Inspection Report

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

Wexham Park Hospital

Wexham Street, Wexham, Slough, SL2 4HL

Tel: 01753633356

Date of Inspections: 22 May 2013
13 May 2013
08 May 2013
07 May 2013

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We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Cleanliness and infection control	✖ Action needed
Management of medicines	✖ Action needed
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Enforcement action taken
Records	✖ Action needed

Details about this location

Registered Provider	Heatherwood and Wexham Park Hospitals NHS Foundation Trust
Overview of the service	Wexham Park Hospital is an acute hospital which is part of Heatherwood and Wexham Park Hospitals NHS Foundation Trust. Wexham Park Hospital provides healthcare to a population of approximately 450,000 people which covers Ascot, Bracknell, Maidenhead, Slough, south Buckinghamshire and Windsor.
Type of service	Acute services with overnight beds
Regulated activities	Diagnostic and screening procedures Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 7 May 2013, 8 May 2013, 13 May 2013 and 22 May 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by other regulators or the Department of Health, reviewed information sent to us by local groups of people in the community or voluntary sector, talked with commissioners of services and talked with other regulators or the Department of Health. We talked with other authorities and were accompanied by a specialist advisor.

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

We looked at all the information we hold about Wexham Park Hospital.

What people told us and what we found

Reflecting national trends, the hospital's accident and emergency department experienced unexpectedly high demand for its services over the winter period and has continued to do so. This has had an adverse impact on the hospital's ability to meet its targets in relation to the four hour A&E waiting time, ambulance handover, and elective procedures. This inspection visit was prompted by these concerns and by the results of the adult in-patient survey, published in April 2013.

We visited the hospital's Accident and Emergency Department (A&E), Emergency Department Decision Unit (EDDU), acute medical unit (AMU), medical interventions day unit (MIDU), acute stroke unit as well as wards 4, 6, 7, 9, and 18. We also visited the paediatrics unit and a number of the hospital's escalation areas. We tracked care pathways for 12 patients, interviewed 56 members of staff and four paramedics, and spoke with 42 patients and relatives.

We found that the A&E department was overwhelmed by a combination of high A&E attendances and a shortage of in-patient beds in the rest of the hospital. The department was very crowded and busy. Our observations showed staff struggling to cope with high numbers of A&E attendances and patients waiting up to eleven hours to be admitted onto a ward. There was a clear focus on managing the demand for in-patient beds, sometimes

at the expense of providing basic care.

Across the hospital, we saw many instances where the care given to patients was good; however, we also saw a number of instances where the quality of care given to patients was below essential standards. The majority of patients we spoke with were satisfied with the quality of care provided. However, we received a number of complaints from patients about the quality of nursing care and poor communication.

We observed a number of instances where peoples' privacy and dignity were not respected. This was particularly the case in A&E and EDDU. We found poor standards of cleanliness and inadequate infection control arrangements in some areas of the hospital. Storage of medicines on wards was poor, with patients and visitors on some wards easily able to access drugs which should have been kept in a locked area. We identified a number of concerns around staffing including high vacancy rates in some areas and an over reliance on bank and agency staff. In all of the patient records we checked, we found evidence of poor record keeping, poor communication, and an absence of care plans.

There were systems in place for identifying risks to patient safety and maintaining the quality of services. However, in many instances, these were ineffective. Where concerns were identified, they were not always addressed and reviewed to ensure standards were maintained. There was a clear emphasis on responding to national and local clinical targets but little emphasis on ensuring that overall patient experiences were positive.

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

What we have told the provider to do

We have asked the provider to send us a report by 19 July 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People's privacy, dignity and independence were not always respected. People's views and experiences were not taken into account in the way services were provided and delivered in relation to their care.

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

Reasons for our judgement

All the wards we visited were split into male and female patient areas. We observed instances of staff speaking respectfully with patients and responding to their calls for assistance or support. We also saw staff draw curtains before providing intimate personal care or medical treatment. Most of the patients we spoke with told us staff treated them with respect and took steps to ensure their privacy.

However, there were a number of instances where standards of privacy and dignity were not maintained. This was of particular concern in A&E and the Emergency Department Decision Unit (EDDU). The current design of the A&E department provided challenges to maintaining privacy and dignity. We observed patients who were brought by ambulance entering the building via the resuscitation area of the A&E department. Paramedics had to wheel them on trolleys through the resuscitation area to the A&E reception desk, which was in an adjacent room. While being transported to A&E reception, they were able to observe other patients and be observed by patients who were already being treated.

From our observations, we found the number of patients' attending at A&E far exceeded the number of A&E beds available in the department. As a consequence we saw patients lined up on trolleys next to each other adjacent to the A&E reception desk when no beds were available. We also saw patients queuing on ambulance trolleys in a corridor leading out of A&E. Staff and ambulance crew told us these practices were a regular occurrence because there was no place to put patients when they arrived. We observed two patients in a bay intended for a single patient (a practice called 'doubling up'). This arrangement meant staff were unable to keep conversations confidential and patients' dignity was not respected.

We found curtains and dividers were available on A&E to provide patients with some privacy but these were not always used. Staff told us they only used the curtains during medical examinations and we observed this to be true. They told us they did not routinely use curtains to divide the bay areas in resuscitation and Majors A because they needed to observe the patients in those bays. They told us if they closed the curtains, they would not be able to view the observation monitors which would alert them to a patient's deteriorating condition.

On the EDDU, we found staff did not support patients to maintain their privacy and dignity. When we arrived on the unit we saw an elderly woman who was confused, sitting in her chair in her bra, who could be seen by all the other patients, visitors and staff in the unit including men. Another patient told us she had been in this condition for some time. The nurse in charge, who accompanied us onto the unit, did not notice the patient in her half dressed state. When we spoke to the two nurses on duty about this patient, they were not sure how they should have assisted the patient.

On the medical interventions day unit (MIDU), we found the unit was split with men being on one side and women on the other. The male side was further divided into a day patient area, a clinic, and an in-patient escalation area. The men attending the clinic were dressed in hospital gowns which did not fully cover their bodies. They were seated in a small waiting area which was clearly visible by other patients and visitors on the unit. We observed one male patient trying to hold the back of his hospital gown closed while running for the toilet. When we asked staff about their arrangements for ensuring the dignity of the men attending the clinic, they told us men were advised to keep their trousers on under their hospital gowns but most of them did not follow these instructions. No further measures were taken to ensure privacy and dignity standards were maintained.

We identified concerns about patient involvement in all of the wards and areas we visited, except the acute stroke unit. Common concerns that patients and their relatives raised with us related to poor communication between staff and themselves; lack of information about plans of care; and feeling their needs and preferences were not acknowledged. With the exception of patients on the acute stroke unit, patients and their relatives were either unaware of or unclear about their care and treatment plans. A common complaint from patients we spoke with was that the results of diagnostic tests were not explained to them. One patient told us, "I don't know what's going on and I don't care." Another frustrated patient told us, "I have been here [on EDDU] for two days. I get no information. No one tells me what is going on or how long I'm staying, only that I'm waiting for a bed somewhere." We spoke to one patient on EDDU who had been waiting for a bed on a ward for two days. He told us he was not given any information about when he might be moved onto a ward or what his test results were.

We checked 12 sets of patient records. Patient involvement in their own care and treatment was not documented. There was no documented evidence patients were given opportunities to express their choices and preferences. Where patients were aware of their care and treatment plans, they told us they were told what medical care they would be given but they were not given choices nor were they involved in making decisions about their care. The relatives of two different patients told us staff did not listen when they tried to tell them about their loved one's individual needs or preferences.

The majority of patients we spoke with were not aware of their plans of care and told us staff did not always explain what was going to happen next. One patient told us, "I don't know what's going on and don't care." Another patient said, "I've had all these tests but no

one tells me what they mean or what will happen after."

In contrast, on the acute stroke unit, patients and their relatives felt very well informed about their treatment plans and told us they were involved in making decisions about their care. One patient told us, "we have been given great family support."

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Patients did not always have their care needs adequately assessed, planned, and delivered. This was a particular concern for patients who were confused or who were assessed as having dementia.

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

Reasons for our judgement

During our visit, we found that the quality of care was inconsistent. Of particular concern were standards of care in the accident and emergency department (A&E), Emergency Department Decision Unit (EDDU), the acute medicines unit (AMU), and areas used as escalation areas. Patients on the acute stroke unit were very complimentary about the care they received.

We observed doctors and nurses in A&E working well together and staff told us there was a real sense of teamwork in the department. Patients with serious conditions were seen by doctors soon after being admitted into A&E and nurses and doctors responded immediately to patients requiring emergency treatment. For example we observed staff respond to a patient who had a major seizure. Doctors and nurses from across the department responded the moment the emergency alarm was triggered. A review of the patient's documentation showed the patient's seizure was dealt with correctly. Patients we spoke with, although unhappy with how long they waited in A&E, were pleased with the treatment they received from doctors and nurses. One patient told us "A&E were fabulous."

However, we found that the A&E department was overwhelmed by a combination of high A&E attendances and a shortage of in-patient beds in the rest of the hospital. Staff told us that the shortage of beds on the hospital's wards meant patients could not be moved from A&E. As a result, the department was often very crowded and busy. The impact of such high numbers of A&E admissions could be felt throughout the hospital. Due to the shortage of in-patient beds, patients were often placed in any available bed rather than in a bed on a ward specific to their needs. This increased the risk that patient care would be delayed and that patients would not receive the care they needed.

On one of the evenings we visited A&E, the unit was very busy and we saw staff running from patient to patient. Patients coming into A&E via ambulance were placed in any available space as there were no free bays. Staff said the effect of these pressures

resulted in delays to assessment and treatment, long patient waiting times, and queues of patients on ambulance trolleys waiting to be triaged. They said the department was often so overwhelmed that, at times, patient safety was compromised.

We saw patients queuing up on trolleys for hours at a time. Staff told us they had no beds for these patients and had no choice but to line them up one next to the other. We spoke with paramedics who were accompanying patients on trolleys waiting to be seen. They told us patients had to queue up in a corridor regularly and described queues of six to nine patients. They said patients were kept on ambulance trolleys for long periods of time, sometimes hours. This increases the risk of patients developing pressure ulcers as a result of skin damage and becoming dehydrated.

On our first day of inspection at 9.15 am, there were four patients who had been waiting for more than four hours to be moved onto a ward. Three of these patients had been waiting for over eight hours. On our second day of inspection, at 19.10 pm, we found 17 patients had been waiting for more than four hours to be admitted onto a ward. When we visited the hospital wards, we checked 12 sets of in-patient medical records. We found that patients regularly waited for more than four hours in A&E. One patient's records showed he waited 14 hours.

We observed some instances of poor communication between staff and patients in A&E. On one occasion, we saw a nurse do an assessment of a patient without introducing herself or speaking to the patient. On another, the relative of a patient in the trauma bay requested medical assistance from two doctors and one nurse, and was ignored by them. She was told by one doctor that "it has nothing to do with me." She was concerned because staff failed to notice the patient's heart monitor was not plugged in. The issue was addressed once we raised it with a member of staff. In another case, over a period of an hour, we observed one patient ask repeatedly for a drink. She received her drink when we brought her request to the attention of a member of staff.

In one instance on the acute medical unit (AMU) we found nursing staff did not follow hospital protocol for diabetic ketoacidosis for stabilising blood sugar levels. The night after the patient was admitted to hospital, their blood sugar level fell below the recommended level recorded in their notes. Patient records showed that staff checked the patient's blood sugar levels at least three times and recorded them, but failed to recognise that the results of the tests indicated the patient's blood sugar level was low and further action was required. This put a patient at risk of going into a diabetic coma. The risk was exacerbated because the incident happened at night when staff might not have realised the patient was unconscious. They may have assumed the patient was asleep. Although the patient's condition was eventually addressed, the incident was not recorded as a near miss in the patient's records nor was it reported to the ward matron. We spoke to the ward matron who had no knowledge of the incident. We also checked incident records and found no evidence of the incident having been reported even though it was potentially dangerous to the patient and should have been reported as a near miss.

Across the hospital, we found poor standards of care, risk assessment, and communication planning for confused patients and patients with dementia. Where patients were screened for and found to have dementia there was no assessment of their communication needs, assessments of capacity to make decisions, or evidence of involving patients or their relatives in care planning. There was no system to ensure patients with dementia had dedicated care and support. On several occasions, we observed confused patients who were very distressed and whose calls for assistance were

ignored. One patient told us "I don't know what they are doing...haven't been told why I am here..."

Measures taken to accommodate patients already on wards, and those being admitted via the A& E department, included the use of areas which were not usually designated as inpatient wards. These areas were called 'escalation areas' and were used to accommodate patients who were nearing their planned discharge date or those who required a lower level of acute medical care. Areas which were in use as escalation areas at the time of our inspection, and which we visited, included EDDU, the medical interventions day unit (MIDU), a step down facility next to the acute medical unit, a discharge lounge, and a day case unit.

We found concerns regarding levels of care in some of the escalation areas we visited. We found, in many cases, the escalation areas were used to provide in-patient beds for elderly people, some of whom had dementia. When we spoke to ward matrons, it was unclear who had overall responsibility for patients in these areas. Sometimes staff were unaware of the reasons patients were in the escalation areas and could not explain their plans of care. Some of the patient records we saw were confusing, incomplete and hard to follow. In almost every patient record we saw, there were no care plans and risk assessments were inconsistent. Where there were care plans, they were often contradictory and there were no associated risk assessments. Some of the more confused patients we spoke with said they did not know why they were in hospital. Staff told us some of the patients did not have any nursing needs and were waiting for social services to organise a package of care for them. They also said that the target was for patients in escalation areas to be discharged within 72 hours of their arrival but that this target was often missed, sometimes by weeks. Some of the patients we spoke with told us they had been on the unit for some time, anywhere from three days to five weeks. The patient records we looked at showed some patients were placed in escalation wards for four or more weeks.

On the first day of our inspection, we visited the EDDU. Staff told us there were five patients who were over the age of 75 and who should have had a dementia screen in line with trust guidelines. We checked the medical records for all five patients; none of them had a dementia screen. Two of the patients had arrived in EDDU the day before and three had arrived during the night. Two of the patients were clearly confused and did not understand what was happening around them. Staff were not sure how to communicate with the two confused patients. In two instances, we saw staff ignore these patients when they needed assistance.

Staff told us two of the elderly patients on the EDDU ward were at risk of falls. When we checked those patients' medical records, there were no falls risk assessments. The nurses on duty said patients did not have falls risk assessments in EDDU. Instead, nurses on the unit reviewed each patient's medical history and from this identified whether a patient was at risk of falls. The lack of a falls risk assessment being undertaken may have led to a patient having a fall which could have been prevented if control measures were put in place in a timely way. Trust board minutes, from May 2013, showed that incidences of falls were above the national average but were decreasing in comparison to previous months.

The rehabilitation / physiotherapy outpatients department was also in use as an escalation area on the first day of our inspection but we were unable to visit the area on that day. When we visited the following day, the department was no longer being used as an escalation area and was empty. Staff confirmed the escalation area had been in use the day before. They expressed serious concerns about the quality of care provided to in-

patients while the escalation area was up and running. They told us it was not an appropriate place to care for in-patients. They said seriously ill patients and patients who required considerable medical support and personal care were admitted to the area. One member of staff described the level of care there as "appalling." A series of weekly reports from April 2013, provided to us by the trust, documented serious failings in the level and quality of care given to patients in this escalation area. One of the reports, dated 22 April 2013, noted the area was staffed by one senior nurse and one healthcare support worker. It also recorded "there are four patients on rehab who require the assistance of two staff. Three out of four of these patients are being nursed in bed with all four patients being incontinent and requiring regular changes, turning and assistance/supervision with feeding." The same report noted these patients had not been washed because there was a shortage of bed sheets. The area was not closed as an in-patient area until the second day of our visit.

A number of patients we spoke with said staff did not respond quickly to call bell requests. One patient told us he sometimes waited up to 20 minutes for a member of staff to respond to the call bell. He said staff would then cancel the call bell, get distracted by something else, and fail to return. He then had to press the call bell again. This was a particular difficulty for him because he needed assistance to use the toilet and used the call bell to request this assistance. Another patient told us he did not need his call bell himself but used it to call staff when other patients needed assistance.

None of the call bells on the EDDU were within reach of patients. In two instances, the call bells were mounted to the wall and hidden behind chairs. When we asked staff about this they told us patients did not need call bells during the day because they could call out to staff when they needed assistance. During the course of an hour, we observed one patient call out to staff on numerous occasions for something to eat or drink. Staff did not respond until we intervened on the patient's behalf. Requiring patients to call out for assistance was of particular concern as two of the three female patients appeared to be very confused and would not have known who to call.

We found a similar issue on ward 18 where call bells were out of patients' reach and some were wrapped around chairs which were adjacent to patient beds. Call bells were also stored out of reach on wards six, nine and the acute medical unit (AMU). One of the patients we spoke with on the AMU told us her call bell did not work. She showed us the manual bell she kept on her table and which she used to ring for assistance. We observed another patient in the same bay who was confused and very distressed. She was unable to call a member of staff for assistance which seemed to increase her agitation.

There were emergency planning protocols at strategic and operational levels. They included arrangements for working as part of a multi-agency response to an emergency.

Cleanliness and infection control ✖ Action needed

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was not meeting this standard.

There were systems in place to prevent and monitor the spread of infection but where concerns were identified, they were not always addressed. Systems for monitoring hand hygiene, infection control, and cleaning standards were fragmented. Standards of cleanliness and infection control were not satisfactory in some areas. Staff were able to access infection control advice.

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

Reasons for our judgement

Staff were familiar with infection control polices and procedures. We observed staff used alcohol gel to disinfect their hands, gloves, and aprons to minimise the risk of spreading infection. Staff followed protocols for the separate disposal of domestic and clinical waste. There were documented divisions of roles and cleaning responsibilities relating to nurses, domestic cleaners, and estates. Staff understood their respective roles. There were ward level cleaning audits which showed high levels of compliance with cleaning standards on some wards. These were not monitored at corporate level to ensure standards were maintained.

Staff told us they could access infection control advice from the hospital's infection control team if they needed it. There was an infection control lead for the hospital and each ward was supported by infection control link nurses. At senior level, there was a Director of Infection Prevention and Control.

Infection related to meticillin-resistant Staphylococcus aureus (MRSA), meticillin sensitive Staphylococcus aureus (MSSA) blood stream, and Clostridium difficile were monitored by corporate management at divisional and board levels. Senior managers also monitored compliance with hand hygiene protocols and the results of infection control and hygiene audits. Outbreaks of infection were reported as incidents and investigated. Action was taken in response to outbreaks of infection.

Infection control arrangements were audited at ward level by the hospital's infection control team as part of their annual programme. These audits assessed compliance against a number of areas including general ward environment, waste handling and disposal, safe handling and disposal of sharps, cleaning and decontamination of patient equipment and medical devices, hand hygiene, and handling and disposal of linen.

Many of the audit results we were shown recorded poor compliance with infection control standards relating to the ward environment. There was no evidence areas of non compliance were addressed. A report provided to the trust's infection control committee by one of the trust's clinical divisions, in April 2013, noted that divisional compliance is above target but audits from specific areas "are patchy and some areas need to demonstrate significant improvement."

An infection control standards audit of A&E, completed by the hospital in July 2012, showed an overall compliance with infection control standards of 56%. During our visit, we found many of the concerns raised by the July 2012 infection control audit in A&E were still outstanding. These included intravenous (IV) fluids stored in an open corridor which was unsupervised and unlocked; vials of emergency drugs left on countertops when they should have been stored in locked cupboards; lack of a cleaning schedule or check list for cleaning trolleys; and equipment being visibly unclean. We also found one mattress and three hospital trolleys stained with a substance that looked like blood, inappropriate storage of dirty linen, and lack of storage space. Compliance with hand hygiene standards, assessed as part of the July 2012 audit, was assessed as 61%. A further audit, from April 2013, showed 45% compliance with hand hygiene standards.

When we visited ward areas, we found there were usually sufficient handwashing facilities including sinks, liquid soap, and paper towels. Alcohol gel for hand hygiene was also available and we saw staff using it. Many patients told us they were satisfied with the cleanliness of the ward they were on, but some of the patients we spoke with were not. Our observations of environmental cleanliness gave equally mixed findings. On some wards we found no significant hygiene concerns while on others we did. We found the floor around one patient's bed was visibly dirty and there were ants crawling on a nearby window ledge and on the curtains around the bed. On another ward, we found an air mattress in the toilet; it was due to be removed for decontamination. In one instance we found bags of incontinence products strewn across two armchairs; rubbish on the windowsill in one of the bathrooms; and clinical stores and equipment piled into the handwashing area of the same bathroom. We found an IV trolley in a treatment room with dried blood and old tape. There was rubbish in two of the trolley's drawers.

We found a clinical waste cupboard which was open and freely accessible to the public. It should have been locked and the door to the cupboard had an electronic key pad. Even after we brought this to the attention of staff and the ward matron, the cupboard remained open. Dirty utility rooms were not always kept locked and often were freely accessible to patients and visitors. There were no cleaning records available for the dirty utility rooms we saw. In one of the utility rooms, we found a pile of bags containing dirty linen on the floor obstructing access to the handwashing sink. Chlorine tablets were stored in unlocked cupboards.

We found particular concerns around infection control arrangements for the physiotherapy out patients / rehabilitation unit which had been used as an escalation area up until the second day of our inspection, 8 May 2013. When we visited this area there were no patients present, however, we found it was dirty with dust visible on surfaces such as ledges. Paint was also seen to be peeling from the walls and ceiling. There were no hand wash sinks. An infection control report, dated 9 April 2013, condemned the area for use as an in-patient escalation area and identified a number of serious concerns regarding infection control arrangements. Similar reports dated 22 and 29 April identify concerns about infection control. The concerns we observed were identified in the infection control audits.

There were male and female toilets outside the escalation area. These were for use by in-patients and out patients. The toilets themselves were in urgent need of repair. The bathrooms were dark and dingy; the floor and surfaces were visibly dirty; toilet brushes were strewn on the floor; and the floors were cracked and broken. The floor covering underneath one of the toilets in the women's bathroom were cut out from the rest of the bathroom flooring and replaced with a wooden covering. The wooden covering was stained and dirty.

During our observation in the escalation area we also looked at the physiotherapy gym, which was adjacent to the escalation area. This area showed poor levels of cleanliness. The walls were dirty and paint was flaking from the walls. Fitness equipment was covered in dust. The rubber physiotherapy balls were visibly dirty. Staff told us a physiotherapy assistant came in every two weeks to clean the equipment. We saw cleaning records for the gym. Between January and April 2013 there was no recorded cleaning of the equipment. The last recorded date was 29 April 2013.

Throughout the hospital, we found a shortage of storage space. We found large items such as bed frames, chairs, and mattresses were stored in the hospital's main corridors. Hoists, walkers, wheelchairs, laundry, and boxes were found on ward corridors. We found one instance where one of two bathrooms was used for storage leaving one available shower for the 26 patients on the ward. Storing equipment in this way poses a risk that cleanliness standards will not be maintained because staff access is blocked. There is also a risk that decontaminated equipment will become contaminated.

Management of medicines ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There was a system for identifying and correcting prescribing errors. Medicines related incidents were reported. However, patients were not protected against the risks associated with medicines because drug storage arrangements were inadequate. Where concerns were identified by the trust's pharmacy team, they were not addressed.

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

Reasons for our judgement

This outcome was inspected as a result of concerns we identified during our inspection visit.

During our visit, we observed the door to two of the treatment rooms we visited were open. On ward four, the treatment room door was propped open with a battery pack for a hoist. Although there was a mechanical digital lock on the door, staff did not know the code for opening the lock. The treatment rooms could be accessed freely by patients and passersby. The controlled drugs cupboard was locked but the remaining cupboards were unlocked. They contained various tablets, capsules, and liquid medicines. We found injection trays on the counter top. These contained ampoules of medication. One of them was adrenaline. Needles and syringes were stored in this room. The treatment room being open was a particular risk on this ward because a number of patients had dementia and were confused.

There was a refrigerator for storing insulin and other medicines. It was unlocked. There was no thermometer to show the temperature at which the refrigerator was operating. Maximum and minimum temperatures were not recorded this meant that staff could not identify if the temperature of the fridge went outside the suitable limits for storage of the medicines it contained. We also found that the lighting in the room was poor. There were four overhead banks of fluorescent lights, three of which did not work. This meant that visibility when checking writing on ampoules could be difficult. These same concerns were identified on ward four in a drug storage audit done in February 2013 by the trust's pharmacy team. Although there was an action plan to address the concerns, we found it was not implemented. Drug storage audits of other wards showed similar concerns and they were not always addressed. We checked the refrigerators in a number of treatment rooms. We found that minimum and maximum temperatures were not monitored to ensure medicines were stored at correct temperatures. One member of staff told us "we're trying to work something out with the pharmacy team.

A number of concerns were identified by a drug storage audit undertaken in A&E in February 2013. The audit found that a number of standards relating to medicines management were not met. These included inappropriate storage of refrigerated medicines, lack of ward level standard operating procedures, failure to monitor the minimum and maximum temperatures of the drugs refrigerator, crash trolleys not being secured with tamper evidence seals, deficiencies in stock checking and ordering. Concerns about the storage of emergency medicines were also raised in an infection control audit from July 2012. At the time of our visit, we observed emergency medicines continued to be stored on countertops and within easy access of patients.

On four of the wards we visited, we found that cabinets which were used to store patients' medication, called pods, were broken. Two of the patients we spoke with told us their medicines had gone missing. Staff told us they had been broken for some time. On one ward, we found the medicines for all the patients on the ward were stored in one cupboard.

Minutes from the trust's medicines safety group meeting in December 2012 identified concerns about the inability to lock pods. The minutes noted medication regularly going missing and an increased need to reconcile drugs as a result of the broken pods. The trust's risk assurance framework identified the storage of medicines on wards as a risk. Staff told us there had been plans to replace the pods but these were put back to finance the hospital's new GP unit.

We spoke to the relatives of one of the patients on the acute medical unit (AMU). They told us that although the patient's medicines were recorded by staff has having been administered, staff were not supervising the patient to ensure he swallowed the tablets. In the patient's confused state, he frequently failed to take his medication and the patient's tablets were found in his bed by his relatives. This happened twice on the dame day. The patient's relatives told us that when they approached the nurse on duty to raise their concerns with her, she became aggressive. They then raised the concern with the ward matron but told us they continued to find tablets in the patient's bed.

There were arrangements for reporting medicines related incidents. Trust board minutes from May 2013 show that these incidents were monitored by the board. There was a system for identifying and correcting prescribing errors. The trust board minutes for March 2013 showed that the pharmacy team reviewed 177 drug charts and corrected 48 prescribing errors.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Although there was a trust wide-recruitment drive in progress, at the time of our inspection there were not enough qualified, skilled and experienced staff to meet people's needs. There were high vacancy rates in some services and on some wards. The trust relied heavily on bank and agency staff to fill shifts, particularly in escalation areas. There were many instances where shifts were short staffed.

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

Reasons for our judgement

This outcome was inspected as a result of concerns we identified during our inspection visit.

The patients we spoke with were almost unanimous in describing staff as "very busy." However, how well patients felt their needs were met differed between wards. Some patients told us staff responded to call bell requests quickly and provided them with the care and support they needed despite being busy. Some patients had more negative experiences. They told us staff did not respond quickly to call bell requests and they often had to wait for some time before getting the help they needed. One patient explicitly stated that the ward he was on sometimes seemed to be "short staffed" and, as a result, he sometimes had to "wait for pain relief." Another patient told us staff seemed to "rush, rush, rush."

We found a number of concerns about staffing levels and arrangements for managerial supervision. The Emergency Department Decision Unit (EDDU) did not have a ward manager to supervise the day to day care of patients. Staff told us the unit shared a ward manager with the accident and emergency department (A&E) because the EDDU was supposed to be part of A&E. We found that the ward managers were unable to supervise staff in EDDU because the demands and challenges of A&E required their presence at virtually all times.

Similarly, we had serious concerns about staffing in rehabilitation / physiotherapy out patients when used as an inpatient escalation area. A report dated 22 April 2013, noted the area was staffed by one senior nurse and one healthcare support worker. It recorded "there are four patients on rehab who require the assistance of two staff. Three out of four of these patients are being nursed in bed with all four patients being incontinent and requiring regular changes, turning and assistance/supervision with feeding". This area was

not being used as an escalation area at the time of our visit.

Staff across the hospital told us they felt there were insufficient numbers of staff to meet the needs of patients. They told us they felt they were under considerable pressure to take on more responsibilities and to work longer hours. The majority of staff we spoke with told us they worked additional shifts to ensure there were enough experienced staff on duty at any one time. A number of staff told us they regularly worked additional hours, sometimes up to two hours a day, which were outside their contracted hours and which were unpaid. Minutes from a joint clinical quality review group, from a meeting in March 2013, noted concerns around A&E staff working additional hours. One member of staff told us that working extra, unpaid hours "was expected." Staff told us there were no arrangements to provide cover for staff on long term sick leave which resulted in some wards being understaffed for long periods of time. On the days we visited there were sufficient numbers of consultants and doctors on the A&E and we saw that people were seen by a doctor in a timely manner.

Staff told us staffing was often inconsistent and risked a lapse in continuity of care for patients. They said nurses and healthcare assistants were often taken at short notice from one ward to make up for staffing shortages on another. The nurses and healthcare assistants could be deployed on any ward in the hospital. This left a shortage of staff on the ward from which the nurse or healthcare assistant was taken. We were told that the ward manager could request bank or agency staff to cover unfilled shifts but the shifts were rarely filled.

On a number of wards, staff expressed concerns about the way in which staffing numbers were decided. They told us that the number of nurses and healthcare assistants which were allocated to wards was based on calculations from a computer programme designed as a workforce planning tool. The use of this tool was confirmed by members of the executive board. Ward staff said, however, that the tool was outdated and did not reflect the current volume of patients for which staff had responsibility or the level of sickness with which patients were admitted to hospital. Staff said there was no connection between the needs of patients on the wards and the number of staff required to meet those needs. We were told that meeting people's needs was particularly challenging when patients had dementia because no additional staffing support was provided for patients with dementia.

We sampled staff rotas across five wards and looked at staffing arrangements for three days in the month of May, chosen at random. We found the rotas reflected the concerns staff raised with us. There were high vacancy rates on five of the wards whose staff rotas we saw. One ward had eight vacancies and there were ten vacancies split between three other wards. The rotas showed shifts on these wards were often filled by agency or bank staff or by the ward matron. Staff rotas showed a heavy reliance on agency and bank staff. The records for one escalation area showed exclusive use of agency and bank nurses and healthcare assistants at night. There was a lack of continuity of staff as the staff on duty were rarely the same individuals. The rotas also showed the same area was short of a healthcare assistant on two shifts each day.

The rotas also showed the wards were short staffed on at least one shift every day, frequently more. One ward was short one staff nurse on every shift we saw and, on some shifts, was two staff members short. We found that ward matrons often provided clinical cover when they were supposed to be engaged in managerial activities, in order to make up staffing numbers. Two of the wards we visited had staff who were on long term sick leave. The rotas showed no provision was made to provide staff cover during their

absence.

The trust's operational performance report from February 2013, which was presented to the trust board in April 2013, found vacancy rates overall were falling with the trust recruiting to 317.17 whole time equivalents (WTE). However, it identified some very specific staffing risks, for example, 17% of speech and language therapy (SALT) staff being on maternity leave. The report noted this as a particular risk because a high number of referrals were being made to the SALT team and new referrals were taking longer to complete. The report stated the subsequent impact was delayed discharges, increased length of stays for patients, and stress to staff. The report also highlighted a higher than expected number of sickness absences over the past year in one of its clinical divisions.

The trust's risk assurance framework, which was presented in a report to the trust's board in April 2013, identified a number of concerns about staffing. These concerns included a shortage of medical clinical leadership in one of its divisions; challenges in recruitment and retention of nurses and middle grade doctors; a shortage of radiologists; and a shortage of nurses and healthcare support workers. The risk assurance framework also recorded a lack of additional support from occupational therapy, physiotherapy, and speech and language therapy to meet the needs of patients in the new modular ward.

Assessing and monitoring the quality of service provision

✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

In managing the unexpectedly high demand on its accident and emergency department and the knock on effect on in-patient beds, the trust failed to ensure the quality of patient care. The trust had systems in place to assess and monitor the quality of the services people received but did not respond effectively to concerns which were raised. There were inadequate systems in place to identify, assess, and manage risks to the health, safety and welfare of people who use its services and others.

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

Reasons for our judgement

In line with national trends, the trust's accident and emergency department experienced unexpectedly high demand for its services over the winter period and had continued to do so since that time. Information given to us from Monitor and from the trust, showed the demand for the trust's A&E services had an adverse impact on its ability to meet its targets in relation to the four hour A&E waiting time, ambulance handover, and elective procedures. The demand placed on the trust's A&E service also contributed to a need for in-patient beds which the trust was not equipped to meet.

Information provided to us from the trust and other stakeholders showed the trust took steps to address these issues. The trust raised concerns about the level of demand and the trust's ability to cope under such pressure with its executive board, commissioners, and other stakeholders. Arrangements were put in place to reconfigure the A&E service and to create additional capacity within the trust through the installation of two new modular units. The trust also brought in an external A&E improvement group to look at ways in which it could improve patient flow. Processes were put in place to track the availability of in-patient beds throughout the day and to provide the trust with an early warning of bed shortages.

Board minutes showed rigorous monitoring against national and local clinical targets. The minutes from May 2013 showed a failure to meet targets in relation to A&E access within four hours; stroke care; and cancer screening and treatment.The minutes also showed the hospital made good progress in assessing patients for thromboembolism (VTE) and the proportion of assessments completed significantly exceeded the national average. The percentage of patients with a urinary tract infection was higher than expected and was

almost double the national average. Information given to us from Monitor showed the hospital was in breach of its four hour emergency access target for quarters three and four of 2012/13.

In focusing on the management of its capacity pressures, however, we found the trust failed to respond to concerns about poor patient experiences and to patient safety risks. Although there were a number of systems in place to identify poor standards of care, these were often ineffective. Executive members of the board undertook "walkabouts" on wards to talk to patients and staff about their experiences but there was no formalised process for monitoring and investigating the concerns which were raised. Quality rounds were undertaken by senior staff to test various aspects of care provided to patients. We found the implementation of quality rounds varied from ward to ward and some quality rounds were more rigorous than others. We also found that where concerns were raised by quality rounds, they were not always addressed. For example, the quality rounds documentation we saw identified concerns around care planning, documentation, and treatment room doors being left open. During our visit, we found these issues were not resolved.

Ward drug storage audits, copies of which were given to us by the trust, identified concerns about the way in which medicines were stored across a number of wards. On our visit, we found the concerns they raised were not addressed. An audit of ward four in February 2013 found the drug room door was propped open by a pedal bin and that a secure key pad was needed for the drug room door. It also found that the cupboards holding medicines were not locked and that fridge temperatures were not monitored. Although there was an action plan in place and a keypad lock was installed on the door to the drug room, we observed the door to be open and unsupervised during our visit. Staff did not know the code for the keypad and so could not enter the room.

An infection control standards audit of A&E in July 2012 identified concerns about the cleanliness of equipment and the environment; lack of a cleaning schedule for trolleys; resuscitation equipment not being checked once a week rather than daily; inappropriate and unsafe storage of medicines; and IV fluids stored unsupervised in an open corridor. Our observations of the A&E department found these issues were not addressed.

Trust board minutes from May 2013 showed monitoring of patient experience targets and identified concerns around patient experiences. However, there was little evidence that the trust used patient experience information to drive improvements to its services. The 2012 adult in-patient survey was published in April 2013. It included information from people who were in-patients at the trust between June and August 2012. On eight out of ten patient experience indicators, the trust scored worse than other trusts of its kind. Trust board minutes from May 2013 acknowledged the publication of the survey results and noted the results would be reviewed by the board at its meetings in July 2013. When we asked board members what the key concerns identified by the adult in-patient survey were, some of them were unable to answer the question. This was a particular concern because the trust's results for the survey were exceptionally poor.

Risks to patient safety and to the safety of others were identified and monitored which included those we identified during our visit. There was an organisational level risk assurance framework which identified the trust's most significant risks. This was supported by divisional risk assessments which recorded risks specific to individual clinical divisions within the trust. Trust board minutes from April 2013 showed that the trust's risk assurance framework was reviewed by the board. However, where risks where identified, they were

not always addressed and resolved. There were a number of examples.

We found poor standards of record keeping in all 12 of the patient records we checked. Documentation which was given to us by the trust showed poor record keeping was a long standing, well known, and recurring concern. According to the trust's risk assurance framework, risks related to poor standards of clinical documentation were recorded in the register in February 2013. To address the issue, a new quality of clinical documentation group was to be established by 1 April 2013. At the time of our inspection in May, the group was not yet established despite poor clinical documentation being listed as one of the trust's top risks.

Failure to respond to complaints within "agreed timescales" was added to the trust's risk assurance framework in April 2012. A review of its quality governance, commissioned by the trust and published in December 2013, found there was a lack of adequate follow up at divisional level of complaints and incident investigations. Board minutes from March 2013 noted on-going concerns regarding the trust's complaints process and that the complaints process was under review.

The risk assurance framework showed "concerns were raised by the [physiotherapy team] regarding [the] safety and dignity of in and outpatients within the [rehabilitation] unit" as a result of using the unit as an escalation area. The risk was added to the framework in April 2013. Action taken is recorded as "all risk assessments completed" and dated 5 April 2013. When we asked the trust for copies of risk assessments for the use of the unit as an escalation area, we were told there were no documented risk assessments. Escalation area reports for 9, 22, and 29 April 2013 identified on-going concerns in unit around the environment, infection control and staffing. They also raised concerns about the placement of highly dependent patients on the unit because it was not equipped or appropriately staffed to provide care to patients who needed more than minimum care and attention. When we spoke to trust board members, some of them were not aware of the seriousness of the patient safety concerns raised in regards to escalation areas.

Minutes from the trust's medicines safety group, dated December 2012, noted a number of incidents related to POD lockers including the inability to lock the pods. It noted medication regularly went missing when patients transferred from A&E to the acute medical unit and this was linked to a number of POD lockers being broken. Medicines storage and transfer of medicines with patients was identified as a risk in the trust's risk assurance framework in February 2013. Throughout the trust we identified concerns regarding the storage and transfer of medication.

The trust failed to respond to concerns identified by staff. This was evident in A&E where trust staff and paramedics told us there were times when the department was so busy that the safety of patient care was compromised. A&E staff told us they raised concerns about patient safety with their managers but their concerns were not addressed. Minutes from the clinical quality review group, a group co-chaired by the trust and former primary care trust, dated 26 March 2013, noted the concerns about staffing and safety raised by A&E staff. Staff we spoke with in A&E told us they felt disempowered and unheard. Staff throughout the hospital and at all levels told us they found it difficult to raise concerns. They told us they felt their concerns would be dismissed and said they were reluctant to discuss concerns with corporate managers because they feared reprisal. Many of the staff we spoke with were aware of the trust's whistleblowing procedures but told us they were afraid to use it.

There were systems in place for reporting incidents and monitoring incidents at all levels of the organisation. Staff were familiar with protocols for reporting incidents and showed us the electronic database on which incidents were recorded. Reported incidents were monitored at board level and reviewed by the trust's patient safety group. Serious incidents involving patient death or significant harm to patients were reviewed by the trust's serious event incident panel and learning points were identified.

Although the trust reviewed serious incidents which were reported, we found staff did not always report less serious incidents or potential incidents (also called 'near misses') which had or could have had a significant and detrimental impact on care given to patients. When incidents where reported, they were not always reviewed in a timely manner. Some of the incidents we saw recorded on the trust's incident reporting database were overdue for investigation and response. Minutes from the May 2013 board report stated that the trust was working through a back log of incidents. It suggested the back log was caused by staff absences from the team responsible for monitoring the incident management database. Failure to review and investigate incidents in a timely manner may lead to a delay in implementing adjustments to practice or protocols which may place patients at continued risk of harm.

The minutes of the May 2013 board meeting also noted staff were given protected time to investigate complaints and incidents. Ward matrons, however, told us they were not given sufficient time to investigate incidents. Some of the ward matrons told us they were not always sure who had responsibility for following up investigations of incidents.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Accurate and appropriate patient records were not maintained. People were not protected from the risks of unsafe or inappropriate care which was a result of poor record keeping.

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

Reasons for our judgement

In all the patient records we saw, we found poor standards of record keeping. Patient records were often incomplete. This posed a particular risk to patients because of the transience of staff on some of the wards and the trust's reliance on bank and agency staff. There was a risk that patients would receive care from staff who were not familiar with their treatment plans and who would rely on patients' records for information about care and treatment.

Throughout the hospital, we found inconsistent risk assessment of patients' needs and very little documented care planning. In some of the patient records we saw, there were risk assessments which were clearly linked to patients' specific needs. These included risk assessments for venous thromboembolism (VTE), pressure ulcers, moving and handling, infection control, malnutrition, and falls. In the vast majority of the patient records we saw, however, risk assessments were either not completed at all or were incomplete. Where risks were identified, there were rarely any documented care plans to show how the risks should be addressed and monitored. In one instance, we found a number of care plans but these often conflicted with one another and did not relate to the patient's risk assessments. There was inconsistent use of an early warning scoring system to identify when patients' health was at risk of deterioration. We found that an early warning scoring system was used in only one of the patient records we saw. The use of such a system is recommended by the Royal College of Physicians so that clinical staff can identify and respond to patients whose medical condition worsens while in hospital.

Discharge arrangements were rarely documented in patient records. There was a section for documenting discharge information which was included in the hospital's standard nursing documentation. These were frequently left blank. In two of the patient records we checked, we found patients were discharged home from an earlier admission to hospital, only to be re-admitted within two or three days. In one of these cases, the patient was originally diagnosed with "confusion" and he was discharged without support even though his medical records stated he lived alone. The patient's medical records showed he had been in hospital for almost three weeks. In the second case, the patient was re-admitted

by their general practitioner because of reduced mobility. At the time of our visit, the patient was waiting for a nursing home placement and had been in hospital for more than three weeks. Many of the patients we spoke with were not sure when they would be discharged.

In all but one of the records we saw, there was no recording of do not attempt cardiopulmonary resuscitation (DNACPR) decisions. In January 2013, the failure to communicate DNACPR decisions was identified as risk in the trust's risk assurance framework.

In one of the patient records we saw, we found a complaint about the continued use of a nasogastric (NG) feeding tube despite the patient's request that it be removed. The patient's preference was not documented in their clinical records. The patient's relative was told by a nurse that the feeding tube would not be removed until an assessment was done by a speech and language therapist but that the speech and language therapy (SALT) service was delayed because of the bank holiday. When we spoke to the ward matron, we were told an SALT assessment was completed for the patient and there was a clinical need for the NG tube. This was not documented in the patient records and was not communicated to either the patient or the relative. In the same patient record, we found poor record keeping led us to conclude the patient's antibiotics, which were given intravenously, were discontinued because of an inability to find a vein. When we queried this with the ward matron she explained that the patient was given oral antibiotics and acknowledged this was not recorded in the patient's nursing notes.

Patient records were also poorly organised and maintained. Medical records were often fragmented. On some wards, there were different sets of records for nursing and medical notes and these were not stored together. In addition to nursing and medical notes, patients' drugs charts were not always kept with nursing or medical notes. We also found information about care organised for patients was sometimes recorded on the trust's real time electronic record system but not in their medical or nursing notes. This posed a risk that patient information about patients' care or treatment would be lost and / or that patients would receive inappropriate care.

In A&E, patient records were not bound together to prevent sections being lost. We found one page of a patient's medical records lying on a table. It was impossible to identify the patient to whom the notes referred. On one ward, patient notes were so poorly organised we could not determine what care patients were supposed to receive. When we asked ward staff assist us in making sense of the risk assessments and care plans, they were unable to do so. On another ward we found records relating to several patients all in one file. This made it difficult to find individual records when they were required. When we requested patient records in order to track patients' care, there were two occasions on the AMU and ward seven where staff found it difficult to find patient records. In one of these instances, they were unable to locate the patient record which we requested. On ward nine, there were different sets of records for nursing and medical notes and these were not stored together.

Concerns about poor record keeping were identified some time ago and continued to be unresolved at the time of our visit. A report published by the Ombudsman in 2012 identified inadequate recording of patient records. Notes, dated January 2012, from the trust's clinical effectiveness group showed that attendees were advised that the use of loose leaf notes in patient records should be reviewed and addressed. Minutes from the trust's medicines safety group, dated December 2012, noted that nursing notes are kept

separate from medical notes on some wards and can be "difficult to source." They noted an incident in which poor record keeping led to an overdose because a revised prescription was not transcribed. Concerns raised in the group's review of another incident during the same meeting included concerns regarding inaccurate documentation.

The trust's serious event review panel, in its review of incidents on 8 January 2013, noted that one of the problems in responding to complaints was the delay in finding case notes and that it was "not a speedy process." In its notes, the panel also identified concerns about the quality of case notes which was, according to the notes, being investigated through two work streams. All the ward level quality rounds we saw, barring one, identified concerns about record keeping and patient documentation. These included incomplete documentation and missing care plans or nursing assessments. A report to the trust's infection control committee, in April 2013, records a lack of documentation for intravenous cannulae and the trust's average for lack of documentation was recorded as 24% non compliance. Ward drugs storage audits from this year also identified poor record keeping in relation to medicines management.

On a number of wards, we found patient records were not always stored securely. There were several occasions where confidential patient records were freely accessible to patients, visitors, and passers-by. We found sets of patient records at an unattended ward reception desk. A trolley containing patient records was stored in a treatment room whose door was supposed to be closed and locked but which we found to be wide open. On one ward, patient records were stored in metal filing cabinets which were stored in an open corridor connecting the male and female sides of the ward. The filing cabinets were situated where they could not easily be seen by staff and could be easily accessed by anybody passing through. The drawers to the cabinet were not locked. The ward matron told us the drawers should have been locked.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: There were insufficient arrangements for ensuring patients' dignity, privacy and independence. The trust did not encourage patients, or those acting on their behalf, to understand the treatment choices available to them. The trust did not give patients, or those acting on their behalf, an opportunity to express their views about what was important to them in relation to their care or treatment. Regulation 17 (1) (a) (2)(a)(c)(f)
Regulated activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The trust did not ensure patients were protected against the risks of receiving care or treatment that was inappropriate or unsafe. Patients' needs were not always assessed and the delivery of care did not always meet patients' individual needs. The welfare and safety of patients was not always ensured. Regulation 9(1)(a)(b)(ii)

This section is primarily information for the provider

Regulated activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: The trust did not ensure patients, staff, and others were protected against identifiable risks of acquiring a healthcare associated an infection through the maintenance of appropriate standards of cleanliness and hygiene in relation to the hospital environment and equipment. Regulation 12(1)(a)(b)(c) (2) (c) (i) (ii)
Regulated activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The trust did not protect service users against the risks associated with the unsafe storage of medicines. Regulation 13
Regulated activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The trust did not take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed to provide care and treatment to patients. Regulation 22

This section is primarily information for the provider

Regulated activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The trust did not ensure that patients were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them. Patient records did not always reflect the care and treatment provided to patients. Records were not always kept securely and were not always able to be located promptly when required. Regulation 20 (1)(a)(2)(a)

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

The provider's report should be sent to us by 19 July 2013.

CQC should be informed when compliance actions are complete.

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

This section is primarily information for the provider

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

Enforcement actions we have taken

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

We have served a warning notice to be met by 12 August 2013 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The trust did not protect patients against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable it to regularly assess and monitor the quality of the services. It did not operate effective systems designed to identify, assess and manage risks relating to the health, welfare and safety of patients and others. The trust did not make changes to the treatment or care provided in order to reflect information relating to the analysis of incidents that resulted in, or had the potential to result in, harm to patients. Regulation 10(1)(a)(b) (2)(c)(d)

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

About CQC inspections

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

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

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

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

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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