Care Quality Commission

Royal United Hospitals Bath NHS Foundation Trust

Royal United Hospital Bath

Inspection report

Directors Offices, Royal United Hospital
Combe Park
Bath
BA1 3NG
Tel: 01225428331
www.ruh.nhs.uk

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Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Royal United Hospital Bath

Inspected but not rated

We carried out this unannounced focused inspection on 22 August 2022 because we had received information giving us concerns about the safety and quality of the medicine core service.

Medical care (including older people's care) includes a range of specialities. Medical care includes services that involve assessment, diagnosis, and treatment of adults by medical intervention, including interventional Cardiology. Medical care services sit within the Medical Division.

There are 12 medical inpatient wards at the Royal United Hospital site with a total of 381 beds. These wards specialise in: Respiratory, Care of the Elderly, Oncology and Haematology, Cardiology, Neurology, Stroke, Endocrinology, Gastroenterology and Acute medicine. The medical division includes: Medical Admissions Unit, Ambulatory Care, Medical therapies, and Coronary Care Unit. It is also responsible for Radiology, Medical Physics and Therapies.

At this inspection we inspected a selection of care of the elderly wards (Cheseldon, Midford and Waterhouse).

As this was a focused inspection at Royal United Hospital Bath (medicine) we only inspected parts of each key question: safe, caring, effective, responsive, and well led.

We considered information and data regarding medical care and gathered feedback around the experience of patients using medical care services in Royal United Hospital, Bath.

We did not rate the medical care core service at this inspection. Instead we looked at areas where we had concerns.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Medical care (including older people's care)

Inspected but not rated

We found:

- The service had enough staff to care for patients and keep them safe but planned staffing levels were rarely met for the wards we visited. Staff understood how to protect patients from abuse. The service controlled infection risk and managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment and gave patients enough to eat and drink. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However:

- Staff did not always keep up to date with their safeguarding training. Staff did not always review patient risk assessments in line with policy. Staff could not always respond in a timely way to patient call bells due to staffing challenges.
- Equipment was not always serviced or stored in line with guidelines. Some wards did not consistently complete daily checks of emergency equipment.
- Staff did not always ensure patient consent was gained. Completion and recording of Mental Capacity Act assessments and Best Interest decisions was not always done. Identification and review of patients who may be being deprived of their liberty was not done consistently.

Is the service safe?

Inspected but not rated

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it but did not always complete annual updates.

All staff received training specific for their role on how to recognise and report abuse but not all staff had completed refresher training within required timescales. The service provided data that showed only 68.3% of registered nursing staff had completed levels 3 safeguarding training by August 2022. Though this was an improvement of 20.6% compared with the completion rates for the previous year 2020-2021, it was still low and did not meet the Trust's target of 90%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were visibly clean and well-maintained. The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff completed hand washing before and after each patient. Alcohol gels were available and used by all staff regularly.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw 'I am Clean' stickers on all surfaces and equipment on all wards. The housekeeping staff told us they felt a valued part of the team and were proud of the work they did.

Environment and equipment

The design and use of facilities, premises and equipment kept people safe but not all equipment was serviced within the manufacturer guidelines. Staff were trained to use them. Staff mostly managed clinical waste well.

Patients could reach call bells and staff mostly responded quickly when called and the service had suitable facilities to meet the needs of patients' families. Whilst on Midford ward we observed a patient who pressed the call bell but was not responded to within 5 minutes. We alerted a staff member to the patient's need, and they supported them immediately. The staff advised that the ward did not have planned staffing numbers and were not able to attend until this point.

The service had enough suitable equipment to help them to safely care for patients. However, we found four pieces of equipment on one ward that had not been serviced within the manufacturer guidelines. Staff did not always store equipment safely. On one ward we found disinfectant tablets left in the sluice on the windowsill with no lid on. This was not in line with the Health and Safety Executive control of substances hazardous to health.

Staff did not always carry out daily safety checks of specialist equipment. On Waterhouse ward there were gaps in the daily record checks of the resuscitation trolley every month for the past six months.

Staff mostly disposed of clinical waste safely. However, we found two sharps disposal bins on Waterhouse ward that were open and overfull. We told staff and they took immediate action to empty these, and we did not see any other concerns with clinical waste disposal during the inspection.

Medical care (including older people's care)

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff knew about and dealt with any specific risk issues. Staff recorded national early warning score (NEWS 2) results on electronic recording systems. The scores were also recorded in patient paper notes at the nurse's station and in nursing assessments which were stored at the patient's bed side.

Staff completed risk assessments for each patient on admission to each ward, using a recognised tool. However, we found the falls prevention plans and pressure ulcer prevention plans were not being reviewed each week as part of the nursing assessment documentation on Midford. On the same ward, there were three examples of patients who were at high risk of pressure ulcers who had not been repositioned as part of comfort rounding within the guideline times.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We reviewed two patient notes with additional support provided by Mental health liaison teams, and we saw they had received further assessment and care planning to support them during their admission.

Staff shared key information to keep patients safe when handing over their care to others. Staff told us they used the SBAR (Situation Background Assessment Recommendation) model when patients were moved between wards. We saw evidence that these were complete through electronic handover and sometimes through use of paper SBAR forms. Forms were consistently signed by the nurse providing transfer and the person receiving the patient.

Shift changes and handovers included all necessary key information to keep patients safe. However, it was observed during the inspection that the handover area used by staff on one ward did not protect patient confidentiality. We fed this information back to the service at the end of our inspection and they made immediate changes to where the ward completed this handover. There was a room allocated for all debriefs and handovers, and all whiteboards from the ward (which held patient personal data) were relocated to this room as well.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. However, staff reported that staffing levels often were not at planned levels for health care assistants. They told us that when there were planned numbers, staff were often relocated to support in other areas that were challenged with staff absence. This was supported by staffing rotas we saw and corroborated by senior leaders of the service.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The service was undergoing a review of staffing numbers and managers showed us how they calculated and reviewed staffing levels. We saw how managers escalated staffing difficulties and how support was gained from other areas as needed. The ward manager could adjust staffing levels daily according to the needs of patients.

Medical care (including older people's care)

The service had reducing vacancy, turnover and sickness rates. There was an ongoing recruitment project at the service which had been successful at recruiting many new staff across the department. The service had introduced weekly payments for bank staff following feedback. However, the service was challenged recruiting and retaining healthcare assistants post pandemic.

Managers made sure all bank and agency staff had a full induction and understood the service. We saw an example of a new staff members induction. This was the same for bank and agency staff.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff.

Managers could access locums when they needed additional medical staff. The service had high levels of locum staff at the time of inspection. Managers made sure locums had a full induction to the service before they started work. Locums on duty during the inspection told us they were well supported and received a comprehensive induction.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The service used electronic patient notes but also kept paper records at patient bed side and at nursing stations. All vital information was updated on all records consistently and staff made reference at their daily multidisciplinary team meeting how helpful it was to have current and up to date information on the patient in all places. When patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely.

Is the service effective?

Inspected but not rated

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural, and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were regularly offered drinks and we saw that there was a choice of meal options available to them. Housekeeping staff checked any nutritional needs when offering drinks and snacks.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We reviewed 20 sets of patients records and found that fluid and nutrition charts were completed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Nurses used the malnutrition universal screening tool (MUST). All patient records we reviewed showed MUST scores were recorded clearly.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff made referrals to therapy staff where input was required. For example, we saw evidence in four records showing input from speech and language therapists and two records showing input from dieticians.

Patient outcomes

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Managers made sure staff received any specialist training for their role. Staff completed competencies relevant to the specialties they were working in. For example, one staff member showed us competencies relevant to patients undergoing dialysis and patients who had experienced a stroke which had been completed and been signed off by the day ward manager.

Managers gave all new staff a full induction tailored to their role before they started work. We spoke with two staff who had begun their roles in the last year. They told us their induction was comprehensive and they felt well supported by managers on the wards. Junior doctors were also positive about the induction process and felt supported by senior staff and the wider medical teams. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff were complimentary of the appraisal process, and we saw evidence that appraisals were complete when due or rearranged quickly if they had been cancelled.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Minutes were shared with staff through email and were available for staff to view in the nurse's station or office. Updates were shared with staff through bulletins.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Ward rounds were completed daily and were attended by the multidisciplinary team. All staff were knowledgeable about patients at the meetings, and they followed up on the previous day's actions for each patient to ensure their care was coordinated. Staff

incorporated patients' personal social situations during ward rounds which aided in communication and discharge planning. Staff worked across health care disciplines and with other agencies when required to care for patients. There were discharge coordinators who supported the wards making referrals to community services and raising safeguarding alerts as required.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We reviewed the records for two patients who were receiving additional support through the mental health teams. Staff were up to date on recommendations and needs of these patients and discussed them at handovers and ward rounds.

Patients had their care pathway reviewed by relevant consultants. All patient records we viewed had been reviewed by the relevant consultants.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They did not always use measures that limit patients' liberty appropriately.

Staff did not consistently understand how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff did not always make or document where decisions had been in their best interest, taking into account patients' wishes, culture and traditions. Patient records we reviewed did not always contain Mental Capacity Assessments or Best Interest decisions where these were indicated. Treatment Escalation Plan (TEP) and Recommended Summary Plan for Emergency Care and Treatment (RESPECT) forms were not consistently fully completed. There were two versions of the Mental Capacity Assessment document being used. One version did not encourage an approach to considering or assessing mental capacity in line with current guidance. Staff did not always record, when required, consent in the patients' records.

Staff received but did not always keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This was provided as electronic learning for all staff who required level 2 safeguarding adults training. For registered staff, this was delivered as part of level 3 safeguarding training which did not have good completion rates as documented in previous safeguarding section of this report. We raised concerns about this following the inspection and the provider responded quickly with a detailed action plan evidencing how they would address the low compliance. The plan included an introduction of one day face to face safeguarding training which would include Mental Capacity Act, Deprivation of Liberty Safeguards / Liberty protection safeguards.

Staff did not all understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005. Staff could not all describe how to access policy or get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff did not always implement Deprivation of Liberty Safeguards in line with approved documentation. Three wards for care of older people were via a swipe card access, potentially restricting access and exit for all patients on the ward. Patients were not aware of this. Risk assessment and rationale for use of bedrails was not consistently recorded in patient notes. Patients who were under continuous supervision and control, and were not free to leave, were not all supported by the correct legal framework.

We raised in this area to the trust leadership team following the inspection. The provider took immediate action and have provided us with a comprehensive action plan which clearly and comprehensively addressed all concerns we raised in relation to this area of the inspection.

Medical care (including older people's care)

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff taking the time to talk to people. Staff advised us they enjoyed the work they did. On one ward we observed a health care assistant playing card games and sharing jokes with patients. Patients were positive about having the extra time and told us it helped them to stay alert and maintain some humour during their stay. Patients said staff treated them well and with kindness. Patients felt listened to by ward staff and they knew how to seek help if they needed it. We saw one family member and two patients approaching staff for support. Staff showed active listening skills before responding to the needs of the people they were speaking to. We also observed a therapy session where a patient was reassured and encouraged by the staff member to build and maintain their independence while on the ward.

Staff followed policy to keep patient care and treatment confidential. Most patients we spoke with were happy that their privacy and dignity was respected. For example, staff pulled curtains around patients when giving personal care.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. When talking to patient's staff regularly checked the patients' wellbeing. We saw a health care assistant and a nurse supporting a patient with a diagnosis of a dementia who was trying to leave the ward and was very distressed. The staff showed empathy and compassion and took time to re-direct them and make them comfortable again. They offered the patient a drink and stayed to talk with them about their life for 10 minutes before continuing with the tasks they were previously doing.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. Feedback from people who accessed and used the service was consistently positive. Patients and their families said staff were caring and attentive and went over and above to make sure they had what they needed.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff had good knowledge of the services available within the hospital but also the wider community. We saw staff sign posting family members to other services that could provide them with additional support.

Staff understood the emotional and social impact that a person’s care, treatment, or condition had on their wellbeing and on those close to them. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. There were rooms available on all wards to support staff when breaking bad news. We observed staff showing care, kindness, warmth, and compassion when having end of life conversations with family members and patients. Staff gave people time to discuss all options and provided reassurance. They had access to and involved the chaplaincy service for additional support when needed. Records evidenced additional support offered or suggested.

Medical care (including older people's care)

Understanding and involvement of patients and those close to them

Staff supported patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed a discharge planning conversation with staff the patient and their family. The staff discussed the plan for discharge and was sensitive to the views of the family members involved. All involved in the discussion were able and encouraged to ask questions about the plan and the care.

Staff talked with patients, families, and carers in a way they could understand. People we spoke to told us staff spoke to them in basic terms, so they had a better chance of understanding.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service.

Is the service responsive?

Inspected but not rated

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Two wards we visited had separate bays for female and male patients. Staff told us that they never breached the standards for these bays.

Facilities and premises were appropriate for the services being delivered. We saw examples of therapy rooms and day rooms that we used for activities with patients. One ward also had a lunch room where patients were encouraged to talk with each other and be away from their beds to eat.

The service had systems to help care for patients in need of additional support or specialist intervention. The service relieved pressure on other departments when they could treat patients in a day. One medical ward had been rebranded as a short stay ward. However, due to the increasing number of admissions and acuity of patients, many patients on this ward had been there for long periods of time.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff ensured patients living with mental health problems, learning disabilities and a diagnosis of a dementia, received the necessary care to meet all their needs. The service had a flagging system to identify patients who had additional needs. This was also recorded on handover whiteboards used for staff ward rounds. Staff had access to learning disabilities service for support.

Medical care (including older people's care)

Wards were designed to meet the needs of patients living with dementia. We saw examples of dementia friendly adaptions on wards. For example, the ward bay doors were in different colours to aid with orientation. Staff used getting to know you type documentation and used hospital passports for patients with additional needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Managers and staff worked to make sure patients did not stay longer than they needed to. Staff told us demand for beds in medicine was high and there were not enough beds to always meet the need for patients. In escalation medical patients were sometimes cared for on non-medical wards. However, there were good procedures to ensure these patients were reviewed by their speciality consultant. Consultants told us they planned each day to ensure these outlier patients were reviewed. Staff had begun planning for winter pressures during our inspection and ward managers told us they were involved in this process.

Managers and staff started planning each patient's discharge as early as possible. There was a discharge coordinator who supported discharge planning. Discharge planning started as soon as the patient arrived on the ward. We saw evidence that this was discussed at handover meetings and ward rounds during the inspection. The multidisciplinary team worked to reduce delays but told us that most delays were related to capacity of social care providers in the community. The service attended regular meetings with wider system providers to ensure they understood capacity and pressures on the wider system. This information was shared with staff and there were processes for staff to escalate when patients had longer stays. Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Managers worked to minimise the number of medical patients on non-medical wards.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The medicine core service had a senior leadership team with the appropriate range of skills knowledge and experience. The leadership of each ward was overseen by matron and ward manager. There was a lead consultant who had oversight of medical care core service in general.

Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging the executive team were. The leadership team felt they received support from the board, and matrons were positive about the impact the Chief Nurse had on improving practise and making positive change. Leaders told us they were passionate about ensuring staff had the best working environment. Staff were well sighted on the work that was ongoing around recruitment.

Leadership and development pathways were available to staff to allow for progression within the trust and regular meetings were held by the leadership team and the rest on their staff to provide updates and discuss changes and opportunities.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

There was a positive culture of person centred care in the medicine core service. Most staff felt respected and valued. All staff we spoke with were proud to work at the hospital and were proud of the work the medicine teams did.

Staff knew about freedom to speak up guardians and about their role. They felt able to raise concerns and were confident in the process available to them. However, some staff we spoke with did not feel actions were taken to ensure staff were supportive of each other when wards were busy. Ward managers were passionate about staff taking care of their own well-being. For example, we observed them encouraging staff to take breaks and stay hydrated during busy periods.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had systems for identifying and recording risks. Risks were identified through the incident management system, they were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. There were systems for identifying learning from incidents, complaints, and safeguarding alerts. Governance meetings had standard agendas and detailed discussions of risk management and mitigation. Recorded risks were aligned with what staff said were on their worry list. Top risks included nursing and healthcare assistant staffing and the high acuity of patients.

Staffing risk was being mitigated through recruitment; this included international recruitment, local recruitment and improving retention of students. There were also business cases pending and approved regarding weekly pay for bank staff and improving pay denominations.

Staff who led audits were clear on performance and where improvements were needed. The leadership team were responsive to staff and took action to make change where risks were identified.

Senior staff had good links with external stakeholders and partners from the wider health and social care departments. They met regularly to discuss the risks to the system and identify achievable solutions.

The trust had developed a winter plan that was due to be presented to board in September 2022.

Medical care (including older people's care)

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust SHOULD take to improve:

Medicine

- The service should ensure that they progress with the action plan produced in response to concerns identified with Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards.
- The service should ensure they continue to address low staff training compliance for safeguarding adults levels 3.
- The service should ensure patient risk assessments for falls and pressure ulcer prevention are reviewed regularly on all wards.
- The service should ensure equipment is maintained and stored as required by manufacturer guidelines and COSHH (Control of Substances Hazardous to Health) regulations.
- The service should ensure all wards consistently complete daily checks of emergency equipment.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and one other CQC inspectors. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation