Inspection Report

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

Maidstone Hospital

Hermitage Lane, Maidstone, ME16 9QQ

Tel: 01622224796

Date of Inspection: 12 February 2014

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Staffing	✗ Action needed
Assessing and monitoring the quality of service provision	✗ Action needed

Details about this location

Registered Provider	Maidstone and Tunbridge Wells NHS Trust
Overview of the service	Maidstone Hospital is an acute hospital operated by the Maidstone and Tunbridge Wells NHS Trust. The trust provides a full range of general hospital services to a population of around 500,000 people in West Kent and parts of North East Sussex. Maidstone Hospital offers most services associated with an acute hospital including a 24 hour accident and emergency service, medical and surgical inpatient facilities, a children's day unit, a midwifery led birthing unit and a range of support and diagnostic services. For this inspection we reviewed the care of patients undergoing surgical procedures, and the provision of care for children.
Type of service	Acute services with overnight beds
Regulated activities	Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 12 February 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by other regulators or the Department of Health, reviewed information sent to us by other authorities and were accompanied by a specialist advisor.

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

What people told us and what we found

When we visited Maidstone Hospital our inspection team consisted of 3 Compliance Inspectors, a hospital governance specialist, a Consultant Surgeon, a Pathology specialist, and two experts by experience.

All the patients that we spoke with were positive about the care they had received before and following surgery. However, some patients told us they were not happy about the number of cancellations and delays they felt that they had experienced whilst awaiting surgery.

We found that patients had not always had an opportunity to speak with their surgeon prior to their surgery. We also found that some patients were not asked for their consent until they were on a trolley waiting to go into the operating theatre. This meant that although patients had consented to surgery, they may not have had sufficient time or information to have made an informed choice.

We found that patients had not always received safe care either before or after their surgery. This meant that risks to patient's health, safety and welfare could be compromised because safe practices were not always followed.

We found that patients did not always receive care from appropriately qualified staff. We found that arrangements were not in place for patients to receive on-going care from their consultant. Children receiving care at Maidstone Hospital did not always have access to staff trained in paediatric medicine. The paediatric resuscitation team did not routinely contain a paediatrician out of hours.

We found the provider did not have adequate processes in place to assess or monitor the quality of the service. This meant that risks to patient's health, welfare and safety were not being managed appropriately.

Within this inspection report we have made some references to a report about the trust written by the Royal College of Surgeons (RCS). This report was commissioned by the trust following the deaths of 5 patients who had had similar surgeries. The trust was reviewed by the RCS in October 2013, and received the report from the review in December 2013.

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

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

Consent to care and treatment ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Before patients received any care or treatment they were asked for their consent.

Reasons for our judgement

SURGERY

Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. However, we found the way consent was obtained was not always in the patient's best interests. For example, staff told us that surgical doctors sometimes obtained written consent for scheduled surgery from patients in the trolley area of the admissions lounge on the day of their planned surgery. During our visit we witnessed this practice. The provider might like to note that patients may not have had sufficient time to make an informed choice on the treatment they wished to receive.

We spoke with one patient who told us they had attended the pre-operative assessment unit on the previous day where they saw an anaesthetist and consultant surgeon. They said, "I was pleased to have the procedures all explained to me and knew what to expect". They went on to say, "The consultant came to see me separately and pointed out where he was going to operate on my body, then told me not to worry". This patient told us that the consultant surgeon informed them of the treatment they required, indicating that they would then feel much better. The patient told us that the staff they had seen were polite, kind and reassuring. Other patients we spoke with following their operation remembered signing a form. Some patients told us that they had been given good explanations by the nurse in the pre-assessment clinic and others said they had not had an opportunity for discussion with their consultant. Some patients said they were unaware who their consultant was.

We observed patient care in all areas of the operating theatre department. We also looked at audits of the World Health Organisation (WHO) Surgical Safety checklists. The intention of such a checklist is to ensure that all conditions are optimum for patient safety, and that all staff are identifiable and accountable. The checklist system ensures that errors in patient identity, site and type of procedure are avoided completely. By following a few critical steps, health care professionals can minimise the most common and avoidable risks endangering the lives and well-being of surgical patients.

We found that appropriate checks were made throughout the time before the operation as to whether a patient had given consent and if so, to which procedure.

PAEDIATRICS

We spoke with staff who cared for children in the accident and emergency department and the children's assessment and day surgery units. Children were seen in the accident and emergency department and admitted to the assessment or day surgery units up to the age of 16 years, or older if they had particular needs that were best met in a paediatric environment.

Staff we spoke with had some understanding of consent by competent children. We asked staff about what they would do if a young person attended alone, or with a friend, and did not want their parents informed of their attendance or given details of their condition. Most staff were aware of the guidance issued by the General Medical Council and Royal College of Nursing about consent by children and young people. However, the provider might like to note that two staff told us they would inform the parents automatically but re-thought their answer when we asked about emergency contraception or miscarriage. They said they would try to persuade all young patients to share information with their parents but would maintain confidentiality if requested and the child was deemed competent to give informed consent.

The parents or guardians of all children attending for day surgery had been asked to sign written consent for the procedure. This was often obtained at the pre-assessment clinic but was otherwise signed on the day of surgery. We observed a staff member working with one family who had attended a pre assessment clinic. We saw the mother was given time to ask questions and discuss concerns about her child's surgery.

From the documents we reviewed we could see that parents had signed consent and were given a copy of the consent form relating to their child. Records showed that staff ensured the adult signing the consent form for a child had legal parental responsibility and was entitled to sign consent. We saw that there was a space on the consent form for a competent child to give consent or a younger child to endorse their parent's consent. This meant that children were involved in decisions around consenting for their care when possible.

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.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

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

SURGERY

We found that patient's needs had not always been appropriately assessed, and care and treatment was not always planned and delivered in line with their individual care plan.

We saw that patients had access to a nurse led pre-assessment clinic prior to their operation. We spoke with staff who told us that patients were given information about the procedure they would be having. We saw that observations were documented such as the patient's weight and medical history and patients underwent a series of tests for example blood pressure and an electrocardiogram (ECG) a test that measures the heart rhythm. They were also screened for Methicillin-resistant Staphylococcus Aureus (MRSA), a bacteria many people carry on their skin or in their nose. Staff told us that if there were any problems, for example with an ECG, the patient would be referred for further testing.

We saw that patients were prepared for their operation in the admissions lounge before being taken to the operating theatre department. Staff told us that this involved physical examination of the patients as well as nursing assessments and safety checks. Staff told us that anaesthetic staff carried out physical assessments of patients in a private consulting room located in the admissions lounge. They said that there were no examination couches in the consulting rooms so when an examination requiring a patient to lie down was necessary; it took place in the trolley bed area of the lounge. We looked at one consulting room. We saw there was no examination couch in this room. We saw records that demonstrated anaesthetic examinations had taken place in the admissions lounge. The trolley bed area of the admissions lounge was not a private area and any discussion could be overheard by other patients waiting in the area. This had the potential to impact on the information that a patient shared with the person examining them.

Staff told us that pre-operative nursing documentation was recorded in "pathway booklets". Integrated care pathways are used within the trust as a tool to guide staff on the care required for patients undergoing particular treatments. Surgical care pathways are used by

the multidisciplinary team to plan and record care and to assist staff in determining that all is well following surgery. Their function is to ensure that all patients receive optimal care based on good practice guidance. We looked at the enhanced recovery colorectal surgery pathway. We saw that this documentation included; patient's name, date of birth, home address and next of kin details; relevant past medical history; allergies; current medication; an assessment of nursing requirements and a pre-operative check list. The pre-operative check list enabled staff to prepare the patients safely for their forthcoming operation. For example, by ensuring they were wearing a wrist band with the correct identification details on. The completed care pathway document showed us that staff had provided the appropriate care to the patient.

However, the RCS report of October 2013 detailed that there was a backlog on patients on the waiting list. It said that 85% of patients waiting over 18 weeks were waiting for upper gastrointestinal surgery appointments. The reason for the backlog and delay in treating was found by the report to be poor attendance by consultants at the outpatient clinics. Clinics were usually managed by surgical registrars rather than consultants. One incident report showed that, on one occasion, no doctors had turned up for the outpatient clinic. Patients received an apology but there was no investigation of the situation. This meant that patients did not always meet with their consultant prior to surgery.

On one of the wards we visited we saw that there was a completed 'Infection Control Rapid Risk Assessment for Patients with Diarrhoea or Vomiting Symptoms' in one patient's records. This identified that the patient required to be isolated to reduce the risk of cross infection to other patients. The assessment was dated 9 February 2014 and indicated that a side room had been requested. During our visit on 12 February 2014 we saw that the patient was still being nursed in a bay with other patients. Staff told us that there had been no side room available and that patient had continued to be nursed in the bay with other patients since the 9 February 2014. This placed other patients at risk of contracting the infection and was a particular risk to post-operative patients who are likely to develop complications from dehydration, the pressure of vomiting on wounds and systemic infection.

Patients' personal information was not always kept confidential by staff. We witnessed a member of staff discussing the personal details of one patient in a public area of a ward that could be overheard by other patients and visitors. In the admissions lounge we saw that there were three trolley bed areas adjacent to each other separated by fabric curtains. We witnessed a member of staff discussing intimate personal details with a patient in one of these areas that could be overheard by patients who were in the adjacent areas. We accompanied a patient from the admissions lounge to the operating theatre entrance and witnessed a member of staff discussing intimate personal details with a patient at the operating theatre entrance that could be overheard by other patients.

Care and treatment was not always delivered in a way that would ensure patient's safety and welfare.

We saw that there was a policy for the 'Safe Handling of Specimens in the Operating Theatre'. This outlined the procedure to be undertaken for any specimens that had been taken during the operation. We saw that it stated that, "Patient details should be checked with the patient's notes and not the operating list to avoid potential confusion with other patients with similar details". We saw that the patient's notes and specimen label had to be shown to the responsible person (a senior member of the theatre staff) prior to the specimen being sent to the laboratory. We observed a member of staff preparing specimens during one of the operating procedures. We saw that they checked the patient's

details on the consent form, specimen pot and specimen book. We saw that they showed the patient's notes and specimen labels to the responsible person before sending them to the laboratory. This meant that in the operating theatre, specimens were managed in such a way as to minimise the risk of them being mislabelled.

We looked at how units of blood were obtained when patient required a blood transfusion whilst in the operating theatre department. We saw that a written request was given to a porter who took it to the blood bank located in the hospital. The porter took the blood from the fridge and then returned to the operating theatre department with it. Staff told us that on a busy day with all four theatres running to capacity, this could sometimes be difficult and resulted in delays. Theatre staff sometimes had to wait for blood to arrive. We saw that the Trust had invested in a new electronic system, whereby theatre staff could enter the patient's details and the request for the units of blood would go directly to the blood bank. Porters would then use a bar code system to remove the units of blood and deliver to theatres. Currently, staff were undergoing training to be able to operate this system but it was not yet in use. We visited the blood sciences laboratory which included the blood transfusion service for the hospital. There was an acknowledged difficulty in the provision of an adequate out of hours service, mainly due to shortage of adequate and appropriate staff. We found that this situation had remained on the hospital risk register from October 2012. The blood transfusion laboratory submitted three incidents to Serious Hazards of Transfusing (SHOT), the national reporting scheme for transfusion incidents, in last the 12 months. These incidents were transfusion errors caused mainly due to inadequate system of blood tracking. We found that these incidents had not been listed in the Directorate Quality and Safety committee report (January 2014) which meant there was a lack of clear governance and therefore an inability to learn from these incidents to improve patient safety. This had a direct impact on patient care and welfare and placed people at risk of harm from incorrectly managed blood transfusions.

There was a written policy that governed the activity of transferring patients within the hospital. Staff told us that all patients taken to the operating theatre department were escorted by a member of staff. We saw a member of staff accompany a patient from the admissions lounge to the operating theatre department where the patient was handed over to staff in that department for further care. This meant that patient safety was maintained during transfer between the admissions lounge and the operating theatre department because a trained member of staff accompanied them.
For one patient, we observed appropriate manual handling techniques with enough staff to safely transfer the patient from the operating table to the trolley. The patient had been given regional anaesthesia, so was awake. We heard staff speaking to them reassuringly. The patient was transferred to the recovery area and was cared for by two recovery nurses. When we spoke with the patient they told us that they felt they had been informed about the surgery and any complications that could happen. We looked at care records and saw that charts, such as drugs charts, were updated regularly. Where risk assessments called for particular monitoring to take place, such as fluid intake, we saw that this had taken place.

We visited the surgical wards twice. On the first visit, we saw that the wards were calm with a quiet but friendly atmosphere and we observed staff chatting to patients on a one to one basis. This demonstrated good care, which the patients we spoke with all appreciated. On the second visit, we found the wards were much busier with a fire alarm sounding for a considerable time adding to the noise levels and unsettled feel of the ward. There was also a medical emergency situation occurring that we noted was dealt with well. We asked patients about how readily help and assistance was available on the wards. Several patients told us that it might be up to 30 minutes before a call bell was answered but two

patients, who had major surgery the day before, said, "Someone came quickly". All patients had the call bells within reach on one of the wards. On the other ward we noticed two patients who were unable to reach their call bells. We pointed this out to staff who immediately placed the call bells within the patients' reach.

Patient's care and treatment did not always reflect relevant research and guidance.

One member of staff told us that they were not aware if there were any hospital guidelines on the frequency that staff should check and record a patient's vital signs after surgery. For example, the patient's heart rate, blood pressure and respiratory rate. They told us that a patient's vital signs after surgery would be checked and recorded every 30 minutes for the first two hours, then every 60 minutes for the next two to four hours and thereafter every four hours. Another member of staff told us that there were local guidelines on the frequency that staff should check and record a patient's vital signs after surgery. Staff were unable to provide evidence of these local guidelines. This member of staff told us that a patient's vital signs after surgery would be checked and recorded every 15 minutes for the first hour, every 30 minutes for the next hour, hourly for the next hour, then two hourly for the next two hours followed by four hourly thereafter. There was little consistency in what staff told us about the frequency that staff should check and record a patient's vital signs after surgery. The frequency of observation did not appear to be governed by the condition of the patient or the complexity of surgery they had undergone.

We looked at one patient's records that demonstrated vital signs had been checked and recorded after surgery after 20 minutes initially, then after 25 minutes, followed by every 30 minutes for the next hour, then after 35 minutes, one hour and five minutes, hourly for the next two hours and then two hourly. Another patient's records demonstrated vital signs had been checked and recorded after surgery after 20 minutes initially, then 40 minutes, followed by one hour and 45 minutes and then eight hours later. This was inconsistent with the information staff told us.

There was a written policy that provided guidance for staff in the monitoring of adult patients using physiological observations (the patient's vital signs) as an early warning system if complications should arise. This policy did not specifically state the frequency that staff should check and record a patient's vital signs after surgery. The policy stated "Four hourly observations as a minimum for acutely unwell patients and new admissions to acute care wards" and, "Any increase in the frequency of observations will be determined by the patient at risk (PAR) score algorithm". PAR scoring is a system used by hospital staff to identify patients at risk of deterioration. Patient's vital signs are checked and recorded with each parameter being awarded a score. An overall PAR score is calculated by adding together the individual scores awarded to each parameter. The resultant score is compared to a flow chart informing staff of action required if any. For example, the flow chart indicated that an overall PAR score of four instructs staff to "Inform trained nurse, inform junior doctors, increase frequency of observations, consider continuous monitoring". This meant that there was a risk to patients that became unwell after surgery if their initial vital signs were stable with a PAR score of 0. Staff following the written policy would then check and record the patient's vital signs again in four hours. Post-operative patients whose condition deteriorated in that four hour period would potentially not be identified early increasing their risk of harm.

We saw that there were two types of vital signs records where staff documented patients' observations, such as heart rate and blood pressure. The adult observations chart contained information for staff on how to calculate a patient at risk (PAR) score whereas the adult neurological observations chart did not. The adult vital signs guidelines and

clinical standard stated "All patients should have their PAR score calculated on admission and for every subsequent set of observations". We looked at 246 sets of vital signs records. We saw that a PAR score had been calculated on 226 occasions. This meant that staff were not always following hospital policy each time a set of vital signs were checked and recorded.

There were arrangements in place to deal with foreseeable emergencies.

We saw that staff qualified in immediate life support (ILS) were on duty in the theatre and accident and emergency department. We looked at training records and saw that all theatre staff had received training in basic life support (BLS), ILS, moving and handling and fire evacuation/simulation. We saw that the hospital had procedures and equipment in place for dealing with foreseeable emergencies. There was an emergency trolley sited at appropriate point that contained emergency resuscitation equipment including a defibrillator. We looked at the records and saw that these were checked daily.

There was an adult resuscitation team available 24 hours a day 365 days a year, including a dedicated member of staff to manage the patient's airway. We saw good leadership skills by one doctor in charge of a patient's care during a medical emergency. Staff told us that there was a policy governing resuscitation activity in the hospital that was available to them on the intranet. They told us that the policy indicated that resuscitation equipment in each ward and department was to be checked daily. We saw records that demonstrated the resuscitation equipment on one of the wards we visited had been checked daily in February 2014. Staff on this ward told us that there was a system in the hospital that enabled them to replenish resuscitation equipment 24 hours a day and they experienced no difficulties obtaining replacement items. However, there were no records demonstrating that the resuscitation equipment in the admissions lounge was being checked on a daily basis in line with the hospital policy governing resuscitation activity. This meant that missing or broken equipment may not have been identified and placed people at risk in the event of a sudden collapse.

Staff told us that the procedure for deciding that a patient should not be resuscitated, in the event of a sudden deterioration in their condition, was detailed in the policy governing resuscitation activity in the hospital which was available on the intranet. We looked at the records of one patient where a decision not to offer cardiopulmonary resuscitation had been made and saw that staff had followed the policy governing resuscitation activity in the hospital when documenting the decision.

We saw that lead gowns, used to protect staff from ionising radiation, were in good repair. Anaesthetic gas shut-off valves were visible and accessible for emergency shut-off. We were told that the emergency call bell alarm system for each clinical area was checked daily in the morning. The provider had good systems in place that allowed staff to track which instruments and equipment had been used during which operation.

PAEDIATRICS

We were not able to speak with many families attending the accident and emergency department with children but were able to look at feedback provided by families as part of the 'Friends and Families test'. This is a method of evaluating services provided by hospitals that was first introduced in April 2013. Patients are asked the question "Would they recommend the hospital wards and / or accident and emergency department to a friend or relative based on their experience of using services there". The feedback we saw was positive. Comments included, " Everything fantastic here again," as well as,

"Excellent", "Super-efficient", "Fast", "Caring "and "Thorough".

Patient's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

We visited the children's day surgery unit and saw that a pre-operative assessment clinic was being provided for children who were booked in for day surgery at a later date. The assessment clinic was led by a nurse with specific responsibility for assessing and preparing children and their families prior to surgery. Children were seen by appointment and we noticed that the time allocated to each child meant the process was unhurried and relaxed. This meant that children had time to become familiar and comfortable with the ward environment and that as a consequence the impact of hospitalisation was reduced.

Staff told us that special local anaesthetic cream was applied when the child was admitted so that they could have a cannula inserted without any pain. Staff told us that cannulas were usually inserted in the anaesthetic room, to further reduce discomfort and anxiety in the child. We observed that one parent was encouraged to remain with their child whilst they were being anaesthetised. Following surgery, when the child was ready to be discharged from the recovery unit, they were collected by a registered nurse with one parent. They were brought back to the ward where their bed area had been prepared with oxygen and suction equipment readily available for use in the event of an unexpected emergency.

Some specialist tests and services were carried out by visiting paediatric nurse specialists, such as an endocrine nurse. Children were admitted to the unit for blood tests and remained in the care of the nurse specialist throughout their stay. Other children attended daily to allow them to complete a course of intravenous antibiotics, for example, as outpatients. Good practice guidance recommends that children are admitted for the minimum time possible to prevent behavioural changes and reduce the impact of hospitalisation. The practice and use of the children's assessment unit demonstrated a commitment to this.

We saw that a new casualty assessment card had been introduced recently to improve the consistency of assessment records of children attending the accident and emergency department. The card had been amended to include revised guidance for staff as to the action they should take if the vital signs of a child fell outside accepted parameters. The scoring system had been improved to reflect the wider variance of children and young people's vital signs compared to those of adults in order to improve early recognition of a deteriorating child.

Children who needed further assessment or treatment were admitted to the Riverbank day unit. The unit was open daily from 8am to 8pm. The last admission to the unit was 7pm. Outside of these times children that needed further assessment were transferred to another hospital. Children were transferred by either ambulance or, if agreed with the doctor, in the care of their parents. A paediatric early warning system (PEWS) was in use to alert staff to any changes that might indicate deterioration in a child's condition. This allowed for the early reassessment by medical staff and rapid transfer, if necessary.

The Riverbank unit had a high dependency room for children awaiting transfer who were very unwell or who were considered infectious and required isolating. We were told that there were always senior paediatric nurses on duty who had completed training in the management of the deteriorating child, the PEWS system and EPLS training. Nursing staff rotated between all areas of the trust where children were cared for, including the

main paediatric unit at the other hospital (Pembury Hospital).

Care and treatment was not always planned and delivered in a way that was intended to ensure patient's safety and welfare.

Staff training records we looked at in the Accident and Emergency Department showed all the registered nurses in the department had completed Paediatric Immediate Life Support Training (PILS) and some also completed the higher level European Paediatric Life Support Training (EPLS). Junior medical staff working in the department had also completed the EPLS training. We were told by an emergency department consultant that the staff regularly took part in resuscitation practice scenarios to ensure they maintained their skill level and were working effectively as a team. We saw that there was dedicated equipment available in the department for the resuscitation of children and babies. Whilst there was no obstetrician or neonatologist on site, we were told that an anaesthetist with paediatric skills was always available for such an eventuality. However there was not always a paediatrician available for a preterm delivery in the accident and emergency department. This meant that staff were able to respond appropriately to an unexpected emergency situation involving children but that the recommended staffing levels for units that provide emergency care to children were not being met.

We looked at the care of children in the accident and emergency department and on the paediatric day surgery unit and children's assessment unit. The numbers of seriously ill children attending the accident and emergency unit at Maidstone hospital was limited because all such patients using the 999 call service were taken to one of two hospitals with a dedicated paediatric unit and support services. Those attending Maidstone hospital were brought in by their parents or carers, usually with relatively minor conditions and injuries. However, some parents are unaware of how sick their child is and some instinctively drive their child to the nearest hospital, as stated in 'Standards for children and Young People in Emergency Medicine' (Royal College of Paediatrics and Child Health, 2012). There was a midwifery led birthing unit at Maidstone hospital but no neonatal support services were available on site. This meant that when pregnant women presented at the unit in premature labour; very occasionally this resulted in the delivery of a pre-term infant in the accident and emergency department.

Patient's care and treatment did not always reflect relevant research and guidance.

There was a separate waiting and play area for children, siblings and accompanying adults to the accident and emergency unit. Dedicated paediatric consulting rooms were sited immediately off the families waiting area. These rooms were brightly decorated and had been made as child friendly as possible. We noticed, however, that a child was being cared for in the 'majors' area of the main accident and emergency department, alongside acutely ill adult patients. We were told by nursing staff that all paediatric patients were triaged shortly after arrival in the department by a registered nurse with a minimum of 18 months experience in the unit. They were not necessarily a registered sick children's nurse but had all completed in-house training in the care of children. Their role as "navigator" was to triage patients and direct them towards the most appropriate level of care. This might mean transferring the child to a resuscitation room, to the 'majors' area or to see a doctor or nurse practitioner in the minor injuries area. This confirmed to us that children were not always cared for in an appropriate environment. The provider might like to note that the document 'Standards for children and Young People in Emergency Medicine' (Royal College of Paediatrics and Child Health, 2012) recommends that children are always cared for in areas of the emergency department where there is visual and auditory separation from adult patients.

We asked staff how long children and babies were fasted for pre-operatively. We were told that for children could have clear fluid up to 6am on the morning of surgery and that babies could have milk feed at 2am. All children were required to be made 'nil by mouth' from 2am when the theatre list started at 8am. We asked what the latest time a child was taken for surgery was and were told by the nurse in charge that they had never known a later theatre slot than 11am. Patient information that we saw confirmed that what we had been told was in line with the hospital policy on pre-operative fasting. This adhered to the Royal College of Nursing guidance for multidisciplinary teams (produced in conjunction with the Royal College of Anaesthetists), 'Perioperative fasting in adults and children' 2005. There were arrangements in place to deal with foreseeable emergencies.

There was a paediatric resuscitation team available during normal working hours. Outside of this time there was no paediatrician available in the hospital. Staff told us that in the event of a paediatric resuscitation event outside of normal working hours, staff in the hospital would manage the emergency situation until a paediatrician arrived from home. This meant that children who required resuscitation outside normal working hours did not have the same level of expertise available to them which had the potential to impact negatively on their care.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet patient's needs.

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

Reasons for our judgement

SURGERY

There were not enough qualified, skilled and experienced staff to meet patient's needs.

We found that patients undergoing surgical procedures did not always see their consultant prior to or following surgery. Staff we spoke with told us there had been no surgical job planning for three years. NHS job planning is a professional agreement that sets out the duties, responsibilities and objectives of a consultant. They form an annual prospective agreement about the work a consultant will do for the NHS; it includes where and when they will work and how much time is spent on their NHS work. They were introduced in 2003 to improve patient care and safety. The lack of job planning at Maidstone Hospital meant that the responsibility of individual surgeons was unclear and the time spent conducting NHS work within the hospital was not specified. This impacted on the continuity of care for patients because surgeons did not routinely attend the multidisciplinary meetings and did not take responsibility for the care of patients from admission to discharge. The RCS standard for Good Surgical Practice 2014 says that consultant surgeons should take full responsibility for management of their patient, leading the surgical team to provide the best possible care. This responsibility should encompass pre-operative optimisation to post-operative recovery.

We looked at the job plans available. We were told they were not up to date. We found they were not an accurate reflection of the work that was being undertaken by surgeons within the hospital. The job plans did not correspond with the current practice of surgeons at the hospital. We found that the current working arrangements for the surgeons meant they operated on patients who they then were unable to see subsequently, due to being at the other site or involved in private work. The current working patterns did not allow consultants to discuss and obtain consent from patients, operate on them and then see them subsequently on the ward. This practice put patients at risk because it increased the likelihood that complications would not be identified in a timely manner.

Our analysts had reviewed all the data we hold on the hospital and compared it to other

similar hospitals. What they reported showed that poor oversight of patient care by surgeons was affecting patient outcomes. In four of the 13 specialities we considered, the emergency readmission rate following elective surgery was worse or much worse than expected. The specialities where the readmission rates were better were those where the surgery was minor, including paediatrics and dermatology.

We found that in order to help with emergency surgery at another trust location, two staff grades surgeons had been employed to provide cover for the consultant surgeons who were mainly at Maidstone hospital doing elective work. There was little or no consultant input into these high-risk cases and no data collection on outcomes. We were told by theatre staff that this was stressful for the consultants and coupled with the need to drive between hospitals meant they were constantly late for the start of surgical lists. The two trust hospitals were forty minutes' drive apart.

The October 2013 report by the RCS found that surgeons who had operated on a patient with post-operative complications were often not involved in their subsequent care. The report says that, sometimes, a surgeon was not contactable when the intensive care team wanted to involve them in a decision about the next steps in the care of critically ill patients.

We found that due to the poor job planning arrangements, surgeons sometimes travelled between sites during the working day and junior doctors operated on lists when the consultant in charge was not present and was on a different site: this was contrary to the guidance issued by the RCS and compromised patient safety and surgical training. This meant there were times when there were inadequate numbers of appropriately skilled and qualified staff to ensure patient safety. It also meant that, at times, patients who developed unexpected complications needed to be transferred between hospitals for an intensive care bed under the direction of a more junior doctor. This placed people at further risk of harm because there were not always adequate numbers of appropriately skilled and qualified staff to ensure patient's safety.

The RSC report further stated 2013 that some surgeons involved in upper gastrointestinal surgery, "Agreed amongst themselves, at short notice, who would attend a fixed clinical session such as an operating list". The reviewers were given a shared job plan and timetable but this bore little resemblance to what was actually happening. The report said, "The reviewers were told by the surgeons that the timetable was 'aspirational'. It was commonly reported to the reviewers that the physical whereabouts of the surgeons was often unknown due to the incomprehensible nature of their joint job plan".

All theatre staff we spoke with knew of the Association for Perioperative Practice (AfPP) guidelines for staffing levels of operating theatres. One member of the operating theatre department staff told us that, "99% of the time the guidelines were met". They said that sometimes shortages were filled with agency staff. Documents we inspected showed appropriate staffing levels. We were told that all of the theatre staff were multi-skilled and qualified to work in all three areas that is; anaesthetics, operating theatre and recovery.

Staff we spoke with told us that they felt valued and supported by their immediate colleagues. One member of staff told us that they had a "Supportive manager" whereas another member of staff told us "I receive little comment from management" and indicated that this left them feeling unsupported by their manager. One health care assistant told us that she "loved being part of the ward team". They said that they were a good team and when short staffed, everyone rolled up their sleeves and just "got through the work". They felt they were valued by the other staff. They said, "Even the doctors are polite and treat

me as an equal. I feel valued and love working here. I have worked here for six years. There are only three night staff (registered nurses) to cover 19 patients. This this is too low when people are so unwell".

We looked at the incident reporting system and saw that concerns about understaffing of the admission lounge had been identified as a concern. We saw these were being addressed. This was confirmed by a member of staff who told us that additional staff were being recruited in response to patient safety concerns being raised by staff in the admissions lounge.

We looked at the data that the trust managers provided us with. We saw that there was a noticeable shortfall in both qualified and unqualified nurses in post on the surgical directorate wards. The trust had calculated that there was a need for 191.6 full time registered nurses to staff the surgical directorate. There were only 164 in post. Unqualified nursing staff, health care assistants posts, were also unfilled with a determination that 72.3 full time staff were required but only 59.4 posts filled. This meant that the surgical directorate was running with almost a 20% vacancy rate for nursing staff.

We looked at the staffing arrangements in the pathology department. The histopathology laboratory was operating as two separate laboratories; we found that some staff trained in one area of the laboratory unable to support the other due to lack of competency and familiarisation of laboratory procedures. Staff told us that the laboratory "Feels like working in a factory, was "Overstretched", and that they "Do not feel supported". Staff said they felt "cut-off from the lab".

Staff told us about a serious incident that had occurred in May 2013 where the biopsy specimens for two patients had become confused. We were told that at the time of this incident the department was experiencing an increased workload, with pathology services being provided to a neighbouring Trust. We were told that some staff were, "double-booked on benches" (meaning they were expected to do two jobs at the same time). Our Specialist Professional Advisor found that that new staff had not been adequately inducted in laboratory procedures.

On the day of inspection we found that the staffing in the laboratory and office was inadequate and inappropriate for the volume and complexity of workload. We found that this compromised the ability of the hospital to provide a safe and quality assured service. Use of agency staff was restricted. Bank office staff were being used on a very short term basis. This meant that permanent staff had to oversee the constant induction and training of new staff and created inconsistencies in output. The close supervision that is required for 'new' staff affected the productivity of existing staff. This situation was confirmed by staff that we spoke with and the staffing rota for the laboratories.

On the day of inspection we were informed that there were approximately 1000 histopathology diagnostic reports outstanding, over a period of two weeks. This meant that patients who were awaiting treatment had delays to their care as the clinicians did not have the test results on which to base their treatment plans. Staff informed us that a lack of adequate and appropriate staff in the laboratory and office had resulted in a backlog of reports to be sent out.

PAEDIATRICS

We found shortfalls in the staffing levels for children related to the hospital 'Out of Hours' provision. Staff told us that there was not always a paediatric nurse on duty in the hospital.

The hospital employed one paediatric emergency nurse practitioner but they were not able to cover all shifts. This resulted in times when there were no nurses with paediatric qualifications available to care for sick or injured children. The guidance document 'Standards for children and Young People in Emergency Medicine' (Royal College of Paediatrics and Child Health, 2012) recommends that, "Sufficient Registered Nurse(child) are employed to provide one per shift in emergency departments receiving children. Maidstone hospital was not meeting this standard.

We spoke with staff in the accident and emergency department about their experience and training in the care of sick children. We were told that the triage nurse had at least 18 months experience in the department but was not necessarily a paediatric nurse. We were told that the Emergency Nurse Practitioners were, "Very experienced and used to dealing with children". Staff told us they all felt competent and sufficiently knowledgeable to care for very ill babies and children but there was no formal assessment of their capabilities to do so. The document 'Standards for children and Young People in Emergency Medicine' (Royal College of Paediatrics and Child Health, 2012) recommends that, "In emergency care settings where nurses work autonomously to see and treat patients (usually called EPNs) they undergo an assessment of competencies in the anatomical, physiological and psychological differences of children". Maidstone Hospital was not following this recommendation and as a consequence, it was unclear whether staff were fully competent to meet the needs of sick children.

We found that out of hours paediatric advice and support was not always immediately available at Maidstone Hospital, including at night and during weekends.

We were told by medical and nursing staff that a junior doctor worked from 9am to 7pm on Monday to Friday on the children's day unit. They were supported on site by a paediatric consultant from 9am to 10am and by a registrar from 10am to 6pm. Paediatricians were sometimes also on site during the day at their outpatients clinics and could be called if there were serious concerns about a child. From 6-7pm a consultant paediatrician was on call. We were told that the registrar liaised with the accident and emergency staff about any children who were being seen in the department and that they would not leave the hospital until a plan of care for the child had been established. Staff told us that clinical staff in the accident and emergency department had a minimum level of knowledge, skills and competencies in caring for children and young people. This included recognition of a seriously ill child, basic life support, pain assessment and recognition of vulnerable children. However, we were also told that the arrangements for medical cover for paediatric patients meant that although there was adequate representation on the paediatric cardiac arrest team during the day, this was not the case at night and at weekends when there was no paediatrician.. As there is no time when a child is more likely to suffer a cardiopulmonary crisis, the current arrangement for providing resuscitation to a child meant that children may be at risk of harm.

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 did not have an effective system to regularly assess and monitor the quality of service that patients received.

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 has had stable senior leadership at board level for a number of years. There was a clear organisational structure to board committees. One of the key roles of the board was to understand the nature of the risks the organisation faces and to assure themselves that everything possible was being done to manage those risks. We found that this was not the case at Maidstone hospital; the board members that we spoke with could not provide that level of assurance.

We found that the trust undertook significant public and patient engagement through its Patients Experience Committee. However, this committee's links to the trust's Quality and Safety Committee had not been reviewed to ensure that performance reporting lines and escalation arrangements were clear. This meant that information gathered through engagement was not necessarily fed upwards to inform the board. Information was being gathered but not used.

The Quality and Safety Committee had undertaken substantial work on operational oversight, such as the development of dashboards of care. A dashboard is snapshot of data relating to a particular ward or department. Dashboards use several performance indicators to help staff and managers see how well a part of the service is doing compared to other areas or how well it is doing over a period of time. We saw examples of how the number of falls on individual wards had been reduced overtime.

The board also relied on the quality and safety committee to provide strategic assurance too when this should have been the responsibility of the whole board. We saw that the Quality and Safety Committee met for just 12 hours a year.

We saw that the membership of the Quality and Patient Safety Committee was wide and this meant that is was unclear as so to 'who is holding who to account'. The wide range of membership had the potential to confuse the answer to this key assurance question. The current arrangements meant that the non-executive and executive directors worked

together to hold the directorate managers to account. It was less clear how the non-executive directors held the executive team to account and whether they were aware that this was their ultimate responsibility. One non-executive director that we spoke with made it clear that they were unable to say that they were fully assured about the safety and welfare of the patients at Maidstone hospital under the current governance arrangements.

The board had a programme of 'Board to Ward' visits (board members visit wards and departments to monitor the quality of care being provided) which can be very effective ways of checking that what directors were told in board reports happened in practice. However, when we spoke to staff and non-executive directors we found that these did not appear to have a data driven purpose and would have benefited from a greater structure and focus to add to the informal listening approach that was in place. The visits were used as an opportunity for non-executive directors to meet staff rather than as an opportunity to gather data and check information provided at board meetings.

We found that non-executive directors did not take part in visits to wards and other areas where patients received care (with the exception of the chair) between October and December 2013. One ward manager commented that their ward had only had one visit in the last year. This key aspect of verification of information and communication had been flagged previously to the trust board in an external assurance report on the trust's Quality Governance Assurance Framework in September 2013.

There was evidence that learning from incidents and investigations did not take place and was not robust. We found that appropriate changes were not implemented.

Following the deaths of five patients who underwent complex surgery at Maidstone hospital over the preceding two year period, an RCS review of the surgical speciality was commissioned by the trust. The deaths related specifically to patients undergoing complex laparoscopic upper gastrointestinal surgery. From discussion with board members and managers, we found that the review of upper-gastroenterological surgery by the RCS in October 2013 had not been purposely used to date by the board to assess whether similar issues exist elsewhere in the trust. It was not recorded on the trust's Risk Register. This meant that poor surgical practice and risk to patients was possibly more widespread across other surgical specialities.

We reviewed how well the trust monitored the quality of the services it was providing. We found that there was inadequate collection and verification of data by the trust and that this had resulted in poor care being allowed to persist. Data the trust used was heavily dependent on a commercial organisation to provide and analyse information relating to the hospital. We found that some of the data being used was inaccurate. The trust acknowledged that they had, "Issues with data collection and validation processes" historically. For example, issues with data collection and validation had resulted in inaccuracies in the mortality rate data recorded for individual surgeons.

The governance committee of an acute NHS hospital should be collecting data as a minimum (by named consultant) for transfusion rates, infection rates, readmissions within 30 days, returns to theatre, transfers to high dependency and intensive care, mortality rates and survival rates for oncology cases. They should be required to explain the discrepancies and concerns highlighted by their information and governance teams. We saw from data reviewed by our analysts that orthopaedic surgeons at the trust were undertaking up to four times as many operations as the national average. This is something that should have been explored to determine whether it posed a risk to patients.

We spoke with senior staff about how medical and surgical care was monitored at the hospital. We found that there had been no dissemination of learning over four recent serious incidents'. We did not see any drive or determination to ensure that the risk of recurrence was reduced. Our judgement about this was based on discussion with senior staff in the operating theatres, the surgical wards and with a consultant surgeon from the speciality where one of the serious incidents had occurred. None of the staff we spoke with were aware that there had been a serious incident. This meant that the organisation was not demonstrating learning from incidents and that risk to patients had not been reduced.

We saw that the hospital had a policy governing resuscitation activity that was dated October 2011 with a review dated of October 2013. This meant that this policy was out of date. However, we saw that minutes of the Standards Committee meeting that took place on 13 December 2013 indicated that the committee had extended the review date of this policy to 31 March 2014. We looked at six other hospital policies. For example, the patient transfer policy and procedure. We saw that they were all dated indicating when they came into force and that they all contained planned review dates. This meant that the hospital had a system in place to ensure that policies were kept up to date. Policies contained details of how the hospital would monitor and audit activity governed by the policy. This meant that the hospital had a system in place to assess staff compliance with the guidance set by the policies.

There was a policy governing incident reporting and management. Staff told us that it was available to them on the intranet. Staff we spoke with were aware of how to report an incident or near miss using the hospital reporting system. One member of staff described reporting a recurring incident situation that resulted in action being taken in the hospital to resolve the issue. Another member of staff said that when they reported an incident they subsequently received no feedback. In the Pathology laboratories, we noted from discussions with staff and from examination of some documents that learning from incidents was adhoc and not shared. Staff told us that the communication system was not open and transparent.

Staff described a variety of ways that governance issues were communicated to them including; verbally by their direct line manager; via email; through group meetings, such as bed meetings; via the hospital intranet; at staff meetings; during handover; via staff notice boards. We were given a copy of a memo dated 4 December 2013 from a ward manager to the ward staff. This memo showed us that there had been an incident with a centrally placed intravenous catheter recently that had been cited as a reason a patient became suddenly unwell due to an air embolism entering their circulation. If an air embolism stops blood getting to the brain, tissue in the brain will be starved of oxygen and die. This can cause permanent brain damage. The memo asked staff to check all lines on all shifts and introduced new working practices on the ward.

Staff told us that they were aware that there was a whistleblowing policy available on the intranet (entitled the speak out safely (SOS) policy and procedure) that governed the reporting of concerns they may have, such as malpractice. Staff we spoke with were able to describe the action they would take to raise any concerns. However, none of the staff we spoke with had witnessed any concerns and therefore had no experience of using this system in the hospital. The report provided to the trust by the RCS in October 2013 had criticised the trust response to whistle-blowers. We were told that there was an open and transparent culture but that is not what the team from the RCS found. A group of staff had complained anonymously to the GMC about a surgeon. This had been investigated internally by one of the trust managers but had been dismissed as malicious and

inaccurate. The RCS review team found that some of the issues raised with the GMC had some substance to them, such as a lack of presence on the wards, and were not malicious. During the review visit by the RCS, the team interviewed staff who reported feeling intimidated when raising concerns about the surgeons.

We found weakness in the quality assurance and governance processes in the pathology laboratories. We were provided with a copy of a Serious Incident (never event) dated 11 Sept 2013. This showed that the slides were mislabelled and described the context in which this incident happened – transfer of workload and staff from neighbouring trust, staff vacancies, cramped laboratory space and lack of checks on accuracy of slide labelling. The serious incident was only discovered after three months during which two patients were harmed. A slide check on labelling had not been carried out at the time although this had been resolved at the time of our inspection with a second slide check introduced. We saw the standards operating procedure for the slide labelling and checking had subsequently been revised.

A lack of laboratory space had also been identified as a factor contributing to the incident. Additional space was identified as necessary but on the day of inspection we observed that staff continued to work in a cramped space which increased the risk of closely placed slides becoming muddled. This demonstrated that despite being aware of issues that compromised patient safety the hospital failed to implement the necessary actions to reduce the risks.

A review of 229 cases near the time of incident found no other mislabelling errors. We were told by pathology staff that the serious incident report had not been seen by 'all' histopathology staff including the consultant histopathologists; this demonstrated a lack of sharing of learning. There were no further audits nor reviews of procedures or clinical cases to assure quality improvements had become embedded in practice. This demonstrated that there was a lack of robust quality and governance processes.

We saw the minutes of the Pathology Quality Committee dated November 2013 and those of the Directorate Quality and Safety Committee dated January 2014. The minutes demonstrated that quality and safety issues were discussed by senior staff at managerial level. It showed us that relevant matters were disseminated to staff in team meetings, at quarterly intervals. However, staff were not involved in the design of the preventative action or in sharing the learning, confirming a lack of openness and transparency and thus lack of a robust governance process within the pathology department.

We saw a document called the service continuity plan. It stated that managers must assess staffing levels against workload to determine the impact of staffing level and that they were required to communicate concerns to senior managers. We were informed that, despite this document, secretarial staff shortage in histopathology office has not been addressed and had impacted on a significant number of histopathology diagnostic reports awaiting submission to clinical requestors to enable appropriate patient care. Although the hospital and department had appropriate strategies in place to identify staffing concerns, these were not translated into operational improvements. We found that turnaround time of histopathology reports was not monitored due to a breakdown of the monitoring system.

When we looked at how the care of sick children was monitored. We found that the local arrangements were effective with ward and department level staff working to ensure that the service they provided was well led and safe. However, we did not find any evidence of board level oversight of the services for children at Maidstone Hospital. The guidance

document 'Standards for children and Young People in Emergency Medicine' (Royal College of Paediatrics and Child Health, 2012) recommends that all providers or urgent and emergency care monitor the care provided for children using nationally defined indicator sets and use this, and additional data, when planning service improvement and proposing future quality indicators. When we spoke with staff and managers, they were not able to tell us how many children were seen in the accident and emergency department each month or each year.

The report issued by the RCS following their review of upper-gastroenterological surgery raised concerns that surgeons were not attending the multi-disciplinary team (MDT) meetings to discuss the treatment options and advise on the best surgical care for patients. Their recommendation was that surgeons should be present for at least 75% of all MDT meetings. There was no evidence that this was happening at the time of the inspection and no clear drive by the executive team or board to ensure that progress was made towards this target. This meant that decisions about care and treatment were not always made by the appropriate staff at the appropriate level. It demonstrated that the monitoring systems across the hospital were not sufficiently robust to inform a cycle of continuous improvement.

The report from the RCS in October 2013 discussed the governance of the complex upper gastrointestinal surgery services at Maidstone hospital. The report said that a clinical nurse specialist had undertaken a range of audits relating to the service. The review team noted the audits were well conducted but were concerned that the positive outcome of audits relating to issues, such as GP letters and whether patients received copies of letters, may have created a false sense of security and masked the serious concerns that the review team identified.

We looked at data given to us by the trust which related to extended anticoagulant therapy in cancer patients undergoing major abdominal surgery. The collection of this data was following changes to the National Institute for Clinical Excellence Guidance (NICE) number 92 recommendations. We saw that at the time the guidance was published a hospital audit for the year ending December 2012 showed 63% compliance with the trust policy. The initiative to improve the level of compliance was put in place and followed up with a subsequent audit ending in January 2014. There was a significant improvement with 83% compliance with the trust policy at this time. We were told that this had been brought about by working with junior doctors, through staff training, awareness raising and by ensuring there were prompts on the surgical pathway documentation. Ongoing monitoring to ensure the improvements were embedded was via the ward dashboards. This demonstrated that some aspects of care were monitored effectively and that the hospital was able to bring about improvements where individual members of staff took responsibility for the initiative.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The registered person must ensure that service users are protected against the risk of receiving care or treatment which is unsafe through ensuring the planning and delivery of care and treatment meets the individual needs and ensures their welfare and safety. Regulation 9 (1) (b)
Regulated activities	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The registered person must take appropriate steps to ensure that at all times there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying out the regulated activity. Regulation 22
Regulated activities	Regulation

This section is primarily information for the provider

Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The registered person must protect services users and others who may be at risk, against the risk of unsafe care and treatment by means of the effective operation of systems designed to enable the registered person to: regularly assess and monitor the quality of services and identify and manage risks relating to the health, welfare and safety of service users and others who may be at risk form the carrying on of the regulated activity. Have regard to the complaints and comments made and views of expressed by service users and those acting on their behalf. Any investigation carried out by the registered person, appropriate professional and expert advice. Where necessary make changes to the treatment or care provided in order to reflect information of which is it reasonable relating to analysis of incidents and the conclusions of local and national service reviews Regulation 10 (1) (a) (b) (2)(a) (b)(i) (ii)(iii) (iv)(v)(vi) (c) (i) (ii)(d(i)(ii)

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 02 May 2014.

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.

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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