Care Quality Commission

Inspection Report

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

Royal United Hospital Bath NHS Trust

Directors Offices, Royal United Hospital, Combe Park, Bath, BA1 3NG

Tel: 01225428331

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19 June 2013
18 June 2013
17 June 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:

Standard		Outcome
Respecting and involving people who use services	✗	Action needed
Care and welfare of people who use services	✗	Action needed
Cooperating with other providers	✓	Met this standard
Safeguarding people who use services from abuse	✗	Action needed
Assessing and monitoring the quality of service provision	✗	Action needed
Records	✗	Enforcement action taken

Details about this location

Registered Provider	Royal United Hospital Bath NHS Trust
Overview of the service	Royal United Hospital Bath is an acute hospital on the edge of Bath just over a mile from the centre of the city. The hospital covers a local population numbering around half a million people in Bath and some parts of North East Somerset and Western Wiltshire.
Type of service	Acute services with overnight beds
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 Nursing care 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 Royal United Hospital Bath NHS Trust had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Cooperating with other providers
- Safeguarding people who use services from abuse
- 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 17 June 2013, 18 June 2013, 19 June 2013 and 20 June 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 specialist advisor.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

This inspection visit was to follow up compliance actions from the responsive inspection that was conducted in February 2013. At that time concerns were raised about the manner in which some patients had been discharged without adequate information and support. At this inspection we also reviewed governance systems and the mental capacity assessments that took place at the hospital.

We took a nurse with us who had expert knowledge in discharge arrangements, a psychiatrist with an expertise in the Mental Health Act 1983, who spoke with voluntary patients who were receiving treatment for their mental health, and a manager within CQC with expertise in Governance arrangements in acute trusts.

During our inspection we looked at three areas of care at the hospital. These were all the older people's wards, the emergency department and the day surgery unit (DSU). We also visited the theatre recovery area.

We met and talked with many patients during our visit. Staff were approachable and open in their discussions with us. Where patients were not able to talk with us for various reasons, we spent time observing how care and support was delivered. We saw and were given written evidence from the trust. This included patients' notes, hospital records and recordings of their clinical observations.

We met with consultant medical staff, pharmacists, therapy staff, registered nurses and healthcare assistants. The majority of staff we met with showed a professional and caring attitude towards their patients. We also met with hospital directors and senior management staff.

We found the trust ensured they met patients' treatment and care needs on the day surgery unit as it was no longer being used routinely as a facility to care for inpatients from other parts of the hospital. They had also ensured correct information and support resources were put in place for patients discharge from the older people's wards we visited.

We met with fifteen patients and six patients' visitors. Comments included "I'm sleeping fine at night"…."haven't rung the bell – there's no need" (as they pointed to the staff around and available to support). Four visitors on two different wards also gave us positive comments, one of them telling us how the patient they were seeing was "improving."

We discussed patients with staff on all of the wards. We made observations of patients who were too unwell or frail to talk to us. We saw some warm and kind interactions between staff and patients.

We visited four older people's wards. On three of these wards we found the systems in place for the assessment, planning and delivery of care were not fully effective in ensuring patients care needs were met. We also found records were not being completed in a consistent manner, including records of patients' fluid intake and output on these wards. Patient's privacy and dignity were respected. However, on two of the four older people's wards, at the time of the inspection visit, we saw instances where patients were not having their privacy and dignity maintained.

On one older people's ward we found there were not suitable arrangements in place to protect people against the risk of excessive control. This was related to the use of assistive technology ('tagging') patients with cognitive impairment who were at risk if they left the ward.

We saw there was a system in place to regularly assess and monitor the quality of service that people receive and to identify, assess and manage risks to the health, safety and welfare of patients and others. These internal quality assurance mechanisms had not been effective in ensuring improvements required as a result of our last inspection had been implemented. We saw a number of improvements had been made and were in the process of being implemented.

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

What we have told the provider to do

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

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

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

processes. We will publish a further report on any action we take.

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Patient's privacy and dignity were respected. However, on two of the four older people's wards, at the time of the inspection visit, we saw instances where patients were not having their privacy and dignity maintained.

We have judged that this has a minor 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 last inspection on 4 to 6 February 2013, we found inpatients accommodated on the day surgery unit (DSU) were not having their privacy and dignity maintained. At this inspection we visited the DSU and spoke with seven patients, three relatives and four staff. We also looked at the trust's action plan following our last inspection and what actions it had taken. To establish if there were any inpatients who had stayed overnight in the unit we started our inspection of the DSU at 10:20 on Monday 17 June 2013. The DSU had re-opened at 7:30 am that morning because it had been closed over the weekend. We saw there was no evidence of any inpatients being cared for on that ward and that the only patients were those arriving for day surgery that day We also returned to the DSU at 14:00 on 20 June 2013 to review the situation. We found all of the patients on the DSU had been admitted for day surgery only and so there were no inpatients on the DSU on either of the occasions we visited.

We saw the trust had completed the actions in their action plan dated May 2013. For example they had "reviewed DSU admission criteria and reinforced with staff the use of DSU for 23 hour patients". Staff told us this meant it was much "easier" for them to ensure patient's privacy and dignity were maintained. A registered nurse told us "the changes have made everything better for patients. Patients are here for much shorter periods now." The trust had also 'reviewed DSU admission criteria' to ensure patients' needs could be met on DSU. Staff confirmed this had taken place and staff were clearer who the ward was "actually for".

At our last inspection patients reported disturbed sleep due to the amount of night time activity on the ward and there was a lack of washing facilities. We saw the hospital's action plan stated they were in the process of 'providing an additional shower'. This was to stop mixed gender shower rooms on the unit. We saw building works to provide a second shower

room were nearly complete when we visited. Patients on the DSU were positive about the environment and the staff team. Comments included “staff are always nice when I come here.”

In the action plan, the trust stated ‘DSU staff were made clear of DSU function when the trust is in red or black escalation’, meaning when urgent admissions mean the trust had to provide additional bed capacity in areas not usually used for inpatient care, such as DSU. Staff members we spoke with confirmed they knew about this plan but one staff member told us “they were still anxious” about what would happen when the “time came”. We discussed this with the Matron who told us there were action cards with instructions for staff to follow if the trust went into black escalation, which we saw at the nurses’ station.

We visited the four designated older people’s wards over a four day period. Across all the wards we visited we spoke with 17 patients and made observations of care for a six further patients who were too unwell or frail to talk to us. We spoke with six patients’ visitors. We spoke with 23 members of staff including registered nurses, healthcare assistants and therapists and the matron. We read 32 inpatients records and 4 post discharge patient records. We also completed timed observations of a lunchtime meal for an hour period.

These were in two separate bays in one ward. Although we saw generally people’s privacy and dignity were respected, we observed a few instances where this was not the case.

On two of the older people’s wards the hospital had suitable arrangements to ensure patients’ privacy, dignity and independence. On one of these wards, we met with a frail elderly patient. They were smartly turned out in their own clothes, including a tie. They said they appreciated being supported to dress in the way they wanted. They told us they were comfortable and we observed their fingernails were very clean.

We saw another patient on the same ward was being addressed by the first name they preferred, not the name documented in the front of their records. We saw there was clear documentation relating to the patient’s preferred name in their records. A member of staff told us it was important to make sure staff addressed a patient in the way they preferred.

However, on the other wards we visited we saw the hospital did not have suitable arrangements to ensure people’s privacy, dignity and independence. On one of these two wards we were alerted to a patient in soiled bed because of the odour which permeated into the corridor. We observed the patient waited 10 minutes in this odorous, soiled bed, before staff came to help them. The call bell was not accessible to this patient, as it was on the wrong side for the patient to reach. The patient who was immobile was calling for help during this time. At the point when we had decided it had been too long and we were about to look for staff to help, staff came to support them.

On the same ward we were about to visit a visibly frail patient when staff appropriately asked us to wait until they had given them personal care. This personal care was not fully effective. When we visited the patient, half an hour afterwards, we found they had brown food supplement staining round their mouth and their left hand had dirty finger nails.

On the other ward, we saw two female patients, on different occasions, in toilets with the toilet door wide open. One patient had their underwear visible round their legs. One of the occasions took place when there were visitors to the ward, so the patient could have been seen by visitors. The first patient we observed was having difficulty standing; they had a Zimmer frame in front of them and were visibly struggling. We saw there were nursing and healthcare assistants in this area and they did not assist them. We brought this to the

attention of the nurse in charge.

We asked nursing staff on this ward what they understood by patient dignity. They were unable to explain or relate the issue to the delivery of care to patients. We asked them how they and the unqualified staff showed respect for patients. They had a similar difficulty in describing the care they gave to patients which ensured patients were treated with dignity.

The Nursing and Midwifery Council's Guidance for Care of Older People (2009) states registered nurses "have a responsibility to ensure that care which older people receive is of a consistently high standard whether it is provided by yourself, a colleague or someone you delegate care to. You need therefore to be continually monitoring and challenging if poor care is provided by colleagues and championing the quality of each older person's care experience. It is important that you give feedback to colleagues on their competence in caring, especially in relation to their behaviour and attitude". In the light of our findings we found this guidance was not being followed consistently.

We asked the senior nursing staff about why the staff had not assisted these two patients in a timely manner. We asked about the system for monitoring the patient care given by staff, including care assistants. We were told "I am always telling the staff about this sort of thing" and "I keep telling the girls but what can I do"…"I just cannot be everywhere." They stated it was "difficult" for qualified staff to always know what was being delivered by the unqualified staff. They stated that, while the ward sisters were meant to be supernumerary this could not always be the case due to patient acuity and overall activity.

We asked about one ward which was divided into two parts which was very busy. We were told often the senior nurse on duty held the bleep in charge of the whole ward. Each part of the ward had its own registered nurse in charge. Often, "cover" had to be obtained from other wards. We saw this was the case on two out of the three days we were on the ward. The most senior of the qualified staff had overall charge for both parts of the ward, in addition they had to undertake clinical work on their own side. We asked about the patients on the other side. The nurse in charge was unable to tell us about those patients in detail because the only information available to them was nursing information included in the shift handover notes. Nursing staff told us this impacted on their ability to supervise the way in which staff were delivering care and treatment.

Care and welfare of people who use services

✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were systems in place for patients' to have their care needs, assessed, planned and delivered. On three of the older people's wards these systems were not being used in a co-ordinated and consistent way. Care delivery by staff generally was managed to meet patients' care and treatment needs, but risks remained of inappropriate or unsafe care. At times there were delays in the assessment of patient's mental health needs in the emergency department.

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 the last inspection on 4 to 6 February 2013 we found that patients being cared for and treated on the day surgery unit (DSU) were not having their care needs adequately assessed, planned and delivered. The care and treatment arrangements on the unit were not organised around the range of care needs of the patients accommodated there.

We started our inspection of the DSU at 10:20 on Monday 17 June 2013. There had been no patients accommodated overnight and the unit had therefore opened at 7.30am that morning. Patients being cared for on the unit were those arriving for day surgery that day. We also returned to the DSU at 14:00 on 20 June 2013 to review the situation. We found all of the patients on the DSU had been admitted for day surgery. There were no inpatients on the DSU on either of the occasions we visited during our inspection visit.

At this inspection we found the trust had met its action plan dated May 2013 in relation to the DSU, in that DSU had returned to being a 23 hour ward.

In their action plan the trust had stated they would review availability of documentation within DSU. A ward clerk was to appointed for DSU who would be responsible for maintaining a supply of relevant documentation. A shift coordinator would ensure all patients had appropriate nursing documentation completed, including initial and on-going risk assessments. We saw all these actions had been completed. We saw the ward clerk busy on both day we visited carrying out duties, including the management of patients' notes and records.

We spoke with seven patients and three relatives who all made positive comments about the DSU. These included "staff are lovely" … "my experience has been very positive"… the surgeon was "really clear and helpful".

We spoke with five registered nurses and a matron who confirmed inpatients had not been admitted to the DSU for the past six weeks. The staff we spoke with were positive about the changes. A registered nurse told us “it’s massively changed”. A member of staff also told us a new clinical lead had been appointed to lead the DSU. This member of staff said that they felt this was a positive improvement in service provision allowing them to discuss concerns and develop the service.

A matron told us inpatients were no longer accommodated in the DSU for over 23 hours following their Spring to Green week” initiative in May 2013. They told us the initiative had been trust-wide to make long term improvements, increase patient safety, improve staff morale and work towards the trust’s capacity status being maintained at a ”green” escalation level.

We read the report summary of the ‘Spring to Green week’ summary of outcomes completed by the trust after the event. It stated the aim was to “ensure the right patient is in the right bed”. It explained ‘the week was managed in the same formula as a critical incident with a command centre and performance against each expected outcome measured throughout the day’.

The matron told us the impact the event had on the DSU. The improvements included increased bed availability, the IT was improved so all computers could be utilised and they had two computers on wheeled trolleys. This meant staff could make assessments at the patient’s bedside and make more space in the previously crowded work station.

The matron and the registered nurses described the regular reviews held about patient status to improve bed management. The matron told us if the DSU needed to be used as an inpatient facility in the future on a temporary basis, it would be ensured staff had all the inpatient documentation they would need to care for patients safely. The matron told us if the unit went into increased escalation, patient placement in the hospital would be reviewed on a case by case basis regularly throughout the day. The aim was to make sure each patient was in the correct bed to meet their needs.

The head of adult social care for Wiltshire Social Services confirmed an improvement in bed management in the hospital. They told us that since May 2013, they had found older patients were no longer being moved around the hospital and were placed on wards appropriate to meeting their needs.

A member of staff on the DSU told us there was still some anxiety among members of staff about what would happen in DSU during any future periods of black escalation. Following the ‘Spring to Green’ week the trust stated there were improvements. For example, bed occupancy decreased from 99.4% in April 2013 to 88.1% in May 2013. Extra capacity beds above baseline bed capacity (opened in response to an escalation situation) had reduced in May to zero, from 71 beds in April. We were not able to judge how much the improvement was related to the ‘Spring to Green’ action plan and patient flows in and out of the hospital associated with the wider health and social care system. We saw the Trust had developed action cards for all staff detailing what they should do in a period of black escalation. There had also been a mock inspection completed by the senior management in the Trust to assess progress against their action plan.

Following our inspection of February 2013 we received information, from a range of sources, about patients remaining on the recovery unit of operating theatres for extended periods of time, care on the older people’s wards and the carrying out of mental health assessments in the emergency department. At this visit we looked at these areas. On three of the four older

people's wards we found shortfalls in assessment, care planning and delivery of care in the areas of nutrition and hydration, pain management and pressure area care. In the emergency department we found delays in the assessment of people's mental health needs. At the time of the inspection we found the arrangements in theatres and recovery were satisfactory following the 'Spring to Green' week initiative.

We met with three members of staff in the operating theatres and recovery unit. They told us patients remained on recovery only while they were recovering from their operations. They were then taken to the wards as soon as they were deemed medically fit to do so. They told us that during the period of black alert earlier in the year, they had experienced some patients waiting on the recovery unit until a bed was available on a ward. The theatre manager told us how this had been managed and we looked at their data. The manager described how communication systems had worked across all of the operating theatres during this period, to minimise risk to patients. This had involved making sure theatre personnel, including surgeons, were aware of the situation with bed capacity. The theatre manager showed us the hospital's system for making risk alerts when lengths of stay in the recovery unit were extended. These alerts were made using the hospital's electronic risk management incident recording system. The theatre manager showed us how they were sent reports from the system regularly, so they could monitor the situation and ensure senior managers were aware of potential risks to patients.

All of the staff we spoke with described the work which had taken place during "Spring to Green" initiative six weeks previously and how this had given them time to look at practice across operating theatres and recovery to ensure the service operated safely and patient safety was maintained. The operating theatre manager showed us the current report from the electronic risk management system which showed us patients remained in recovery only for the periods required according to their status.

We visited the four designated older people's wards over a four day period. We spoke with fifteen patients and made observations of care of a six further patients who were too unwell or frail to talk to us. We spoke with six patients' visitors. We also performed observations of a lunchtime meal in two bays on one ward. We met with 23 staff, including registered nurses, healthcare assistants and therapists. We read the records of ten of the patients we met with and discussed patients' needs with staff. We also read a further 32 paper records in depth and followed a sample of five of these records through to the hospital's electronic record keeping system and looked at how the data was carried across. This was so we could understand how needs assessment and care and treatment planning were recorded and used by staff for the delivery of care and treatment.

Three patients on two of the wards gave us positive comments. These included "it's all good here" …."I'm sleeping fine at night"…."haven't rung the bell – there's no need" – pointing at the staff around and available to support. Four visitors on two different wards also gave us positive comments, one of them telling us how the patient they were seeing was "improving."

We discussed two patients with four staff on one of the wards and they showed a clear understanding of how to care for them. We saw what they told us about these two patients had been fully documented so staff knew how to care for them safely. On all of the older people's wards we visited, we saw people being moved and handled safely. This was done in accordance with national guidelines. During our periods of short observation we saw many instances of warm interactions between staff members' and patients'. On three of the four older people's wards we found that although there were systems in place to check patients' care needs were being assessed, planned and delivered, these systems were not being used in a co-ordinated and consistent way. Because of these inconsistencies the trust could not be sure care and treatment reflected published guidance from expert bodies. We

found the arrangements in place on Victoria ward were working effectively. Ward staff were aware of and following systems in place to ensure patient's care and treatment needs were met and risks to their health and welfare reduced.

Guidance from the National Institute for Health and Clinical and Healthcare Excellence (2012) (NICE) "Patient experience in adult NHS services; improving the experience of care for people using adult NHS services" states patients need to have their "physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief". Providers need to "Ensure that the patient's nutrition and hydration are adequate at all times, if the patient is unable to manage this themselves, by: providing regular food and fluid of adequate quantity and quality in an environment conducive to eating…placing food and drink where the patient can reach them easily…encouraging and helping the patient to eat and drink if needed".

On two of the three wards where we found problems there were issues relating to hydration and nutrition. Staff showed us their use of the comfort round records. This was a monitoring tool to check on patient's welfare needs. These were completed for all the patients we saw.

Patients were offered drinks as part of comfort rounds, but this did not necessarily result in sufficient fluid intake and the information being included in fluid balance charts.

We looked at 100 fluid balance charts of 37 patients who had been identified as at risk of too much, or too little fluid intake. The hydration chart gives a visual assessment of how much fluid the patient has drunk. Fluid balance charts document the balance between intake and output of fluids. So these can be measured and monitored each day and any discrepancies identified to ensure patient safety. These were not completed as required by the instructions in the trust's new Hydration Bundle policy. We saw 90% of the fluid charts had not been used to assess these patients' total intake and output, even when the patients' had infections and / or were very unwell / had difficulty in drinking or feeding themselves. This contradicts good practice and the trust policy. As a consequence it was difficult to ensure these patients care was adequately monitored and assessed, because staff could not assess their patient's condition in relation to their fluid balance each day.

Following our last inspection the trust had recently introduced a new hydration chart for patients who were able to drink and did not need their output monitoring. We asked staff about this practice. They all said it was confusing having several different systems for recording and managing fluid intake, in use at the same time (fluid charts, hydration charts and comfort rounds). We spoke with four members of staff who all told us fluid balance and hydration information was not being used to help inform assessment and planning of care and treatment. One of these staff members said "no one looks at them anyway."

On one ward, we saw a service user had a full jug of water on their bedside table. They were holding a beaker with a small amount of liquid in it. They told us they knew they were meant to be drinking more. Although this patient had a hydration chart they did not have a recorded assessment of their hydration needs. The patient's day to day hydration had not been assessed by totalling the amount of fluids they had been able to drink in 24 hours. When we did this we found on 19 June 2013 they had drunk a total of 350ml in 24 hours according to their hydration chart. This patient demonstrated to us how they were unable to lift the jug of water, as it was too heavy. We saw, and their care plan indicated, they had needs associated with shortness of breath. There was no assessment of their ability to drink independently, or whether they needed assistance to ensure adequate fluid intake. During an observation period at lunchtime we saw their jug remained full. The level of fluid in their beaker also remained the same. No member of staff poured a drink out for the patient or reminded them to drink throughout our observation period.

On one ward we met with a patient whose records included a fluid balance chart and staff confirmed had been seriously unwell. The patient was too unwell to talk to us for any length of time. They said "I get thirsty and I don't know how to get a drink if I want one." They were lying on their side, with their back to the bedside table where their water jug and glass was placed. They had a note from the speech and language therapist pinned up on the board above their bed which stated they were only to be given drinks when alert and sitting up. We checked this patient's fluid chart at 16:35, the last recorded fluid intake was a drink at 14:00 the previous day. This patient did not have records included in their notes of the total fluid they had drunk each day to support assessment of their hydration. The patient did not have a plan of care about how they were to be supported to drink to prevent risk of dehydration. During our observations we did not see staff giving this patient support to help them drink.

The ward staff were also not ensuring this patient's dietary needs were met. At 14:30, this patient had a container of a dietary supplement on their bedside table, which was three quarters full. We asked a registered nurse to show us the patient's nutritional risk assessment. The registered nurse showed us the hospital's electronic record keeping system where nutritional assessments were made individually for all patients. This patient's electronic nutritional risk assessment had last been completed on 9 May 2013 and the patient was found to be at nutritional risk. This was six weeks before our visit, whereas the hospital's policy stated nutritional assessments should be carried out as a minimum once a month.

This patient had a food chart. It was incomplete and did not show if they had been supported in taking the supplement. The last entry showed they had eaten three "spoonfuls" at breakfast the day before. The previous record to that had been made on 9 June 2013, when the patient had been documented as eating all of their breakfast and lunch, but the record had not been completed for the evening meal. When we returned to the patient at 16:35, the level in the food supplement had not changed and no additional record of the nutritional support the patient had been given that day.

We asked a senior member of the nursing staff about completion of the patient's nutritional record. They told us they had noticed these records had not been made. They told us the member of staff who was assisting the patient was the person who was meant to make the record. There were no assessments in the patient's records of how much they had eaten on a daily basis and there was no plan of care to direct staff on how they were to plan to reduce the patient's nutritional risk.

On another ward, a patient's visitor told us they had noticed a patient had struggled to eat. We asked a registered nurse to show us this patient's nutritional risk assessment to see if this patient had been assessed as being at risk. The registered nurse showed us the patient's nutritional risk assessment on the hospital's electronic record keeping system and we saw it had not been completed. The registered nurse told us this was because the patient had not yet been weighed so the risk assessment could not be completed. The patient had been in the hospital for several weeks.

During our observation period, we saw a member of staff placed the patient's lunch on the table in front of them and gave them a spoon, saying it would be easier for the patient to eat with a spoon, as they were having a soft diet. The patient sat and looked at their lunch for three minutes, but did not start to eat. Their visitor then gave the patient their lunch. When the patient had eaten all they were able to, the visitor showed us the person had eaten approximately only a quarter of their meal.

The visitor told us they thought concerns about the patient's difficulty in eating had been reported to the ward sister. We looked in the patient's medical records but there were no notes made about the patient having difficulty in eating. There were also no notes about the patient being given a soft diet. The patient's medical records did not show they had been referred to a relevant therapist about their difficulties in eating.

We asked a member of the nursing team who was working in the area about how the patient ate. They told us the patient usually needed help with most meals. We looked at the patient's day to day chart about how much assistance with eating they required. Entries in the records had not been completed to assess the assistance this person needed to eat. The patient did not have a care plan about how their nutritional risk was to be reduced, to ensure their health safety and welfare.

On the third ward where we found problems we met with two patients who were assessed as being at risk of pressure ulceration. Both patients were thin and frail. Staff confirmed they were unable to move their positions independently. We asked staff about changing patients' positions when they were assessed as being of risk of pressure ulceration. They told us patients' had their position changed every two hours and pressure relieving equipment was provided on their beds. We saw both patients had been provided with appropriate pressure relieving equipment on their beds.

The NICE guideline Pressure Ulcer Management (2005, updated 2010) states that pressure ulcers, once developed can seriously affect a patient's health, are painful and can increase risk of infection. Therefore the emphasis must always be on their prevention. This includes care of the skin, pressure relieving devices, appropriate nutrition and hydration. The use of pressure relieving equipment alone does not reduce risk. People at risk need to ensure they change their positions regularly and where they are not able to do this independently, there needs to be a system in place to make sure this happens. This is a summary of the NICE guidelines on good practice in relation to the management of pressure ulcers.

One patient who was assessed as having a risk of developing pressure ulcers did not have a plan to ensure the care they were delivered met their needs and reduced their risk. The patient's comfort round records which documented matters such as their position in bed were not completed daily. Three days before our inspection this patient's records showed that although checks had been carried out six times between 06:30am to 01:30am the next day, during this 18 hour period their position had not been moved from being on their back. This patient's record documented red areas had been observed on their heels four days before our inspection. We asked staff how they were given information on meeting patients' needs. They told us this happened at handover and they wrote on the printed handover sheets about what they were to do for each patient. We looked at the ward handover sheet for this patient on the day we visited. It stated the patient's pressure areas were "intact", there was no further information about the patient or how often they should have their position changed. We asked a member of staff why the patient had remained on their back all the time. They told us the patient had a chest condition which made lying on their side difficult for them. They told us staff ensured the patient's pressure areas were relieved when they attended to them during comfort rounds. We looked in the patient's records and saw they did not have a care plan about how pressure ulcer risk was to be reduced.

The second patient we reviewed for risk of pressure ulceration did not have a care plan in place to ensure their individual care needs were met and their risk reduced. The patient had an additional medical need which could further increase their risk, particularly to their heels. Their records also had not been completed to show whether their position had been changed regularly.

We asked staff how they knew these patients' positions were regularly changed. They told us patients should be moved during comfort round assistance every two hours. But they were unable to confirm this had been done as there were no accurate records. They said patients' risks were shared at the safety briefing at shift handover, but this did not include detailed information about how often patients' had been moved position and skin integrity status at each shift.

NICE guidelines "Patient experience in adult NHS services; improving the experience of care for people using adult NHS services" (2012) states: "If a patient is unable to manage their own pain relief: do not assume that pain relief is adequate….ask them regularly about pain…. assess pain using a pain scale if necessary (for example, on a scale of 1 to 10)….provide pain relief and adjust as needed".

Ward staff were not assessing patient's pain or putting relevant care plans in place to ensure the patient was comfortable. We heard a frail patient calling out in a distressed manner throughout our 2.5 hours on a ward. During this period the patient remained in the same position in a chair by their bed. This person told us "my knees are killing me". We saw the call bell was not accessible to this patient. We asked a registered nurse to attend to the patient. This nurse was gentle and kindly toward them. However after the registered nurse left the patient, they continued calling out in distress. An hour and a half later, we heard the patient calling out "please my legs." The patient was still calling out in a distressed manner an hour later when we left the ward.

We read the patient's records. A fortnight before our inspection it was documented the patient was experiencing pain in their knees, which was not being controlled by their prescribed pain relief. A further note of pain in their knees was made for this patient a week before our inspection. The patient's records did not show any other assessments of their experience of pain. They did not have a pain management care plan. The information about the patient's calling out had not been included and the cause assessed in any care plan.

We visited the emergency department (ED) to review the assessment and care of patients attending who had mental health care and treatment needs. Initial mental health assessments of ED patients were carried out by trained ED staff using the Mental Health matrix which had been developed for this purpose by another provider and commissioned by the local clinical commissioning group.

We found there were delays in the assessment of patients in the ED who needed specialist mental health assessments. These delays were longer than recommendations in current guidelines. The Royal College of Psychiatrists, and the British Association for Emergency Medicine, have recommended specific response times for mental health services providing a service to emergency departments. Staff in the ED told us specialist mental health assessments were not always timely. We were told particular difficulties occurred out of hours and at weekends. Emergency department staff we talked with were very concerned, because such delays could increase potential risks to patients in distress.

On the day of the inspection, we were told patients requiring inpatient treatment could be admitted directly to a ward for treatment for their physical injury without any specialist mental health assessment, or advice about risk management in relation to their inpatient admission. This could include patients who may have met the criteria for detention under the Mental Health Act 1983, should they have had an assessment in the ED. On the inpatient ward the patient would therefore have their assessment carried out by the senior nurse on duty using the risk matrix, rather than a specialist mental health practitioner. This gives rise of risks to patients, staff and others visiting the ward.

We found the draft policy “Observing patients with mental health problems” would be implemented once the patient was on the inpatient ward. We found this would involve identification of risk factors by the admitting nurse, who would also determine the appropriate level of observation using a ward based mental health assessment. Consideration of / referral to the mental health team for advice would then be given. Because this admitting nurse is not a specialist mental health practitioner risks remain.

We asked the ED senior staff on duty about what actions had been put in place to remedy the identified delays in specialist mental health assessments. They told us the responsibility for managing patients’ wait for admission was that of the commissioners and the mental health trust. The trust monitored waiting times from attendance at ED throughout the assessment process. The monitoring data was kept under review by the ED department and concerns about waiting times raised at trust operational group meetings. We found for example in the week ending prior to our visit five patients had waited in the department for over four hours. Each one of these patients had attended out of hours. We found one patient waited ten hours in the emergency department before admission to the local mental health unit. From the notes of meetings we reviewed the trust had been working with the local mental health trust for over a year to try to resolve the length and number of delays. Although some improvements had taken place, progress was slow and delays were still occurring.

Cooperating with other providers

✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

Patients discharged from the hospital could be confident the hospital had suitable arrangements to communicate necessary information about their care and treatment to ensure continuity of care and minimise risks arising from the transfer of care.

Reasons for our judgement

At the last inspection we were concerned about the way the hospital worked to ensure patients care needs would be continued by other care providers after discharge from the hospital. We found patients discharged from the hospital could not be confident that the hospital would communicate necessary information about their care and treatment to ensure continuity of care and minimise risks arising from the transfer of care.

We read the provider's action plan dated May 2013. This stated a transfer of care form from the hospitals' electronic record keeping system would be "rolled out" to all wards. Standards for discharge would be promoted on each ward through a range of matters including "awareness sessions with each ward and sisters meetings." Audits would take place on the completion of discharge checklists, transfer of care forms and discharge medicines policy standards. Review meetings with external providers would be held regularly and issues around discharges would be a standing agenda item.

We read 32 patients' records on the four elderly care wards. Four of these records on two of the elderly care wards showed evidence of regular discussions with the patient, their family and other relevant supporters, such as domiciliary care providers, about their current condition and social circumstances. We saw discharge information was in place for these four patients. This information took relevant matters into account to ensure a safe discharge for the patient. For example an occupational therapist told us about a patient who wanted to return to their own home and how they had supported the patient in doing this, including seeking support for the patient from community occupational therapy services. This information was fully documented in the patient's records. There was evidence of issues being followed up when patients were discharged. For example, we saw evidence for a different patient of being referred to falls clinic after their discharge, to ensure all factors relating to their risk of falling in the community had been considered.

The provider might find it useful to note the trust's discharge process recording remained incomplete. We looked at 32 patient records and saw few documented discharge plans. Where there were discharge plans, these had been completed on the day of discharge. Staff told us the "white boards" were used as the primary discharge planning document. White boards were available at nurses' stations on all the wards. These listed the patient's

name and relevant information such as which therapist they had been assessed by and their medical fitness for discharge. Such information was not documented in all of the patient's records.

We contacted nine care homes to where patients had recently been discharged. We also contacted two large care providers and Wiltshire and Bath and North East Somerset Social Services. We did this to check whether appropriate information, dressings and medications had been sent by the hospital. The feedback given to us by these providers was positive. Comments included, "it's much better than it was." They described information from hospital as "helpful and accurate"…" sufficient to meet the person's needs"… "not much cause for concern from hospital discharges". Wiltshire Social Services reported they were "working better with the hospital" and "liaison has really improved."

Overall we found there was a marked improvement since the last inspection in the quality of information given to other providers at the time of discharge. The provider might find it useful to note there were some exceptions.

Three providers told us there could be issues relating to receiving discharge summaries from the hospital. They said there could "occasionally" be such difficulties, such as information from the nurses on the ward was sometimes not consistent with the information in the notes. A social worker involved in patient discharge from a local authority told us the information which the nurses from the older people's wards sent to their team had limited nursing information. They told us the lack of detail in the information was not useful for social workers when making a decision about the best place for patients to be discharged. For example the information about people's mental cognition or mobility was mostly "one word". In the case of mental cognition we were told the word "dementia" was often recorded. They told us there was no more detailed information about the nature, impact or support the person needed. They told us information from the discharge nurses was "better" and more useful to them when deciding upon a future placement for the patient. However, as the information sent to them was often "unreliable" they tended to come to the ward themselves to see the patient.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not suitable arrangements in place to protect people against the risk of excessive control.

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 spoke with two patients on one older people's ward who were communicating an objection to staying on the ward by trying to leave and telling us they felt they were being held against their will. Both patients were wearing electronic tagging devices. We found the tags on both patients were very tight. We were told by trust managers the tags can become tight as a result of patients movements. We reviewed these patients' records to ensure the requirements of the Mental Capacity Act (2005) (MCA) and the Deprivation of Liberty Safeguards (DoLS) had been followed. Where methods of control are used, the least restrictive option that is appropriate should be applied in accordance with the legal provisions.

For one of these patients' we found an entry in their clinical notes dated 14 June 2013 highlighted in pink "does not have capacity to leave the ward. For DoLS if she tries". This entry was not signed. In the patient's notes there was a reference to a capacity assessment; it did not say how and when this would occur. The reference was unsigned and undated.. A standard form in use by the trust, 'Risk Assessment and Care Plan – Patients at risk of leaving the ward unattended' had been filled in. The use of this check list had not been used as intended. The parts of the form which prompted the staff to consider all potential and available options for the choice of the least restrictive measure for restraint had not been completed. The form stated this should be reviewed every 24 hours. The form requires the member of staff completing the form to confirm a capacity assessment had been carried out. The MCA (2005) requires that a capacity assessment should be specific to each decision. It was not clear that the patient's capacity assessment had been reviewed to ensure the patient was not capable of making a decision about the use of the tagging device.

For the second patient we reviewed, we found that entries in the clinical records indicated the patient was "fit for discharge" and "can go home", which seemed inconsistent with the need for the restrictions of an electronic tag. We checked this patient's records and could not find the trust checklists for capacity assessment or best interest assessments, even with the help of nursing staff. We saw that a 'Risk Assessment and Care Plan – Patients at risk of leaving the ward unattended' form had been completed on 18 June 2013, which was four days after the tag had been applied.

The trust's draft policy for "Observing patients with Mental Health problems" states "An assessment of the patient's capacity, in relation to their best interests, and adherence to Deprivation of Liberty Safeguards (DoLS) requirements is undertaken in all cases when the use of assistive technology is being considered." The trust's policy "The Mental Capacity Act 2005 incorporating the Deprivation of Liberty Safeguards" (Nov 2011) includes in the appendices template forms and checklists for carrying out mental capacity assessments and making best interest decisions. Furthermore the consent and capacity checklist states, "full details, as appropriate to the gravity of the decision to be made, must be entered in the patient's records". These forms had not been included in the notes of either of the patients where assistive technology (electronic tags) had been used, or reference to consideration of the details of the checklist criteria.

We discussed the 'tagging' arrangements with the staff, including the most senior nurses on duty on the ward in some detail. The staff we spoke with were not aware of a policy for the use of electronic tags. We were told the assistive technology had been introduced after a serious incident in 2009 when a patient had left the ward unattended. They told us they had not received any training about applying the tags. They told us they did not find the process or documentation helpful in making decisions. They told us they did not rely on the information recorded in the forms intended to support decision making, instead they relied on discussions at the multi-disciplinary meetings, or the nurse in charge of the ward would make the decision. There were no records of these meetings to show how the best interest decisions had been reached. There was no evidence of alternatives to 'tagging' which were less restrictive being considered. There was no evidence that the risks and benefits of various options being considered to maintain the safety of patients at risk of leaving the ward. The trust had drafted a policy which may have helped support staff to better understand the process. At the time of the inspection the policy was in draft version and was due to be approved for use by the trust in July 2013.

In terms of best interest decision making the ward staff seemed to rely on the agreement of patients relatives for the use of 'tags' as consent; instead of carrying out a proper process for best interest decision making.

The main protection for patients on the ward at risk of wandering was 'locked' control of entry and exit through the ward main doors, which was activated by a swipe card and a switch on the nurses' station. This control was not fully effective due to the amount of traffic in and out of the ward and the way in which staff managed this. At the start of our inspection there was a helpful note on the door explaining to visitors not to let anyone they did not know leave the ward. This notice was removed sometime during our visit. A registered nurse told us "It's a real problem. Staff walking past the ward just let people in". We found hospital staff visiting the ward were placing patients at risk by their own working practices, as patients could leave whilst people were being let in. During our visit one patient fitted with a 'tag' managed to leave the ward in this manner.

During our visit the tagging device alarm was being activated continuously, so that there was a continuous bleeping noise. Staff told us they had become desensitised to the noise. They told us "it's always going off and sometimes we just don't notice".

We also looked at supporting evidence in the ward log for the use of electronic tags. We found the log was inconsistently completed and no entries were logged after March 2013.

We found that one patient had been tagged for a period of about five weeks (27 April 2011 to 3 June 2011). Neither patient we spoke with was recorded on the register. The register did not always identify when tags were removed, even on discharge.

Comments from staff, including the most senior nurses on duty on wards where assistive technology was used showed limited understanding of the MCA(2005) and DoLS. Staff did not give adequate consideration to alternative interventions, other than tagging.

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 provider had a system in place to regularly assess and monitor the quality of service that people receive and to identify, assess and manage risks to the health, safety and welfare of people using the service and others. The internal quality assurance mechanisms were not effective in ensuring the action plan from our last inspection had been implemented.

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

The trust had systems to in place to assess and monitor quality of the service. It also had systems in place to identify, assess and manage risks relating to service users health, welfare and safety. Although these systems were designed and operated to control all parts of the trust's services, there was a gap between policy decisions and assurances at board level and the way in which care was delivered on the older people's wards. The trust's quality monitoring system had not been effective in ensuring improvements required as a result of our last inspection had been implemented.

Four compliance actions were made at the last inspection in February 2013. We looked at the trust's governance arrangements in June 2013 in more detail to see how the trust board was informed about our concerns and the actions taken to address them. The trust told us they had met its action plan dated May 2013, although the Chief Operating Officer told us they were aware the action plan might not be fully 'embedded' into practice in the wards. The Trust Board Annual Governance Statement for 2012/13 noted that the Trust Board had monitored the completion of actions following our last inspection.

We spoke with nine staff involved with the governance arrangements. These included the Chief Operating Officer, Medical Director, Deputy Head of Risk and Assurance, Director of Human Resources, Lead for Quality Assurance, and a Non-Executive Director that chaired the Non-Clinical Governance committee.

We were also provided with a range of documents submitted by the trust spanning the period of November 2012 to June 2013. These included the Strategic Framework for Risk Management, which itself had eight related policies, which included the 'Incident reporting and management policy and procedure'. In addition we viewed a sample, selected by the trust, of nine sets of minutes from a selection of Clinical, Divisional Clinical and Specialty governance meetings. Minutes were also viewed from Oncology Haematology, Medical

Division and Emergency Departments. 14 sets of minutes were received in respect of Matrons meetings, and Matrons and Ward Managers' meetings.

We found that the Trust Board led on integrated governance, delegating key duties and functions to its six sub-committees. Three of these committees were tasked with providing assurance to the Trust Board: The Clinical Governance Committee; Non Clinical Governance Committee; and Audit Committee. Each of these committees was chaired by a Non-Executive Director of the Trust Board. The minutes of each of these committees had been presented to trust board meetings for review and discussion. Both the Clinical and Non Clinical Governance Committees meet bi-monthly and were tasked with ensuring Clinical and Non Clinical systems were effective and robust.

Whilst each of the committee meetings was held separately, there were combined meetings of the clinical and non-clinical governance committees that ensured joint oversight. These joint meetings were held every three months and took place prior to trust board meetings.

The three remaining sub-committees were the Management Board responsible for the operational delivery, the Remuneration Committee and Charity Committee.

The trust had an internal quality assurance programme in place and this included the conduct of audits. This included audits of the areas of non-compliance identified at the last inspection (February 2013) as 'mock inspections'.

We asked senior nursing staff about the monitoring of fluid balance and hydration records, which had been found to be of concern at our inspections of November 2012 and February 2013. We were told this was done as informal spot checks on an 'ad-hoc' basis. There were no records made of these checks. Feedback was carried out with individual nursing staff, but this was not a system wide approach across the older peoples wards' to monitor and feedback the outcomes of audit findings.

The trust told us the audit results of the new arrangements for monitoring hydration risks were reported to the trust's CQC action plan steering group and the Nutrition and Hydration Steering Group. During this inspection we found hydration records were not completed as required by the trust's own policies. We were told by nursing staff on the older people's wards it was "confusing" having several different systems, for recording and managing fluid intake, in use at the same time (fluid charts, hydration charts and comfort rounds).

There were systems and processes in place for reporting, collating and managing incidents and risks across the organisation. The trust strategic framework for risk management (date) 20 December 2012, review date 20 December 2015) described the process for monitoring, review and updating identified risks. The framework explained that the frequency of monitoring progress against identified actions could vary, but should be 'undertaken, as a minimum, every three months'. We found the risk assessment action plan summary regarding 'the assessment relating to wandering / absconsions older people's unit' was last reviewed on 21 January 2010. At this inspection we found the trust's policy and procedure for initiating and monitoring use of electronic tagging devices for patients at risk of wandering was not being followed, and was not fully meeting the safeguards laid out in the Mental Capacity Act 2005.

The trust used an electronic data management system for the identification and management of risk. Most of the staff we spoke with knew how to use the electronic incident reporting forms. Those staff who did not, knew who to ask for assistance to ensure incidents were reported. All information reported into the electronic incident reporting system was

reviewed centrally by the Deputy Head of Risk or Risk Administrator. Contact was made with the reporter in regards to any discrepancy in terms of compliance with trust policy. In the event that the identity of the reporter was now known, contact was made with the ward / departmental manager.

A quarterly report of all patient safety incidents was produced and provided to divisional clinical governance meetings, which reported to the operational governance committee, management board meetings and ultimately the trust board. The Theatre Manager demonstrated to us how they used their own data.

In terms of recording we found that the divisional clinical governance meeting on 13 May 2013, had no minuted discussion in regards to a number of agenda items. For example, the review of red incidents, external regulatory issues; business from corporate leads for clinical governance; issues for operational governance committee; and finalise action plan/risk for management board.

We found that minutes of two of the three medical division clinical governance meetings (31 January 2013 and 28 March 2013) and all three of the emergency department clinical governance committee meetings (27 March 2013, 24 April 2013 and 29 May 2013) reported no nursing presence. We asked the Chief Operating Officer about this, who explained the Trust's expectation was for the assistant director of nursing to be a member of the divisional clinical governance meetings. A recent change in operational responsibilities might have resulted in the absence on the reported occasions. We were concerned about this since our last inspection report referred to breaches of regulations which related to nursing practice.

Following the compliance actions identified in the inspection of February 2013, the trust's action plan provided to CQC was disseminated down to matrons. Nurses, care assistants and therapy staff we spoke with on some wards and units were fully aware of the Trust's action plan. Staff on other wards and units were aware of new documentation, but not the action plan or the compliance actions arising from our last inspection. We also found that the 10 sets of Matrons meeting minutes reviewed from 12 March – 11 June 2013 did not contain any information with regard to clinical incidents or lessons learned. For example, none of the staff we spoke with told us they regarded low fluid intake or dietary intake as an important matter to report. Therefore the trust board did not have effective oversight into these aspects of care.

Some older people's wards and units held regular ward meetings at which governance information was disseminated and which were minuted. On other wards and units these meetings did not take place.

Whilst there was a programme of trust management meetings in place, omissions in terms of minuted discussions, and irregular meeting attendance increases the potential for incomplete information being reported through the governance structure, and decrease the level of assurance provided at each stage.

At the inspection of November 2012 we also reported on the need for development of supervision systems for all staff in between appraisals. The trust had informed us they had agreed to fund additional nursing time so that supervision could be implemented. We found there was a developed appraisal system and all staff we spoke with confirmed they had received an appraisal during the past year. None of the nursing and care staff we spoke to in the four older people's wards, the day surgery unit and the theatres told us they had regular supervision. In theatres a pilot form for use during supervision had been developed in the last month, but it had not been implemented. Lack of regular supervision also increases the potential for incomplete information being cascaded downwards through each level of the governance structure.

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.

People were not protected from the risks of unsafe or inappropriate care and treatment by means of the maintenance of accurate and up to date records.

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 the last inspection on 4 to 6 February 2013, we found people were not protected from the risks of unsafe or inappropriate care and treatment by means of the maintenance of accurate and up to date records.

Following our inspection, the trust sent us their action plan dated May 2013. This stated how they would become compliant. They stated a range of actions they would take, including revising their health records management policy to more accurately reflect where documentation should be recorded / filed. They would test a new hydration record chart which would then be "rolled out for use across the trust". They would promote "use of the fluid intake and output / fluid balance charts through awareness sessions" in each ward and sisters meetings.

We found the hospital had made improvements in the day surgery unit (DSU). We looked at two patients' records. These two patients talked to us about their experiences. They had had all their pre-operative assessments completed before they went down to operating theatres.

Other patients needed their notes available to staff as they were just about to go down to operating theatres. We saw both patients had detailed pre-operative records. The information in these records fully reflected what both the patients and staff told us about the patients' conditions. For example one patient told us about an allergy and how it could affect them in certain circumstances. We saw their records included full information about this allergy, so all staff involved in this patient's treatment and care could be aware of the patient's needs in this respect.

The Nursing and Midwifery Council (NMC) Record Keeping: Guidance for Nurses and Midwives (2009) states that " Records support "the delivery of services….effective clinical judgements and decisions….patient care and communications," makes "continuity of care easier" and provide "documentary evidence of services delivered." Records also help to "identify risks" and enable "early detection of complications." The NMC states a registered

nurse should “record details of any assessments and reviews undertaken, and provide clear evidence of the arrangements you have made for future and on-going care. This should also include details of information given about care and treatment”. Records should also “identify any risks or problems that have arisen and show the action taken to deal with them”.

We visited the four designated older people’s wards over a four day period. We found records were not being completed in a consistent manner across all four wards. We met with fifteen patients and made observations of care of a six further patients who were too unwell or frail to talk to us. We spoke with 23 staff, including registered nurses, healthcare assistants and therapists. We looked at the records of ten of the patients we met with and discussed patients’ needs with staff. We also looked at a further 32 patient records in depth and followed five of these records through to the hospital’s electronic record keeping system.

When we looked at these 32 patient records we found there were no recorded discharge plans in these patients’ notes. Staff told us that the ward “white board” was used to plot progress to discharge following admission, rather than writing it in patients’ records. We saw medical staff made a note in their multidisciplinary records of the patient’s potential length of stay soon after admission. This was a broad assessment, in units of days or weeks. The multidisciplinary notes written by the doctors focused on the diagnosis, ordering of tests and investigations, reviewing results and prescribing treatment. In the 32 records, there were references to medical fitness for discharge but this approach was not used consistently. There were, for instance, differences between the doctors on duty and between individual wards, in that different doctors had different systems as did different wards. The senior staff on duty during our inspection told us that the ward white boards were the main reference document to track a patient’s progress towards discharge. The whiteboard records were not a permanent record.

The trust’s Health records policy (30 April 2013) in relation to patients’ notes was to use multidisciplinary notes in which all staff involved with the patient made their records. A separate nurses' record was not maintained. The medical staff wrote in the patients’ multidisciplinary notes every day. In the 32 records we looked at, we saw nursing staff did not write in the multidisciplinary records every day. Nursing care notes were not recorded in the 32 records we looked at and accordingly, there was no permanent record of the nursing care delivered and so the records were not accurate and up to date.

We asked four senior nursing staff where we could find records relating to patients. They told us a daily handover sheet and white board were used on a daily basis. We were given copies of daily nursing handover sheets. These recorded information about all of the patients on one or two sheets of A4 paper. Each entry had to be fitted into a small space allowing just a few words and some letters of abbreviation. The nurse in charge of the ward was given this at shift handover and they kept it in their pocket for reference during the shift.

These notes were destroyed at the end of a 24 hour shift after relevant information had been uploaded to the hospital computerised system by the night staff. Senior nursing staff told us the hospital’s electronic record keeping system was not always used on a shift by shift basis.

This was because the main nursing handover took place using the handover sheets and any relevant information over the day was added by the senior nurses, to reflect information relating to changes in the patients’ conditions. This was done in a very brief, abbreviated or shorthand way. There was a delay in the hospital’s electronic recordkeeping system being up to date because it was update by adding the information form the handover sheet only once a day, by the night staff. Effectively, the trust was using four patient information

recording systems: the hospital's electronic record keeping system; handover sheets; patients' written notes and the white boards, in addition to any records held at the end of the patients' beds. Staff we spoke with told us they did not have time to use all of these equally and they chose the system they found the quickest. This means that staff could be using information that was not up to date. The fact that there were a number of concurrent systems in use also increased the risk for inaccuracies to be introduced into the recording system.

We asked to see patients' records on the trust's computerised record keeping system during the first two days of our inspection on one ward. We were unable to do this because it was being used by another member of staff. We were told that this was a regular occurrence.

When we asked to see the hospital's computerised record keeping system again during the same two day period, the member of staff had difficulty logging on. We were told that this often happened and because of time limitations it restricted the use of the system. On the same two days when we asked to follow through patients' records on the hospital's electronic record keeping system, it was not possible to access the system because it was already in use or the office where the computer was kept was in use.

We asked nine staff about the use of discharge planning records and all were uncertain about their contents. We looked at the trust policies Discharge Nursing Documentation Standards (2013) and Discharge policy (2011). The policy relating discharge documentation stated all patients discharged from the RUH will have a discharge plan completed 48 hours prior to discharge. The discharge policy (p5) states an initial assessment and plan must be completed by a registered healthcare professional within 24 hours of admission. The trust provided us with audit results dated May 2013. The results showed the rate for completion of the "discharge plan checklist – within 48 hours of discharge" was 32%. The rate for compliance with completing the "discharge checklist" on the day of discharge was 36%.

When we looked at 32 patient records, within all of these were fluid balance charts. In addition some patients' records contained a hydration chart. This chart had been introduced following our last inspection. This was in line with trust policy "All patients should have fluid balance charts or hydration charts" (RUH, Hydration Policy 2013 p.5). We looked at 100 fluid balance charts and where available, the newly introduced hydration charts. We saw 90% (90) of the fluid charts did not have daily totals of intake and output. This applied even when patients had infections and/or were very unwell/had difficulty in drinking or feeding themselves. This contradicted good practice in this area (Royal College of Nursing 2012) and trust policy (RUH, 2013, p5). We saw in 10% (10) of cases the daily totals were aggregated but even then were not transferred to the multidisciplinary notes, so were not included in the plan of care.

In addition, we found for the same proportion of fluid balance records, that an inaccurate intake had been recorded. For example, we saw that "sips" was written on the fluid balance charts as a measure of intake. We were told by staff that writing "sips" was not acceptable, but there was not time to review every record, every shift. Imprecise wording is open to different interpretation and where a patient is at dehydration risk such records were not accurate in enabling assessment of hydration. It was also contrary to trust policy which stated "accurate measurement of intake should be recorded" (RUH, 2013). Also less than 10 per cent of the 100 fluid balance charts we reviewed had entries recorded for the intravenous fluids that had been administered. Therefore it was not possible in these cases to tell if patients were sufficiently hydrated.

The trust policy (RUH 2013) stated the registered nurse "remains accountable for ensuring the patient is drinking and is hydrated." We therefore spoke to the nurses in charge of each three shifts on four wards. We asked them to tell us about fluid and hydration recording.

They all said the fluid balance and the new hydration charts were not well completed. We showed them several examples of records and asked them to select others on the ward. We found in both instances, the charts were not completed according to trust policy or in a way in which it would be possible to know if a person was having adequate fluid intake. We asked the nurses for their comments. They all said recording on these charts was not adequate.

We also repeated this process with a senior sister and the unit matron and they both said the same. One of them said “we know our fluid balance charts are not good but something has got to give. We now do comfort rounds and the staff have a lot of additional paperwork to do.”

Staff told us the primary document for recording care was the multidisciplinary records, which were paper records. We asked nine staff if there could be another location which held the records of patients’ fluid intake, they said there was not, apart from the multidisciplinary record. We asked the staff how they would know if a person was thirsty or becoming dehydrated. They told us the staff were good and “noticed” when people were off colour, but they were unlikely to refer to the fluid balance chart or the hydration chart unless a problem had already been noticed.

When we looked at patients’ individual records we saw hydration charts and fluid balance charts were not consistently completed. This meant the trust could not be assured that vulnerable patients were sufficiently hydrated or received sufficient hydration to facilitate recovery. For example, we observed a nurse call the doctor because they were concerned about a patient’s urinary output. We found that a note about this was recorded in the multidisciplinary notes. When we looked at the patient’s fluid balance chart for that day and the previous three days, there was no reference to input or output for that period.

As hydration and fluid charts had not been completed, staff could not be assured they knew the amount of fluids vulnerable patients had drunk. For example on three days for one patient on one of the wards, the last record of fluids was at 15.00 on each day. We asked staff about this. They told us there were drinks rounds during the afternoon at teatime and at the evening meal. They said staff had probably forgotten to document what the patient had drunk, so they did not know what the patient had actually drank.

On another patient’s record on a different ward at 14.30, there had been no documentation of fluids taken in by the patient since 14:00 the previous day. This patient had a urinary catheter in situ.

We looked at a hydration chart for another patient on the same ward. We saw none of their records had been totalled. We totalled these records ourselves, this showed they had drank 275mls one day, there was no record made for the next day. The following day the patient had a total of 215mls and on the next day 250mls. The trust’s recommended minimum that a patient should drink each day is 1200mls. They showed signs of confusion and may have had difficulty in asking for a drink.

On a third ward another patient had been given a hydration chart to complete themselves. We observed this patient throughout our lunchtime observation period and saw the liquid in their jug and glass remained at the same level. We asked the patient about their hydration chart. They showed us the chart. We saw they had written “2.00” at 07:00 and “200” at 12:00 for the following day. When we asked them about this they said they had not been sure of what to write on the chart.

We looked at the new trust policy on fluids (RUH 2013). We saw this policy was comprehensive and would, if implemented appropriately, have addressed many of the

issues we had raised above. We asked nine staff why it was not being implemented. We were told “we know we should – there is just not time”….“we have to prioritise so we choose other things”…“I keep saying to the staff they should do – but they don’t always listen”, “it’s a new policy” When we pointed out the previous policy was similar, they told us “we have just never done it – it’s something else we will have to take on” …“there is no point- no one ever looks at them.”

We asked if the completion of fluid balance charts was monitored. A matron told us they did some spot checks, but the results of these were not recorded in a formal manner or analysed. Staff members were unable to describe how they could learn from such spot checks and develop future practice. We were told that the trust audit team also undertook audits. These were not available during our inspection on the wards. Staff on the wards were not aware of information about their own compliance rates for completion of fluid balance and hydration charts. Although on some wards staff knew improvements were needed following our last inspection, on other wards this was not the case.

The trust’s own research on the ward where the new hydration record was trialled had found 61% of patients could have had better levels of hydration. This research was carried out on patients who were independent and able to help themselves to fluids. On the older people’s wards we saw, and were told by nursing and medical staff, the acuteness of the patients’ condition and care needs of the wards’ populations were very high. We know from other research in this area that older people, in particular, can become dehydrated very quickly (Royal College of Nursing – Wise up to water, 2012 and Hydration Best Practice, 2013; Royal College of Physicians, Acute Care Toolkit 2: High quality acute care, October 2011). We brought the issue of recording patients’ fluid intake to the trust’s attention in our last report.

We looked for evidence of nutrition and weight being recorded. We asked staff to show us the location of all records relating to nutrition, hydration and weight. We were aware records were stored in patient’s files and some on the computerised system. We invited staff to show us all the records they had access to in order to ensure were not missing any relevant information.

We found, where nutritional risk assessments forms were completed, these were not updated. We found 10 records of weight in the 32 records we looked at. In the records of one patient who had very recently been discharged, we saw they had lost 6.6kgs in the 15 days during their stay in hospital. There was no care plan to identify if this weight loss was part of a planned treatment programme or due to poor nutritional intake. There was no record in their multidisciplinary notes of additional nutritional support or referral to a specialist.

A patient who had been assessed in May 2013 as being at risk of poor nutrition had a food chart, but it was incomplete as there were only records made of what they had eaten for eight of the days in a three week period. Of these eight records, only one recorded breakfast, lunch and supper. On four of them there was documentation of what the patient had eaten for two of the three meals, on two of the records, what the patient had eaten for one meal and one was incomplete. This meant staff could not be assured the patient was eating enough to assist recovery.

Another patient’s medical records stated they should be put on a food chart. Two days later their records stated "dietary poor oral intake.” Their first food chart was dated three days after the initial request from the doctors. It was not completed for each meal the patient was offered or ate.

We looked at six patients' nutritional assessments on two different older peoples' wards. We asked the registered nurse in charge on each ward about these patients' nutritional risk assessments. They told us all nutritional risk assessments were completed on the hospital's electronic record keeping system. Paper records were not used. The registered nurses showed us the hospital's computerised nutritional risk assessments. Three of the patients had not had a nutritional risk assessment completed on this system. One patient had an assessment completed but it had last been performed in April 2013 and for another patient over a month before our inspection. We asked the two registered nurses about these patients' nutritional risk assessments. They told us all patients were assessed on admission and those at risk assessed every month. They showed us that the three patients who had not had an assessment was because they had not been weighed and the hospital's computerised assessment form could not be completed if a patient had not been weighed. They said they did not know why the patients had not been weighed. One of the registered nurses told us they did not know how to use the hospital's electronic record keeping system, so they did not know why the nutritional assessments had not been done. The other registered nurse also said they did not know why the nutritional assessments had not been completed and would look into the matter.

We noted the hospital was on "green alert" on two days of our inspection and "amber" on the third. This meant the hospital was not under any significant pressure which might impact upon their ability to maintain patients' records accurately.

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 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: Generally patient's privacy and dignity were respected. However, on two of the four older people's wards, at the time of the inspection visit, we saw instances where patients were not having their privacy and dignity maintained. Regulation 17 (1)(a)
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: Care delivery by staff generally was managed to meet patients' care and treatment needs, but risks remained of inappropriate or unsafe care. This was because systems were not used in a co-ordinated and consistent way. At times there were delays in the assessment of patient's mental health needs in the emergency department. Regulation 9 (1)(a)(b)(i)(ii)(iii)
Regulated activity	Regulation

This section is primarily information for the provider

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: There were not suitable arrangements in place to protect people against the risk of excessive control. Regulation 11(2)(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 provider had a system in place to regularly assess and monitor the quality of service that people receive and to identify, assess and manage risks to the health, safety and welfare of people using the service and others. The internal quality assurance mechanisms were not effective in ensuring the action plan from our last inspection had been implemented. Regulation 10(1)(a)(b)

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

The provider's report should be sent to us by 19 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 29 November 2013 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were not protected from the risks of unsafe or inappropriate care and treatment by means of the maintenance of accurate and up to date records. Regulation 20(1)(a),2(a)(b)

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.

Judgement	Definition
✓ **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.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk

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