requirements relating to workers
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 24 April 2012, checked the provider's records, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

We were supported on this review by an expert-by-experience who has personal experience of using or caring for someone who uses this type of care service.

What people told us

We spoke with people using the service (patients), relatives, and staff in all of the areas we visited. In total we spoke to 28 patients.

Patients told us that they felt their privacy and dignity was respected, that staff ensured curtains were closed during personal care and treatment.

We were told that patients were involved in their care and treatment. One patient told us "the doctor explained it to me"; another told us "staff come quickly when called". The relatives of one patient told us "The consultant explained everything to us on dad's behalf".
Other patients spoken with confirmed that their condition, care and treatment had been discussed with them and without exception they were all satisfied with the care they had received since being admitted. One comment seemed to sum up the feeling of patients "I can't fault the nurses here; they all do a wonderful job. It can't be easy for them; they are so busy but seem so cheerful and always make time for you".

Overall most patients told us they were happy with their admission process but two patients said there had been a delay in Accident and Emergency Department.

Another patient told us that they had been seen by a speech and language therapist who had provided them with advice about swallowing that they had found helpful.

We spoke with a total of 19 staff and they told us they had received training in privacy and dignity, equality and diversity, respecting patients' choices, the Mental Capacity Act and Deprivation of Liberty Safeguards.

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

People's privacy and dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

The provider was meeting this standard.

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

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Where people did not have capacity to consent, the provider acted in accordance with legal requirements.

The provider was meeting this standard.

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

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

The provider was meeting this standard.
Outcome 05: Food and drink should meet people's individual dietary needs

People were protected from the risks of inadequate nutrition and dehydration.

The provider was meeting this standard.

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

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

The provider was meeting this standard.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

The service does not fully protect people against the risks associated with the unsafe use, management and storage of medication by means of making the appropriate arrangements for the ordering and storing of medicines.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

The provider was meeting this standard.

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

People were cared for by staff that were supported to deliver care and treatment safely and to an appropriate standard.

The provider was meeting this standard.

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

The provider had developed a system to regularly assess and monitor the quality of
service that people received but this has only been introduced very recently.

There was evidence that learning from some incidents took place and appropriate changes were implemented but it was too soon to see whether new processes were effective. In addition, there were instances where, had incidents been assessed as serious, rather than minor, there would have been greater awareness and opportunity to learn from the incidents.

We would wish to see further improvements and embedding of practice as detailed in the evidence section for this outcome.

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

**Actions 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. We will check to make sure that this action has been taken.

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

**Other information**

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

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

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

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

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*
Outcome 01: Respecting and involving people who use services

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
The provider is 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 patients and staff on all of the wards we visited. In some wards we spoke to relatives as well. In total we spoke with nine relatives and one former patient.

Patients told us that they was treated with respect and dignity and that their independence were respected.

All the patients we spoke with on the wards told us that they had choices in their personal care. One patient told us they liked to have a shower and that staff helped them with this. Another told us they could choose to have a wash on their own and the staff helped to dry them.

On one ward a patient waiting to shower told us they would have a long wait as the shower was busy. On this ward, Wilmington, there was only one shower for 23 patients. However staff told us that patients also had the option of using a bath in the ward opposite if they preferred.

A former patient visiting a ward told us that their recovery was due to the excellent team on the ward including doctors, nurses, healthcare assistants and therapists. Their
relative told us the ward team had been wonderful and that they had been taken aside when their relative became ill and everything had been explained to them. They confirmed they had been provided with good supporting literature.

All patients confirmed that curtains were pulled fully around before care or treatment was commenced. They told us they were asked what was their preferred form of address.

All patients spoken to with the exception of one told us the call bells were answered quickly, and we observed this to be the case most of the time when we were on the wards.

On one ward we heard a patient consultation that included discussion about the patient's diet and appetite. Relatives of the patient told us they "felt they could have asked the consultant anything". Patients told us they felt involved in their care and treatment and that this was discussed with them.

**Other evidence**

In the main entrance foyer at Eastbourne District General Hospital (EDGH) we saw a laminated poster, provided by East Sussex Healthcare NHS Trust, which was entitled: "Our commitment to Privacy and Dignity". This was a statement by the trust about the level of commitment towards ensuring high standards of privacy and dignity for patients, delivering on single sex accommodation across all areas of the trust, unless there was a clinical justification that prevented them from doing so. On all wards visited, bays were segregated by gender. On two wards, the Medical Assessment Unit and Wilmington we were told that occasionally a bay may be mixed due to clinical need.

All staff spoken with across the wards visited were able to describe practices followed to ensure that patients' privacy and dignity and confidentiality was respected. These practices also ensured patients were fully informed and understood any potential care and treatment to be provided. We observed staff closing curtains on wards and also saw that other staff did not enter until given permission. Throughout the inspection we observed staff on all wards speaking to patients, quietly and in a respectful manner.

Staff described to us how they managed the admission and assessment processes and subsequent care and treatment in a way that respected patients' privacy and dignity. This process also highlighted patients' individual care needs. Staff further confirmed to us that, as far as practicable, patients on the ward were given choices regarding their care and day to day activities, including menus and how and where they receive personal care, including bathing or showering. This confirmed what patients had told us.

We were shown documentation in place for each patient including a newly developed 'Summary Plan'. This was an initial, 'at a glance' information sheet, including personalised care and individual nursing needs. We were also shown Clinical and Nursing Assessments and Treatment / Care Plans for each patient. We were assured by staff that patients had been consulted about these documents.

Staff told us that consultants or doctors informed patients about their care and treatment they were to receive. Following this, staff checked that patients fully
understood the information they had been given and the consultants or doctors could also be asked to come back if further clarification was needed.

Staff told us that prior to discharge, patients would be seen by the Hospital Intervention Team (HIT). This team comprised of nurses and social care staff who would assess and establish the level of care and ongoing support that the patient would require when going home. This ensured that the patient's autonomy and independence was being considered.

When we asked patients if they were involved in decisions about the service by way of questionnaire, or otherwise all replied no. The provider may find it useful to note that there were no forums for patients to feed back their experiences about how the service was run. This meant that patients did not routinely have their views taken into account in the way the service was provided.

Staff told us that patients' spiritual needs and any specific requirements would be highlighted during the initial assessment. However most patients spoken with had not been asked about spiritual need and had not been given a leaflet about the chaplaincy service. They told us, however, that they did not have any spiritual needs to be met. The trust may also find it useful to note that patients were not routinely being informed of spiritual services.

**Our judgement**

People's privacy and dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

The provider was meeting this standard.
Outcome 02: Consent to care and treatment

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
The provider is compliant with Outcome 02: Consent to care and treatment

Our findings

What people who use the service experienced and told us
Patients we spoke with and their relatives, if present, told us that they felt consulted and involved in their care and treatment.

Other evidence
At our inspection in September 2011 we found 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. We asked the trust to take action to address this. Evidence gathered at this latest inspection showed the provider had achieved compliance.

When we looked at patient files we found evidence of staff seeking consent for everyday personal care activities. We also noted patient consent to treatments in clinical files and this corresponded to entries in the notes of discussion with the patient or a relative about proposed treatments.

On every ward we viewed a sample of files of patients who were deemed to lack capacity and noted that capacity assessment information was in place in all but two files. There was no evidence that either patient had suffered any negative impact as a
result of this omission.

All staff spoken with said that the completion of a mental capacity assessment would not impact the way they worked with patients on a day to day basis, and that they would continue to seek consent or ask patients for their preferences in respect of day to day activities.

The trust may find it useful to note that across three wards of approximately 84 patients, we looked at 12 patient records and found three where the mental capacity status on do not attempt resuscitation (DNAR) forms did not correspond to that recorded in the patient notes. There was no evidence to indicate any of the three patients concerned had experienced a negative impact as a result of this contradiction, but this was brought to the attention of the ward matron or sister in charge to address.

All DNAR forms viewed had been completed by an appropriately qualified medical professional and were legally acceptable, but as a result of some omissions in recording not all had been completed in line with best practice and the trust's own policy. When we asked about this we were informed that the trust had undertaken a recent audit of DNAR information and was working to address inconsistencies in their completion. As a result of shortfalls we had identified at our inspection an e-mail directive was sent by the trust to all wards instructing an urgent review and amendment of all incomplete DNARs. On the final day of inspection we saw evidence confirming that this issue had been addressed.

Nursing staff told us that if a form was not completed correctly they would consider it to be invalid and would bring it to the attention of the relevant medical professional for them to review it. A member of the resuscitation team told us that if staff had any doubts they contacted them for advice. We were told that all nursing staff received DNAR training when they completed their induction. Nursing staff also told us that any orders to not attempt resuscitation were discussed with patients' relatives if appropriate, and if necessary, best interest meetings were held.

In discussion, staff were aware of the use of mental capacity assessment and deprivation of liberty safeguards authorisations to support treatment decisions and in what circumstances these might be used. We found evidence of best interest meetings and staff had an awareness and, on some wards, an experience of independent mental capacity advocates to aid with decision making.

**Our judgement**

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Where people did not have capacity to consent, the provider acted in accordance with legal requirements.

The provider was meeting this standard.
Outcome 04:  
Care and welfare of people who use services

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

We spoke with on average four patients on each of the six wards visited. Patients told us they were generally satisfied with the care they received. Patients and visitors commented on the time spent waiting for doctors and for medication when they were due to be discharged. We were told by one visitor "I'm not sure what we are waiting for I think it's the doctor, but I'm not really sure, someone will tell us soon I expect". Another patient told us "call bells can take a while to be answered, but only at busy times, staff try to respond quickly". One patient said, on one occasion they had had to wait 20 minutes and this caused them anxiety.

On one ward patients said that appropriate support equipment had transferred with them if they moved between wards and they had not experienced any delay in the provision of equipment.

All of the patients spoken with on this ward said that they saw doctors and consultants regularly and plans for treatment were discussed with them. Two patients on this ward and one on another referred to seeing so many people that there was inconsistent information provided. However, one person said that one particular consultant helped them to sort it all out.

On another ward patients felt that plans for their discharge had been discussed with them. There were mixed responses regarding the quality of care and support provided. Some patients said that the care provided was excellent and that staff understood
needs and they were well cared for. However, one patient said that particularly at night, patients could feel ignored and not listened to. Two of the eight patients spoken with on this ward said that they did not think they could complain, whilst others said that they would if they had concerns.

On one ward one patient described a very good experience, and they said doctors were 'brilliant', lots of advice was provided and they said that staff could 'not be faulted in any way'. Their relative also said that the service provided had been 'excellent'.

A patient in another ward said that they had been fully involved in discussions and decisions regarding their care and treatment. An example of this was that they had been assessed as needing a soft diet but requested a pureed diet.

Patients we spoke with told us pain was well managed.

**Other evidence**

At our inspection in September 2011 we found that there was inconsistency in the quality and accuracy of documentation across wards, a lack of personalisation within care plans and discharge planning was not well planned and documented. We took enforcement action against the provider to protect the health, safety and welfare of people using this service. Evidence gathered at this latest inspection showed the provider had achieved compliance.

In each area we visited, we spoke with on average four patients and with any relatives with them. In two areas we were joined by an expert by experience who spoke with seven patients in one area and eight in another area. We looked at clinical and bedside notes linked to each of the patients we spoke with.

We found that integrated care pathway (ICP) documentation was in use in all the areas we visited, and was completed by medical, nursing and allied professionals. Clinical notes contained ‘at a glance’ information which was a useful guide to the needs of each individual patient.

All staff spoken with clearly described the admission procedure. Nursing staff on Wilmington ward, the specialist stroke ward, told us how they started the admission process in the accident and emergency (A&E) department. They worked closely with staff there and this helped to speed up treatment and recovery times.

All grades of staff told us how they were involved in the documentation of care. We were told that although healthcare assistants (HCA) had not had specific training in care plan documentation, they were supervised until confident and competent to complete the documentation appropriately.

Staff were clear about what should happen if a patient had a fall and the measures to be taken to prevent further falls. Completed accident forms were seen in patient notes, when accidents had occurred.

One patient had completed a fasting period overnight, pending a scan. Their call bell was not in reach so they had not been able to request a drink. A request was made on their behalf for a drink and a staff nurse came and discussed their wishes regarding
food. Despite alerting staff to the position of the call bell this was not repositioned. A further request was made to a HCA, who moved the call bell.

We saw evidence on one ward that when a patient refused care, this was respected and fully recorded in notes along with the treatment that was provided.

We looked at care documentation for patients due to be discharged during our inspection. With the exception of Jevington ward discharge planning was documented in the patient notes section of the ICP and not the discharge planner. However there was no evidence that this impacted adversely on patients awaiting discharge.

We were told that the multi-disciplinary discharge policy and procedure was either available on the ward or on-line for staff to refer to as needed.

When we looked at the records for a patient with complex needs, we noted that a number of professionals were involved in their care and in the discharge process. Each recorded their notes relevant to their area of expertise. However, the trust may find it useful to note that there was no one single record that pulled together everything that needed to be in place at the time of discharge. A sister on the ward confirmed that a new form was due to be piloted that would enable more holistic recording of needs prior to discharge.

All staff spoken with told us that discharge arrangements were discussed during weekly multidisciplinary meetings. We spoke with an occupational therapist (OT) who told us that everyone was involved in the discharge process and if there was a problem the process would stop until it was put right.

Our judgement

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

The provider was meeting this standard.
Outcome 05: Meeting nutritional needs

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
People we spoke with gave us mixed feedback about the food. People told us that breakfast was generally good and there was always a choice of food. Other people told us although there was a choice, the choices were often very similar for example both meals offered would be pasta based. People who had specific religious dietary requirements told us that choices were always available.

People told us that food was hot most of the time and hot drinks were always available. Others told us that they were provided with food outside their mealtimes.

Other comments included: "Food was all right and they had never had to push anything away" and "it's not what you get at home as its mass produced food". Another person said they had not had any green vegetables and they would really like some.

The Patient Environment Action Team Assessment completed in 2012 recorded that the quality of food at Eastbourne District General Hospital was found to be excellent.

Other evidence
A Dignity and Nutrition inspection conducted by the CQC in April 2011 found inconsistencies in completion of nutritional assessments and not all patients had the support they needed at mealtimes. We asked the trust to take action to address this. Evidence gathered at this latest inspection showed the provider had achieved compliance.
During the inspection we visited six wards. We made observations; spoke with patients, visitors and staff. We identified and case tracked 15 people and had an overview of records for a further 20 patients.

All wards visited had implemented a red tray and red lid system for people who had identified concerns regarding nutrition. On the stroke ward the red trays had been replaced with red, non slip mats. Staff had a clear understanding of the system and when to use it. Adapted cutlery and crockery was available. Staff told us supply was variable as equipment often went missing. On the stroke unit we were told equipment was always available for patients who required it.

Staff knew patients needs and had implemented the red tray even if the malnutrition universal screening tool (MUST) and nutritional assessments had not identified concerns. Systems were in place that informed all staff, including housekeeping staff, of patients' individual dietary needs.

The MUST was used on all the wards we visited. MUST scores were recorded on admission at the time of initial assessment and were reviewed weekly or more frequently if assessed as necessary. If patients were unable to be weighed this was recorded on the chart. Patients' body mass index (BMI) was recorded weekly.

Patients identified as at risk or requiring specialised diets had dietician and speech and language therapists (SALT) involvement. Specialised diets were clearly identified. Information recorded from the dietician and SALT team provided guidance for staff about how to support patients with eating or swallowing difficulties. One patient had been identified as requiring pureed food and it was recorded that they had to be fed slowly with a teaspoon. This patient had also been identified as at a high risk of choking. Staff were observed feeding this patient appropriately.

Referrals to dieticians and the SALT team were made over the telephone. We were told there may be a delay in assessments due to prioritising needs. For example there was no dietician or SALT cover at weekends. So that patients would not experience any negative impact from these delays, staff told us that patients' immediate hydration and nutritional needs would be met by alternative means, such as intravenous fluids until they could be seen by a dietician or someone from the SALT team.

We assessed the care documentation which was pre-printed. This included a care plan for nutrition and hydration. We saw that two patients identified as requiring nutritional support did not have a nutritional care plan in place. However, there was evidence within the care documentation that patients had been referred to the dietician and SALT team. We informed the sister about the care plans and we saw this was resolved. The daily records reflected the care delivered was as detailed in the care plan.

We observed that mouth care was being provided to people who needed it. However, when we checked the notes of these patients this was not always well recorded. The trust had implemented weekly audits of patient documentation to address inconsistencies in recording and this work was ongoing.

Patients' food consumption was monitored through the use of dietary intake charts, which were generally completed and informed staff if patients had eaten all or part of the meal. However, staff did not always ensure they had recorded when food or drinks
had been offered. We found no evidence that any of the patients whose records we viewed had experienced any negative impact as a result of these omissions.

At mealtimes staff ensured that people were sitting upright in bed or assisted into bedside chairs. Tables were adjusted to the correct height for patients. To ensure meals remained hot for patients who required assistance, they were not removed from the trolley until staff were available to assist. Meals were seen to be served in a timely manner.

Water jugs and beakers were placed on bedside tables and were seen to be regularly refreshed. These were placed within reach of patients. Hot drinks were available throughout the day. All of the wards visited had a small kitchen, and snacks were available for patients. Staff told us there was limited access to cooked meals outside of mealtimes, and they were not available at night. There was a large supply of supplement drinks available.

All of the wards had a link nutrition lead. Staff received initial training to undertake the role. Staff told us there was no formal nutritional training. All wards visited told us they had undertaken their own training on the ward with support of the dieticians. Staff told us dieticians were keen to share knowledge and support staff in their learning.

Our judgement

People were protected from the risks of inadequate nutrition and dehydration.

The provider was meeting this standard.
Outcome 07:
Safeguarding people who use services from abuse

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
Patients spoken with said that they felt safe and that they were well treated by staff.

When we asked more able patients about their observations of care given to vulnerable patients they told us that they thought the needs of these patients were being appropriately supported by staff. None of the patients spoken with expressed concerns about this, commenting that staff were very attentive and kind to these patients.

We met and spoke with family members of patients who told us they had no specific concerns about the safety and welfare of their relatives. They understood that they could raise concerns directly to the ward matron or through the patient advice and liaison service (PALS).

Other evidence
At our inspection in September 2011 we found that people were not always supported appropriately to make decisions or to give consent. In addition, systems for monitoring the quality and safety of services were not robust. We found that risk was not accurately recorded. We asked the trust to take action to address this. Evidence gathered at this latest inspection showed the provider had achieved compliance.

We visited six wards and spoke with a minimum of three nursing and healthcare staff on each ward.
Staff told us that training in respect of safeguarding, mental capacity and deprivation of liberty safeguards (DOLS) was delivered in different formats, with classroom training provided to band six nurses and above along with other medical professionals. All other staff received this training through information provided on the ward and through ward discussions. One doctor we spoke with said they had not received this training yet. The trust had identified that clinical staff required this training and a programme of training started in August 2011 and was ongoing.

Staff said that they had been provided with reading materials in respect of mental capacity that they had been required to read. All healthcare assistants and nursing staff spoken with said they had found this very informative.

The majority of healthcare assistants and nursing staff spoken with demonstrated a good understanding of safeguarding, mental capacity and DOLS, and were able to cite examples of when they might be used.

In discussion, nursing and healthcare staff indicated an improved confidence in challenging poor practice and raising alerts in respect of colleagues. All staff spoken with knew the name of the member of trust staff undertaking safeguarding responsibilities and training.

In discussion, ward sisters told us that they were raising safeguarding alerts for patients in respect of care they may have received prior to admission to the ward. However, the provider may find it useful to note that there was currently no system in place for wards to record how many safeguarding alerts they had raised in respect of other agencies or poor practice on their own ward.

The majority of patients without capacity to make decisions about their care and treatment had an assessment completed; this was called Nursing Care Plan for Adults Lacking Capacity. There was a system of review in place for these. However, we found in a small number of patient records where patients had regained capacity, documentation had not been updated to reflect this. However staff were aware of the change in capacity. There was no indication that these patients had experienced any negative impact as a result of documentation not being updated. Weekly audits of patient documentation were seeking to address such inconsistencies.

Staff were able to give examples of patients who had been on the ward and for whom a DOLS authorisation had been applied. They were able to explain why this had been done and the outcome and impact it had on the patient. Records showed that patients were removed from DOLS as soon as it was felt they were safe. Staff understood about the need to involve independent mental capacity advocates (IMCA) and the use of best interest meetings to help with decision making. We saw evidence of best interest meetings for some patients.

On wards visited where there were patients with some challenging behaviour, we asked staff how they managed this. Most staff spoke about how they usually tried to engage and talk with the patient concerned, would use distraction techniques such as walking with the patient. Sometimes if it was necessary the Matron would make a request for additional one to one staff support for the patient.

We looked at incidents and accidents recorded by each ward visited. We found these
were reported appropriately but some wards did not retain copies for their information. We looked at incidents reported by the six wards visited. We found five incidents where we queried whether the assessed level of concern fully reflected the seriousness of the individual incidents. Ward matrons and ward sisters were unable to tell us whether these incidents may have been escalated at a later stage by senior managers. The trust may find it useful to note that when we spoke with Ward matrons and sisters, they were unclear how recorded incidents and accidents were triaged once they were sent from the ward.

Serious incidents identified as such by the ward were reported through the same route as all other incidents and matrons and sisters said they received feedback from these. Learning from safeguarding alerts or serious incidents that had occurred on the ward was cascaded to staff on that ward, but was slow to be cascaded to other wards to reduce the risk of re-occurrence elsewhere.

Matrons and sisters told us that there were five weekly quality meetings when trends within wards would be looked at and this included safeguarding alerts.

We asked East Sussex Social Services about their experiences of working with the trust and whether this had improved in the reporting and management of safeguarding alerts. They told us that there was positive progress with trust senior management who were supportive of collaborative working with other agencies regarding safeguarding alerts. There were now joint fortnightly meetings at an operational level where middle managers from both adult social care and the trust worked well with open communication. They had demonstrated this in recent work with adult social care in respect of a pressure ulcer protocol and a revised hospital Safeguarding Adults At Risk (SAAR) protocol and some good practice examples had come out of this work.

**Our judgement**

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

The provider was meeting this standard.
Outcome 09: Management of medicines

What the outcome says
This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement
The provider is non-compliant with Outcome 09: Management of medicines. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We talked to 17 patients on five wards regarding their medicines.

Patients were complimentary about the care received and they told us that they had all their medicines as intended and prescribed.

Two of these patients told us they were frustrated at the long wait for their medicines to take home as there were delays.

One person told us that they had not had their medicine one day as it had not been available.

Other evidence
We looked at medicine storage arrangements on all the wards visited. We saw that some of the medicines were not stored safely. There were patients' own medicines on work tops, behind nurses' stations and on top of individual medicine cupboards. We saw some medicines kept in unlocked cupboards. In one area medicines were in an unlocked fridge.

The nurses we spoke to confirmed that the storage available for these medicines was not always sufficient. We saw some medicines kept in unlocked cupboards. These
included injections and medicines prepared for people to take home. In one area medicines were in an unlocked fridge. We also observed a drug trolley left unlocked and unsupervised whilst medicines were being given in a side room. These medicines could be accessed by unauthorised people which could lead to harm and the medicines not being available for the people who needed them.

The trust carried out an audit on security of medicines in February 2012 and their findings were similar to those found on this visit. This audit recommended that improvements were to be completed by end of July 2012. However, we found that some medicines were not stored securely and posed a risk to patients.

All of the six nurses we talked to said the service from pharmacy was slow particularly with regards to medicines needed on discharge. Ward staff reported waits from two hours to whole days before medicines to take home were available on discharge. There were delays at each stage of the process. One nurse said 'I have been known to drop patient's medicines to their home after work myself'. Another staff member told us that couriers have to be arranged to take medicine to patients' homes when they were not ready. One person we saw, who had been told they would be discharged the previous night, had been waiting for their medicines from 10:00 am on that day until 2:00 pm the following day.

We asked pharmacy staff about this. They told us of changes to some processes that had been implemented to try and improve the situation by reducing the distraction to dispensing staff. They had introduced an answer phone for all calls to the pharmacy. Calls were screened regularly and pharmacists could be bleeped if needed urgently.

Pharmacy service to the wards was based on the needs of the individual ward. This ranged from a visit from a pharmacy assistant to top up their stocks to a set level, to pharmacists attending consultant ward rounds. We saw that patients' medicines were checked when they are admitted to make sure that they were prescribed as needed.

We saw evidence that there had sometimes been a medicine supply problem which meant that people did not get their medicines as prescribed. This was reflected in the records of pharmacy incident reports we were shown. Thirteen of the 28 incidents reported from 2012 related to a supply problem. The pharmacy has carried out an audit to look at this. The initial results collected showed that of the 742 omitted doses of medicines counted, 105 were due to unavailability.

It was noted in the report that some of the doses omitted would have been available from other parts of the hospital. This means that patients were not getting their medicines as prescribed as the arrangements for supply of medicines was not appropriate or not known to sufficient hospital staff.

**Our judgement**

The service does not fully protect people against the risks associated with the unsafe use, management and storage of medication by means of making the appropriate arrangements for the ordering and storing of medicines.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.
Outcome 12: Requirements relating to 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 staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement
The provider is compliant with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
We spoke to people using the services but their feedback did not relate to this standard.

Other evidence
Appropriate checks were undertaken before staff began work. We looked at 20 staff files for the purpose of checking compliance on staff recruitment. Not all the files contained the employees’ job descriptions. Whilst it would be good practice to do so the trust was not required by the regulations to include job descriptions in staff files. Where there was one we were able to see that the job application provided evidence that the applicant had the skills, qualifications and experience that the job description demanded. Many files contained the notes of the applicants’ interviews; these also showed that the applicants’ suitability was tested in interview.

The regulations required that certain information is obtained from people seeking employment at the trust. This included, but was not limited to, a recent photograph, proof of identity, a Criminal Records Bureau (CRB) check, employment history and references. We found that all the files of the staff recruited since the regulations came in to force in April 2010 contained the required information. The provider might like to note that on one occasion the reference had insufficient information to be followed up. However that individual was already working at the trust albeit on a placement through an employment agency. The individual's first reference was the trust’s line manager for whom he was working.
Where CRB disclosure indicated that there were significant events in an applicant's past the decision on whether to employ them was made on an individual basis. The manager concerned and the HR advisor for that department made the decision and a note of their discussions was retained.

There was a requirement to check a job applicant's reason for leaving their previous employment where they had been employed working with children or vulnerable adults. There was also a requirement to check employment history, including reasons for gaps in employment. On the files we saw this had been done.

Where staff were members of professional bodies such as the Nursing and Midwifery Council, General Medical Council or the Health Professions Council there was evidence in the files that their registration was current. We saw print outs of the relevant web page of the professional body's website or a copy of their 'PIN' card. The HR department maintains a spreadsheet of staff registration. This was accessible to the managers of the various departments.

Staff that were no longer fit to work in health or social care were referred to the appropriate bodies. We saw evidence that, where an individual was considered unfit to practice, (or in this case was unfit to practice at a particular level) their case was referred to their professional regulating body.

**Our judgement**

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

The provider was meeting this standard.
Outcome 14:
Supporting staff

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We spoke to people using the services but their feedback did not relate to this standard.

Other evidence
The trust had a training needs analysis which was conducted by an external consultant. Mandatory training followed the guidance laid down by the NHS Litigation Authority. This set out the training that should be undertaken by individuals in various roles including the frequency of updating.

The trust's mandatory training policy clearly set out these directives. The trust aimed to achieve 85%-90% compliance with mandatory training. Given the impact of maternity leave, long term sickness and staff turnover 100% compliance all the time was not achievable.

We looked at trust records relating to all mandatory training across six wards. The levels of compliance were high. Trends were seen across wards, with some wards achieving a higher level than others. We saw evidence that staff who did not attend training were identified and booked onto follow up courses.

Local managers were responsible for training in conjunction with the Human Resources (HR) department. There were monthly performance indicators that told managers how their unit was progressing towards compliance.

Most of the mandatory training courses were updates and refreshers. Where for
example 66% of staff had received basic life support training, it did not mean that 33% were untrained. In the vast majority of cases it meant that their refresher course was overdue, sometimes by months, but often just by a few weeks. Generally staff could either do e-learning or physically attend a training event to comply with mandatory training. Mandatory training for new staff was conducted as part of the induction process.

Staff we spoke to said that they had completed their mandatory training. They told us that completion of mandatory training was reviewed at their annual appraisal by their manager. They said that the trust was ‘good’ at training and that there had been a ‘big push on mandatory training at executive level’. When staff missed mandatory training they received a letter with a new course date which was copied to their manager. If the course was not attended then the matter was notified to the next most senior line manager. Failure to attend a third time had to be explained in person to the Chief Executive Officer.

Matrons said that mandatory training was completed at induction. They believed this was beneficial as the staff member could then be fully deployed without frequent abstractions to complete the training.

Agency staff were subject to a national agreement. There was a base checklist of training and the trust received a guarantee from the agency that their staff had completed the training. Additionally the trust received evidence that their annual professional registration was in date. We were told that bank staff were almost always the trust’s own staff (working additional hours) and their training was covered as part of their regular duties.

Staff were able, from time to time, to obtain further relevant qualifications. The trust supported staff to attend external and discretionary training. There was a budget for training, a substantial proportion of which comes from the Strategic Health Authority and was generally devoted to raising clinical skills. Many courses were held at Greenwich or Canterbury Universities and we saw that staff had attended Professional Theatre Practice, Emergency Care for Children and Surgical intervention courses at these universities.

The full range of additional courses available was much wider and included formal training workshops, study days, master classes and conference. The majority are clinical, although there were some leadership courses such as; The Supervisors Development Certificate, and Managing Poor Performance. The trust supported healthcare assistants (HCA) to train as nurses. One matron commented that she ‘loses one (HCA) a year to nursing’.

There was a trust wide induction which had to be completed on-line by new staff before they commenced work at the trust. There was also an induction local to the unit on which a new staff member was employed to work and we saw from recruitment files that these had been completed. Staff we spoke to said that the induction was meaningful and allowed one to have a better picture of how the whole trust operated and to become familiar to forms used in the trust.

There was an induction process for volunteer staff. They could not start work until it had been completed. However where the volunteer’s activity was limited such as to laying
out hymn books in the Chapel the induction simply comprised of watching a DVD about the trust followed by a question and answer session.

In respect of monitoring staff competencies to ensure patients were safe there was a good system in place for reporting medication errors by staff and monitoring their competencies after this. We spoke with one staff member who was involved in a medication incident and they confirmed their competency had been monitored and their personnel record recorded the incident for a period of six months. However matrons and sisters were unaware of any formal process for monitoring the frequency of incidents attributable to individual staff, unless those staff remained on a particular ward when the performance management route would be followed.

**Our judgement**

People were cared for by staff that were supported to deliver care and treatment safely and to an appropriate standard.

The provider was meeting this standard.
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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<tbody>
<tr>
<td>The provider is non-compliant with Outcome 16: Assessing and monitoring the quality of service provision. We have judged that this has a minor impact on people who use the service.</td>
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<tr>
<td><strong>Other evidence</strong></td>
</tr>
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<td>At our inspection in September 2011 we found that quality monitoring systems were ineffective and supporting documentation was weak. We took enforcement action against the provider to protect the health, safety and welfare of people using this service. Evidence gathered at this latest inspection showed the provider had not fully achieved compliance.</td>
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East Sussex Healthcare NHS Trust had made considerable progress since the last Care Quality Commission inspection in September 2011. However, many of the initiatives that have been introduced were too recent for us to fully assess how effective the new systems and processes for monitoring quality were. Staff and board members were very positive about the changes and said they could identify improvements at ward level but that it was too soon to provide hard evidence that the changes were sustainable.

We spoke with many directors and staff from the trust both individually and in small groups. Some conversations took place as formal interviews and others less formally as we went around the wards and departments.
We saw a strong professional relationship between the Chair and CEO. Other people described it as having "a certain degree of tension and challenge" and felt this was a really positive thing, saying "nothing gets past the Chair nowadays: He is interested and demands to know about everything. " The Chair was able to describe his role fully. He was clear his role was strategic and to lead the Board rather than to manage the trust on a day to day basis.

Partnership working was said to be much more important and there was a willingness to engage with a range of stakeholders including patient groups and voluntary groups. Specific mention was made that a representative from the East Sussex Local Involvement Network (LINk) now attends board meetings.

Each of the Non-Executive Directors we spoke to was able to talk about their role and involvement in monitoring the quality of services provided by the trust. They had committed to making regular visits to wards and departments.

The Head of Assurance told us that they had introduced a Risk Management Strategy. They were beginning to use a new risk register format so that it contained more relevant information than the one in current use.

Each Head of Nursing held a Quality Review meeting with their team of ward matrons every four to six weeks. We were invited to attend one meeting that took place during our visit. Each ward matron presented the data they had collated for the month and presented it to the group. The information that we saw was based on a number of key performance indicators such as the number of falls that patients have had or the number of complaints about the unit. The information was compared to how that clinical unit performed in previous months, so that any month on month changes could be identified and any trends acted upon.

We spoke with the Director of Clinical Operations who was the lead doctor for Hospital Standardised Mortality Ratio (HSMR). The HSMR compares the expected rate of death in a hospital with the actual rate of death. One of the issues discussed was around the number of people dying unexpectedly at this trust compared to other similar trusts when compared nationally. Last year, East Sussex Healthcare NHS Trust appeared to fall just outside the levels that comparative data suggests is usual.

The Director of Operations was asked to undertake a review of mortality and morbidity across the acute hospitals to determine exactly what was going on and what this information meant. He explained that the issues that came up were not about high death rates but about the way that they were failing to record deaths against the correct diagnosis. We looked at the statistics for the period of time since the review began and compared it to the previous year. We saw that there was a month on month reduction in the mortality rate.

At the time of our inspection, the trust process for managing complaints was being changed and the new systems were ready but not yet implemented. There was evidence from the Quality Review meetings that complaints were being well managed within the divisions. However, there was scant evidence that there was a wider analysis and learning from complaints, with no apparent benchmarking outside of divisions.

We saw a copy of the 2011 to 2012 Trust Clinical Audit Forward Plan. Although we saw
that some areas of the trust had completed the planned clinical audits, other areas, notably children's services, women's health and pharmacy, had not. This meant that the trust had not been monitoring its clinical practice widely enough to improve the quality of all services that people received.

We were told that the trust had until recently had a problem in closing investigations into serious incidents in a timely manner. We saw a report which demonstrated that this had been the case until very recently. We saw that the trust had set up a Serious Incidents Review Group (SIRG) that had recently started to meet weekly to address outstanding serious incidents. We were also told that they had started to record serious incidents in a document that could track actions as a result of incidents. We saw that there had been a small reduction in the number of serious incidents still being investigated. It was too soon to be able to evaluate whether improvements could be sustained.

We looked at all the incidents reported to CQC via the National Patient Safety Advice (NPSA) before we visited. We also saw records of other incidents during our visit. Whilst many were relatively minor and had been adequately addressed through the divisional channels, there were clear examples where the incident had been downgraded inappropriately. If the situations had been assessed as serious incidents, rather than minor, there would have been greater awareness and more opportunity to learn from the incidents.

We spoke with many staff about how they learnt from success stories and how positive achievements were celebrated. We listened to positive stories from ward matrons. The Chair told us that if he received a letter or card where a specific clinical unit was praised, he personally takes it over to the unit team and says thank you. Like many other initiatives within the trust, the celebration of success and learning from 'good news' stories is still in its infancy but is showing signs of progress.

Our judgement

The provider had developed a system to regularly assess and monitor the quality of service that people received but this has only been introduced very recently.

There was evidence that learning from some incidents took place and appropriate changes were implemented but it was too soon to see whether new processes were effective. In addition, there were instances where, had incidents been assessed as serious, rather than minor, there would have been greater awareness and opportunity to learn from the incidents.

We would wish to see further improvements and embedding of practice as detailed in the evidence section for this outcome.

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.
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>
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<th>Outcome</th>
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<tbody>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
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<td>Outcome 09: Management of medicines</td>
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<tr>
<td>Family planning</td>
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**How the regulation is not being met:**

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| Treatment of disease, disorder or injury | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 | Outcome 16: Assessing and monitoring the quality of service provision |

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We would wish to see further improvements and embedding of practice as detailed in the evidence section for 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 the date that the final review of compliance report is sent to them.

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

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

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

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

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

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

**Compliance actions**: These are actions a provider must take so that they achieve compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

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

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<td>Author</td>
<td>Care Quality Commission</td>
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<td>Audience</td>
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