

University Hospitals of Leicester NHS Trust Leicester Royal Infirmary

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Medical care (including older people's care)	
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Summary of findings

Letter from the Chief Inspector of Hospitals

University Hospitals of Leicester NHS Trust is a teaching trust formed in April 2000 following the merger of Leicester General Hospital, the Glenfield Hospital and Leicester Royal Infirmary. The trust has 1,978 general and acute beds. Of these beds, 141 are maternity beds and 49 are critical care beds.

University Hospitals of Leicester NHS Trust provide specialist and acute services to a population of one million residents throughout Leicester, Leicestershire and Rutland. The trust's nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, cancer and renal disorders reach a further two to three million patients from the rest of the country. The trust provides services from three hospital sites, Leicester Royal Infirmary, Leicester General Hospital and the Glenfield Hospital.

Leicester Royal Infirmary is close to Leicester city centre and provides Leicestershire's only emergency department. The hospital has approximately 967 inpatient beds and 68 day-case beds.

We carried out this unannounced focused inspection of wards 42 and 43 on 18 July 2017, in response to concerning information we had received about patient care on these wards.

We did not inspect any other core services or wards at this hospital or any of the other locations provided by University Hospitals of Leicester NHS Trust. During this unannounced focused inspection, we only inspected the key questions of safe and caring.

We did not rate the two key questions at this inspection because the scope of the inspection was limited to two wards.

Our key findings were as follows:

- Safety concerns were not consistently identified or addressed quickly enough. We found staff were not always reporting staffing shortages as incidents and on a number of occasion we had to prompt staff to consider reporting concerns we identified as incidents.
- Systems, processes and standard operating procedures were not always reliable to protect patients from avoidable harm as staff were not following these, for example medicines, infection prevention and control and completion of patient records.
- Compliance with resuscitation, fire safety and safeguarding adults and children training was low particularly amongst medical staff.
- Staff did not always assess, monitor or manage the risk to patients for example we saw fluid balance charts which were not up to date and patients did not always get their medicines when required. Care records were not always completed or updated appropriately.
- The risks associated with anticipated events and emergency situation were not fully recognised, assessed or managed.
- Staff mostly responded compassionately when patients needed help and support, however we observed isolated cases where patients were not treated with compassion or afforded dignity and respect.
- We found there was little evidence of patients receiving regular two hourly care rounding. Whilst staff were in and out of the bays we did not always see they checked on each patient's needs.
- Feedback from patient and relatives was mostly positive about the way staff treated them.
- Staff helped patients and those close to them to cope emotionally.

Summary of findings

- Staff explained the treatment and care they were delivering to patients in a way patients could understand. We also heard staff talking to patients who required support with their personal hygiene, involving them in their care.
- We saw clinical nurse specialists on the wards providing reassurance for patients who were anxious. This included spending time with the patient, explaining what the patient should experience and how staff would help.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- The trust must take action to ensure that there are sufficient number of suitably qualified, competent, skilled and experienced staff to make sure that they can meet peoples care and treatment needs.
- Ensure fire exit doors and entrances to wards are not blocked.
- Ensure staff are aware of and receive training in specific fire evacuation plans for the wards and that staff are familiar with the trust major incident and business continuity plans.
- Ensure staff receive training in the use of evacuation equipment.
- Ensure there are sufficient numbers of nursing and medical staff trained and in date with resuscitation and safeguarding adult and children training.
- Ensure nurses follow systems and processes to ensure they minimise the risk of spreading infection when patients are being barrier nursed in side rooms.
- Ensure nurses follow national guidelines and local policies when administering medication to patients.
- Ensure medications are stored securely and at the correct temperature.
- Ensure staff follow instructions on prescription charts including supplementary insulin charts so that all medicines are administered as prescribed.
- Ensure patient records are complete, including the completion of end of life care plans, fluid balance charts risk assessments and care rounding documentation.
- Ensure staff report incidents in line with their incident reporting policy.
- Ensure systems are put in place to enable staff to identify whether a piece of equipment such as a commode has been cleaned between patient use.

In addition the trust should:

- Ensure cleaning products are locked away and are not accessible to patients on Wards 42 and 43.
- Ensure staff follow the correct procedure for the partial closure of sharps bins in line with their sharps management policy.
- Ensure oxygen cylinders are stored securely to minimise the risk of injury if they are knocked over.

Professor Ted Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

**Medical care
(including
older
people's
care)**

Rating Why have we given this rating?

Systems, processes and standard operating procedures were not always reliable to protect patients from avoidable harm as staff were not following these, for example medicines, infection prevention and control and the completion of patient records.

Compliance with resuscitation, fire safety and safeguarding adults and children training was low particularly amongst medical staff.

Staff did not always assess, monitor or manage the risk to patients. For example we saw fluid balance charts which were not up to date and patients did not always get their medicines when required. Care records were not always completed or updated appropriately.

Feedback from patient and relatives was mostly positive about the way staff treated them.

Staff mostly responded compassionately when patients needed help and support.

Staff helped patients and those close to them to cope emotionally.

Staff explained the treatment and care they were delivering to patients in a way patients could understand. We also heard staff talking to patients who required support with their personal hygiene, involving them in their care.

Leicester Royal Infirmary

Detailed findings

Services we looked at

Medical care (including older people's care)

Detailed findings

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Background to Leicester Royal Infirmary

University Hospitals of Leicester NHS Trust is a teaching trust formed in April 2000 following the merger of Leicester General Hospital, the Glenfield Hospital and Leicester Royal Infirmary. There are 967 inpatient beds and 68 day-case beds located at Leicester Royal Infirmary.

University Hospitals of Leicester NHS Trust provide specialist and acute services to population of one million residents throughout Leicester, Leicestershire and Rutland. The trust's nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, cancer and renal disorders reach a further two to three million patients from the rest of the country.

Leicester, Leicestershire and Rutland have a population of approximately 1.03 million, with 32% of people living in the city, 64% in Leicestershire and 4% living in Rutland.

The three areas have significant differences. The city of Leicester has a younger population, whilst the county areas have an older population. The city of Leicester is an ethnically diverse population with over 37% of people being of Asian origin.

In Leicester city, 75% of people are classified as living in deprived areas and there are significant problems with poverty, homelessness and low educational achievement. In Leicestershire over 70% of people are classified as living in non-deprived areas, although there are pockets of deprivation and in Rutland, over 90% of people are classified as living in non-deprived areas. Demographic and socio-economic differences manifest themselves as inequalities in health and life expectancy in the city is 5.6 years less than in Rutland amongst men and 2.5 years less amongst women.

Our inspection team

Our inspection team was led by:

Inspection Manager: Simon Brown, Care Quality Commission.

The team included two additional CQC inspectors, Fiona Collier and Kathryn Palmer.

How we carried out this inspection

We received a number of concerns from a variety of sources in relation to patient care on wards 42 and 43.

We used this information to inform our inspection planning. We also spoke with the local Health-watch teams, the clinical commissioning groups (CCGs), NHS Improvement and NHS England.

Detailed findings

We carried out an unannounced focused inspection on 18 July 2017, specifically visiting wards 42 and 43 at Leicester Royal Infirmary. The concerning information we had received before the inspection related to the key questions of safe and caring so our inspection focused on these two areas.

During the inspection, we carried out a number of activities to gather evidence, including talking with

patients and their relatives, staff interviews, direct observations of patient care and a review of patient records. We also requested specific information from the trust at the time of our inspection visit.

We did not rate the two key questions at this inspection because the scope of the inspection was limited to two wards.

Medical care (including older people's care)

Safe

Caring

Overall

Information about the service

University Hospitals of Leicester NHS Trust provides medical care (including older people's care) as part of clinical management groups (CMGs). At this unannounced focused inspection, we visited wards 42 and 43. These wards are part of the cancer, haematology, urology, gastroenterology and gastro intestinal surgery (CHUGGS) CMG.

The trust has 896 inpatient medical beds across three hospitals; 506 are located within 23 wards at Leicester Royal Infirmary (LRI). During our unannounced focused inspection, we visited wards 42 and 43 only.

Ward 42 is a 28 bedded ward specialising in the care of patients with stomach and bowel conditions and ward 43 is a 28 bedded ward specialising in the care of patients with liver disease and those requiring nutritional support.

During our inspection, we spoke with 17 patients, five relatives and 16 members of staff. Staff we spoke with were all involved in the care of patients on wards 42 and 43 and included junior and senior nurses, matrons, specialist nurses, healthcare assistants, catering staff, housekeeping staff and junior and senior doctors. We also spoke with three members of the senior leadership team at the trust.

We observed interactions between staff, patients, and patient's relatives, considered the environment and looked at 11 sets of medical and nursing care records. We also reviewed 20 sets of patient observation and sepsis screening pathway records.

Summary of findings

We inspected the key questions of safe and caring and we do not have sufficient evidence to rate at this inspection however our findings were:

- Safety concerns were not consistently identified or addressed quickly enough. We found staff were not always reporting staffing shortages as incidents and on a number of occasions we had to prompt staff to consider reporting concerns we identified as incidents.
- Systems, processes and standard operating procedures were not always reliable to protect patients from avoidable harm as staff were not following these, for example medicines, infection prevention and control and the completion of patient records.
- Compliance with resuscitation, fire safety and safeguarding adults and children training was low particularly amongst medical staff.
- Staff did not always assess, monitor or manage the risk to patients. Fluid balance charts were not up to date and patients did not always get their medicines when required. Care records were not always completed or updated appropriately.
- The risks associated with anticipated events and emergency situation were not fully recognised, assessed or managed.
- We observed isolated cases where patients were not treated with compassion or afforded dignity and respect.
- We found there was little evidence of patients receiving regular two hourly care rounding. Whilst staff were in and out of the bays we did not always see they checked on each patient's needs.

However:

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- Feedback from patients and relatives was mostly positive about the way staff treated them.
- Staff mostly responded compassionately when patients needed help and support.
- Staff helped patients and those close to them to cope emotionally.
- Staff explained the treatment and care they were delivering to patients in a way patients could understand. We also heard staff talking to patients who required support with their personal hygiene, involving them in their care
- Clinical nurse specialists on the wards provided reassurance for patients who were anxious. This included spending time with the patient, explaining what the patient should experience and how staff would help.
- Observations and early warning scores (EWS) were recorded digitally using electronic devices which were easily accessible to nursing and medical staff. EWS scores were calculated automatically on the observations which were inputted; this meant the EWS would be calculated accurately.
- Staff were compliant with best practice regarding hand hygiene. There was access to hand washing facilities and personal protective equipment, which included gloves and aprons. Staff wore these when required.
- At the time of our inspection wards 42 and 43 were mostly visibly clean. This included patient bathrooms and toilets.

Are medical care services safe?

We do not have sufficient evidence to rate this key question at this inspection however our findings were:

- Safety concerns were not consistently identified or addressed quickly enough. We found staff were not always reporting staffing shortages as incidents and on a number of occasions we had to prompt staff to consider reporting concerns we identified as incidents.
- Systems, processes and standard operating procedures were not always reliable to protect patients from avoidable harm as staff were not following these, for example medicines, infection prevention and control and the completion of patient records.
- There were periods of understaffing which the trust were unable to address quickly. This had an impact on patient care.
- Compliance with resuscitation, fire safety and safeguarding adults and children training was low particularly amongst medical staff.
- Staff did not always assess, monitor or manage the risk to patients for example fluid balance charts were not up to date and patients did not always get their medicines when required. Care records were not always completed or updated appropriately.
- The risks associated with anticipated events and emergency situation were not fully recognised, assessed or managed.

Incidents

- An incident reporting policy, which included the incident grading system and external and internal reporting requirements was available to staff. Incidents, accidents and near misses were reported through the trust's electronic reporting system.
- Staff were familiar with the process for reporting incidents. However staff did not always report incidents when they should have done. For example, staff said they did not always submit incident reports when the ward staffing levels did not meet the staffing levels as planned according to the dependency and acuity of the patients. This was because they did not

Medical care (including older people's care)

have time to report such events and said they saw very little change if they did report staffing problems. In addition, throughout our inspection, we observed other events which warranted the submission of an incident report but staff did not feel it was necessary to formally report the incident. For example, where the lock on the medication refrigerator had been broken and staff were unable to lock the refrigerator in line with the trust's medication policy.

- Wards 42 and 43 reported 201 incidents between January and June 2017. The top three themes related to slips, trips and falls, staffing and ongoing care monitoring. The majority of incidents resulted in low or no harm to patients.
- Monthly morbidity and mortality meetings were held within the clinical management group. These meetings reviewed patient deaths and treatment complications in order to develop improvements to patient safety and aid professional learning. As we were following up specific concerns and we had no concerns about these meeting or content at our last inspection we did not look at minutes of these meetings at this inspection. A junior doctor we spoke with confirmed they attended these meetings.
- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff were aware of their responsibilities with regards to duty of candour and posters were displayed in staff areas reminding them of these.

Safety thermometer

- The hospital participated in the national safety thermometer scheme. Data was collected on a single day each month to indicate performance in key safety areas for example, falls with harms, catheter associated urinary tract infections, pressure damage and venous thromboembolism (VTE). VTE is the formation of blood clots in the vein. Data for ward 42 from July 2016 to June 2017 showed an average harm free care rate of 99%. This better than the trust average of 94%. In the same period ward 43 showed an average harm free rate of 85%. This was much

worse than the trust average of 94%. This is because there was one avoidable pressure ulcer on ward 43 in June 2017. The trust monitored performance as part of the ward metrics. Action plans were in place to address the low scoring areas.

- Safety thermometer data was not publicly displayed on ward 42 and 43. This meant staff, patients and the public could not see how the ward was performing in relation to patient safety. Following our inspection the trust told us they had considered displaying the safety thermometer on wards, however as a point prevalence study they did not feel it to be a meaningful representation of patient safety or a reflection of actual incidents.

Cleanliness, infection control and hygiene

- In the period January 2017 to June 2017 there had been one clostridium difficile (c. difficile) positive toxin samples and four Meticillin-susceptible Staphylococcus Aureus (MSSA) bacteraemia reported on ward 42. C difficile is an infective bacterium which causes diarrhoea, and can make patients very ill. These are small numbers based on events that occur infrequently.
- In the same period ward 43 reported two clostridium difficile positive toxin samples and two MSSA bacteraemia. These are small numbers based on events that occur infrequently.
- At the time of our inspection wards 42 and 43 were mostly visibly clean. This included patient bathrooms and toilets. Domestic staff were present on the ward during our inspection. Patients did not raise any concerns about the cleanliness of the environment, however we did note a floor in the treatment room on ward 43 was visibly dirty and this posed a risk of cross contamination in an environment where intravenous medications [medications administered into a vein] were being prepared for administration.
- Staff were compliant with best practice regarding hand hygiene. We observed staff wash their hands or use hand-sanitising gel between patient contacts. There was access to hand washing facilities and personal protective equipment, which included gloves and aprons. Staff wore these when required.

Medical care (including older people's care)

- Hand hygiene data between January and June 2017 showed on average 91% of staff on ward 42 and 89% of staff on ward 43 were following best practice in relation to decontamination of hands. The trust target was for compliance of 90% and above.
- All staff were observed to be adhering to the trust's dress code, which was to be 'bare below elbows'.
- When we inspected this service, including wards 42 and 43 in June 2016, we raised concerns staff were not consistent in keeping side room doors closed for patients requiring source isolation as this posed a risk of spread of infection to others. This was a breach of Regulation 12 (2) (h) of the Health and Social Care Act (Regulated Activities) Regulations 2014. At our inspection of ward 43 on 18 July 2017, we found doors were left open to side rooms where it had been identified patients might present a risk of spreading infections to others. We raised this with the ward sister and matron to determine whether a risk assessment had been undertaken. The matron confirmed a risk assessment should have been undertaken but this had not taken place.
- On ward 42 we observed four commodes stored in the sluice. We could not see if these had been cleaned and were ready for patient use although they looked visibly clean. We found the same issue at our last inspection in June 2016. Staff said it was normal practice to clean them after each patient use and they would not be returned to the sluice until they had been cleaned. We were not assured this would be the case as we observed a staff member return a commode to the sluice and did not observe that it was cleaned immediately.
- Arrangements for the management of clinical specimens were not sufficient. On ward 42, at 8 am, we observed four swabs and one urine sample which had been labelled and placed in a clear bag on the nurses' station. Seven hours later, we noted these samples remained on the nurses' station. Urine specimens need to be sent to labs within 2 hours of collection or refrigerated for up to 24 hours otherwise there is a possibility the contents will give false readings when finally tested. We raised this as a concern with the nurse in charge who said they had not had time to print off the labels and arrange for

these to be transported to the laboratory but they would do so before the end of their shift. This posed a risk of cross contamination and a delay in the reporting of results for patients.

- Processes and procedures were in place for the management, storage and disposal of general and clinical waste, disposal of sharps such as needles and for keeping the environment clean. Staff mostly adhered to these process and procedures; however, on ward 43, we found the temporary closure device on all sharps bins open. The trust had a sharps management policy, which stated sharps bin closure should be left in the partial close position when not in use, especially if the bin is in an accessible patient or visitor area. Although sharps bins complied with the UN 3291 or the BS 7320 standards, we found all sharps bins were left open. This did not comply with the trust's sharps management policy and increased the risk of unauthorised access, needle stick injury and accidental skin puncture from a used needle.

Environment and equipment

- We checked the resuscitation equipment on both ward areas. The resuscitation equipment we checked was visibly clean. Single-use items were sealed and in date, and emergency equipment had been serviced. Resuscitation equipment on ward 42 had been checked daily by staff and was safe and ready for use in an emergency, however on ward 43 we found the resuscitation trolley had not been checked for two days prior to our inspection on 18 July 2017. Staff said this was due to staff shortages.
- A medical equipment library was available on this hospital site. Staff did not raise any concerns regarding provision and access of equipment. A pressure relieving mattress was delivered promptly to ward 42 after staff had requested this. However, although the mattress was delivered to the ward in a timely manner, it was not placed on the patient's bed immediately. We noted the mattress was still in the same place two hours later. We spoke to nursing staff about this who said they would arrange to put the mattress on the patient's bed as soon as they had enough staff to undertake this task. When we returned to the ward 30 minutes later, the patient was being nursed on the mattress. A delay in transferring patients onto pressure

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relieving equipment such as a specialist mattress increases the risk of patients developing pressure ulcers or could lead to deterioration in the patient's skin integrity.

- We reviewed seven items of patient-care equipment. All were visibly clean and ready for use. All patient-care equipment had been routinely checked for safety with visible safety tested stickers demonstrating when the equipment was next due for service.
- We found the sluice doors on both ward were open allowing easy access to this area. Within this area we found unlocked cupboards containing cleaning materials, this meant these products could be accessed by people who did not have authority to access them. In addition, it posed a risk to patients who could potentially be confused and may access these areas. We raised this with nursing staff at the time of our inspection. We returned to ward 42 later in the day and found the sluice door was closed and the cupboard door locked.
- We found portable oxygen cylinders were not secured securely. This posed a risk as the cylinders may fall resulting injury to staff and patients. We raised this as a concern at the time of our inspection and were told brackets had been ordered to rectify this issue. The brackets had arrived on the ward but staff said they had to wait for finance approval to get the estates department to secure these to the wall. We were therefore not assured the immediate risk had been mitigated. We raised this with the chief nurse at the end of our inspection.
- We observed a fire exit door and entrance to ward 42 was restricted by cleaning trolleys and metal cages, this posed a risk to staff, patients and members of the public when entering and exiting the ward. It also posed a risk to the delay in evacuation of the ward in the event of a fire or similar incident. We raised this as a concern to the chief nurse at the end of our inspection who said she would take action to rectify this immediately.
- A fire risk assessment had been carried out in April 2017 on ward 43; this identified a number of environmental issues such as damaged fire doors and doors which did not automatically close when the fire alarm sounded. There was no time line on the action

plan for rectifying these issues and the issues remained at the time of our inspection. We raised this with the chief nurse at the time who said she would discuss this with the estates department.

- Fire extinguishers were present, in date and easily accessible in both ward areas and in the immediate vicinity.

Medicines

- The hospital used an electronic prescribing and medication administration (EPMA) record system for patients, which aimed to facilitate the safe administration of medicines.
- A pharmacist visited the wards each weekday and an on-call service was available out of hours.
- Pharmacy staff checked the medicines patients were taking when they were admitted were correct and records were up to date. Medicines interventions by a pharmacist were recorded on the system to help guide staff in the safe administration of medicines.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant patients had access to medicines when they needed them.
- Medicines, which required storage at room temperature, were not always stored managed appropriately. We found medication requiring secure storage in a refrigerator on ward 43 was being stored in a refrigerator with a missing padlock. Although these medications were stored in a locked room, staff who were not authorised to access them, for example healthcare assistants could access the medication storage area and could potentially access these medications.
- On ward 42, we found a specific medication, which should have been stored out of direct sunlight, was being stored in direct sunlight in a warm locked room. The thermometer in the room was not working and there was no evidence staff had recorded the temperature of the room. We escalated this to staff at the time of our inspection who replaced the thermometer immediately.
- Medication refrigerator temperatures were not always recorded on a daily basis as they should have been.

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There were gaps in the recording of the fridge temperatures. For example in June 2017, the fridge temperatures on ward 43 had not been recorded between 3 June 2017 and 12 June 2017. There were also no temperatures recorded for the 17, 18, 21, 24 and 25 June 2017. In July up to the time of our inspection on the 18 July 2017, the fridge temperature had not been recorded on eight occasions. Staff said this was due to not having time because of poor staffing levels.

- On ward 43 a patient had a medication pot containing two tablets on their bedside table. We asked the nurse who was administering medications if they had left these medicines with the patient. The nurse confirmed they had not administered these medications but they had been left from the day before. This meant the patient had missed some of their medication and increased the risk of this patient taking the medication at an inappropriate time. The medicine could also have been taken by another patient. Administering medication in this was against trust policy and Nursing and Midwifery Council guidance.
- On ward 43 a patient was receiving a subcutaneous infusion to manage their symptoms at the end of their life. The infusion was being delivered by a syringe pump, which did not adhere to current NHS patient safety guidance. Staff on the ward told us they had attempted to source a syringe pump which met the NHS patient safety guidance but none were available. This was a concern had been highlighted at our comprehensive inspection in June 2016. In addition hourly checks should have taken place on this syringe pump to ensure it had been running correctly. Hourly checks had not taken place. This meant there was no evidence to suggest staff had an oversight in relation to whether this syringe pump was running at the correct speed or whether there were any complications with the route of administration.
- On ward 43, we looked at three glucose monitoring and insulin prescription charts. Two were completed correctly; however the third chart had been re-written by a doctor and did not contain any patient identifiable details. We noticed insulin had been administered to a patient using this chart on 16 and 17 July 2017. We spoke with a nurse about this, who confirmed there was no way of identifying to which

patient the insulin prescription chart belonged. This increased the risk of the medication being administered to the wrong patient and meant the nurses who administered the insulin and the clinician who had prescribed it had not adhered to national guidelines or the trust's medicines code.

- We looked at the records of three patients on ward 42 who were prescribed insulin. Staff were not always following instructions for the administration of the insulin as prescribed on the prescription charts. Patients were prescribed fast acting insulin to be administered should their blood glucose levels exceed a certain level. Staff were not administering insulin in line with the prescription.
- On three occasions between 11 and 16 July one patients BM was above 16 and they did not receive the prescribed insulin. On eight occasions between 11 and 17 July another patients did not receive insulin despite blood glucose levels exceeding 16. A third patient had blood glucose readings above 16 on 11 occasions between 6 and 17 July 2017. There was no documented evidence to suggest the patient had received insulin as prescribed. We could not find any evidence in the patients records as to why this wouldn't be given. Not administering insulin to a patient when the blood glucose levels are high could put patients at serious risk of harm or even death. We raised this as a concern with the nurse in charge and the chief nurse at the time of our inspection.
- On ward 42 we observed staff accessing the electronic EPMA system through a computer. The computer could not be unplugged due to a broken battery. This meant staff using this computer were unable to take the medication administration record to the patient when administering medicines. This increased the risk of administering medication to the wrong patient, administering a medicine to which a patient may have an allergy or by the wrong route. It also meant safety measures in relation to administering medicines were overlooked. The staff member was mentoring a student nurse at the time. Administering medicines in this way is against the trust policy and a breach of the Nursing and Midwifery Council (NMC) guidance. We raised this as a concern to the chief nurse at the time of our inspection.

Records

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- Records were paper based and risk assessments were held at the patient's bedside, whilst nursing care plans and evaluations were stored on a shelf behind the nurses' station. Medical records were stored in notes trolleys on the ward. Medical records were locked in digitally coded cabinets when not in use so as to avoid unauthorised access.
- We looked at 11 sets of patient care records. Care records did not always follow a chronological order, which made them difficult to navigate. This meant staff may not easily be able to find a specific care record if it was required.
- Nursing care records included core care plans for; breathing and circulation, pain, communication, pressure area / wound care, mobility, elimination and continence, nutrition and fluid balance, personal hygiene, rest and sleep, psychological and emotional well-being, promoting health and safe care and discharge. However, these were not personalised to each individual patient and we saw examples where care records were not always completed or updated appropriately. For example, a patient on ward 43 was receiving oxygen started by a nurse the night before our inspection. When we checked the care records there was no documentation to explain why the patient had required oxygen in the night. In addition, nursing evaluations were not always written in line with the care plans for the patient.
- In all 11 care records we looked at we found fluid balance charts were not accurately completed or always totaled up. This meant there was no accurate record of each patient's fluid intake and output. We spoke with nursing staff, including the matron about this. All staff, including the matron, acknowledged this was a problem and was due to time constraints as a result of being short staffed. Data provided by the trust following our inspection showed on average between December 2016 and May 2017 90% of fluid balance charts on ward 42 and 74% on ward 43 were up to date and calculated correctly. Data varied each month between 50% and 100%. Staff were unaware of actions that had been taken to address the low scores.
- On ward 43, a patient receiving end of life care had an end of life care plan in place. This should be reviewed on an ongoing basis with a continuation of the care plan on a daily basis. The records indicated the end of life care plan had not been updated since 14 July 2017, some four days prior to our unannounced inspection. We raised this as a concern with the matron, who took action to photocopy paperwork to ensure the end of life care plan could be completed.
- Patient records were multidisciplinary and we saw nurses, doctors, and allied health professionals had made entries.
- On ward 43, there was a locked confidential waste bin, however this was stored by the main entrance to the ward and was not secured to the wall. This increased the risk an unauthorised person could remove it from the ward.

Safeguarding

- The trust had a safeguarding lead at executive level in addition to local named leads for children and adult safeguarding. Staff were aware of the safeguarding leads and none reported any issues accessing them for advice and support.
- There were suitable arrangements in place to safeguard women with or at risk of female genital mutilation (FGM) and child sexual exploitation.
- The safeguarding leads were visible on the wards and we spoke with one of the adult and child safeguarding leads at our unannounced inspection of ward 43 who confirmed they received appropriate referrals relating to the patients on ward 43.
- On ward 43, we identified a patient who had not received their medications as prescribed. We understood this medication had been left by the bedside from the previous day. We considered this constituted neglect. We raised this with a member of staff on the ward who did not think this constituted neglect and stated a safeguarding referral was not required. However, following our explanation that this constituted neglect; the staff member agreed they should raise this as a safeguarding in line with the trusts safeguarding procedures. We were not assured that staff knew what constituted a safeguarding concern. Following our inspection the trust told us the definition of neglect and acts of omission include: ignoring medical, emotional or physical needs

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withholding necessities of life such as medication or adequate nutrition. They also said the Leicestershire Adult Safeguarding Board thresholds, would not classify this neglect.

- Information received after our inspection showed as of June 2017 training compliance in safeguarding children for nursing and care staff was 80% and, safeguarding adults 91%. Medical staff compliance in safeguarding children was 63% and safeguarding adults 69%. The trust did not supply us with the levels of each training module staff undertook. All of the safeguarding figures fell short of meeting the trust target of 95%.

Mandatory training

- Mandatory training for all staff groups included; fire safety training, moving and handling, infection prevention, equality and diversity, information governance, safeguarding children (levels one and two), conflict resolution, safeguarding adults (level one), health and safety and basic life support.
- Data provided to us following our inspection showed 88% of nursing and care staff on wards 42 and 43 were in date with mandatory training modules. Compliance varied between each module for example 79% (information governance) and 97% (infection control). Data for medical staff showed average compliance rate of 67% with mandatory training modules. Compliance varied between each module 44% (resuscitation training) and 75 % (information governance). The trust target for mandatory training was 95%. Most modules fell short of meeting this target.
- Resuscitation training compliance for nursing and care staff was 85% and medical staff 44% this meant there were not sufficient members of the team up to date with resuscitation. Compliance with this training was much worse than the trust target of 95%.

Assessing and responding to patient risk

- Nursing staff used an early warning scoring system (EWS), based on the National Early Warning Score, to record routine physiological observations such as blood pressure, temperature, and heart rate. EWS was used to monitor patients and to prompt support from medical staff when required. Observations and EWS

were recorded digitally using electronic devices which were easily accessible to nursing and medical staff. EWS scores were calculated automatically on the observations which were inputted; this meant the EWS would be calculated accurately.

- We reviewed 20 sets of observations across wards 42 and 43. The majority of observations had been recorded at the correct intervals and in a timely manner.
- Patients with a suspected infection or an EWS of three or more, or those who looked unwell or had a sudden change in mental state were to be screened for sepsis, a severe infection which spreads in the bloodstream, using an 'Adult Sepsis Screening and Immediate Action Tool'.
- We randomly chose to look at 16 patients who had scored a EWS of three or more to see if a sepsis screening tool had been completed. The majority of patients had a sepsis screening tool completed however five patients who had been on the ward for a long period of time did not have completed sepsis screening tools in their records. On closer review of the patients it was found they were already being treated with antibiotics and were therefore on the correct treatment.
- Data provided by the trust following our inspection showed between January and June 2017 100% of patients on ward 42 and 99% of patients on ward 43 who scored a EWS of 3 or more were appropriately screened for sepsis in line with the trust protocol.
- Patients being treated for sepsis were to be treated in line with the 'Sepsis Six Bundle', key immediate interventions increase survival from sepsis. There is strong evidence the prompt delivery of 'basic' aspects of care detailed in the Sepsis Six Bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions when applied within the first hour. Giving an intravenous antibiotic within the first hour is one of the key steps in the sepsis six bundle. In the period January to June 2017 7 out of 9(77%) patients on ward 42 and 9 out of 17 (53%) patients on ward 43 who were identified as having red flag sepsis received their antibiotic within one hour of the identification. These percentages are low, the trust were working to address

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the low compliance trust wide and included additional training of staff. We saw this being delivered during our inspection. EWS and sepsis data was reviewed fortnightly at the EWS & Sepsis Review Group (chaired by the Medical Director / Chief Nurse). Data was reported to the Executive Quality Board and the Quality Assurance Committee.

- A critical care outreach team (CCOT) was available 24 hours a day, seven days a week. The team worked closely with the nursing and medical teams in the intensive care units within the trust and supported ward staff in the detection and management of critically ill and deteriorating patients. The aim of the CCOT was to ensure deteriorating patients received appropriate and timely treatment in a suitable area.
- The CCOT had access to patient's observation through a mobile digital device so they could monitor the deteriorating patients from wherever they were in the hospital. The CCOT attended ward 43 to support nursing staff with the management of a patient when a patient had scored a high EWS following a drop in their blood pressure during our visit.
- Nursing staff said CCOT would support them with any deteriorating patient, or patients they were concerned about. We saw the critical care outreach team delivering a deteriorating patient training session to staff on ward 42 the time of our inspection.
- On ward 43, nursing staff said and we saw there was a major haemorrhage protocol, which could be activated if a patient experienced a gastrointestinal bleed.
- There was a gastrointestinal bleed service which covered the three UHL sites.
- Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools, however we did find there were gaps in these assessments. When we asked staff about this they said they did not always get time to complete these in a timely manner.
- Staff were aware of and we saw protocols in place to support the nutrition of patients who may require

artificial nutrition. . These were used when dietetic staff were not available. This minimised the risk of a patient becoming malnourished whilst they were waiting for a dietetic review.

- We observed medical staff assessing patients for the risk of acute kidney injury and placing a sticker in the patients records using a care bundle. Such bundles were evidence based and aligned to best practice guidance and ensured the risk to patients was minimised. Acute Kidney Injury (AKI) is sudden damage to the kidneys that causes them not work properly. It can range from minor loss of kidney function to complete kidney failure. AKI normally happens as a complication of another serious illness.

Nursing staffing

- Patient acuity and dependency data was collected using a nationally recognised 'Safer Nursing Care Tool'. Acuity means the level of seriousness of the condition of a patient. The patient acuity and dependency scores were collected electronically and matrons and the senior nursing teams confirmed this data on morning board rounds and unannounced visits to clinical areas. The data was considered alongside staffing information from the electronic rostering system and patient information including admissions and discharges and additional tasks undertaken in different clinical areas.
- Staffing levels were displayed at the entrance of wards 42 and 43. Information displayed indicated actual staffing levels were not meeting the planned staffing levels and highlighted what action was being taken to address the gap in the staffing levels. We spoke with the nurses in charge of the shifts on both wards who told us of the actions they had taken to try to source additional staff, but it was a regular occurrence to be short staffed and told us they "had learned to work short staffed". Both nurses in charge said they had and continued to request bank and agency staff to fill the gaps in the rosters in line with the escalation policy.
- On the day of our unannounced inspection, the planned staffing levels were five registered nurses and four healthcare assistants, the actual staffing levels on ward 43 were three registered nurses and three healthcare assistants. This meant there were not enough staff to meet the dependency and acuity of

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the patients on the ward. Staff said there had been two registered nurses on duty the day before. The nurse in charge of ward 43 was also responsible for carrying the 'duty bleep' and as such was troubleshooting staffing issues across the clinical management group, whilst co-ordinating the ward and caring for a specific group of patients. This meant they might be taken away from direct patient care for periods of time reducing the number of nurses available to deliver direct patient care.

- Ward 42 at the time of our inspection was short by two registered nurses and one healthcare assistant against their planned staffing levels for the day. This meant there were not enough staff to meet the dependency and acuity of the patients on the ward. Internal escalation had taken place but there had been no additional support provided to the ward.
- We looked at the planned versus actual registered nurse staffing levels for the 28 day period between 19 June 2017 and 16 July 2017 for ward 42. On 23 occasions on the early shift, 25 occasions on the late shift and six occasions on the night shift the ward did not meet the planned staffing levels. There were three occasions on a late shift when ward 42 was short by two registered nurses. This meant there were not enough staff to meet the dependency and acuity of the patients on the ward during these shifts.
- We looked at the planned versus actual registered nurse staffing levels for the 28 day period between 19 June 2017 and 16 July 2017 for ward 43. On 26 occasions on the early shift, 28 occasions on the late shift and three occasions on the night shift the ward did not meet the planned staffing levels. On three occasions the ward was short by three nursing staff on an early shift. This meant there were not enough staff to meet the dependency and acuity of the patients on the ward during these shifts.
- At the time of our inspection ward 42 had nine and ward 43 had 11 nurse vacancies. The ward was actively recruiting but was finding it difficult to fill the vacancies. This is a national problem and not one specific to this hospital. The trust had created plans to address the vacancies which included the matron working clinically on the ward one day each week.

- Nursing staff said a shift handover occurred at each shift change and would include a handover by the patient's bedside. We saw a member of staff come on to a late shift and begin to deliver patient care without a direct handover from staff. This posed a risk to patients as the staff member may not have the full information they required to deliver care to the patient. The day staff were still present on the ward at this time.

Allied Health Professional staffing

- Dietetic and Speech and Language Therapy (SALT) staff were available 9am to 5pm, Monday to Friday. There was no out of hours, weekend or bank holiday cover, however staff had sufficient protocols to support the delivery of care to patients in the absence of these specialist.

Medical staffing

- Two junior doctors covered each of the wards between Monday and Friday 9am to 5pm.
- Consultants and registrars carried out ward rounds twice weekly.
- At night there was a registrar who covered the wards with junior doctors.
- At the weekend there was one consultant and registrar on call covering both wards. They were supported by a junior doctor.
- Consultants were available out of hours on-call. If a consultant was not in the hospital, they could be contacted and available within 30 minutes if required.
- Consultants worked across both wards. Each ward had an allocated consultant who would remain the consultant for the ward for a period of two weeks. This meant patients had continuity of care.
- We observed junior and senior doctors reviewing management plans and patients at the time of inspection. Junior doctors said they always had access to consultants and registrars if they wished to discuss any concerns.
- There was a process in place for handover between one shift and the other. We did not observe this at our unannounced inspection.

Major incident awareness and training

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- There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken by ward staff in the event of a utilities failure or major incident. However three out of four staff (two of whom were often in charge of the wards) did not know about and were unable to locate the major incident and business continuity plans for the ward despite these being located adjacent to the nurses' station. This meant staff may not respond appropriately in the event of specific incidents.
- We were told some staff had completed a 'table top exercise' for fire evacuation. Evacuation training was included as part of fire safety training but was not ward specific. Data provided by the trust following our inspection showed 79% of nursing and care staff on wards 42 and 43 and 73% of medical staff were in date with fire safety training. This was much worse than the trust target of 95%. The trust did not supply us with a breakdown on the number of staff who had received ward specific fire evacuation training.
- We did not see any ward specific evacuation plans displayed and staff were unable to locate these. We were therefore not assured staff would know how to effectively evacuate the ward in the event of a fire or similar incident.
- There was suitable evacuation equipment adjacent to the stairwells to support staff in the evacuation of patients; however, staff said they had not been trained to use this equipment but it was self-explanatory.

Are medical care services caring?

We do not have sufficient evidence to rate this key question at this inspection however our findings were:

- Feedback from patient and relatives was positive about the way staff treated them.
- Staff mostly responded compassionately when patients needed help and support.
- Staff helped patients and those close to them to cope emotionally.

- Staff explained the treatment and care they were delivering to patients in a way patients could understand. We also heard staff talking to patients who required support with their personal hygiene, involving them in their care.
- We saw clinical nurse specialists providing reassurance to patients who were anxious. This included spending time with the patient, explaining what the patient should experience and how staff would help.

However:

- We observed isolated cases where patients were not treated with compassion or afforded dignity and respect.
- We found there was little evidence of patients receiving regular two hourly care rounding. Whilst staff were in and out of the bays they did not always check on each patient's needs.

Compassionate care

- During our unannounced inspection of wards 42 and 43 we found most members of staff to be polite and courteous to patients; however we did observe isolated incidents on ward 42 where doctors and catering staff were not courteous in their manner.
- On ward 43, we saw nursing and care staff responding with compassion when patients requested help and saw a number of examples of good care. For example, we saw nurses and care staff asking patients whether they were comfortable and whether they required pain relief.
- Across both wards we spoke with 17 patients and five relatives. All of the patients we spoke with told us staff of all levels were kind and caring. One patient told us they "Could not fault the care". Another said "The nurses are all kind". A relative of a patient told us they were very happy with the care on the ward and found all the staff to be responsive to the needs of their family member.
- During our inspection we found both wards were audibly quiet, call bells were on low volume, this allowed the patients to rest. We noted call bells were responded to in a timely manner.

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- We reviewed the NHS Friends and Family Test (FFT) results for wards 42 and 43 between January and June 2017. The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care. Results showed on average 94% of patients on ward 42 and 92% on ward 43 would recommend the ward to friends and family. This was in line with the trust average of 94%. The scores varied each month. For ward 42 scores were between 78% (April 2017) and 100% (June 2017) and for ward 43 79% (May 2017) and 100% (February 2017).
 - We saw posters displayed around the walls entitled 'caring at its best at night'. These highlighted the things staff would do to ensure patients were able to sleep and remain comfortable overnight, for example noise, lightings, waking patients, observations and continence care and comfort. We asked some patients if nursing and care staff delivered 'caring at its best at night'. They all confirmed they did.
 - During our inspection we heard staff introducing themselves to patients and relatives using 'hello my name is'. 'Hello my name is' a campaign, aimed at improving communication with patients and each other. This is recognised as a key part of building trust and supports providing compassionate care.
 - On ward 42 we observed a patient ask for help from a member of staff who they thought was a nurse, the patient was asking for a fellow patient who needed to use the toilet. The member of staff responded by saying "I am not a nurse" and continued to proceed with the task they were doing, the member of staff made no attempt to locate an appropriate member of staff, and had no eye contact with the patient. We alerted a member of care staff to the patient's needs and they were assisted immediately.
 - On another occasion we observed a member of the food ordering staff open a side room door without knocking. The member of staff communicated from the door way asking a patient what they wanted to order for evening and then shut the door. There was no additional communication with the patient and the manner in which they spoke to the patient was abrupt..
 - We found there was little evidence of patients receiving regular two hourly care rounding. Whilst staff were in and out of the bays they did not always check on each patient's needs. Care rounding charts were in place in each bay and on each side room door. We saw gaps in the completion of these; we were therefore not assured care rounding was always taking place at the times when it should be. Care rounding is a structure process where nurses on the ward carry out regular checks with patients at set intervals.
- ## Understanding and involvement of patients and those close to them
- Most patients had access to their call bell. This meant they could attract the attention of staff if they needed to. For those patients who did not have access to call bells, they were mobile or were able to summon help by other means.
 - All patients told us they felt involved in decisions about their care. We also observed and heard nurses ensuring patients had a choice, for example, where patients were receiving nutritional supplements, a choice of flavour was offered.
 - We observed staff respecting the wishes of a patient who did not wish to have their position changed.
 - Staff explained the treatment and care they were delivering to patients in a way patients could understand. We heard staff talking to patients who required support with their personal hygiene, involving them in their care.
 - The relatives of one patient on ward 43 told us they felt communication had been poor on the ward and they had not always been kept informed of decisions being made about the care of their family member. However, a relative of another patient told us they had been fully involved in the care of their family member and felt full explanations had been communicated to enable them to understand the treatment options available. This relative also told us continuity of care was good because the same staff members were involved in the care of their family member.
- ## Emotional support

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- Patients had their psychological and emotional well-being needs assessed as part of the care planning process, however we did not see this was documented again as part of the on-going care process.
- Nursing staff could provide emotional support but found this difficult at times due to staff shortages.
- Staff assisted patient to access the hospital chaplaincy service where necessary.
- We saw clinical nurse specialists providing reassurance to patients who were anxious. This included spending time with the patient, explaining what the patient should experience and how staff would help.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- The trust must take action to ensure that there are sufficient number of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs.
- The trust must take action to ensure fire exit doors and entrances to wards are not blocked.
- The trust must take action to ensure staff are aware of and receive training in specific fire evacuation plans for the wards and that staff are familiar with the trust major incident and business continuity plans.
- The trust must ensure staff receive training in the use of evacuation equipment.
- The trust must ensure they have sufficient numbers of nursing and medical staff trained and up to date with resuscitation, safeguarding adult and children and fire training.
- The trust must ensure nurses follow systems and processes to ensure they minimise the risk of spreading infection when patients are being barrier nursed in side rooms.
- The trust must ensure nurses follow national guidelines and local policies when administering medication to patients.
- The trust must ensure medications are stored securely and at the correct temperature.
- The trust must ensure staff follow instructions on prescription charts including supplementary insulin charts so that all medicines are administered as prescribed.
- The trust must ensure patient records are complete, including the completion of end of life care plans, fluid balance charts risk assessments and care rounding documentation.
- The trust must ensure staff report incidents in line with their incident reporting policy.
- The trust must ensure systems are put in place to enable staff to identify whether a piece of equipment such as a commode has been cleaned between patient use.

Action the hospital **SHOULD** take to improve

- The trust should ensure cleaning products are locked away and are not accessible to patients on Wards 42 and 43.
- The trust should ensure staff follow the correct procedure for the partial closure of sharps bins in line with their sharps management policy.
- The trust should ensure oxygen cylinders are stored securely to minimise the risk of injury if they are knocked over.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Care and treatment must be provided in a safe way for service users</p> <p>12(2)(a) assessing the risk to the health and safety of service users of receiving the care or treatment.</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• Care records were not regularly reviewed or completed. <p>12(2)(b) Doing all that is reasonably practicable to mitigate any such risks.</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• In all 11 care records we looked at we found fluid balance charts were not accurately completed or always totalled up.• Staff did not always report incidents which had the potential to cause harm such as low staffing levels and failed medication administration. <p>12(2)(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• There were low numbers of staff trained and in date with resuscitation, safeguarding adult and children and fire training. <p>12(2)(d) ensuring the premises used by the service provider are safe to use for their intended purpose and are used in a safe way.</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• Staff were unfamiliar with major incident and business continuity plans.

Requirement notices

- Staff did not know or have access to the specific evacuation plans for the wards.
- We did not see specific evacuation plans for each ward.
- Staff had not had specific ward evacuation training.

12(2)(e) ensuring the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way.

How the regulation was not being met:

- Staff had not had training for evacuation equipment.

12(2) (g) the proper and safe management of medicines.

How the regulation was not being met:

- Medicines were not always kept securely. The lock on the door to the medication room on ward 42 was broken. On ward 43, medication was stored in a medication refrigerator, which was not lockable due to a missing padlock.
- Medicines were not always stored at the right temperature. On ward 42 medicines should have been stored out of direct sunlight but was being stored in a warm room in direct sunlight. There was no monitoring of temperature in this room.
- Medicines were not being administered in line with national guidance and local policy. On ward 42, nurses administering medication to patients did not take the medication administration record with them. On ward 42, nurses did not always administer insulin to patients as prescribed, even when the patient's blood glucose was dangerously high.
- On ward 43, nurses did not always stay with the patient to ensure they had taken their medication.
- Staff were not always following instructions for the administration of the insulin as prescribed on the prescription charts. On three occasions between 11 and 16 July one patients BM was above 16 and they did not receive the prescribed insulin. On eight occasions between 11 and 17 July another patients did not receive insulin despite blood glucose levels

Requirement notices

exceeding 16. A third patient had blood glucose readings above 16 on 11 occasions between 6 and 17 July 2017. There was no documented evidence to suggest the patient had received insulin as prescribed. We could not find any evidence in the patients records as to why this wouldn't be given.

12(2)(h) Assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those are health care associated.

How the regulation was not being met:

- Staff were not consistent in isolating patients at risk of spreading infection to other on wards 42 and 43. We saw doors left open to side rooms where it had been identified patients might pose an infection control risk to others.
- There was no standardised approach to ensuring commodes were clean after each patient use.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

All premises and equipment used by the service must be: 15(1)(e) properly maintained.

How the regulation was not being met:

- We saw a fire risk assessment had been completed which had an associated action plan. We did not see the findings of this assessment had been acted upon despite improvement being required.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced staff person must be deployed in order to meet the requirements of this part.

How the regulation was not being met:

- Planned versus actual staffing levels on both wards 42 and 43 were not always met which impacted on patients care and treatment.
- Sufficient staff were not always deployed to cover wards 42 and 43.