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

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Tel: 01753633356

Date of Inspections: 21 October 2013
19 October 2013
17 October 2013
16 October 2013

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

Respecting and involving people who use services	✖	Enforcement action taken
Care and welfare of people who use services	✖	Enforcement action taken
Cleanliness and infection control	✖	Enforcement action taken
Management of medicines	✓	Met this standard
Safety and suitability of premises	✖	Action needed
Safety, availability and suitability of equipment	✖	Action needed
Staffing	✖	Enforcement action taken
Assessing and monitoring the quality of service provision	✖	Enforcement action taken
Records	✖	Enforcement action taken

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

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Wexham Park Hospital had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Cleanliness and infection control
- Management of medicines
- Safety and suitability of premises
- Safety, availability and suitability of equipment
- Staffing
- Assessing and monitoring the quality of service provision
- Records

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 16 October 2013, 17 October 2013, 19 October 2013 and 21 October 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 were accompanied by a pharmacist, reviewed information sent to us by other regulators or the Department of Health, talked with other regulators or the Department of Health and took advice from our specialist advisors. We 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

At our previous inspection of Wexham Park Hospital in May 2013, we found the hospital was in breach of a number of regulations and, in many instances, delivered care that was below essential standards. There were particular concerns about the care provided to patients in the accident and emergency department (A&E) and the impact this had on the ability of in-patient wards to provide essential standards of care required by the regulations. Following that inspection we issued a warning notice to the trust against regulation 10: assessing and monitoring the quality of service provision.

Our inspection in October 2013, to which this report relates, was a follow up inspection to determine whether the trust had addressed the concerns we raised during our previous inspection. We inspected the hospital's accident and emergency department (A&E),

emergency department decision unit (EDDU), acute medical unit (AMU), medical intervention day unit (MIDU), and wards 1, 3, 4, 5, 7, 9, 17, and 18. We also inspected in-patient paediatrics, the neonatal unit, diagnostic imaging, and rehabilitation. We also inspected the hospital's maternity service in response to concerns which were raised with us. This included triage and assessment, labour ward, post natal ward, and birthing centre. We tracked care pathways for 12 patients, looked at 24 sets of patient records and 45 drug charts, interviewed 137 members of staff and 3 paramedics, and spoke with 56 patients and/or their relatives.

We found the trust had made significant improvements in some areas, particularly in managing capacity issues in A&E and ensuring the movement of patients from A&E and onto in-patient wards. At the time of our inspection, the A&E department was undergoing an expansion and refurbishment programme. Dedicated facilities for assessing and treating patients were newly in place. There were improved systems for assessment and triage, reduced waiting times, and improved arrangements for protecting patients' privacy and dignity. Standards of care and clinical assessment in the EDDU were improved. Two new wards had been developed to provide additional hospital beds and reduce the hospital's need to use escalation areas. New systems were in place for setting up and opening areas which were not normally used to accommodate in-patients, called escalation areas. We found the storage of medicines was better managed.

A number of wards we inspected were well led and well managed. These included wards 1, 3, and 5 as well as MIDU and the neonatal unit. Patients on these wards were pleased with the care they received and spoke highly of the staff. We observed staff worked well together as a team; patient records were up to date; the wards were clean; and patient care was of a high standard.

We re-visited the medical wards we had previously inspected and found marked improvement in the standard of care provided on some but not all of them. We had particular concerns about the leadership and management of AMU / ward 7 and ward 4. On these wards, we observed many instances of poor practice where the quality of care fell significantly below essential standards. Patients' privacy and dignity was not always respected; medical and nursing notes were not complete or up to date; there were poor arrangements for ensuring the confidentiality of patient records; and standards of hygiene and cleanliness were not maintained. These wards were also found to be consistently short staffed. The care some patients received was below essential standards and put them at risk of harm. We raised our concerns with trust managers during our inspection so that safety issues could be addressed immediately.

We found many areas of the hospital were in need of refurbishment and redecoration. Signage was poor and many people told us they found it difficult to find the area of the hospital which they needed. There were inadequate arrangements for ensuring hospital facilities and equipment were appropriately maintained. With limited exception, we found patient areas across the trust to be dirty and dusty. In some instances, the poor condition of the premises prevented the proper cleaning and disinfection. Equipment was not always cleaned or replaced when needed.

There were systems in place to identify risks to patient safety and maintain the quality of services. As we found in our previous inspection, however, these were often ineffective. There were examples of breaches in care that were not picked up through the trust's quality monitoring arrangements. We found staff did not always comply with trust policies and procedures. Specific examples of this which we found were not identified by the trust. Staff did not always report incidents of harm to patients. There were systems in place for

implementing National Institute for Health and Clinical Excellence (NICE) guidelines but the use of the guidelines was not robustly audited. Where audits raised concerns, the concerns were not always addressed. The use of national guidelines other than those published by NICE were not systematically implemented, monitored or audited.

While lessons from incidents and complaints were identified by managers and clinical leads at governance meetings, they did not always translate into changes on wards or in clinical practice. Lessons learned were not always communicated to staff on ward level. On the labour ward, midwives and doctors told us lessons learned from a series of serious patient safety incidents were not communicated to them. They felt this contributed to tensions between labour ward staff and to the development of a culture of blame and suspicion.

There was a lack of engagement between trust managers and ward level staff. Staff did not feel they were encouraged or empowered to raise concerns and make suggestions for improvement. A number of staff across the hospital expressed concerns about bullying and harassment from managers. In some instances staff raised concerns with us but told us they were reluctant to speak with us for fear of reprisal from their managers and asked not to be named.

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 08 January 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to local area team (NHS England), General Medical Council, Monitor, Health and Safety Executive and Local Authority: Commissioning. We will check to make sure that action is taken to meet the essential standards.

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 ✖ Enforcement action taken

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.

Patients' privacy, dignity and independence were not always respected. Their views and experiences were not taken into account in the way the service was 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 taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Standards of privacy and dignity in some areas of the hospital were improved since our last inspection, most notably in A&E and EDDU. On many of the wards, we observed staff speaking courteously and professionally to patients and their relatives and responding to their calls for assistance. Many of the patients we spoke with on the medical and surgical wards felt staff treated them with respect and took steps to provide as much privacy during consultations and examinations as hospital facilities permitted.

Privacy and dignity arrangements in A&E during triage was significantly improved. This was mainly due to an expansion of the A&E department since our last inspection and the provision of a dedicated space for triage and assessment of patients. We found patients who attended A&E via ambulance were taken directly into the rapid access treatment area and were assessed there by clinical staff. After having this assessment, patients were either discharged or taken to individual cubicles in another area of the department to await further treatment. At this inspection, we did not observe any instances of patients queuing on trolleys while waiting to be seen by a clinician.

Although the improvements to the physical layout of A&E resulted in improved arrangements for respecting patients' privacy and dignity, we observed instances in A&E where staff behaviour showed a disregard for patients' privacy and dignity. The curtains in the cubicles in an area of A&E known as 'Majors A' were not drawn between patients. We found a patient whose blanket had fallen down to their ankles and who was then exposed from the waist down. He was visible to all passers-by in the area. When we brought this patient's condition to the attention of a nurse, she made a hand signal to demonstrate the patient was drunk and shrugged her shoulders. This was in front of other patients and

staff. Staff told us, as they did in our previous inspection, they did not draw curtains because they needed to observe patients who were connected to monitors. When we checked, we found only a few patients were actually connected to monitors or other equipment that required direct supervision by staff.

We observed adequate standards relating to privacy and dignity on many of the wards we inspected, however, we found consistent and frequent breaches of privacy and dignity standards on AMU and Ward 7. Although these two wards were divided into male and female in-patient areas, we found several of the isolation rooms on the female side were occupied by male patients. Staff on the female side of the ward told us this was because they needed to place the male patients in isolation rooms and the isolation rooms on the male side of the unit were all occupied. We found one bay area on the male side which was occupied by women. Staff told us this arrangement was in place because there were not enough beds with equipment to monitor patients' vital signs on the female side of the ward. Female patients were put into available beds on the male side because the male side had available beds with monitoring equipment.

There were inadequate arrangements to ensure the privacy and dignity of patients in these mixed gender areas. The doors to the isolation rooms used by the men on the female side were left open. The position of the beds in those rooms allowed the men to observe the female in-patients and be seen by them. There were no designated female toilets on the male side and no designated female toilets on the male side. When we asked staff on the male side of the ward where the female toilets were, they were unable to tell us.

During one of our inspections of the AMU / Ward 7, as we entered one of the bays, we observed staff assisting a patient to use a commode by their bed. The curtains around the patient's bed were not drawn and their attempts to use the commode were observed by the three other patients in the bay. The curtains were drawn around the patient when staff saw our inspectors enter the bay. The other patients in the bay told us this was routine staff behaviour. In one instance, we observed the nurse in charge of Ward 7 respond to a patient complaint by asking "how do you expect me to know?" When we asked the sister in charge about the patient, she described the patient as "depressed" and "bipolar." We asked about the process for referring patients for mental health assessments. The nurse in charge was not able to tell us how to access mental health support for patients. She said "[the patient] doesn't need that."

We observed staff on AMU / Ward 7 provide personal care to patients without any verbal interaction with them. On two occasions, we observed two staff members pull the curtains around the patient receiving care. Staff on the ward told us it was standard practice to close curtains when they gave patients personal care. On one occasion, we observed no conversation took place either between staff members or between the staff members and the patient. The care was provided in silence; there was no verbal interaction with the patient. On another occasion, we overheard staff have a discussion about the hospital's Care Quality Commission inspection while they provided a patient with personal care. The conversation continued for just over eight minutes. There were no verbal interactions between staff and the patient during this period.

We were approached by the family of a patient who was admitted to the AMU. We were told the patient had been instructed by ward staff to urinate and defecate in her bed, which the patient had done, but that staff had failed to clean the patient for several hours after the event. We subsequently met the patient and found staff cleaning the soiled mattress and replacing it with a new one. When we asked staff what had happened, they refused to speak with us. We looked at the patient's nursing and medical notes. We found that the

patient had been seen by a nurse at some point in the morning but no further care was documented for the rest of the day.

On Ward 17, we saw a nurse empty and change a patient's catheter bag in full view of other patients and visitors with a patient in an adjacent bed. Both patients and visitors expressed embarrassment to us about the event but staff did not appear to notice. Several members of staff witnessed the changing of the patient's catheter bag and failed to intervene or draw the patient's curtains closed to provide privacy for the person.

We received mixed responses from patients about their involvement in decision making and in staff communication. Many patients commented positively on this issue. One patient on ward 4 told us "they have told me what is happening right from the start and I have no problems except the nurses seem so busy." A patient and his wife, on ward 7, said they were "happy with the care we have received" and felt that "the communication has been good and the staff are lovely." Comments from a number of patients on ward 18 included "I am well cared for," "the nurses are kind," and "the sisters are lovely."

An equal number of patients commented on the lack of involvement and poor communication they experienced. One patient on the AMU told us "the treatment here has been good but the communication is sometimes a problem because the staff don't seem to understand." Other comments from patients on this ward were "I have been waiting all day for a scan and now I have no idea what is happening because they don't talk to me" and "my problem is that they [staff] do not seem willing to share information with me and I have had tests but not heard anything." These views were supported by the trust's own assurance checks, called quality rounds, which were undertaken on AMU on 16 and 17 October 2013. These found some patients did not feel involved in their care planning or involved in making decisions about their care.

A few families described some of the doctors on the post natal ward as "rude." Some of the parents on the postnatal ward also said they were not always told what would happen next or when. For example, one couple was told their child would be transferred to the special care baby unit immediately. When we spoke with them four hours after this was agreed, the baby had not been transferred. The parents were not told the reason for the delay and were very anxious.

A number of patients and their relatives also raised concerns about last minute changes to discharge arrangements and how this was communicated with them. We found this was a particular issue on ward 4 and the AMU. Relatives told us they would be called by the hospital to collect the patient from the ward or discharge lounge but, on arrival were advised that the patient would no longer be discharged. Patients and relatives told us they were not given an apology or an explanation for the change in discharge arrangements. One of the patients we spoke with, who had communication difficulties but who managed to speak to us with the help of the patient in an adjacent bed, told us she had been due to go home the day before and had been "dressed ready for discharge" but had then been "returned to the ward, undressed and put back by her bed." The patient went on to say that "no one explained anything to me and I was very distressed." Another patient we spoke with confirmed this and said "she just sat there and cried." When we asked the sister on duty about this issue, she was not aware of it.

Several relatives expressed concerns about the lack of information given to them when they called a ward to enquire about a patient's condition or to make arrangements for the patient, for example, transport arrangements. They said, when they telephoned, they were told they could not be given any patient specific information because their identity could

not be confirmed. On one occasion, we observed a member of staff on ward 7 answer the telephone and say "I can't tell you anything because I do not know who you are." When we asked staff about the procedure for providing patient information over the telephone, we were told relatives were sometimes given a password which they could use when they called in order to verify their identity. Staff told us this system did not always work and was not used across the hospital.

Relatives told us they were not always able to get a hold of staff on the ward when they rang on the telephone. We spoke with two visitors, on different wards, who had rung after hours to enquire about the condition of their relatives who were in hospital. They told us no one had answered the telephone and so they travelled to the hospital to check on their relatives' condition. During our out of hours inspection, we observed the telephone ring at the nurses' station on ward 4 for five minutes and it was not answered.

Many patients criticised the limited choice of menu options and found the meals on the menu were unappetising. They felt there was an insufficient variety of meals on the menu and questioned why there were so many cheese based meals. One patient told us "I think they have shares in a cheese factory as there is quite a lot of cheese on that menu." Another patient said "[the food] is hot when it arrives [but the selection of meals given are] not the right ones." Patients who were admitted to the hospital for extended stays told us the menu was not changed from time to time to give them "some variety." Several patients of Asian background were not aware there was an additional menu available with alternative choices which might better suit their cultural preferences.

Care and welfare of people who use services ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not consistently planned and delivered in a way that was intended to ensure patients' safety and welfare. Patients were not always given the care and treatment they needed. This was a particular concern on the AMU / ward 7 and ward 4.

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

We found patients received good care on wards 1 and 3 (surgical wards) and on ward 5 (medical ward). Patients on these wards felt well cared for and spoke highly of the staff. Parents on the inpatient paediatric unit were complimentary about the care their children received, particularly from nurses. Standards of care provided in some areas were significantly improved since our last inspection, most notably in A&E, EDDU, MIDU and ward 5. However, the quality of care remained inconsistent across the hospital's medical inpatient wards. Of particular concern at this inspection was the quality of care given to patients on AMU / ward 7 and ward 4.

At the time of our inspection, the A&E department was undergoing an expansion and refurbishment programme. We found improved systems for assessment and triage. Dedicated facilities for assessing and treating patients, called rapid access treatment (RAT), were newly in place. The RAT worked well and encouraged the movement of patients through A&E. We observed a patient come in with chest pains. The patient was seen immediately in RAT by a doctor. We looked at the patient's initial care plans and assessments; these were clearly written and showed the use of professionally recognised clinical guidelines.

The handovers we observed between hospital staff and ambulance crew were efficient and quick. Ambulance crew commented that the hospital's A&E was a "major improvement." They told us that since the RAT area was opened, handovers were quicker and they no longer queued along the corridor with patients or waited to transfer them to A&E staff. There was a significant reduction in breaches of the four hour A&E waiting target for discharge or admission to a ward.

Doctors, nurses and other healthcare staff worked well together. We spoke with the stroke coordinator who was in A&E during one of our inspections of the department and looked at

the documented stroke pathway. It was good, easy to understand, and clearly linked to NICE guidelines. There were effective links with the region's trauma network and staff understood the procedure for transferring patients to more specialist trauma centres.

While the standard of care on A&E was satisfactory, there were some staff practices which concerned us. A patient told us that on two occasions, after arriving at A&E with chest pains, they were asked by reception staff to have a seat in the waiting room and wait there to be seen by a doctor. These instructions were contrary to a sign at reception which indicated people attending reception with chest pains should be seen by a doctor immediately. We raised our concerns about this incident with the ward sister. They told us the hospital's policy is that patients who attend A&E with chest pains must be seen and assessed by a doctor as soon as they arrive in A&E. The ward sister also told us the receptionist was new and had induction training but was not able to explain why the receptionist failed to follow the hospital's policy.

On one occasion, we observed a nurse approach a queue of patients who were waiting to be seen and ask each one in turn for their name and the reason for their visit to A&E. This was because there was a breakdown in communication which involved a lack of handover from one team to another. In the event, the nurse managed the situation well. None of the patients needed urgent medical attention and none had conditions which would have rendered it inappropriate for them to wait for an assessment.

Standards of care and clinical assessment in the EDDU were improved. One of the patients we spoke with told us "staff respond when I need them" but also that she "was told I needed a scan yesterday but have not heard anything since." Staff told us there was more management and supervision of EDDU than there had been at our last inspection. They said they felt there was more leadership on the unit and they were better supported. They also told us the EDDU was used strictly as a short stay unit where patients stayed for up to 48 hours. We saw evidence of this on the second day of our inspection when we found the patients with whom we had spoken in EDDU the day before had been moved to the AMU.

At the time our inspection, we did not observe any areas which were being used inappropriately to accommodate patients for whom there were no beds on the hospital's established wards. The use of areas which are not usually used to accommodate inpatients, called escalation areas, was restricted. Staff told us new procedures were in place for identifying and approving the use of such areas for inpatient care. Two new wards were opened to provide additional hospital beds and reduce the hospital's need to use escalation areas for patient admissions.

There were improved arrangements for ensuring patients with dementia were cared for on in-patient wards rather than in escalation areas. We observed a number of interactions, mainly on wards 5 and 18, between nurses or healthcare assistants and patients who were confused and, sometimes distressed. Staff were able to reassure these patients and calm them. There were instances, however, when staff were seen to be short tempered with confused patients and caused patients distress. Some members of staff told us they had dementia care training and that it helped them to provide better care to patients. Others were not trained or were not sure they had training.

Women who used the hospital's maternity service said they felt involved in developing their birth plans and had sufficient information to enable them to make choices about their care and treatment during labour. They felt well cared for by midwives and said that personal care was given with professionalism. All but one of the women we spoke with said they

had adequate pain relief during and after labour and were given information about pain relief choices. Women who had emergency caesareans to deliver their babies told us the risks of surgery were explained to them. They also said that although they had not planned to have a caesarean section, they felt they had a positive birth experience. Women on the postnatal ward and their partners praised the care they received from midwives on the ward.

We found examples of good care on many of the wards we inspected but we also observed examples of poor practice which were common across in-patient wards. Where risks to patients were identified, they were not always addressed or monitored. Some patients who were assessed as needing a pressure relieving mattress to prevent the development of pressure sores, did not always have them. Patients who were at risk of malnutrition or dehydration were not always given assistance to eat and drink.

The trust used a document called "intentional rounding" to monitor and record care which was given to patients. It specified a series of checks which staff were required to do for each patient and how often these checks had to be done. The frequency of checks varied between patients, depending on their need. In almost every set of patient records we saw, excluding those on wards 1 & 3, we found patients were not checked as often as their intentional rounding documentation required. This was a persistent issue on the AMU/ ward 7, ward 4, and the post natal ward. Staff told us there was not always enough time to complete all the tasks which were required of them, including filling in the intentional rounding documentation. They said they were not always able to check patients as often as they should and often the checks were done but not recorded. Relatives of two patients we spoke with told us they had observed occasions where staff completed the intentional rounding forms but did not actually do the required checks.

On ward 4, intentional rounding for one patient showed they were required to have certain checks every two to three hours throughout the day to prevent them from developing pressure ulcers. According to the intentional rounding form, between 10 October and 13 October 2013, there were 11 instances where checks were recorded as having been provided at far greater intervals than planned. On five of these occasions, there was a 7.5 hour or more gap between documented checks. On one occasion, there was an 11.5 hour gap and on another, there were no checks recorded at all after 1.00 pm. We cross checked the information in the intentional rounding tool with the nursing notes; there was no evidence in the nursing notes that the checks were completed and documented there instead. The failure to carry out checks and observations as stipulated in the patient's intentional rounding forms put the patient at risk of receiving inadequate care to ensure their safety and welfare.

Again on ward 4, we checked the intentional rounding records of a patient who was initially supposed to have four hourly checks which later in their stay changed to two hourly checks. Between 4 October and 16 October, there were 19 instances where checks were recorded as having been provided at far greater intervals than planned. On eight of these occasions, there was a nine hour or more gap between documented checks; on two others the gaps were in excess of 11.5 hours; and on three days no checks were recorded between the early afternoon or evening and the morning of the next day. We cross checked the information in the intentional rounding tool with the nursing notes; there was no evidence in the nursing notes that the checks were completed. The failure to carry out checks and observations as stipulated in the patient's intentional rounding forms put the patient at risk of receiving inadequate care to ensure their safety and welfare.

When we looked at patient records, we found instances where nurses did not deliver the

care specified in patients' care plans and occasions where nurses did not follow doctors' instructions regarding the frequency of observations or checks which were requested. For example, on AMU / ward 7, a patient with an insulin infusion was required by a doctor to have their blood sugar level monitored every hour. When we looked at the blood sugar level checks, we found that immediately after the doctor's order the checks were done hourly but later on the same day were done two hourly. There was no evidence in either the medical or nursing notes that the doctor's instructions to nursing staff had changed. Also, no reason for the change to the frequency of observations was documented in the patient's nursing notes. When we raised this issue with the nurse responsible for this patient, she was unable to explain why the frequency of blood sugar level checks had changed. She told us she would find a doctor to change the instructions regarding the frequency of the checks. When we returned later to check the patient's record, we saw a doctor had amended the instruction to nursing staff regarding the required frequency of observations to two hourly observations. The patients' records did not document the reason for the change. The failure of staff to carry out prescribed checks and observations put the patient at risk of having their blood glucose level drop too low before being detected causing seizures, other adverse outcomes or even death.

On ward 4, we observed one instance where a very fragile patient, in considerable distress, complained of chest pains and waited 40 minutes for an electrocardiogram (ECG) to be recorded. An ECG checks a person's electrical activity of the heart. At 2.00 p.m. the patient experienced chest pains. At 2.30 p.m., the patient's relative raised concerns with us regarding the delay by clinical staff in recording the ECG. Nurses on the ward told us that a doctor had requested a set of observations and an ECG to be performed twenty minutes before we arrived on the ward. The doctor confirmed this with us. We spoke with the nurse responsible for the patient's care. She was aware the observations and ECG had not been done but did not appear to be overly concerned. The ECG was completed at 2.50 pm. The delay in recording an ECG put the patient at risk of not receiving care and treatment which they may have needed.

On ward 18, we observed a patient's intravenous (IV) infusion pump in alarm; the pump had stopped infusing due to a blockage in the infusion tubing. We observed the staff response to the IV infusion pump alarm. We found it took ward staff 10 minutes and 52 seconds to check the pumps, silence the alarm, and correct the blockage to allow the IV infusion to continue. They delay in responding to the IV infusion pump put the patient at risk of not receiving the medication they needed.

On the AMU, we spoke with a patient who told us her "leg needed to be raised at all times" but that her leg "continued to slip off the pillow." She explained that she had called a nurse to "put it back for me but the nurse lifted my leg by the toe [that was injured] which caused me great pain." The patient told us they did not think the nurse intended to cause them pain but felt the nurse "did not know anything about me or why I was there." The failure of staff to understand the patient's care and support needs put the patient at risk of receiving unsafe care and/ or causing them unnecessary pain and distress. The patient also said "because you came to speak to me they have treated me very quickly this morning. It is the quickest I have been washed and tidied up."

We spoke with relatives of patients on two different wards who said staff failed to provide basic care when partners or relatives stayed with patients for long periods of time during the day. They said ward staff assumed relatives would provide personal care, assistance with eating, support to mobilise, and give medication. We were told these arrangements were not discussed with patients or relatives but that the care was "simply not provided." In one instance, we found the relative wearing an apron and gloves, provided by ward staff,

to give personal care to the patient in lieu of the staff. The failure of staff to communicate with and implement plans of care for patients and their relatives put patients at risk of receiving inadequate and unsafe care.

We received information from support workers who care for people with learning disabilities. They commented on what they felt was a poor level of support from hospital staff for patients with learning disabilities. Their main concerns were that hospital staff had a poor understanding of individuals' needs; were not trained in how to communicate with patients who have learning disabilities; and did not share sufficient information with support workers to enable them to adequately support the patients in their care. The trust's risk assurance framework, which was presented in a report to the trust's board on 3 October 2013, noted concerns about the availability of trained and experienced staff to lead and advise on learning disabilities issues. The inability of staff to communicate with and support patients who had learning disabilities put patients with learning disabilities at risk of receiving care which did not meet their needs.

Cleanliness and infection control ✖ Enforcement action taken

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 inadequate systems in place to prevent and monitor the spread of infection from one patient to another. 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 inadequate in many areas.

We have judged that this has a moderate 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

With the exception of wards 1, 3, 5, MIDU, the neonatal unit, and the physiotherapy gym, cleaning standards across much of the hospital were not improved since our previous inspection. The hospital was not appropriately maintained in some areas and this made cleaning difficult because the surfaces and areas were not always able to be satisfactorily cleaned or decontaminated. We also found that cleaning standards were not always audited. Staff hygiene practices were sometimes inadequate. There were particularly poor standards of hygiene on AMU / ward 7 and ward 4.

We found many of the hospital's wards and clinical areas were dusty and unhygienic. Sticky residue from adhesive tape was not properly removed from equipment or clinical surfaces which made them difficult to properly clean and disinfect. Drip stands were not cleaned properly; one nurse told us they cleaned IV drip stands by putting them in the shower. On one ward, we found IV drip stands stored in the shower room and saw they were rusty. Rust prevents equipment from being effectively cleaned. This presents a risk of cross infection when rusty equipment is used by more than one patient.

Some trolleys which were used for patient care were dusty and dirty. When we asked ward staff to show us how they cleaned the trolleys, they told us they only cleaned the top surface of the trolley rather than the whole trolley. The wheels of many of the trolleys were dirty and rusty. There were no systems for marking equipment as having been cleaned and ready for use. The infection control team told us staff were prevented from using systems to identify trolleys as being clean because there was an assumption that if a trolley was put away in storage, it was clean. Mobile equipment which is not cleaned properly poses a risk of cross infection between patients.

In A&E, one of the clinical treatment rooms and the minor operating room were very dirty. Shelving, flooring, lighting, and equipment were covered by a layer of dust. When we touched the shelving in the minor operating room; the finger print marks were clearly visible several hours later when we revisited A&E. This showed that cleaning had not occurred since we last looked at the shelving and equipment in that room. This was the despite several patients having been treated in the room between our checks. The minor operating table itself was covered with dust, hair, and small bits of unidentifiable material. Several work surfaces in resuscitation were dirty. In an area of A&E called Majors C, blood pressure monitoring equipment was sticky with old adhesive tape, the ledges were dusty and the sinks seals were exposed and had buildt up lime scale. The water cooler, which was used by patients and visitors, was dirty and caked with lime scale. Limescale build up prevents equipment from being effectively cleaned. This can present a risk of cross infection between patients and can encourage the growth of legionella, a water borne bacteria.

We observed some nurses thoroughly wipe down all mattress surfaces but others only wiped down mattress tops. When we asked who was responsible for cleaning mattresses, nurses gave us different answers. Some nurses told us they were responsible for cleaning mattresses and trolleys. Other nurses told us cleaners were responsible for cleaning mattresses and trolleys and nurses were responsible only for wiping down mattress tops between patients. We looked at a record of cleaning checks for A&E and found many gaps where the checks were not recorded as having been done. Where cleaning checks were recorded, they showed A&E was found to be clean. No concerns about cleanliness were recorded against these checks.

Cleanliness standards varied across the maternity unit. In the assessment and triage area balls of dust and hair were clearly visible on the floor. There was a layer of dust on several pieces of equipment and on the shelving in clinical areas regularly used to assess and monitor women in labour before admitting them into the hospital. In one of the rooms there was a very large number of dead insects in the light fixture; the light fixture was directly above the bed which women used when they were assessed. In the same room, we found a jug of discoloured water. Staff told us this was so they could give women water when they needed it. Staff were not able to tell us how long the jug of water had been kept in the room. In the foetal assessment unit cubicles, the bed frames and cardiotocography (CTG) machines were dusty and the surface of the cupboards was sticky. A CTG machine records foetal heart rate and contractions during a woman's labour and delivery of a baby.

The rooms used for labouring women on the labour ward were clean. However, the room with the birthing pool and the ward's storage areas were dusty. Many of the doors and surfaces on the labour ward were chipped, making them difficult to clean. In the labour ward theatre, we found the resuscitaire (equipment used to provide care and warmth to babies just after birth) was dusty and diathermy equipment (a piece of equipment used in surgical procedures) was stained. Staff told us the cleaners on the labour only worked part time and they needed additional cleaning support. They also said that over bank holiday weekends, theatres were not deep cleaned for three days. Staff told us they had voiced their concerns about the inadequacy of the ward's cleaning arrangements to senior staff but did not feel the issue was addressed. The postnatal ward was generally clean although the resuscitaire in the nursery was dusty and a bin full of dirty nappies was used to hold open a door on the main corridor.

The shelves, curtain rails, radiators and beds (called plinths) in the outpatients' rehabilitation area were covered in dust. We showed this to the physiotherapists on duty who acknowledged our findings but expressed surprise at the level of dust. They were not

sure who was responsible for checking the cleanliness of the department. A substance that looked like black oil was leaking from one of the plinths. Equipment in the diagnostic imaging department was very dusty. We used a white tissue to wipe the surface of a CT scanner; the part of the tissue which made contact with the CT scanner turned a dark grey with dust. In the interventional radiology room, blood was splattered around the base of the table which patients used and in cracks of the table. Staff told us this area was difficult to clean. Failure to maintain hygiene standards presents a risk of cross infection between patients.

Many of the medical adult in-patient wards we inspected were not clean and we had particular concerns about hygiene and cleanliness on AMU / ward 7 and ward 4. The physical environment of these wards was dusty, dirty, and deteriorated. When we checked the cleanliness of curtain tracks on these wards, large clumps of dust fell down from them. Bed frames, equipment, trolleys, and shelving were dusty. Windows and window sills were dirty. The fabric and material of some of the physical surfaces, for example, around sinks, door frames, cupboards, walls, and radiators were in such a state of disrepair that they could not be cleaned properly. We found significant deposits of lime scale on some of the hand wash sinks. Limescale build up prevents equipment from being effectively cleaned. Failure to ensure facilities and equipment are adequately cleaned and decontaminated presents a risk of cross infection between patients.

On one occasion, we found a bag of IV fluids, an insulin infusion syringe, and associated IV tubing discarded in a hand wash sink in one of the bay areas on the AMU. On another occasion, we entered the AMU to find dirty laundry strewn across the ward's main corridor. When we spoke with staff about this, they told us the dirty laundry had not been collected since the night before. A member of staff told us she "had called the relevant department which [she felt had been] caused by a shortage of staff with the contractor who collected the laundry." The failure to ensure soiled laundry was stored appropriately and collected promptly resulted in a risk of spreading bacteria between patients, staff, visitors and contaminating equipment.

On ward 7, we found crockery and cutlery and toast left beside a clinical sink along one of the main corridors. The sink itself had a wooden splash back which was encrusted with lime scale. Three drip stands and a ladder were stored in a bathroom which was used by patients. The sluice hopper in one of the sluice rooms had large deposits and debris under the rim and the hopper was very stained. The macerator in the same sluice room was broken and a yellow bag containing used disposable bedpans and urinals with bodily fluids on them were inside of it. The yellow bag should have been contained in a bin and the contents of the bedpans should have first been disposed of in the sluice hopper. We brought this to the immediate attention of senior managers who removed the bag. The arrangements for storing and cleaning equipment and for waste disposal presented a risk of spreading bacteria between patients and to other people.

When we inspected the ward the next morning, the bag had been reattached to the macerator and we found used bedpans and urinals in it again. Staff on the ward were not aware that the practice of using the yellow bag in this way was not an acceptable practice for infection control purposes. When we returned to ward 7 on another day, we found a notice on the sluice room door stating that the room was not to be used "at all." We observed a cleaner in the room and found the cleaner removing a yellow clinical waste bag for disposal. When we looked in the bag, we found used disposable bed pans and urinals despite the sign on the door. Inadequate practices for disposing of human waste presents a risk of spreading bacteria between patients and to other people.

On ward 4, the medication room was tidy but the stacking units for storage were dusty and dirty. Plastic boxes with syringes and other equipment inside of them were dirty. The tops of the drawers were encrusted with unidentifiable dried liquid. Four trolleys, used to support patient care, had dirty wheels and wheel guards. The male sluice was clean and tidy but the commode lids were dirty on the sides and underneath with what looked like faecal matter. A sign on the door to a store room stated "Do not place stores on the floor. The floor space must be free of storage at all times." We found over a dozen boxes on the floor, four IV stands, one set of steps, yellow bins and sharps bins. Many sinks had lime scale around the taps. The sink by the nurses' station had a piece of plinth missing, making it difficult to clean. The white sealant on the skirting board was coming away in many places. Inappropriate storage arrangements and a failure to maintain good hygiene standards presents a risk that patients could be treated with dirty or contaminated equipment.

On most of the medical wards we inspected, we observed an unusually high number of open bottles of a disinfectant wash called 'Hibiscrub' in toilets and shower rooms and on windowsills and counter tops. This product was used to prevent the spread of meticillin-resistant staphylococcus aureusis (MRSA). Staff told us they bathed patients with it as a matter of course in order to reduce the spread of infection and that doing so had been a very effective way to keep infection rates controlled. The trust's policy required the daily bathing of patients with Hibiscrub. However, in order for Hibiscrub to be effective, the trust policy stated it must not be diluted. We found that although staff regularly used the Hibiscrub when washing patients, they often diluted it. The trust's infection control team told us they had identified this concern previously but the practice continued. The practice of using diluted Hibiscrub to wash patients presents a risk the Hibiscrub will not disinfect patients' skin and therefore will be ineffective in reducing the risk of cross contamination of MRSA.

As we found in our previous inspection, there were ineffective systems for identifying and monitoring poor hygiene. The trust's infection control team continued to audit infection control standards at ward level on an annual basis. However, as before, staff told us wards which were found to be below the trust's minimum threshold for compliance were not routinely reaudited to ensure non compliance was resolved. Where concerns about cleanliness were identified at ward level, they were not escalated through the hospital's clinical governance structures nor were they addressed. The infection control team showed us an infection control escalation policy but this was not signed off by the board for publication at the time of our inspection and so was not used by staff. Inadequate arrangements for monitoring and identifying breaches in hygiene standards puts patients at risk of harm caused by the spread of infection.

We spoke with the hospital's infection control team and with the trust's managers who told us ward matrons were responsible for maintaining and monitoring cleanliness and hygiene on their wards. We were told it was at the ward matron's discretion how this was done. They said concerns in hygiene and cleanliness would be identified through checks undertaken by the hospital's compliance team which was responsible for ensuring basic standards of quality were met at ward level and by daily quality rounds which were completed by ward matrons or ward sisters.

The documented quality round for ward 4 on 15 October 2013, confirmed that the cleanliness checks for the shift were done. It included a comment from the ward sister which stated they were not happy with the cleanliness of the ward that day and that "night staff keep the ward clean and tidy but the multidisciplinary team makes it difficult to keep the ward tidy no matter how many times they are told." In the quality round for ward 7, on

the same day, a ward sister reported that "equipment is not clean / dust free" but that they were "satisfied with [the] cleanliness of the ward."

An infection control standards audit, completed on ward 4 on 24 October 2012, noted a compliance score of 67% for the general ward environment. It also found "there was visible dust on high and low surfaces and the air vents. A majority of the hand washing facilities are visibly dirty with lime scale present…clinical room: the shelves, the benchtops and cupboards are dirty and marked and are need of regular cleaning…the floor edges have visibly dust and grit…" We found similar concerns on this ward during our inspection.

An audit tool called a "Care Setting Process Improvement Tool: In & Out Patient Areas / Departments" was completed for AMU in July 2013 by an associate advanced nurse practitioner for infection control employed by the trust. A copy of this was given to us by the trust during our inspection. The audit found that the overall score for infection control for the ward was 75% compared to the trust average score of 82%. The audit also found that not all furnishings and fittings were visibly clean or in a good state of repair; not all surfaces were smooth, impervious with coved edges for easy cleaning; floor and hand wash basins were not visibly clean; bed and trolley bases not visibly clean and free from dust; not all cupboards were visibly clean; macerator or bed pan washer was not visibly clean; commodes were not in good state of repair; items were not stored appropriately; dirty linen was not stored in a designated area until collected. These findings were almost identical to those of our inspectors during out inspection.

A similar audit was undertaken for ward 18 in August 2013. It found that the overall score for infection control for the ward was 76% compared to the trust average score of 81%. The report found that the furniture, hand wash sink, beds and trolley bases were not visibly clean; the environment was not free from visible damage; and furnishings and fittings were not visibly clean. The cleanliness of the sluice area was of particular concern as was the cleanliness of mobile equipment such as drug trolleys, notes trolleys, and mobile x-rays. Concerns were also noted about stethoscopes and suction machines not being clean and dry.

The associate advanced nurse practitioners who undertook the audits attended the trust's infection control committee meetings. When we checked minutes from the July 2013 infection control committee meeting and the infection service quarterly reports to the infection control committee between January and June 2013, we found no evidence the concerns identified in the audits were discussed. We asked trust managers where the findings from these audits were reported. They were unable to tell us. We looked at divisional healthcare governance meetings. We found that while infection control issues were often discussed in the context of limiting the spread of microbes, there was no evidence that issues relating to environmental cleanliness were considered.

The infection control team told us they did environmental audits of cleanliness and reported their findings to the infection control committee. We saw documentary evidence of this, however, the report of audit findings to the infection control committee was limited to compliance scores which were highly aggregated. Where a ward achieved, for example, 82% compliance there was no information regarding areas where the ward might have fallen significantly below expected standards. In the environmental audits we saw, a ward could achieve compliance above the 80% threshold but still have significantly low scores for the cleanliness of the general ward environment, cleaning of patient medical equipment, or handling and disposal of linen. The findings were also limited to those wards which met or exceeded the trust's 80% compliance threshold. Inadequate arrangements

for reporting and monitoring breaches in cleaning standards posed a risk that the trust might not detect concerns cleanliness.

We spoke with staff from the estates department and cleaning team. They told us audits of cleanliness were done by an auditor in the estates department who worked independently from the department. They said the auditor did not have sufficient time to undertake a full cleaning audit of all patient areas as recommended in national cleaning standards. However, they also said there were plans in place to extend their working hours to enable this. Inadequate arrangements for monitoring and identifying breaches in cleanliness and hygiene presented a risk the trust might not be able to take remedial action when required.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

At this inspection we looked at medicines management within the hospital due to non-compliance with this outcome identified at the inspection in June 2013.

During this inspection we looked at the management of medicines, medicines storage, records relating to people's medicines and talked to two pharmacists and eight nurses working on three wards, three other in-patient areas and the accident and emergency department. We spoke with one patient, who stated that they had been given sufficient information about their medicines.

Appropriate arrangements were in place in relation to obtaining medicines. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual patient basis, arrangements were in place for the units to obtain medicines outside of normal hours. Medicines for discharge were ordered from the pharmacy, with an average waiting time of between 70 and 100 minutes once the prescription had reached the dispensary. Therefore medicines were available when people needed them.

Medicines were prescribed and given to people appropriately. Appropriate arrangements were in place in relation to the recording of medicines. The prescriptions and records of administration that we looked at were clear and complete. Therefore people were receiving their medicines as prescribed.

Medicines were kept safely. The trust's pharmacy conducted an annual medicines security audit in November 2012, this was due to be repeated in November 2013. The wards also conducted their own audit every three months; five examples were provided, these contained action plans where any discrepancies were noted. The ward staff were checking controlled drugs every 24 hours in line with the Trust medicine management policy and controlled drug record audits were being completed every three months.

Emergency medicines were kept on both the wards and other in-patient units; we saw evidence that they were being checked on a daily basis. All stock medicines were stored in locked cupboards, within secure rooms and all patient own medicines were stored in locked dedicated lockers at the bedside. Intravenous fluids were stored in locked rooms; the provider may find it useful to note that some boxes were stored on the floor. The

minimum, maximum and current temperatures of the medicine refrigerators were being monitored at on a daily basis on all areas inspected; the provider may find it useful to note that on one ward area there were gaps in the records for a number of days in the last month. The ambient temperatures of medicine storage areas were also monitored and action was taken when the temperature exceeded 25 degrees Celsius. Therefore the trust could assure itself that medicines had been stored at the correct temperature and were safe to use.

Medicines were managed safely. We looked at how medicines were handled and saw appropriate arrangements were in place for confirming and reviewing people's medicines on first admission to hospital. When patients were admitted to the hospital doctors recorded and prescribed their medicines. This was checked by the pharmacy team to make sure all the information was correct.

We asked the chief pharmacist about the arrangements for auditing medicines handling at the hospital. A programme of audit was in place and there were clear procedures for reporting and acting upon information from medicines audit. All the nursing and pharmacy staff we spoke with were aware of how to report any medicines incidents and the chief pharmacist explained how these were monitored and assessed. Incidents involving medicines were recorded on an incident reporting system and the pharmacy department recorded the pharmacist interventions once a month. The information from these systems about medicine errors and the quality of prescribing were graded and used to identify trends to determine actions needed to prevent their reoccurrence.

Safety and suitability of premises ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People who use the hospital, staff and visitors were not protected against the risks of unsafe or unsuitable premises.

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.

The overall hospital estate was in need of significant and urgent maintenance and redecoration. Many of the hospital's public thoroughfares and clinical areas were poorly maintained. In some cases, this posed an actual risk of harm to the health and safety of patients, visitors and staff. The poor physical condition of some of the medical wards, particularly the AMU, meant that many areas could not be properly cleaned. The impact of the estate's poor condition on infection control arrangements was noted by the infection control team in their reports to the trust's infection control committee.

Throughout the hospital, we found chipped walls and woodwork. On some of the hospital's main corridors, there were broken windows. In the hospital's main reception, we found dirty seating and a seat which was so damaged that the inner wooden frame jutted out of the fabric cover. The concerns we raised at our previous inspection about the male and female bathrooms outside of the outpatients rehabilitation area were not addressed. We found an A4 sheet of paper with the words "out of order" scribbled on it outside one of the toilets in the female bathroom and a broken window in the male bathroom. Walls and doorframes on the labour ward were chipped, cracked and broken in many places. One of the doors on a corridor leading to a labour ward theatre was smashed in. When we asked staff what happened to the door, they could not remember. They told us it had been there for so long they no longer noticed it.

There was a lock on the door to ward 18 which worked when the door was forced closed, but the door did not lock because it did not shut properly inside the door frame. A portable air conditioner in the clinical treatment room on ward 4 was not installed properly. It was placed on a countertop and a plastic tube attached to the back of it carried water to a bowl on the floor in the middle of the room. The bowl of water was a trip hazard to staff that entered and used the room. The overhead lights in the same room were filled with insects and were attached to the ceiling with strong, black tape. We observed the wall and ceiling near the changing rooms in the radiology department to be stained and discoloured. Staff

told us a radiator had "exploded" some time ago and it had left these stains. While the radiator was removed, the stains were not. This was visually apparent and indicated appropriate maintenance had not occurred to correct the paint on the wall or the ceiling panel above it.

Throughout the hospital we observed evidence of water damage from leaks in the roof. There were large patches of peeling, flaking and stained paintwork on ceilings. This was particularly evident in outpatients' rehabilitation, radiology, and a number of in-patient wards. Staff told us the roof leaked whenever it rained and that it was a constant challenge to contain and manage these leaks. Early one morning during one of our inspections, we found a section of ceiling in one of the hospital's main corridors (colloquially referred to as 'the crossroads' by staff) had leaked during the night. We saw water dripping from the ceiling and a large pool of water on the floor. Inspectors were required to alert this to staff so that appropriate safety precautions could be taken by the trust in managing the risks of slips or falls. Several of the hospital's quality round reports, which are completed by ward matrons and ward sisters, mentioned concerns about the roof leaking on their wards.

The flooring in some parts of the hospital was broken or buckled. The flooring in the area called 'the crossroads' was cracked and broken. The cracks were small in width but extended across the length of the corridor. As a coincidence, during our inspection we witnessed a man trip and fall over one of the cracks. We observed hospital staff walk by without offering him assistance. Our inspectors assisted the man and reported the incident to the help desk. We were told by the helpdesk that the cracks in the flooring had been reported on numerous occasions as a result of people falling over them. We reported the issue to senior managers. The trust responded less than an hour later by taping over the cracks.

We found warped flooring in the corridor leading to the entrance of ward 18. This was of particular concern as there were mainly elderly patients on ward 18, some of whom had dementia and some of whom had difficulty walking. The doors to the ward were not always locked and the ward itself was located at the end of a very long corridor, geographically isolated from the rest of the hospital. The risk was that patients who were confused or unsteady, could fall over the flooring and might not be found for some time due to the ward's out of the way location.

Shower facilities on ward 18 were unsatisfactory and inadequate. This was despite us alerting the trust to this in our previous inspection where the assisted bath was used as a storeroom and was not accessible. This meant there was one shower for 26 patients. During this inspection all beds in the ward were occupied by patients. We found the assisted bath had been removed entirely and converted into a storage room. This left just one shower for the 26 patients who were on the ward when we inspected. The existing shower was not suitable for patients who were unable to mobilise for themselves and was too small for patients who needed to be taken there in a shower chair. We noted a new shower room was being built at the entrance to the ward, however, it did not include provision for an assisted bath. Staff told us they had raised concerns about the size of the planned shower room as it could not accommodate a patient with a zimmer frame (this is a type of walking aid) or equipment such as a hoist needed to help a patient if they collapsed. They felt their concerns were disregarded. The outcome, they said, was that only patients who were able to walk or sit in a shower chair would have a shower. All other patients would have to have a bed bath.

A review of the hospital's hot and cold water systems, commissioned by the trust and

undertaken in July – September 2013, identified a number of high and medium risk remedial actions needed to ensure the hospital's water was safe from bacteria including Legionella and Pseudomonas species. In the main, these actions were related to the poor condition of some of the hospital's plumbing, poor maintenance and cleaning of water tanks, and inadequate flushing of low use outlets. There were also examples where alterations to rooms and departments had taken place leaving many dead legs in water pipes and unused water outlets. These posed a risk for Legionella bacteria to develop as water was unable to be flushed through the entire system. Failure to maintain the safety of the hospital's water supplies puts patients whose immune system is compromised at risk of developing water borne illnesses.

Patients and visitors told us the hospital's signage was confusing and they found it difficult to find where they needed to go. The instructions for finding wards 4 and 18 were particularly confusing. In order to get to ward 18, people must first pass through ward 4. There were no instructions to this effect and the signs on ward 4 directing people to ward 18 were inadequate. Speaking specifically about ward 18, several visitors we spoke with commented on the difficulty of finding the ward.

During our out of hours inspection on Saturday, 19 October 2013, we observed people who came in through the main entrance. They were confused and searched for signs telling them where to go. In the course of half an hour, six people approached us for directions to wards where their family members were being treated. We assisted them to locate where to go within the premises. There were no staff or volunteers to assist or direct them at this time. On another occasion, our expert by experience helped two visitors find the GP treatment area as this did not appear on the location map.

There were poor security arrangements in A&E and across the hospital's adult in-patient wards. A daily quality round for ward 4 from the 15 October 2013 noted the ward was not secure as there was no lockable security system in place. According to the daily quality round, security had been on the ward's risk register "for the last 24 months." On two separate occasions, we saw confused, distressed patients wandering onto wards to which they were not admitted. The doors leading into the treatment area of A&E were not always locked. We observed members of the public walk into the department and they were not challenged by staff. When the doors were locked, the intercom system was sometimes used to let people in without asking them who they were. Patients had access to an unlocked door which led into the department's reception office. During our out of hours inspection, we found the main entrance to the hospital was unsupervised and there were no security arrangements. The doors to the wards we inspected were open and unlocked and there were no reception staff. Staff did not challenge visitors to the ward.

Safety, availability and suitability of equipment ✖ Action needed

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was not meeting this standard.

Patients were not always protected from the risks of providing treatment and care due to out of date, broken, faulty, or unsuitable equipment.

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.

There were systems in place for reporting faulty equipment. Staff told us equipment was usually fixed quickly but also said there were regular exceptions. They said response times often depended on the nature of the equipment with specialist clinical equipment taking more time to fix or replace than more general equipment such as call bells.

Across the hospital, we found equipment which was not fit for purpose and which the hospital condemned shortly after our arrival. On many wards, we found trolleys and IV stands which were rusty. The wheels and wheel guards on some of the trolleys were either very dirty or had disintegrated to the point where the trolleys could not be moved without use of brute force and considerable shuddering. When we queried the condition of the trolleys with ward matrons, they took them out of use and we later observed them to be marked as "condemned."

On the AMU, we saw a broken disposable pan macerator. There was a paper towel taped to the top of it which read "out of order." It was not clear from the note how long the macerator had been out of order or whether the issue had been reported to the trust's estates department so the macerator could be fixed. A trust document called "Site Manager Daily Quality Control" stated the bed pan macerator was reported as broken on 7 September 2013. Staff we spoke with, including the lead nurse for the ward, did not know how long the machine had been broken and were not concerned that it was not fixed. The lead nurse was not able to tell us what arrangements were made to fix or replace the macerator. Several days later, we found a note on the macerator stating it was condemned. Staff from the hospital advised a replacement had been ordered after we brought this to the trust's attention during our inspection. There was also a broken macerator on ward 4. It was reported as broken on 24 September 2013.

On the labour ward, there was a resuscitaire which was broken. Records we saw showed it was reported to be broken on 30 September 2013. Staff told us they asked for a progress report but did not receive a reply. During one of our visits to the postnatal ward

during this inspection, we found eight requests to condemn various pieces of furniture such as armchairs and wardrobes. When we spoke to the midwife in charge she was not aware of the reason why these were being condemned. On both the AMU and the postnatal unit, in the main corridor, we found first aid kits with clinical contents which had expired several years ago. When we asked staff why the first aid kits were kept on the wards, they were unable to tell us. Ward managers expressed surprise when we told them the contents of the first aid kits were expired.

On ward 18, there were no hoists for lifting patients who required assistance or had reduced mobility. Staff told us the hoists were kept on ward 9, which was geographically distant from ward 18, and this made it difficult to access them when patients needed to be moved. We found a black bag containing rubbish hanging from a fire door on ward 17. The ward matron did not notice this until we pointed it out. Staff told us they hung the bag on the door because there was no waste bin available in that area.

The call bells we checked during our inspection were in working order. Most patients told us their call bells worked; where the call bells did not work, patients told us they were given manual, hand held bells to use. Staff told us the call bell system often broke down but was fixed soon after they reported the fault. A number of quality monitoring rounds done by ward sisters and ward matrons, copies of which were given to us by the hospital, showed call bells regularly needed repair.

Staffing ✖ Enforcement action taken

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.

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. There were many instances where shifts were short staffed.

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

Staffing arrangements were not significantly improved since our last inspection. Despite on-going recruitment, almost all the wards we inspected were regularly short staffed. Although there were minimum staffing levels for each ward, this did not often reflect the actual number of nurses and healthcare assistants on duty on the wards and did not take into account issues concerning skill mix or work load. Staffing and skill mix was a serious concern most notably on the AMU / ward 7 and ward 4. We raised this with the trust as a patient safety issue during our inspection. Throughout the hospital, there was a high reliance on agency and locum staff to fill vacancies.

As during our previous inspection, patients and visitors we spoke with commented on how "busy" staff were. Many patients and relatives from AMU / ward 7 and ward 4 commented on the lack of nurses and healthcare assistants available on some shifts. One patient on ward 7 told us "the nurses are good, they work so hard but sometimes they seem to be short of staff, especially at night." On ward 4, a patient who had been in the hospital for three weeks said "the nurses are really good although very busy."

Staff expressed concerns to us about staffing levels, especially on AMU / ward 7 and ward 4. They told us there were often insufficient numbers of staff to meet the needs of patients on these wards. We were told this was partly due to the high dependency of patients who were admitted to these wards but also too many shifts were short staffed because vacancies could not be filled. Although agency staff were requested, they were frequently unavailable to fill vacancies. Staff also told us the division of work between nurses and healthcare assistants had changed since our last inspection. In contrast to our last inspection nurses rather than healthcare assistants were responsible for completing patient observations. They felt there were too few nurses to carry out the work which was already required of them and resulted in a lower standard of care being given to patients.

Staff raised specific concerns about the lack of additional staffing support to care for patients diagnosed with dementia. They said there was not enough time to care for patients with dementia especially when the patients suffered from an acute illness, an infection, pain, or dehydration which sometimes caused them to become aggressive or challenging. Staff told us patients with dementia often needed one to one care and this was not possible to give because "nurses are scarce." Staff felt patients with dementia needed more support than the current number of nurses that worked on shifts could provide. On several occasions, we observed a healthcare assistant or a nurse was asked by their ward manager to sit with a distressed or confused patient. Staff told us this effectively reduced the team by one individual and put additional pressure on existing team members to do that staff member's work. They said additional staff were not requested at these times to ensure all patients received the care and support they needed.

In the evenings and weekends, there was a lack of reception staff both at the main hospital entrance and on its wards. People visiting patients told us this made the hospital seem unfriendly and uncaring. There was no one point of contact to whom questions could be directed. This was a particular problem for some visitors because the hospital's signage was difficult for them to follow. Instead, ward staff found themselves continually interrupted by visitors and relatives who had no one else to ask. Staff felt this interrupted their clinical duties and delayed their work, although they said they were happy to help people who asked.

We sampled staff rotas across four wards and looked at staffing arrangements for three days in October 2013, chosen at random and within a single seven day period. We found the AMU was short one nurse on five of the twelve shifts we looked at and short of healthcare assistants on seven of these shifts. Of the existing nurses on duty at any one time, one of them was a nurse in charge who did not have allocated patients to look after. There was significant use of agency nurses and healthcare assistants on every shift. On two shifts, there were as many agency nurses on duty as there were permanent nurses. The risk assurance framework for AMU / ward 7 identified the following risks: staffing levels due to high level of vacancies and vacancy level at 10%."

A tool used to monitor staffing levels, posted at the entrance to ward 4, covering the period from 1 October – 16 October 2013, showed the ward was short of nurses on four early shifts; short of healthcare assistants on five late shifts; and short staffed on three night shifts. Information for eight shifts was not completed. We checked the staff rotas for ward 4 and spoke to staff about staffing levels. They told us patients on this ward were usually older adults and needed considerable support and care, many of whom had dementia diagnoses. We found the ward was short one nurse on four of the ten shifts we looked at, short two nurses on one shift, and short one health care assistant on two others. On three shifts, the ward was short at least one nurse and one healthcare assistant. There were not always sufficient numbers of experienced and suitably qualified staff to ensure patients were given the care they needed.

When we spoke with the ward matron on ward 4, they told us they were rarely able to carry out their managerial activities because they often had to provide clinical cover as a result of nurse shortages. There were three out of six shifts where there was no ward manager. Agency nurses and healthcare assistants were used on every shift. We looked at the risk assurance framework for ward 4. It Identified the following risks: risks to patient safety due to lack of medical cover; gaps in training for large number of new nursing staff; staffing levels due to high level of vacancies. The ward matron and nurse lead for the ward told us new nurses had been recruited; they were having induction training at the time of

our inspection.

We also spoke with staff in the maternity unit about staffing levels. They told us that approximately 16 midwives left in September 2013 to start health visitor training. Although new midwives were recruited, most or all of them were newly qualified. Staff told us this put considerable pressure on existing midwives to train and support the new cohort of staff while also carrying out their usual responsibilities. A group of midwives on the birth centre told us "we've been allocated preceptrees..but we don't often see them for weeks because our shifts don't coincide" and "it's hard to support [the newly qualified midwives] when we can't meet up." Appropriate actions were not taken to ensure there were sufficient numbers of suitably qualified, skilled and experienced staff to safeguard the health and welfare of women and their babies.

Staff on the assessment and triage unit in maternity felt there were sufficient numbers of staff when the unit was not busy but "when the unit gets busy…we try to do five things at once…we can ask midwives from the labour ward and foetal assessment unit to come and help…but sometimes managing it all is stressful and women end up queuing." Staff in assessment and triage also expressed concerns about accessing doctors on the weekend. During our inspection out of hours, we noted several women waiting to see a doctor. When we asked staff how long women could expect to continue waiting, we were told "a long time." Staff explained this was because, on weekends, the triage service is covered by doctors on the labour ward who do their rounds and then often go into the operating theatre to assist in surgery. The midwives we spoke with felt women in triage were not seen as a priority.

Staff told us there were good arrangements for ensuring consultant cover on the labour ward and in ensuring the continuity of consultant care. However, staff raised concerns about the number of and quality of care provided by locum doctors used on the ward. They said the frequent use of locum doctors put additional pressures on labour ward staff as locums were often not familiar with the hospital's systems and procedures and needed considerable support from midwives. On one of our inspections of the labour ward, there was a locum doctor on duty and, we were told by staff, a different locum doctor had worked the night before. Staff on the labour ward were also concerned about what they felt was a high level of sickness absence amongst consultants and midwives in the unit. This was a particular concern for them because it put extra pressure on existing staff, most of whom already worked long hours. At the time of our inspection, we were told three consultants were off sick, one was on leave and one was "not around." On our out of hours inspection, we saw the labour ward team was understaffed by one midwife.

Minutes from the speciality clinical governance group for paediatrics held in September 2013, showed that mandatory staff training was cancelled due to concerns about staffing levels. The minutes noted more than eight vacancies in paediatrics, three recent resignations, and a number of staff absences due to sickness or maternity leave. New nurses were recruited and working as healthcare assistants while managers waited for them to be registered with the Nursing and Midwifery Council. When we spoke to staff, they told us staffing continued to be a worry mainly because many experienced nurses on the ward had left during the summer period. Managers we spoke to told us it was difficult to attract and retain staff and cited numerous reasons. These included the location of the hospital, the reputation of the location, and the hospital did not attract the London weighting on top of staff salaries like some locations closer to London.

Trust board papers from 3 October 2013, included a discussion about an on-going

shortage of speech and language therapists (SALTs). The lack of SALTs was identified as a concern in our previous inspection report. During this inspection, ward staff told us there was often a delay of up to 48 hours for a patient to be seen by a SALT. They also said, however, that several nurses were trained to do swallowing assessments "as a back up" for when a SALT was unavailable.

Minutes from a meeting of the trust's professional executive committee in September 2013, also highlighted a lack of porters which was causing a delay in getting patients to radiology from A&E. This meant patients had to wait for transport assistance for their medical imaging slots and that radiology staff had to wait for patients to be brought around to the unit.

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.

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 systems in place for implementing National Institute for Health and Clinical Excellence (NICE) guidelines but the use of the guidelines was not robustly audited. While lessons were learned from incidents and complaints, they did not always result in improved care for patients.

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

We found the trust had made marked improvement in some areas since our last inspection, particularly in managing capacity issues in A&E and ensuring the movement of patients out of A&E and onto in-patient wards. New systems were in place for setting up and opening areas as escalation areas. However, there remained significant gaps in the trust's identification, monitoring, and response to risks to patient care and safety. Although there were systems in place to identify poor standards of care, we found examples where they continued to be ineffective.

There was a lack of leadership and management of cleanliness and hygiene across the hospital. Responsibility for hygiene and cleaning was divided between estates, cleaners, and nursing staff. Audits of cleanliness were done by an auditor in the estates department who worked independently from the department, infection control link nurses, and the infection control team. There was no coordination between these parties that ensured concerns found in the various audits of cleanliness were identified and addressed. Board level assurance regarding infection control measures focused on the spread of microorganisms and infection. There were no clear and specific quality indicators related to standards of cleanliness. The lack of a coordinated system for identifying, assessing and managing risks related to standards of cleanliness meant that patients were cared for and treated in an environment which did not protect them from the spread of infection.

Matrons and ward sisters completed daily quality checks to assess whether specified quality standards were met on the wards for which they were responsible. We examined a sample of these and found inconsistencies and inaccuracies in the way they were completed and in the responses they gave. For example, daily quality rounds which were

completed for ward 18 and AMU / ward 7 on the 16 and 17 October 2013 showed ward sisters answered 'yes' to the question 'is the entry to the ward secure.' During our inspection on those days, we found the wards were not secure. The quality rounds on those days gave an inaccurate account of security arrangements which were intended to maintain patient safety. Quality monitoring systems failed to identify risks relating to the welfare and safety of patients.

On the post natal ward, we looked at audits which included a check of 10 patient records a day for the three weeks up to and including the day of our inspection. In every case, the ward's audits found intentional rounding on patients to check their welfare was complete. We chose four sets of patient records at random; intentional rounding documentation in each set of records showed significant gaps where care was not recorded as provided. When we asked for an explanation about the gaps, the ward matron could not explain the inconsistency. The system for monitoring intentional rounding on the post natal ward did not identify gaps which may have alerted managers to risks relating to the health, welfare, and safety of patients.

Quality rounds often failed to identify poor quality standards, and where they did, the concerns were not addressed. For example, many of the quality rounds we saw identified staffing shortages including wards 3, 4, 6, 7, AMU, 9, and 18. We found shifts were consistently unfilled on a number of these wards. Some of the quality rounds we saw failed to identify poor cleanliness and hygiene practices. Where they did, they were accompanied by mitigating comments such as "cleaning in progress" or "part way through cleaners schedule." The lack of effective measures to identify, assess, and manage risks resulting from breaches in quality standards put patients health, safety, and welfare at risk.

We found there was ineffective communication to ward staff about the purpose and the results of audit and performance information. Staff told us they did not understand why they were asked to complete daily quality rounds. Some staff told us it was a "CQC form" which they were required to complete for the CQC. Staff were not sure how the information from the daily quality checks was used to monitor or improve patient care.

On ward 18, there was a document in the public notice board called "confused patients." The document listed all the days in the month of October and showed that from 1 October – 16 October 2013 each day was coloured in red. Staff told us this meant they did not meet their target. When we asked them which target this was, they were unable to tell us. We asked them to explain what risks the documented was intended to monitor and they told us they did not know. Ward staff were not always able to identify the risks to patients on the ward. This meant they were unable to mitigate those risks. The lack of effective measures to identify and manage risks resulting from breaches in quality standards put patients' health, safety, and welfare at risk.

On ward 4, there was a similar document in the public notice board called "incidents of unmonitored cardiac arrhythmia per day." It showed that from 1 October – 11 October 2013 there was one documented instance where patients who should have been monitored for cardiac arrhythmia were not monitored. We asked staff to explain this document to us but they were unable to do so. When we asked what was done to ensure there were sufficient monitored beds, staff did not know. Ward staff were not always able to identify the risks to patients on the ward. This meant they were unable to mitigate those risks. The lack of effective measures to identify and manage risks resulting from breaches in quality standards put patients' health, safety, and welfare at risk.

Where performance information raised concerns, staff were unable to tell us what was being done to improve performance. On the post natal ward, we found signs in the public notice board with the results of infection control audits. Two out of the three audits showed a compliance of 84% and 80% respectively for two different infection control measures. When we asked staff what action was being done to improve compliance, they were unable to tell us. On ward 18, the public notice board included information about compliance with safety standards, called "safety thermometer." The safety thermometer showed the results for 1 – 19 October 2013 were 69.2% against a target of 85%. We asked staff what was being done to improve the performance of the ward. They told us they "were not sure." Staff did not understand the results of performance information and this put patients at risk because staff did not know what was required in order to improve standards of care.

The trust's policy, procedure and guidelines for prescribing, preparation and administration of injectable medicines and infusions stated two members of staff should administer and check them. The policy required two clinicians to check and sign the patients' medication documentation to show drugs were given as prescribed. This was in line with professional guidelines. We found nurses across the hospital did not follow this policy consistently. Some nurses told us they were not required to give IV infusions or medicines in pairs and others told us they were required to give such medicines in pairs but only one person had to sign patients' medication records. When we looked at medication records and infusion charts we saw just one nurse signed for the administration in the majority of cases. This was not in line with trust policy and professional standards regarding medicine administration and documentation issued by the Nursing and Midwifery Council. We also observed nurses did not record the completion of the infusion and the volume infused when they changed IV bags. The lack of effective measures to identify and manage risks resulting from a failure of staff to follow the trust's policy put patients' health, safety, and welfare at risk.

Chlorine tablets (used to make up a disinfectant solution) were available in all wards and stored in the dirty utility rooms for infection control purposes. The trust's risk assessment for the use of chlorine tablets identified staff who handled the product; confused and wandering patients, and unaccompanied children could be at risk of harm from the prepared solution. Control measures were stated as "chlor-clean tablets and haz tabs must be stored in a locked cabinet…chlor clean audits are undertaken to monitor compliance." On most of the wards we inspected and in A&E, we found chlorine tablets and solution were not kept in locked storage. Staff were not aware of the requirement to keep these in locked cupboards and could not identify the risks of not doing so. Even when we alerted staff that the trust's own risk assessment required the tablets to be locked away, we continued to find them freely accessible on some wards when we returned to inspect on other days. In some dirty utility rooms, there was no provision of lockable cupboards to ensure tablets could be locked away. In other dirty utility rooms, staff had the ability to lock the tablets away but did not know where the keys for the cupboards were kept. The lack of effective measures to manage risks resulting from the use of chlor-clean tablets put patients' health, safety, and welfare at risk.

A number of wards we inspected were well led and well managed. These included wards 1, 3, and 5 as well as MIDU and the neonatal unit. Patients on these wards were pleased with the care they received and spoke highly of the staff. We observed staff on these wards working well together as a team; patient records were up to date; the wards were clean; and patient care was of a high standard. Managers on these wards were professional, encouraged team work, and recognised the challenges facing staff on their

wards.

However, we found poor leadership and management on some wards, most significantly on the AMU / ward 7 and ward 4. Although there were some examples of outstanding care provided by specific individuals, the general culture of these wards was not patient focused or caring. Patients told us staff often commented they had "too high expectations of the NHS." This was a comment which staff also made to some of our inspectors during our inspection. Patient feedback from these wards was mixed and some patients were pleased with the care they received while others were not. Staff on these wards were not well organised or well managed.
We observed instances were patient care fell below essential standards; patient records were not up to date and patient confidentiality was not maintained; risks to patients were not identified or, where they were, they were not addressed; and wards were unclean. Inadequate leadership and management put patients are risk because care that fell below essential standards was not always identified or managed.

We found there was a lack of responsibility and accountability amongst clinical leads, ward managers, and ward staff for ensuring quality standards were maintained. As we found in our previous inspection, staff on ward 4 continued to leave the treatment room door open and unsupervised despite the risks from stored medications and other equipment in the room. A relative of a patient on the ward told us a member of staff had put a call bell in the patient's hand and had commented this was "because CQC was hanging around." We observed the patient was not able to use the call bell because of his medical condition. This showed a lack of care for and understanding of the patient's condition. On AMU, we found a store room with a notice that read "do not place stores on the floor. The floor space must be free of storage at all times." There were more than a dozen boxes on the floor, four IV stands, one set of steps, and an assortment of bins. The failure to enforce quality standards, put patients at risk of receiving care that did not meet essential standards.

Clinical governance arrangements within division C, which includes A&E and the hospital's in-patient medical wards, were described by staff as "challenged." We were told consultants did not attend divisional board meetings; instead they attended separate consultants' meetings. This was reflected in the minutes of divisional board meetings we saw. There was no clinical lead at divisional board level and trust managers told us they struggled "to get clinical engagement." There were separate divisional clinical governance meetings for doctors and nurses. Trust managers told us the trust has sought external support to address these issues. However, there remains a risk that the lack of engagement and cooperation amongst clinical staff could result in poor teamwork and communication which could adversely affect the standards of care patients receive.

We had concerns about the leadership and management of the maternity service. Between 8 June 2013 and 25 July 2013 there were nine serious untoward incidents (SUIs) on the ward. The trust commissioned an external review and received verbal feedback of the findings on 2 August 2013. The trust took immediate steps to address the concerns raised by the review and we found evidence of this during our inspection. However, the findings from the review were not fed back to the doctors and nurses who worked on the labour ward and who were aware of the high number of SUIs. Doctors and midwives on the labour ward told us they were unaware that recent changes on the ward were a direct response by the trust's managers to the findings of the review.

Midwives and doctors we spoke with expressed confusion and frustration at the trust's failure to communicate the outcome of the review. They said this had resulted in a "blame

culture" where staff "did not trust one another" and where "everyone's thinking: whose fault is it?" They felt that while doctors and nurses worked well together on the labour ward, there were tensions between staff in senior midwifery positions and medical consultants. Staff said the lack of information prevented them from moving forward and making improvements as a team. Junior doctors said they felt there was a consequent risk to patient safety because doctors "had become risk averse and were afraid to make decisions." We were told junior doctors frequently sought advice from consultants because they were "too afraid to make a mistake." The knock on effect, doctors said, was that consultants were "overloaded and demotivated."

Labour ward staff told us they felt the lack of feedback following the SUIs was symptomatic of a general lack of engagement from the trust's management. Trust managers told us they were reluctant to share the findings of the review with staff until publication of the formal report. This was despite the need to make immediate changes in order to ensure women and babies were safe. At the time of our inspection, however, the report was not yet published. The trust told us it would share the results of the review with staff at the end of November 2013. Inadequate communication about the findings of the SUI investigations led to a culture where staff did not always feel able to raise potential concerns about patient care. This put patients at risk of receiving care that was unsafe.

There was a system of clinical audit which included a forward audit plan and encouraged clinical engagement from staff across the trust. However, the results of audits were not always monitored and re-audited where concerns were previously identified to check whether improvements were achieved. Audit findings from the College of Emergency Medicine were not clearly linked to the clinical audit programme. Minutes from the emergency medicine clinical governance group (from April 2013) and the clinical effectiveness group (from May and August 2013) showed results from clinical audits were reviewed, but there was no clear system for ensuring the results were used to improve the quality of care for patients. The lack of a robust clinical audit programme where poor results were addressed and re-audited put patients at risk of receiving care that did not meet professional standards.

There was evidence that National Institute for Health and Clinical Excellence (NICE) guidelines were reviewed and implemented. This was evident in the minutes of clinical governance meetings which we saw. Changes to NICE guidance were communicated to staff through a dedicated staff newsletter and through the staff intranet. Arrangements for ensuring NICE guidelines were systematically implemented and embedded were still in development and were led by a recently established NICE steering group.

However, the quality and safety of specific services were not always linked to or audited against professional guidelines. Clinical audits relating to maternity care were not recent and there was no evidence their findings were implemented or monitored. The trust did not have a clear system for ensuring it met the professional recommendations set out in 'Standards for Maternity Care', published by the Royal College of Obstetricians and Gynaecologists (RCOG) and other professional groups. The lack of a coordinated system for ensuring professional standards were implemented and audited put patients at risk of receiving care that did not meet professional standards.

Key issues from incidents and complaints were identified at divisional clinical governance meetings and trends were monitored at trust level. Staff told us incident trends were sometimes shared with them and this was done through the staff intranet and newsletter. There were systems in place for reporting, learning from, and responding to incidents and complaints but these did not always translate into improved outcomes for patients. For

example, the trust's board minutes for May, July, and October 2013 showed that the most common complaints were about treatment and diagnosis, communication, and professional conduct. According to the board reports, although the percentage of complaints in each of these individual areas varied from month to month, they remained the subject of the most common complaints about the trust in that six month period. There was an ineffective system for managing the risks of inappropriate or unsafe care and treatment which were identified through patients' complaints.

We looked at complaints we received from patients prior to our inspection and checked whether improvements were made. We received a copy of a complaint dated 14 August 2013 about ward 4 which was sent to the trust and which included concerns about standards of cleanliness. The trust investigated the complaint and found concerns about cleanliness were substantiated. When we inspected ward 4, we found concerns around cleanliness were not resolved. The failure to learn and embed learning from complaints put patients at risk of receiving poor care and treatment which could have been avoided.

Between the 29 May 2013 and 3 September 2013, we were copied into six complaints from patients or their relatives and these had common themes including poor communication of information, poor staff attitude and conduct, concerns about care treatment, and lack of compassion from staff. The trust investigated the complaints and trust managers told us the complaints were upheld. Despite having identified areas of improvement, concerns in these areas were not adequately resolved. As detailed earlier in this report, one of the most common criticisms patients made to us about the care they received at the hospital was in regards to poor communication. We observed instances of poor professional conduct and care which was below essential standards and these have been mentioned previously in this report. The failure to learn and embed learning from complaints put patients at risk of receiving care and treatment which did not benefit from continuous improvement.

Permanent staff could access the trust's incident reporting system (called Datix) in order to report an incident but most staff could not access and see the results of past incidents. We were told only managers had access to the part of the incident reporting system which would allow them to review past incidents and they had passwords for this. We witnessed a number of incidents during our inspection and asked managers whether they were reported. Many managers were unable to tell us because they could not remember their password. Failure to ensure managers were able to access incident recording and reporting presented a risk that incidents would not be assessed and managed so that necessary changes could be made to patient care.

Where managers were able to access the trust's incident reporting system, we found incidents were not always reported. For example, on ward 18 we observed a patient who had sustained a head injury prior to our inspection and which required stitches. Staff explained to us that the patient had fallen two days previously while on the ward and injured their head in the fall. We looked at the patient's medical and nursing notes. There was no record showing that the patient's fall and subsequent head injury were reported as incidents. When staff checked the trust's incident management database, they could not find a record of this incident. Failure to identify and report incidents presented a risk that incidents resulting in harm to patients were not analysed and, therefore, necessary changes were not made to their care and treatment.

Staff on A&E told us that many incident investigations could not be completed because doctors, nurses, and other clinical staff did not respond to requests for information. They said this led to a "back log of open incident investigations." When we inspected A&E on

17 October 2013, we looked at Datix records and found 14 incidents which were not fully investigated even though the deadline for investigating them had passed. Failure to investigate incidents presented a risk that preventable incidents of harm were not detected and measures were not put in place to guard against their recurrence.

Staff we spoke with across the hospital told us they were generally pleased with the support they received from their immediate managers but spoke of a corporate culture of "bullying and harassment" and "fear." Some members of staff were reluctant to speak with us and said they were afraid of reprisal from the trust. Some members of staff asked not to be named and only agreed to speak with us when reassured that the conversation was confidential. During our inspection, three members of staff spoke to us under formal whistleblowing arrangements to discuss concerns they had about the quality and safety of care at the hospital. Staff said there was a lack of engagement from trust managers and they did not feel involved in making changes to improve services for patients.

Staff told us they had concerns about care provided to patients and said they felt unheard when they raised their concerns with trust management. These issues were previously noted in an "employee engagement survey" from June 2012 which was commissioned by the trust. In the survey, staff identified many aspects of their work which they enjoyed but they also criticised the lack of staffing; the "blame culture"; lack of management presence on ward; lack of patient focus; top down management; lack of staff engagement and; poor communication from management. A lack of engagement and cooperation amongst trust managers and staff posed a risk that poor teamwork and communication could result in substandard care being given to patients.

We asked the trust managers to explain the actions they had taken in response to the employee engagement survey. The trust's managers said they had responded to the staff survey and showed us the action plan for this. When we told them staff did not feel the concerns they raised in the staff survey were addressed, the trust's managers told us there was considerable staff resistance to change and this adversely affected how teams worked together and communicated in order to deliver patient care. They told us they were addressing concerns about staff performance and felt this may have led to staff feeling they were bullied.

Records

✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

Patients were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. Confidential patient information was not kept secure.

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

We found some improvement in record keeping since our last inspection. These were mainly through the use of standardised care plans and risk assessments. Although the trust took steps to respond to the concerns we raised previously about record keeping, these were recent and the impact of the trust's activities was limited. Many of the patient records we looked at remained disorganised, incomplete, and fragmented. We found completion of patient risk assessments and care plans remained inconsistent, although significantly improved in EDDU. The exception to this was on ward 1. Patient records on this ward were well maintained, care was fully documented, and records were easy to follow. We found no records relating to discharge planning in any of the records we saw. Confidential patient information was not always kept confidential. This was a particular concern on the AMU / ward 7 where the lack of security regarding patient information was most evident.

We looked at patient records on EDDU and found screening and assessments were completed for the patients on the unit. One set of records related to a patient with learning disabilities. The patient had an initial assessment and there was clear documentation of relatives' involvement in the process. However, when we spoke with some of the nurses on EDDU, they told us there was a specific 'traffic light assessment' which should be used to assess patients with learning disabilities. This assessment was not in use on the unit and staff told us the form was not available to them. Staff had not followed the trust's procedure for documenting assessments specific to people with learning disabilities to ensure their care was appropriate. This posed a risk that the needs of people with learning disabilities might not be adequately assessed and addressed.

Patient records were poorly organised and maintained. On ward 18, poor patient record keeping arrangements presented serious risks to patients. When we asked to see one individual's patient records, we were given the wrong records three consecutive times.

Staff were unable to match the patient we asked about with the correct patient records. Medical and nursing notes were mixed up. We found staff were using different systems for keeping patient records. This led to confusion about where to record the care and treatment patients received. We were told this was because the ward was moving to a new record keeping system which meant there was a mix of 'old' and 'new' medical and nursing records for each patient. When we looked at patient records on the ward, we found substantial records of care were missing, inconsistent or duplicated. When we revisited the ward, the new recording keeping system was in use. However, when we looked at patient records, we found parts of nursing assessments in medical folders and medical assessments in nursing folders. This posed a risk that the correct patient records would not be found when they were needed and that patients would receive inappropriate or repeated care because staff were unable to determine what care and treatment had been given.

Patient records were sometimes illegible and confusing. Patient care was often difficult to follow and track. We saw risk assessments and care plans were not always completed. Some of the ward daily quality checks we saw also identified this as a concern. Some care plans were poor and provided little, if any instruction, about the care patients required. On ward 18, we found a patient who was assessed as being at risk of malnutrition and dehydration. Their care plan stated "ensure food chart." There were gaps in the patient's food chart which suggested they had no breakfast or lunch on two out of four days. This was not identified as a concern by staff on the ward. Changes to patients' care were not always documented. Plans of care agreed by one doctor were sometimes changed by another doctor with no explanation. We found little recorded evidence of patient involvement in care planning. Inadequate maintenance of patient records and poor recording of decision making put patients at risk of receiving inappropriate or repeated care because staff did not always know what care and treatment need to be given.

Many of the patient records we looked at contained significant gaps in the recording of care provided. The trust used a document called "intentional rounding" to monitor and record care which was given to patients. Intentional rounding is a nationally recognised tool which, according to the Royal College of Nursing, is used to assess patients' needs at one or two hour intervals. There is no requirement to use this tool but it is considered good practice. The trust used an adaptation of this tool and patients were supposed to be assessed at anywhere between one and four hours, depending on their individual needs. In most of the patient records we saw, the trust's intentional rounding tool was not completed correctly and showed gaps in the recording of care patients received. When there were gaps, there was no documented evidence elsewhere in patients' records to demonstrate they received the care specified in the intentional rounding form. This posed a risk that patients might not receive the care they needed.

We also found different versions of the intentional rounding tool were in use on different wards. On one ward, varying versions of the tool were used by different staff members on the same ward and, on another, staff did not use the standard template at all; they documented their checks on a blank A4 sheet of paper, which was not approved for use by the hospital.

Records for a patient on ward 4, whose medical condition was being closely monitored, stated they were to have two hourly neurological observations. We saw there were gaps in the frequency with which the observations should have been done. Moreover, the checks which were done on this patient indicated their condition continued to deteriorate between checks. Neither the medical nor the nursing notes documented the patient's rapid deterioration and there was no information about what action was being taken in response.

When we raised our concerns about this patient's care with nurses on the ward, they were not aware of the seriousness of the patient's condition. The patient was later transferred to another hospital with a more specialist unit to meet their needs. The failure to undertake and record patient observations with the required frequency, put the patient at risk of further deterioration.

We found instances were nurses documented patient care they had given long after they had given it. On AMU, we observed a nurse completing a patient's neurological observations several hours after the observation were done. When we questioned them about this practice, they said they could remember which checks were done and at what time during the day. On ward 18, the intentional round documentation for a patient whose records we looked at had not been completed. When we asked the nurse who was responsible for the patient's care about this, they told us they would do this "later." Completing nursing records retrospectively is a contravention of professional guidance on record keeping which is issued by the Nursing and Midwifery Council. The guidance specifies that patient records should be contemporaneous, that is, care must be documented at the time it is given. Failure to maintain contemporaneous patient records poses a risk that care may not be recorded at all, that it may be recorded incorrectly, or not recorded in time for other healthcare professionals to be aware of risks or concerns.

Ward staff told us new templates for recording patient care were developed after our previous inspection. However, staff also said they were not trained in how to use the new templates and there was no guidance for their use. One ward manager told us "we were sent [a] new patient record tool but staff and I were given no information on how to use the new system. The paperwork was left on my desk and I had to find folders to file the new records." The lack of training in completing the trust's new record keeping system meant staff did not know how to record the patient care they gave. This presented a risk that patient records would not be completed accurately and doctors and nurses might not have the information they needed in order to make appropriate judgements about the care patients needed.

In contrast to our previous inspection, an early warning scoring system to detect deteriorating patients was clearly in place. We found copies of it in many of the patient records we looked at. We found the same version of this tool was used across in-patient wards. Staff mostly understood how to use the tool to calculate scores and seek assistance. However, they were not always able to link the underlying medical issues leading to a patient's deterioration with the scores in the tool. This presented a risk that staff might not always understand the seriousness of the patient's condition and might not respond appropriately.

As we found during our inspection in May 2013, do not attempt cardiopulmonary resuscitation (DNACPR) decisions were not always recorded for patients who needed them. However, we found the trust took preliminary steps to address the issue by identifying the scope of concerns regarding the recording of DNACPR decisions. A trust audit of DNACPR decisions from August 2013 found staff often failed to communicate with patients and relatives about DNACPR decisions and DNCACPR decisions were not always recorded. The findings of the audit were discussed at various governance meetings and we saw the minutes of these. Concerns around DNACPR decisions were on the trust's risk assurance framework. Staff told us they reported DNACPR decisions which were not completed as incidents.

Patient records were not kept confidential. While the storage of patient records was improved on MIDU and ward 5, it remained poor on some of the other wards we inspected.

On two occasions, a trolley full of patient records was left unsupervised for a minimum of 40 minutes at the reception desk on the AMU. On the same day, we found two offices containing stacks of patient confidential information which were left open and unsupervised for at least 50 minutes. The offices were both on the AMU's main corridor and were easily accessible to patients and visitors. No one challenged us when we entered one of the offices and looked through patient records, filing cabinets, and a storage cupboard. We found patient records in the storage cupboard amongst other objects. The doors to ward 18 were often unlocked and it was possible to access patient files in an unlocked and unsupervised office near the entrance to the ward. We found three cabinets containing confidential patient information in a public seating area in the outpatients physiotherapy waiting area.

On all the wards we inspected, we found patient identifiable information written on a white board at the nurses' station. The information was visible to anybody walking by the station. When we asked staff why the white boards were in use, they told us the boards were convenient and helped them to monitor patients on the ward. None of the staff we spoke with identified the use of the whiteboards in this way as a breach of patient confidentiality.

During our out of hours inspection, we found the door to the ward matron's office on the AMU was open. The office was located on one of the ward's main corridors and was easily accessible to all passers-by. Staff did not challenge us when we entered the room. We found an unlocked filing cabinet with confidential staff information including personal records and performance appraisals. We raised this issue with a staff member on the ward at the time so the filing cabinets and office could be locked to secure the records.

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 Maternity and midwifery services Treatment of disease, disorder or injury	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The registered person must ensure that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of appropriate measures in relation to the security of the premises and adequate maintenance. Regulation 15(1)(b)(c)
Regulated activities	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	**Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety, availability and suitability of equipment**
	How the regulation was not being met: The registered person must make suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment by ensuring that equipment provided for the purposes of the carrying on of a regulated activity is properly maintained and suitable for its purpose. Regulation 16(1)(a)

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

The provider's report should be sent to us by 08 January 2014.

This section is primarily information for the provider

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 31 January 2014 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Diagnostic and screening procedures Maternity and midwifery services 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 unsuitable arrangements for ensuring patients' dignity, privacy and independence. The trust did not enable patients to make, or participate in making, decisions relating to their care or treatment. The trust did not treat patients with consideration and respect. The trust did not provide service users with appropriate information and support in relation to their care or treatment. Regulation 17(1)(a)(b)(2)(a)(c)(f)(2)(a)(b)

We have served a warning notice to be met by 31 January 2014 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Diagnostic and screening procedures Maternity and midwifery services Treatment of	**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

disease, disorder or injury	of receiving care or treatmen that was inappropriate or unsafe. Patients' needs were not always assessed and the delivery of care did not always meet patients' individual needs. The safety and welfare of patients was not always ensured. Regulation 9(1)(a)(b)(ii)

We have served a warning notice to be met by 31 January 2014

This action has been taken in relation to:

Regulated activities	Regulation or section of the Act
Diagnostic and screening procedures Maternity and midwifery services 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 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)

We have served a warning notice to be met by 31 January 2014

This action has been taken in relation to:

Regulated activities	Regulation or section of the Act
Diagnostic and screening procedures Maternity and midwifery services 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

We have served a warning notice to be met by 31 January 2014

This action has been taken in relation to:

This section is primarily information for the provider

Regulated activities	Regulation or section of the Act
Diagnostic and screening procedures Maternity and midwifery services 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 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 10(1)(a)(b) and 10(2)(c)(i)(ii)(d)(ii)
We have served a warning notice to be met by 31 January 2014 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Diagnostic and screening procedures Maternity and midwifery services 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)

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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