

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

Dorset County Hospital

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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	✓	Met this standard
Care and welfare of people who use services	✗	Action needed
Meeting nutritional needs	✓	Met this standard
Management of medicines	✗	Enforcement action taken
Staffing	✗	Action needed
Supporting workers	✗	Action needed
Assessing and monitoring the quality of service provision	✗	Action needed
Records	✗	Action needed

Details about this location

Registered Provider	Dorset County Hospital NHS Foundation Trust
Overview of the service	Dorset County Hospital is a district general hospital providing acute inpatient and outpatient services. It has approximately 430 inpatient beds, 10 operating theatres, and provides specialist services, including oncology and renal. It has a maternity unit delivering approximately 2000 babies/year. It has an Emergency Department which has a Trauma Unit which forms part of a trauma network in the Wessex region set up to improve emergency care for patients who suffer life-threatening injuries.
Type of services	Acute services with overnight beds Community healthcare service Dental service Community based services for people with mental health needs
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury

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Why we carried out this inspection

We carried out this inspection to check whether Dorset County 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
- Meeting nutritional needs
- Management of medicines
- Staffing
- Supporting workers
- 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 26 June 2013, 27 June 2013, 1 July 2013 and 2 July 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 were accompanied by a pharmacist. 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.

What people told us and what we found

We undertook this inspection to check that improvements had been made where compliance actions had been served at our inspection in November 2012. We also received information prior to our inspection which led us to inspect the additional outcomes.

Our inspection of the hospital included four compliance inspectors, a pharmacist inspector, a specialist advisor who has experience of working within NHS organisations and an expert by experience. We focussed on ten wards within the hospital but also looked at other areas as part of the inspection for the management of medicines and assessing and monitoring the quality of service provision. As part of the inspection of the wards we spoke with a minimum of two patients on each ward and relatives where available. We also spoke with staff throughout the organisation from the chief executive through to staff working in clinical areas. We spoke with staff from a variety of areas including clinical governance, human resources, doctors, nurses, therapists and support staff.

Patients were treated with consideration and respect and their privacy, dignity and independence were maintained. One patient told us that staff were "responsive and caring.

When I am in here I feel safe. It is good quality care."

Patients' needs were not always assessed and care plans were not always in place to meet the needs of patients. Patients spoke highly about the food they were offered and were given a choice of suitable food and drink to meet their nutritional needs. Some patients had access to activities.

Storage arrangements for some medicines were unsatisfactory. This meant that the trust could not be assured that these medicines would be safe to use.

There were not always sufficient staff to meet patients' needs. Staff had access to training but some training was not always undertaken. Staff told us that they felt supported however they did not always receive supervision in line with the trusts policy. Staff received appraisals.

The trust had systems in place to regularly monitor and manage the risks associated with infections. The trust had made arrangements to monitor their clinical audit plan. However, these arrangements may not have been effective.

Records were incomplete and did not always demonstrate that patients' needs were met.

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 16 October 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Dorset County 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 ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Patient's privacy, dignity and independence were respected.

Reasons for our judgement

Patients' dignity, privacy and independence were maintained. During our inspection we found that curtains or doors were closed when patients received personal care or required privacy in all areas we inspected. Wards consisted of single rooms and bays of up to six patients. Where there were bays of more than one patient, we saw that they remained single gender. One patient told us that staff always knocked before entering their room and the curtains were kept around. Another patient told us that staff kept curtains around them and talked quietly. All with the exception of one patient we spoke with were satisfied that their privacy and dignity was maintained at all times. Where the patient was not satisfied that their privacy and dignity was maintained on one occasion we saw that the ward had taken action to address this immediately.

Patients were enabled to make, or participate in making, decisions relating to their care or treatment. All of the patients we spoke with told us they were involved in making decisions about their care and treatment. One patient told us that staff always explained things to them. All of the staff we spoke with told us they involved patients. The provider may find it useful to note that it was not always evident within the care planning records that patients were involved in their care and treatment. Therefore there was a risk that patients' decisions may not always be consistently considered.

Patients were treated with consideration and respect. All patients we spoke with were satisfied that they were treated with consideration and respect. One patient told us that staff were "responsive and caring. When I am in here I feel safe. It is good quality care." Another patient told us that staff were respectful and that the nursing staff were "so considerate." We observed a number of interactions between patients and staff, all, with one exception, demonstrated that staff treated patients with consideration and interacted in a respectful manner. For example, we observed a member of staff undertaking clinical observations. Throughout the procedure, the member of staff interacted with the patient and explained what they were doing at all times. The provider may find it useful to note that the exception was when we observed a member of staff supporting a patient to eat their food whilst standing up.

Patients were offered choices. All patients we spoke with told us that they were offered choices such as what to eat. We also observed staff offering patients choices about when they would like their wash. Staff told us that they ensured patients made informed choices by giving them information. They told us that patients' decisions were respected but that they gave them all of the information including the benefits and consequences for each decision.

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

Our judgement

The provider was not meeting this standard.

Some patients did not experience care, treatment and support that met their needs and protected their rights. Patients were at risk of inappropriate and unsafe care.

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

Reasons for our judgement

We received positive feedback from the majority of patients and relatives. One patient told us "I cannot fault it. I cannot speak highly enough of them (staff)." A second patient told us that staff had "looked after me well" and another patients told us that staff had "done everything and more so. So sympathetic, brilliant."

We received some data from the Safety Thermometer, which showed that the numbers of falls with harm, catheters and urinary tract infections and new venous thromboembolisms had been relatively consistent throughout 2013. However, there were increased numbers of new pressure ulcers with numbers of new pressure ulcers in June and July 2013 being more than double than those in April and May 2013. The trust informed us that some patients who had been identified as having new pressure ulcers had come into the hospital with some tissue damage. The trust also told us that where patients did have pressure area damage, the healing time was short. The NHS Safety Thermometer provides a quick and simple method for surveying patient harms and analysing results so that trusts can measure and monitor local improvement and harm free care over time.

Patients were not always protected against the risks of receiving inappropriate or unsafe care or treatment because an assessment of their needs had not always been carried out. We reviewed the assessment records on five wards. We looked at a range of records both electronic and in paper format. We also discussed with staff our findings in relation to risk. We found that the majority of patients needs had been assessed but these assessments were not complete on four of the five wards. There was a risk that because patients' needs had not been fully assessed and their needs may not have been met.

For example, one patient who had been admitted late the previous evening had not had a thorough assessment of their needs. The patient told us that their needs had not been met. We looked at this patient's care records. There was no nursing assessment of the patient's needs and their medical conditions had not been identified. The patient, therefore had not received their medication for diabetes. There was a risk that this patient's needs were not met because their medical conditions had not been assessed.

Another example was a patient who had been identified as having a respiratory condition in their past medical history, but this was not identified in the physical assessment of their respiratory needs. There was no assessment or care plan as to how to meet this patient's respiratory needs.

Patient's needs were not assessed in accordance with the trust's guidance. We looked at 11 records for the assessment of falls, pressure area damage risk and risk of malnutrition across four wards. We found that these risks had been assessed according to the hospitals guidelines for three patients however; eight patients' needs had not been assessed in accordance with the guidance. Patients who had been deemed at risk of falls, pressure area damage and malnutrition's needs had either not been assessed or not were assessed in the appropriate timeframe. For example, one patient had been identified as being at high risk of a fall was required to be reassessed within 48 hours, however the most recent assessment had been more than three weeks earlier.

Patients were able to summon help and assistance. We spoke with 12 patients across five wards. All the patients we spoke with knew how to summon assistance. All patients were aware they had a call bell and three patients told us that they could simply call for or ask a member of staff. One patient told us that staff were "always checking I am OK." All patients told us that call bells were responded to in a timely manner. The majority of the patients we spoke with had call bells in reach. One patient did not have their call bell however they were aware of how to seek assistance. Patients told us that when they sought help or assistance, staff met their needs. Four of the patients we spoke with had not needed to use their bell. All of the eight patients who had rung their call bell told us that staff had delivered what they needed. For example, one patient told us that staff "go out of the way for you" and another patient told us that staff "say, what can I do for you? Then they do it." During our inspection we observed call bells being responded to in a timely manner.

The planning and delivery of care did not always meet patient's individual needs. We found examples on nine of the ten wards where patients' needs were not always met. On one ward we found that plans were in place to manage patients' needs and care and treatment was delivered accordingly. However we found nine wards where this was not always in place. For example, one patient had complex needs around nutrition, pressure area care, continence management and wound care. The planning of care did not ensure that their needs were met. We spoke with two staff about how to meet the patient's needs. We received different responses from the staff we spoke with. There was a risk that patients' needs were not met because staff were inconsistent in their knowledge of how to meet their needs and there was no care plan to inform staff about the care required.

We looked at the use of air mattresses set up for the relief of the risk of pressure area damage for 18 patients across six wards. Eight of the air mattresses were set up correctly, however 10 mattresses were either on the incorrect setting according to their most recent recorded weight or the patient had not been weighed. There was a risk that patients were at an increased risk of developing pressure area damage because systems were not in place to ensure that they were receiving the correct care and treatment.

We looked at the records for seven patients with urinary catheters across six wards. We found that none of the seven patients had care plans for the management of urinary catheters. We also found that none of the patient records included the date the catheter change was due or when the catheter bag was due to be changed to ensure that these were changed appropriately. There was a risk that patients' urinary catheters and catheter bags were not changed in accordance with the manufacturer's guidance.

We spoke with two staff with responsibility for one of the patient's with a urinary catheter. The staff gave differing responses to the frequency of catheter changes and catheter bag changes for a patient. Neither member of staff was able to tell us the date the catheter was due to be changed. The records in relation to the date the catheter was inserted gave conflicting dates however there were no dates for the next planned catheter change recorded. We found that the patient's catheter required changing sooner than both of the staff had informed us according to the manufacturer's guidance. There were no records for any of the seven patients about when the catheter bag was changed and when it was due. There was a risk that the planning and delivery of care did not meet patients' individual needs and they were at risk of unsafe or inappropriate catheter care.

Some patients had access to activities. All patients had their own television which also had a radio next to their bed and the trust had installed internet access across the hospital for patients to access. We saw on one ward where they had a dedicated room for patients with dementia. We observed patients engaged in activities including book making, listening to music and a visit by a dog. The room was decorated with pictures and album covers reminiscent of the 1930s and 1940s. There were games and books available for patients to use. We also saw on another ward that patients had access to facilities where patients could access computers, could participate in cooking, watch the television and there were dedicated staff who attended the ward to undertake activities with patients. However, not all wards had access to planned activities or facilities for patients to spend their time. For example, on one ward we spoke with three members of staff, two of which told us there was not a lot for patients to do and the third member of staff told us that it was a "shame there are not more things." We spoke with three patients on the ward. One patient told us it was "a bit boring." One patient told us that they had access to the internet and they went outside to watch the buses. The third patient told us they could watch the television or listen to the radio.

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Patients were given a choice of suitable food and drink to meet their nutritional needs. We looked at the hospital's menu on the second day of our inspection. We saw that there was a choice of six meal options available for lunch and eight meal options available for supper. The options included hot dishes, salad and sandwiches so that patients who preferred to have a hot meal at a particular time of day were able to choose this. Hot dishes were accompanied by a choice of two types of potato, two types of vegetables or rice. There were four dessert options available at both lunch and supper. The breakfast menu included a choice of cereals, fruit and bread or toast.

We spoke with eight patients and one relative on three different wards about the food provided by the hospital. Patients spoke highly about the food they were offered. For example, one patient told us, "It tastes lovely", while another patient commented: "We are given choices at breakfast, lunch and dinner. The food is extremely good for a hospital. I'm a very picky eater but I can't complain at all." We spoke with a patient's relative who confirmed this saying, "The food here is really good. I'm pretty impressed. There is an amazing variety and it always smells really appetising."

Patients were given a choice of suitable drinks throughout the day. We observed that patients had jugs and cups of water available within their reach which they told us were replenished regularly. Hot drinks were also served to patients at regular intervals during the day.

Patients and their relatives confirmed that they were given enough to drink. One patient told us, "They are good at making sure you have plenty to drink. They give you jugs of water then bring round a choice of tea, coffee, Horlicks or hot chocolate." Another patient, who had recently transferred between departments within the hospital, told us, "I was offered water and coffee immediately I came onto the ward." A relative we spoke with also told us that they had confidence that their family member was given plenty to drink.

Arrangements were in place to provide patients with food if their hospital treatment coincided with a meal time. We spoke with one patient who was nil by mouth because they were due to have a medical procedure. They told us that, as they were missing lunch, arrangements had been made so that they could have a hot meal after the procedure. We spoke with them again later that day and they confirmed that they had been provided with the hot meal as planned.

Snacks were also available between meals for patients who required this. The catering manager told us that the hospital ran a snack box system so that snacks could be provided between meals which included options such as orange juice, sandwiches, yoghurt, cake, biscuits or fruit. This helped ensure that patients did not go hungry if they had missed a meal.

Arrangements were in place to meet the needs of patients who required special diets including vegetarian, vegan, diabetic, gluten-free and soft or pureed food. We observed that where patients had ordered a special diet this was provided. Patients were also able to order a smaller portion of food where this was their preference. One patient told us that they did not "have much of an appetite so I've been able to just have whatever sandwiches I want" and not have to "force myself to have a bigger meal that I can't eat."

Patients' religious and cultural backgrounds were respected with suitable food being available to meet their needs. We spoke with the hospital's catering manager who showed us a separate menu that was given to patients with dietary needs related to their culture or religion. They described the arrangements in place to ensure that appropriately prepared food was readily available for these patients. They told us that staff on the wards were good at communicating with them when a patient was admitted with specific dietary needs to ensure that their needs were met.

Advice from relevant health care professionals was sought to ensure patients' nutritional needs were met. Staff confirmed that they had made referrals to dietitians and speech and language therapists about patients which was reflected in the records we looked at. For example, where a patient had been identified as at risk of malnutrition, we saw that a dietitian had been contacted and fortified supplements had been prescribed for them.

Patients received the help they needed with ordering meals from the hospital menu. For example, the catering manager showed us a food order that had been placed by a patient who had written that they required a gluten-free and dairy-free diet. However, the choices they had made from the menu did not reflect this. The catering manager told us that they were going to visit the patient concerned on the ward to clarify their needs and ensure they were provided with an appropriate diet. We also observed a health care assistant assisting a patient in making their choices from the menu as they were unable to read the menu by themselves.

Patients were given support from staff to enable them to eat and drink sufficient amounts. For example, we observed staff assisting patients with opening cartons of fruit juice, ensuring food and drink was within their reach, supporting patients with cutting up their food and helping them to eat. We spoke with a relative who confirmed that staff had assisted their family member with eating and drinking when they had been unable to eat independently. They told us that, since this time, their family member's needs had changed and they were now able to eat by themselves. We spoke with a member of staff who was aware of the patient's needs in relation to eating and drinking and was able to describe how staff promoted their independence.

The provider may find it useful to note that when we observed lunch on one ward, there was a delay of approximately eight minutes between one patient receiving their meal and receiving support to eat it. The patient was asked twice by different staff whether they wanted help with eating their meal even though their care records stated that they required assistance. The patient was unable to start their meal without this assistance. We also observed one patient on another ward with their food in front of them wrapped in film which was left there for some time and they did not eat it. Later in the evening a member of staff

stated that the patient did not eat after a certain time in the day which needed to go on the hand held staff sheet so they could have their meal earlier. The patient therefore did not have their evening meal as staff had not assessed how to support the patient with their nutritional needs.

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

Our judgement

The provider was not meeting this standard.

Patients were not protected against the risks associated with medicines because arrangements in place for the safe keeping of some medicines were not always followed.

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

At our inspection in November 2012 we found that medicines were not always stored securely. We judged that this had a minor impact on patients who used the service.

During this inspection we found that the provider had not made sufficient improvements. We found that storage arrangements for some medicines were unsatisfactory. This meant that the trust could not be assured that these medicines would be safe to use.

The pharmacist inspector met with the Chief Pharmacist and visited four wards and the discharge lounge at Dorset County hospital. We spoke with 13 members of staff. We looked at the arrangements for storing medicines on four wards. We looked at patient's medicine prescription and administration records on three wards. Compliance inspectors also checked the storage arrangements for intravenous fluids and medicines requiring refrigeration on other wards they visited.

Staff told us that the nurses gave most of the medicines used in the hospital, apart from some inhalers, which patients looked after themselves. We saw that some patients kept their inhalers next to their bed. Patients we spoke with who looked after their own inhalers said they were happy with this arrangement. Although one patient told us that they needed a spacer device to use their inhalers properly, which they had not brought with them. The nurse then made sure that they had the appropriate device. Staff told us that patients could look after all their own medicines while they were in hospital but this did not happen often. The hospital had a self-administration policy, which included checks to make sure that this would be safe.

Appropriate arrangements were in place for obtaining medicines on the ward. Systems were in place to ensure that patients were prescribed the correct medicines while in hospital. There was an 'out of hours service' so that staff on wards would be able to obtain prescribed medicines even when the pharmacy was shut. Prescription records confirmed

that medicines were available for patients when they needed them.

Medicines were prescribed and given to patients appropriately. Prescription charts were signed by the prescribing doctor. We saw that a pharmacist regularly checked the prescriptions. Comments from the pharmacist were recorded. Records had been completed to show that patients had been given their medicines. Codes were used to explain the reason if medicines had not been given. We were told that staff regularly checked samples of patients' prescription and administration charts to ensure that they had been completed appropriately. Systems were in place for recording medicines errors on a central electronic system. The chief pharmacist told us that he was not able to access this information directly but that it was discussed at regular safety meetings attended by a pharmacist.

We spoke with some patients on two wards about their medicines. They told us they were happy with how the nurses looked after their medicines and were given them at the correct times. Patients said that they were able to have pain relieving medicines quickly if they needed them. We saw nurses on three wards giving patients their medicines in a safe and respectful way. We spoke with three patients in the discharge lounge who were waiting to go home. They told us that they had been given their take home medicines by the nurse on their ward. The nurse had given them the information they needed about their medicines.

Staff told us that the trust medicines policies were available on the hospital computer system. We saw that information was available to nurses about the correct way to make up and give antibiotic injections. This helped ensure that patients would be given their medicines safely.

Arrangements were in place for medicines to be kept securely in the hospital. Medicines were kept in locked cupboards. Secure medicines trolleys were used to safely transport medicines around the ward and fixed to the wall when not in use. However on two wards we saw that the storage arrangements for some intravenous fluids were not secure.

Each ward had a refrigerator for storing medicines. The trust had a 'Cold storage of medicines policy.' The policy included the daily recording of medicines refrigerator temperatures. This was to make sure that medicines were always stored at the correct temperature and would be safe to use. We saw that this policy was not always followed.

Temperature record sheets included the minimum and maximum temperatures in the refrigerator since the temperature had last been checked. We looked at records for June 2013 made on nine wards. The minimum and maximum temperatures were recorded on six wards. These were often outside the stated safe range for storing medicines. It was not clear whether staff had checked that medicines stored in these refrigerators would be safe to use. One staff member said that they checked the daily recordings weekly, however we found that they had not picked up that the refrigerator had operated outside a safe temperature range. Another ward said that it was done by the pharmacist. The pharmacist said it was done by the wards.

On six wards the refrigerator temperature had not been recorded for at least four days. One ward had no record for June 2013 and records for only six days in May. A note dated 18 June 2013 stated that the fridge thermometer was broken. Staff had sought advice on this date and a thermometer had been ordered. The trust could not be assured that medicines requiring refrigeration had been stored safely and were safe to use.

A check of the safe storage of medicines carried out by pharmacy staff at the end of 2012 had identified some areas for improvement and an action plan had been produced. It was not clear from this plan who was responsible for action concerning intravenous fluids or whether action had been taken. Lack of monitoring of fridge temperatures was not included in the discussion, recommendations or action plan following this report. This meant that the trust was not assured that all medicines were stored safely.

Suitable arrangements were in place for the safe keeping, recording and checking of controlled drugs which need additional security.

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 always sufficient numbers of qualified, skilled and experienced staff to meet patient's needs.

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

There were not always sufficient staff to meet patients' needs. We went to seven wards to review staffing arrangements against the trust own identified staffing levels. We found that five wards had the appropriate staffing levels on the day of our inspection.

On ward one, on the day of our inspection the staff team was under staffed and was one registered nurse and one support worker below identified staffing levels. The trust were unable to cover these shifts. When we returned to ward one the following day the ward were a registered nurse short for the late shift and were trying to find cover. We spoke with four staff on this ward who all stated there were issues with being short staffed. One member of staff told us that "sometimes" shifts got filled and another member of staff told us when they were short staffed there was a lack of time to spend with patients. They also told us that there was "not enough assessment of patient needs" and gave the example of having two or three patients with memory impairment which may require more staff but staffing would not be adjusted. One member of staff told us that staffing levels had increased.

We spoke with three patients on ward one. Two patients told us there were enough staff however one of those told us this was when not all of the beds were full. One patient told us that staff "just get by in the day" and that the ward were "under resourced." They also told us that the ward needed more staff at nights. We visited ward two and found that they were a support worker short and were unable to fill the shift.

We visited ward three and spoke with staff and patients. We spoke with three patients and one relative. All of them agreed that they staff were both encouraging and professional. One patient told us that they felt well looked after and that there were enough staff to meet their needs. Another patient told us they felt safe and that they could summon staff at any time and were confident they would come. We visited a further two wards who were staffed according to the trust's identified staffing levels during our visit.

We spoke with a senior member of staff who told us about a shortage in staff. They told us

there was one senior staff member post vacant. There was a shortage of senior staff on the ward which has meant they struggled to keep up with their managerial role. This was because they often had to support junior staff on the ward. They told us that they hoped to ensure some of the junior staff were given more opportunities to learn and gain experience so that they could take on more senior responsibilities. However, this would mean even less time in relation to the management of the ward as there was no identified staff member who could fulfil this function. They told us that their staff had lessened the impact of low staffing levels through hard work and "doing that bit extra." We were given a report by the trust on safe staffing levels by the trust. This evidenced that the staff had identified areas of concern and the recommendation of the report was to increase staffing levels in identified areas. The trust told us that the board and senior management team received a report on workforce issues and key workforce performance measures, monthly. They also told us that executives met with senior members of ward staff to discuss safe staffing issues on a six weekly basis and a bi-annual dependency audit was undertaken to ensure staffing levels met the patient dependency requirement.

The senior member of staff also told us about regular meetings between the matrons, ward managers and executive directors to discuss staffing levels.

The CEO confirmed that they had faced some challenges around recruitment of staff but they informed us that the recruitment campaign was on-going. They informed us that local recruitment of staff was an issue and overseas recruitment had resulted in six Spanish nurses having started in the Trust, and at the time of our inspection they were on induction. The trust were aware that there may not have been sufficient staff to perform all essential care required by patients as this was on the trust's risk register but the trust aimed to fill gaps with temporary staff. The staffing risk was added to the risk register aligned to the challenges in recruiting the required numbers of staff to manage the increased dependency of patients as evidenced by the dependency audit. Also the move to supervisory ward sisters meant an increased number of staff were required to provide the necessary backfill.

Staffing levels meant that patients were not always safe and their health and welfare needs were not consistently met. We spoke with staff members on ward three. One staff member told us about the risks associated with what they considered were low staffing levels and lack of experienced staff within the team. They gave us an example of their concerns. The staff explained that they were responsible for monitoring telemetry sets for a number of patients in other wards and giving advice to staff on these other wards as to a patient's condition. Telemetry sets are a way by which staff can monitor vital health information remotely via a wireless computer system. This meant that the other staff member on duty, who may not be qualified to carry out assessments of the patients on the ward, may be at risk. They told us that at night there were usually two staff members covering the ward and if they were supporting a patient they were not monitoring the computer system. Although the staff acknowledged the system had an audio warning system, and so could be alerted to a concern, they explained that they felt this could put patients at risk.

We spoke with visiting relatives and three members of staff on ward four. The ward primarily was set up to meet the needs of patients with dementia and physical health needs. We spoke with the staff member in charge of the ward and asked them if there was an on-going needs analysis and risk assessment (as a basis for deciding staffing levels). The staff member told us that their staffing levels were assessed by the trust. A safe staffing levels report provided by the trust evidenced that they recognised the need to increase staffing levels on this ward. Staff told us that they were continually under

pressure due to the needs of the patients. One staff member told us that in one instance the impact of staffing resources meant that a lunch time medication round was delayed from 12pm to 2pm. Whilst the trust confirmed that this was acceptable, patients with enduring mental health illness benefit from routine. The senior member of staff told us about how the ward was organised, those with the higher dependency being nursed in the side wards closest to the nursing station. They also showed us how dependency was assessed, according to support needs in relation to mobility and personal care needs.

We asked the staff member in charge if there were enough staff to provide meaningful occupation for the patients and how staff provided this for them. They told us that the ward did not plan activities but on an ad hoc basis some patients were invited to join in with activities by the occupational therapist from an adjoining ward. We spoke with one relative who was visiting the ward. They told us that the staff worked hard to meet the needs of their relative. We asked them if they considered that there was enough contact time between the staff and their relative. They told us that the staff were available to support their relative with their personal needs but not to provide any social stimulation.

We visited ward five as part of our inspection. We found that the ward had a six bedded unit which the staff called an "annex" as part of it. A senior member of staff on ward five informed us that the annex was a step down area for patients ready to be discharged. We visited the annex over two days. The nurse in charge of the ward was in charge of the ward and the annex however they were based on the main ward. The nurse in charge was unable to tell us about the current needs of the patients on the annex. The annex was accessed through the ward and had two three bedded rooms along a corridor from the ward. On both days of our inspection, the annex was staffed with bank and agency staff, there were no regular staff. We looked at the bank and agency usage for the annex over the previous four weeks. Bank and agency were used to staff the annex every day throughout the four week period. The same bank and agency staff rarely worked consecutive days. There was a risk of inconsistent care or treatment. We spoke with one agency staff on the annex. They told us that this was the second time they had worked on the annex and their first shift was four weeks ago. They told us that the ward was "staffed by a lot of agency." We spoke with two patients on the annex. One patient told us that "There are plenty of nurses on the ward." However the second patient told us that they had been on the annex for two weeks and "There are just not enough staff on the ward." "Only on two days have I had the same staff. There have been different staff every day since I have been here. There have not been enough IV (intravenous injection) trained staff and they have had to get nurses from other wards." They also told us about an issue with staff delivering their care needs in different ways and "If there had been continuity of staff there would have been no issue." We looked at the trusts incident report. There had recently been an incident on the annex and it was highlighted that this was staffed mainly with bank or agency staff which posed a risk to patients.

The arrangements for the employment of agency staff did not ensure staff were appropriately qualified to carry out the tasks they were employed for. One ward senior staff told us about how they use agency staff as well as bank staff to cover shifts that permanent staff could not. Staff told us that most shifts had either a bank or agency member of staff working the shift.

The trust did not have adequate arrangements in place to ensure that temporary staff recruited had the right skills and experience to meet patients' needs. We spoke with staff in the human resources department and looked at agency staff records and booking systems. We looked at 11 agency staff records. The records that we looked at confirmed that all staff had a current disclosure and barring services check. The records showed that

of the four qualified nursing staff only one of the records contained evidence that the staffs registration number had been checked.

Of the 11 staff records only six recorded that staff had received moving and handling training, five had declarations that references had been taken up and five had made a declaration regarding their health in the last three years. There was an expectation that all agency staff would complete mandatory training as specified by the trust contract between themselves and the agency. A system was not in place to carry out annual checks on agency staff once they had been accepted to work at the hospital. This meant that staff may be working with out of date training or no training at all.

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

Our judgement

The provider was not meeting this standard.

Patients were cared for by some staff who were not up to date with relevant training and did not always receive supervision. Therefore they were not always supported to deliver care and treatment safely and to an appropriate standard.

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

Reasons for our judgement

Staff had access to appropriate training but attendance rates were low in some areas. We looked at the training records the education department gave us. They told us this was the mandatory training information and we looked at the surgery, medicine and family services divisions. We found that across the three divisions, the majority of staff received training in adult basic life support and fire safety. However, we found that staff did not always receive training in conflict resolution, safeguarding adults and safeguarding children. For example, approximately 51% of staff had received safeguarding children level one training, in the surgery division, 40% in the medical division and 36% in the family services division. For conflict resolution training, approximately 23% had received training in the surgery division, 32% in the medicine division and 17% in the family services division. There were systems in place for the training department to identify and highlight the gaps in staff training to departments. However, line managers were responsible for ensuring staff had attended training.

Staff working with patients with dementia did not always receive training in this area. We spoke with 15 staff about dementia training across six wards who cared for patients with dementia. One member of staff told us they had received training in dementia however the remaining 14 had not. One ward told us that the dementia support team visited the ward weekly and one ward which had patients with dementia on the ward during our inspection told us that they sought support for patients with dementia from another ward. One ward told us they had a dementia champion and another told us that they were about to commence the role of dementia champion. Staff had not received dementia training but the trust were introducing dementia champions into each clinical area and a training plan to deliver dementia training to staff was in place. The training was to start in July 2013.

On all wards staff had access to additional training however this was inconsistent. A number of ward managers had undertaken a leadership programme run by the trust and this was a bespoke nine month programme for the multi-disciplinary team. We were told by the director of human resources that another leadership programme was planned for April

2014. We inspected seven wards regarding additional training. Two wards we inspected had access to training that was required to deliver care within their speciality. We found, for example, one ward had recently obtained funding to receive training from a local hospice, there was a weekly education programme on the ward and they accessed training through the Dorset Cancer Network. However some wards did not access regular additional training. Four wards were unable to evidence that staff consistently accessed additional training. On one ward we visited staff did not access additional training such as training on particular health needs for the patients they treated. We spoke with three staff from this ward who told us either they were unable to access training or sometimes could not get onto training. One member of staff told us 'unless it is mandatory training, you are unlikely to get it.' One member of staff on another ward told us that they did not have access to training.

Staff did not receive formal supervision in line with the trust policy which stated that the supervisor and supervisee were to meet 'on average once per calendar month for one hour or as necessary.' However, staff told us that they felt supported. The trust sent us a report dated July 2012 which showed that doctors in training posts had access to regular contact with a clinical supervisor in the specialty and regular contact with a named educational supervisor. We spoke with 12 staff about whether they felt supported. Of those staff, 11 told us they felt supported, one member of staff told us they did not feel supported all of the time. One member of staff told us they felt "100% supported." One member of staff told us that the executives were very visible and the Chief Executive Officer (CEO) had visited the department and had met the teams. Another member of staff described the CEO as "putting patients first", and that they were visible on the ward. One member of staff described the executive team as the "Best executive team (they had) ever had". However one member of staff told us that they had not seen the CEO for a long time.

We spoke with 20 staff about supervision. Of those 20 staff, four told us that they received formal supervision. Eight staff told us they could access informal supervision however these were either "informal chats", following a traumatic experience or when staff asked for it. One member of staff told us that "supervision is not offered unless there is a problem." We were informed of one ward which was in the process of developing a supervision framework and they also held reflective groups. We looked in the files of ten staff across five wards and there was no evidence of formal supervision.

The trust had a plan in place for all ward sisters to become supervisory to support staff. The trust aimed to backfill ward manager posts on all wards with clinical staff to free them up to undertake the supervisory role. This was in place in three wards and had started being rolled out across the hospital. Ward sisters had regular away days that focused on a range of areas to align and support them through their transition to their new role.

Staff received appraisals. We spoke with 20 staff all with the exception of one member of staff told us that they had received an appraisal within the last year. We looked at the staff records of 10 staff. We found that nine of the staff had received an appraisal within the last 12 months which focused on learning and development.

Assessing and monitoring the quality of service provision

✘ Action needed

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 regularly monitor and manage some risks however the risk register was not up to date and audits may not have been effective.

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

At our inspection in November 2012 we found that the trust had systems to monitor the quality of the service, although the information obtained was not always analysed or used to improve the service. We judged that this had a minor impact on patients who used the service.

During this inspection we found that the provider had not made sufficient improvements.

The trust had systems in place to regularly monitor and manage the risks associated with infections. We spoke with senior staff from the trust's infection prevention and control team, looked at committee minutes and reports and reviewed audit reports. The monitoring of infection prevention and control included activities such as, daily visits to each ward, monthly hand hygiene audits and weekly unannounced managerial audits whereby senior staff visited wards and departments to check standards. Changes in practice were made as a result of the monitoring of infection prevention and control. For example, the nurse consultant from infection prevention and control told us that they had recommended changes following surveillance of surgical site infections. We were told that the product used to clean the skin prior to breast surgery had been changed to a more effective product. We spoke with a surgeon responsible for this type of surgery who confirmed that this change had taken place.

The trust had systems in place to assess and monitor the quality of the service through a process of clinical audit. We spoke with the clinical audit lead and two clinical quality facilitators. The trust's clinical audit policy detailed the arrangements for clinical audit selection, reporting and dissemination. The trust had a clinical audit committee and an audit operations group which monitored the trust clinical audit activity. The trust had made arrangements to monitor their clinical audit plan. However, these arrangements may not have been effective as complete records of progress and actions were not maintained. The clinical audit policy stated that the progress of the trust's clinical audit plan should be monitored by the clinical audit committee every four months and by the clinical audit

operations group monthly. Minutes of the clinical operational group were not kept but an action log was maintained. However, the action log did not clearly evidence monitoring of the clinical audit plan.

The trust's clinical audit plan detailed 137 clinical audits which the trust intended to complete in 2013/14. The plan indicated the status for 105 of the 137 audits. The start and finish dates of audits were recorded on the clinical audit database. The trust's clinical audit plan detailed 137 clinical audits which the trust intended to complete in 2013/14. The plan indicated the status for 105 of the 137 audits. The plan did not contain any indication as to when any audit was due to start nor when the audit reports would be expected. This may mean that progress of the plan may have been difficult to monitor. We were told by the consultant nurse for infection prevention and control that saving lives audits were not being completed. However these audits still featured on the clinical audit plan. The annual clinical audit report for 2012/13 stated that less than half (98 out of 223) of the registered audits were completed in that year.

The trust's clinical audit systems did not always lead to appropriate changes in practice. The trust undertook a urinary catheter documentation audit in March 2013. This audit examined whether the catheter insertion and the reasons for insertion were documented in the patients records along with an on-going evaluation of the need for the device. The audit was completed across three older people's wards and 20 patients. One of the main findings of the audit was that 14 patients did not have a documented plan identified for the changing or removal of the urinary catheter. The action plan attached to the audit report indicated that a catheter care pathway would be introduced on all older persons wards to improve practice by August 2013. However, we found that urinary catheters were not managed appropriately in other areas of the hospital and changes were not planned for these departments.

The trust undertook a re-audit of the safe storage of medicines in November 2012. The audit recommended that all intravenous fluids should be adequately stored by 30 April 2013. We found evidence on two wards that there was no lockable storage for intravenous fluids. The audit report observations did not always correspond to the audit findings. For example, the audit report stated that there had been an improvement in the number of refrigerators used to store medicines, however, the data in the report suggested that there had been a reduction in refrigerators meeting this standard. We found that there was no effective on-going monitoring of medicine refrigerators.

We asked to see audit reports for the last three audits completed. These were not detailed on the trust's clinical audit plan. We were told that not all audits completed were detailed on the clinical audit plan. We looked at the clinical audit annual report which indicated that action plans were received for less than half of the audits completed. This was a key area of concern for the trust and their goal was to improve follow up audits and action plans.

Nursing indicators audit looked at documentation in relation to observation charts, nutrition, fluid balance, pain management and pressure area care. These audits were completed monthly by the wards and looked at five sets of patient records to gain a score. The audit results were displayed on information boards on the wards. We found that nutrition records were not always completed, however an audit in June 2013 indicated that these were completed and gave a score of 100%. We also found that documentation relating to falls and pressure area care had not always been completed despite a high audit score. This meant people were at risk of receiving inappropriate or unsafe care as systems for monitoring the quality of the service were not effective.

The trust risk register was not being reviewed by the trust board. We looked at the trust board papers for April, May and June 2013 and found that the board had not reviewed the trust's risk registers. The quality assurance committee expressed concern in March 2013 that the risk register was not up to date and had been withdrawn from the board meeting in March 2013 and commented that the risk register had not been reviewed for four months. We spoke with the head of risk management who told us that a review of how risk registers were used across the trust found that the system varied and the data was difficult to compare. A revised risk register format was introduced in May 2013 and was being evaluated. A policy to support the risk register process was planned for September 2013.

We looked at the strategic risk register which provided a summary of the current strategic risks facing the trust. Further information regarding these risks including action necessary to mitigate the risk and the progress with these actions was included in the individual risk register outline documents. We were told that a key risk summary document contained details of significant risks and was presented to the board. However there was no evidence contained in the board papers that this document had been reviewed by the board.

The trust acknowledged that the process of presenting and managing risks across the divisions varied and more consistency was needed. Pilot local risk registers were being trialled in a number of clinical areas. We looked at the divisional local registers and found that these were not consistently completed or updated. For example, the family services risk register detailed that staffing levels in maternity were below benchmarking levels. The current position of this risk was last updated in May 2012.

The trust operated an electronic system for staff to report incidents. Following an incident being reported an appropriate person would be allocated to investigate the incident. The trust had a risk leads group which consisted of staff across the hospital. This group met weekly and received a copy of all incidents in the trust for the week preceding the meeting. The group discussed significant incidents. We looked at the weekly meeting records and found that this group was supplied with incident information and these were discussed.

The trust had a process in place for investigating significant incidents. We were told that these investigation reports were presented to the trust's scrutiny panel where the lessons learnt and recommendations were discussed. The head of risk management told us about an incident regarding the unsafe use of an epidural line. Following this incident a new process was developed by the trust to reduce the risk of future error. This process involved two staff checking prior to administering medicines and equipment for epidural being at the opposite side to any other equipment used for administering medicines via other lines. A bright yellow sticker had also been introduced to distinguish the epidural line from other lines. We spoke with two midwives who described the change of procedure and the reasons for this.

The trust had identified a risk that there may not have been sufficient staff to perform all essential care required by patients. This risk was entered onto the trust's risk register. We looked at the risk register which detailed the actions taken to reduce this risk. The register stated that a dependency review had been completed and staffing levels had been reset to meet the needs of patients currently accessing the hospital's services.

The trust had made arrangements to review and implement national guidance. For example, we looked at the trust process for managing guidance issued by the National Institute for Health and Clinical Excellence (NICE). We saw that this guidance was examined centrally and sent to relevant clinical departments for them to assess and

provide assurances as to how they were implementing specific guidance. Responses were recorded and rated on a spread sheet.

The trust had established a group to look at the recommendations resulting from an enquiry into the failings at another NHS trust. The group was established in April 2013 and we looked at minutes from two meetings. We saw that a draft action plan had been created which included further examining staff perceptions and learning from incidents.

The trust had implemented the 'friends and family test'. Patients were asked whether they would recommend hospital wards and A&E departments to their friends and family if they needed similar care or treatment. We looked at the results of this test from April 2013 which showed that the majority of the 291 respondents stated that they would recommend the hospital to their friends and family. The trust's board meetings included a section whereby patient feedback was discussed. For example, we saw that feedback relating to a delay in discharge was discussed and medical staff had been invited to attend to explain the discharge process.

The inpatient survey for 2012 was published in February 2013. The trust had developed an action plan following this survey. The action plan was unavailable at the time of inspection due to staff leave. We were provided with an overview of the work being undertaken following this survey which mainly focused on greater analysis of the results. The trust was judged to have improved significantly in two areas and worsened significantly in nine. The areas they had improved included same sex sleeping accommodation. The areas they worsened on included questions relating to the availability of staff.

The trust had a complaints policy and information was displayed on notice boards and leaflets within the hospital which provided information as to how to make complaints. We spoke with the complaints officer who explained that complaints were sent to the relevant department to examine. We were told that learning from complaints was managed by the individual divisions. The trust informed us that the learning from complaints was managed within divisions and scrutinised by the learning from complaints group which was attended by all divisions and supported by members of the public. Detailed quarterly feedback was provided to the Trust Board.

The views of staff were obtained through a staff survey undertaken between October and December 2012. This survey examined staff views in relation to a number of areas including, their role, their personal development and their working environment. The results of this survey were reported to the trust board and an action plan developed to address issues identified by the survey. For example, we spoke with the director for workforce and human resources who told us that the trust planned to introduce a bespoke health and wellbeing program as a result of staff suffering work related stress and feeling pressure to attend work when they felt unwell. This program was planned to be introduced by August 2013. We were told that the chief executive held regular drop in sessions for staff to share their views and experiences.

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 records were not always complete or accurate.

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

At our inspection in November 2012 we found that patients were not protected from the risks of unsafe or inappropriate care and treatment because records were not always appropriately maintained and kept securely. We judged that this had a moderate impact on patients who used the service.

The provider wrote to us to indicate that they had made some improvements such as us they would communicate with healthcare professionals to ensure that records were completed in a timely manner and filed in the appropriate location. However the provider told us they would not be compliant until the development of an electronic patient record had been considered as part of a review of the healthcare record. During this inspection we found that the provider had not made improvements to records where they had told us they would be compliant.

The trust did not always maintain an accurate record in respect of each patient. We found evidence that there were incomplete records on each of the 10 wards we inspected. For example, records regarding the insertion of catheters varied and for two patients there was no record of the catheter insertion. We also found incomplete records for moving and handling. For example, one patients moving and handling record was incomplete and did not include the equipment or the technique to be used. We also saw that two patients moving and handling plans were blank and one patient's record stated that their moving and handling had 'not been assessed' however we observed the patient sitting in their chair after being in their bed. There was a risk that patient's individual needs were not met because records were not maintained about how to meet them.

We found in two patient records that they stated that there was an indication that the patient may not have capacity to consent. This was not initialled or dated in either of the two patient records. There was no evidence of review or further information about this. We spoke with a member of staff about one of these patients. They told us that the patient did have the capacity to consent and the record needed to be reviewed.

We found that admission and assessment records were incomplete in the majority of records we reviewed. We looked at a minimum of two records on each of the wards we inspected. We found that records were completed to varying levels. We found that patients' physical needs were not always recorded. For example, we found that food and fluid charts were not always completed and physical assessments were not always completed. There was one example on one ward where one patient's nutritional risk indicated that they required daily food charts but there were none in use. There was also one example on another ward of a patient's assessment record indicating they were 'thin' however they had not had a nutritional assessment and no food charts were in use.

Patients were not always protected against the risks of unsafe or inappropriate care and treatment because there was a lack of proper information about them. Records did not demonstrate that patient's needs were being met on each of the 10 wards we visited. There were not always care plans available to ensure that staff understood how to meet patient's individual needs. For example, one patient had a stoma but there were no records indicating how to manage the stoma. Staff told us that they met the patients' needs with regards to the management of the stoma however there were no records to support this. There were also no care plans on any of the wards we inspected for the management of urinary catheters or the management of patients at risk of pressure area damage. There was a risk that patients' needs were met inconsistently through a lack of care plans. For example, one patient had been identified as being at moderate risk of pressure area damage and they had pressure area damage. We looked at their repositioning chart over a five day period and found that records were inconsistent regarding the frequency of turns and on one day there were no records of repositioning at all. There was a risk that the patients' pressure area care needs were not met because there was not an accurate record in relation to their needs.

We looked at the care records of five patients requiring wound care management. We found that one patient had wound care assessments completed for their wounds which included information about the appearance of the wounds and their management. However, there were no wound assessment charts for four patients. Staff informed us that they managed the wound care of the patients however there were no records about the appearance of the wound or how it was managed. One member of staff showed us that the dressings used for the wounds were recorded on the hand held staff sheet. There was a risk that changes to the wound or surrounding area were not recorded so staff may not recognise if the wound was deteriorating.

On one ward we visited we looked at the care records for six patients. Each patient had a care plan which had the patient diagnosis recorded. However there was no plan of care as to how to meet these patient's needs, no description of what the diagnosis meant for the patient and no further detail about what their particular needs were. Staff told us that some patients wandered but there were no care plans about this behaviour to inform staff and ensure that patients were protected from the risks of unsafe care. Staff told us that at times they locked the doors to the ward to protect patients who wandered but there was no evidence in any of the six patients' records that this action was taken for their protection. There were no records to demonstrate that patients were not being deprived of their liberty as there were no records for the assessment of patient's mental capacity to make the decision to leave the ward. These records lacked proper information about these six service users in relation to their care and treatment.

On another ward we were told by staff of a particular concern regarding the behaviours of a patient at the time of our inspection. The staff were able to detail the patients' needs however there were no care plans about this patient's particular needs and there were no

risk assessments to keep staff or patients safe. There was a risk that patients' were not protected from the risks of unsafe or inappropriate care or treatment because there was a lack of proper information.

Patients' discarded personal information was kept securely. We saw that discarded personal information was disposed of in confidential waste containers which were kept in secure rooms.

This section is primarily information for the provider

✘ Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services
	How the regulation was not being met: Some patients did not experience care, treatment and support that met their needs and protected their rights. Patients were at risk of inappropriate and unsafe care. Regulation 9 (1) (a) (b) (i) (ii).
Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing
	How the regulation was not being met: There were not always sufficient numbers of qualified, skilled and experienced staff to meet patient's needs. Regulation 22.
Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers
	How the regulation was not being met: Patients were cared for by some staff who were not up to date with relevant training and did not always receive supervision.

This section is primarily information for the provider

	Therefore they were not always supported to deliver care and treatment safely and to an appropriate standard. Regulation 23 (1) (a) (b).
Regulated activity	Regulation
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 had systems in place to regularly monitor and manage some risks however the risk register was not up to date and audits may not have been effective. Regulation 10 (1) (a) (b).
Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records
	How the regulation was not being met: Patients were not protected from the risks of unsafe or inappropriate care and treatment because records were not always complete or accurate. Regulation 20 (1) (a).

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

The provider's report should be sent to us by 16 October 2013.

CQC should be informed when compliance actions are complete.

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

This section is primarily information for the provider

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

Enforcement actions we have taken

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

We have served a warning notice to be met by 30 August 2013	
This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010
	Management of medicines
	How the regulation was not being met: Patients were not protected against the risks associated with medicines because arrangements in place for the safe keeping of some medicines were not always followed. Regulation 13.

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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