Colchester Hospital University NHS Foundation Trust

Colchester General Hospital

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

Colchester General Hospital is part of the Colchester University Hospital NHS Foundation Trust. The hospital is an acute hospital providing accident and emergency (A&E), medical care, surgery, critical care, maternity, children and young people' services, end of life care and outpatient services, which are the eight core services always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection.

Colchester General hospital is a 560 bed district general hospital, in Colchester. The trust as a whole employs over 4,000 staff, the majority of whom are based at Colchester General. The hospital provided a range of elective and non-elective inpatient surgical and medical services as well as a 24-hour A&E, maternity and outpatient services.

We carried out this focused inspection on 8th July 2015 in response to information of concern around staffing, performance and care received by patients in the surgery and medical care inpatient wards. We returned to the hospital on 14th July 2015 to conduct an inspection at night after receipt of further concerns relating to staffing and care provided to patients at night time.

Our key findings were as follows:

- Staffing levels on the wards were meeting the trust defined numbers required with support from agency staff due to the low numbers of permanent trust staff available. However the numbers of staff on duty to provide patient care on Birch and Brightlingsea and Mersea ward were not sufficient to meet the levels of patient dependency seen on the wards during our inspection.
- Staffing levels were determined on numbers of nurses per patients. Acuity and dependency was not taken into account when routinely staffing the wards. Whilst these numbers were met with the support of agency and bank nurses these numbers did not always meet the needs of the patients on the ward.
- There was an inconsistent approach to providing local induction to agency, temporary and redeployed staff. Competency and induction checklists for staff were not available on the wards for the shift leads to review to ensure that safe care was provided to patients and we found that staff had not been inducted or trained to safely work in the service.
- The completion of records was poor on all wards, two medical wards were better than the others however records were incomplete and difficult to navigate.
- IV Cannula Care monitoring and recording placed patients at risk of infection.
- Incidents of poor hand hygiene were observed throughout the wards.
- Consent for procedures did not always follow trust policy, particularly when a person lacked metal capacity to make a decision regarding treatment.
- The use of Deprivation or Liberty Safeguards did not follow the national guidelines in two of the four cases we reviewed.
- The completion of 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms was not undertaken in line with best practice guidelines in eight of 11 cases reviewed.
- Monitoring of deteriorating patient conditions using the national early warning scores (NEWS) was inconsistent throughout the wards.
- Pressure ulcer care recording was limited, particularly on Birch and Brightlingsea wards. There was no grading or treatment plans, review dates, turn requirements or needs assessments. Turns that we saw recorded were tick box based and we were not assured that patients received turns to reduce the risk of pressure damage to their skin.
- Oral Care on Aldham and Brightlingsea was poorly recorded and the observation through physical view was that patients' oral hygiene was in poor condition on these wards.
- On the Emergency Assessment Unit (EAU) the trust was complying with the conditions which were imposed on their registration in December 2014.

Summary of findings

- Staffing levels on the EAU had improved however this improvement was supported by the use of bank and agency staff.

We identified the following areas of poor practice where the trust needs to make improvements.

Importantly, the trust must ensure:

- That the staffing numbers on inpatient wards take into account the acuity and dependency needs of patients.
- That the agency staff, bank staff and trust staff who work on a ward for their first shift receive a local induction to the ward.
- That the medicines policy in place is adhered to in that only staff who have completed competency training on IV medicines are able to administer IV medicines and the responsibility for the keys remains with the nurse in charge.
- That the door to the roof terrace on Birch ward is secure at all times.
- That improvements are made with regard to the awareness and understanding of mental capacity and deprivation of liberty safeguards.
- That patients are informed of decisions not to resuscitate where appropriate to do so and where this is not possible that the Mental Capacity Act 2005 has been adhered to.
- That staff adhere to its policies including resuscitation, consent and moving and handling.

In addition the trust should ensure:

- That the resuscitation trolleys are checked in accordance with the trust policy.
- That it improves the culture of openness throughout the trust so that the staff can speak without fear of consequences for doing so.
- That observations of patients at risk of deteriorating are undertaken in a more timely way.
- That agency and bank staff on wards are appropriately observed and provided with support during their shifts.
- That prescribed medicines are administered in a timely way.
- That a review of the culture around care on Brightlingsea ward is undertaken.
- Review the lighting on Birch ward to ensure that that patients' are able to rest at night time.
- Ensure lessons from incidents are learnt and shared amongst all staff.

The trust is already in special measures we have informed Monitor of these breaches, who will make sure they are appropriately addressed and that progress is monitored through the special measures action plan.

The Care Quality Commission has taken further enforcement action against this trust as a result of the findings from this inspection. This enforcement action, to place conditions on the trust's registration to ensure that patients are protected from the risk of harm, was required because we were not assured that patients would be safe unless we took this action.

A comprehensive inspection will be undertaken in September 2015 to determine if improvements have been made.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care	Not sufficient evidence to rate	Staffing levels on the inpatient wards were not sufficient to meet the dependency needs of patients. The records we examined, in the majority, were poorly completed, disorganised and difficult to navigate and did not provide a clear picture of the care patients required. There were delays in undertaking patient observations and undertaking medicines rounds including delays in providing IV fluids, antibiotics and IV care. Permanent nurse staffing levels on the wards did not meet the needs of patients on the wards we inspected. The numbers on the wards we inspected met the trust defined establishment however there was a high use of agency and bank staff with some shifts operating between 80%-100% bank or agency staff. There was an inconsistent approach to providing local induction to agency staff and the competency and induction checklists for staff were not available on the wards for the shift leads to review to ensure that safe care was provided to patients. On Birch ward we found that the environment presented a health and safety risk to patients with equipment and items being stored in the corridors, the lights were not turned off at night time to allow patients to rest and the door to the roof terrace was open and patients could go outside unattended which could have placed them at risk of harm. Following the inspections we requested assurances of what actions the trust would be taking immediately to ensure that effective systems for the management of agency and staff shortages were in place. The trust did not have the evidence available to provide us with assurances and we therefore took urgent enforcement action to place conditions on the trust's registration to ensure that patients were protected from the risk of harm.

Summary of findings

Surgery **Not sufficient evidence to rate**

Safety systems, processes and standard operating procedures did not operate in a way that protected patients from the risk of harm. Patients were at risk of deterioration were not monitored in accordance with trust policy. Records of patient care were in some cases poorly completed, disorganised and difficult to navigate and did not provide a clear picture of the care patients required.
Medicines were often delayed in administration and there were concerns that IV medicines including antibiotics were not provided in a timely way. There is insufficient attention to safeguarding adults and safeguarding required significant improvement in surgery.
There were substantial and frequent staff shortages which required the high use of bank and agency staff however there was poor management of agency staff which increased risks to people who use services. Staffing levels on the inpatient wards were not sufficient to meet the dependency needs of patients. There was an inconsistent approach to providing local induction to agency staff and the competency and induction checklists for staff were not available on the wards.
There was a notable culture throughout the areas we inspected with staff being afraid to speak up and raise concerns as they feared what would happen should they raise concerns formally.
Following the inspections we requested assurances of what actions the trust would be taking immediately to ensure that effective systems for the management of agency and staff shortages were in place. The trust did not have the evidence available to provide us with assurances and we therefore took urgent enforcement action to place conditions on the trust's registration to ensure that patients were protected from the risk of harm.

Colchester General Hospital

Detailed findings

Services we looked at
Medical care (including older people's care) and Surgery

Detailed findings

Contents

Background to Colchester General Hospital

Colchester General Hospital is a medium sized teaching hospital in Colchester with approximately 560 beds and is the main acute site for Colchester Hospital University NHS Foundation Trust. The hospital provides a range of elective and non-elective inpatient surgical and medical services as well as a 24-hour A&E, maternity and outpatient services to a surrounding population of around 370,000.

In 2013, the trust was identified nationally as having high mortality rates and it was one of 14 hospital trusts to be investigated by Sir Bruce Keogh (the Medical Director for NHS England) as part of the Keogh mortality Review in May that year. Following concerns regarding the authenticity of cancer waiting times the trust was placed in Special Measures by Monitor in November 2013 At that time there was a significant turnover of the executive team. In addition the Chief Executive in post at the time of our inspection was replaced shortly afterwards.

Our inspection team

Our inspection team was led by:

Inspection Manager: Leanne Wilson, Care Quality Commission

The inspection team, on 8th July, consisted of five CQC inspectors and one specialist advisor including one paramedic and two nurses. We inspected Mersea ward, Brightlingsea ward and Aldham ward in Surgery and Birch ward, D'Arcy Ward, Tiptree Ward and Peldon Ward in medical care only. The inspection took place on 08 July 2015 and was unannounced.

The team which returned to the hospital on 14th July consisted of three CQC inspection managers, with specialist skills in nursing and emergency medical care and governance. During this inspection we inspected the Emergency Assessment Unit, Brightlingsea and Birch wards.

How we carried out this inspection

Pre-inspection

This phase involves collating data held by the CQC as part of our ongoing monitoring of the trust.

Public involvement

While on site, we spoke to service users in clinical areas. During and after the inspection members of the public and patients were encouraged to call or email CQC to share their experience of using the service and we received contact from six patients and relatives.

Internal stakeholders

Detailed findings

During the inspection, we talked to staff from all staff groups, allowing them to share their views and experiences with us.

Inspection

The inspection involved an on-site review of:

- Medical care – specifically Birch ward, D'Arcy Ward Tiptree Ward, Peldon Ward and the Emergency Assessment Unit (EAU).
- Surgery – specifically Aldham ward, Brightlingsea Ward and Mersea Ward.

The on-site element of the inspection involved two sub teams of inspectors; each looked at one the services listed above. The teams undertook a number of methods of inspections from staff interviews to direct observations of care.

Medical care (including older people's care)

Safe	Not sufficient evidence to rate
Overall	Not sufficient evidence to rate

Information about the service

The trust provides a comprehensive medical service with a range of specialties including Stroke, Cancer, care of older persons and respiratory care.

For the inspection on 08 July 2015 we inspected the complex medical with the care of older persons' wards which were Birch ward, D'Arcy Ward, Tiptree Ward and Peldon Ward. Each ward has between 28-34 patients some of whom stay on longer term bases awaiting rehabilitation back into the community or social service intervention to find an appropriate place for them to be safely discharged to.

On 14 July 2015 we returned to inspect the Emergency Assessment Unit and Birch ward in response to concerns received regarding staffing and patient care at night.

We examined the records of 20 patients. We spoke with 19 members of staff including doctors, nurses and support staff, four patients and two relatives.

Summary of findings

Staffing levels on the inpatient wards did not meet the dependency needs of patients. The records we examined, in the majority, were poorly completed, disorganised and difficult to navigate and did not provide a clear picture of the care patients required. There were delays in undertaking patient observations and undertaking medicines rounds including delays in providing IV fluids, antibiotics and IV care. We identified concerns regarding the undertaking and completion of assessments relating to mental capacity and Deprivation of Liberty Safeguards. DNACPR was not always undertaken in line with national guidelines. Resuscitation trolleys on Birch ward were not routinely checked.

Permanent nurse staffing levels on the wards were low on the wards we inspected. The numbers on the wards we inspected met the trust defined establishment however there was a high use of agency and bank staff with some shifts operating between 80% and 100% bank or agency staff. There was an inconsistent approach to providing local induction to agency staff and the competency and induction checklists for staff were not available on the wards for the shift leads to review to ensure that safe care was provided to patients.

On Birch ward we found that the environment presented a health and safety risk to patients with equipment and items being stored in the corridors, the lights were not turned off at night time to allow patients to rest and the door to the roof terrace was open and patients could go outside unattended which could have placed them at risk of harm.

Medical care (including older people's care)

Are medical care services safe?

Not sufficient evidence to rate

Safety systems, processes and standard operating procedures did not operate in a way that protected patients from the risk of potential harm. Patients were at risk of deterioration were not monitored in accordance with trust policy. Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) was not always undertaken in line with national guidelines. Resuscitation trolleys on Birch ward were not routinely checked.

Care premises, equipment and facilities were not safe. On Birch ward we found that the environment presented a health and safety risk to patients with equipment and items being stored in the corridors, the lights were not turned off at night time to allow patients to rest and the door to the roof terrace was open and patients could go outside unattended which could have placed them at risk of harm.

There is insufficient attention to safeguarding adults. We identified concerns regarding the undertaking and completion of assessments relating to mental capacity and Deprivation of Liberty Safeguards. Safeguarding and the understanding of safeguarding adults required significant improvement in medical services and we subsequently raised safeguarding alerts to the local authority for two medical patients following our inspection to ensure that patients were safe.

There were substantial and frequent staff shortages which required the high use of bank and agency staff however there was poor management of agency staff which increased risks to people who use services. Staffing levels on the inpatient wards were not sufficient to meet the dependency needs of patients. The numbers on the wards we inspected met the trust defined establishment however there was a high use of agency and bank staff with some shifts operating between 80%-100% bank or agency staff. There was an inconsistent approach to providing local induction to agency staff and the competency and induction checklists for staff were not available on the wards for the shift leads to review to ensure that safe care was provided to patients.

There was a notable culture throughout the areas we inspected with staff being afraid to speak up and raise concerns as they feared what would happen should they raise concerns formally. Senior staff told us that they raised concerns regarding staffing on a regular basis but felt that those concerns were not listened to in all cases and that the high use of agency was accepted.

Staff do not assess, monitor or manage risks to people who use the services. The records we examined, in the majority, were poorly completed, disorganised and difficult to navigate and did not provide a clear picture of the care patients required. There were delays in undertaking patient observations and undertaking medicines rounds including delays in providing IV fluids, antibiotics and IV care.

Following the inspections we requested for information from the trust together with assurances of what actions would be immediately taken to ensure that patients received care from suitably skilled and competent bank and agency staff, also that staff moved around the hospital to provide substantive staff cover were appropriately supported. The trust was unable to provide us evidence or assurances which removed the risk of harm to patients and we therefore took urgent enforcement action to place conditions on the trust's registration to ensure that there is a safe effective process in place relating to the use of bank and agency staff that ensured that patients were not exposed to the risk of harm.

Incidents

- Between 1st January 2015 and 28th May 2015 Birch Ward, D'Arcy Ward, Peldon Ward and Tiptree ward reported 367 incidents. The most reported incidents were low staffing levels, pressure ulcers and patient falls.
- During the same period the EAU reported 310 incidents. The most reported incidents were staffing shortages, reportable pressure ulcers and patient falls. The incident reporting rates for the service were consistent and meant that staff were reporting incidents.
- Birch Ward, D'Arcy Ward, Peldon Ward and Tiptree ward reported 14 serious incidents between 1st January 2015 and 28th May 2015. Five related to pressure ulcers, four related to deteriorating patients, two related to

inpatient falls, one related to a ward closure for norovirus and two were for stays on EAU trolleys for more than 24 hours which breached the conditions imposed on the trust's registration in December 2014.

- The trust was not grading the classification of harm from incidents appropriately. Of the incidents reported between 1st January 2015 and 28th May 2015 73 of the 677 incidents were classed as 'no harm' or 'low harm' which was not appropriate. For example a hospital acquired pressure ulcer at grade 3 classed as 'low harm'. A patient with a NEWS of 4 increasing to a NEWS of 7 without medical intervention as medical staff were unavailable classified as 'No harm', patient peri-arrest following hypoglycaemic episode classified as 'no harm'. A patient had received 15minutess of blood transfusion when their observations were repeated the patient's blood pressure dropped significantly was classified as 'no harm'. On the incident records it records the trust will not declare harm level until the investigation had concluded (up to 45 days) which is not in line with duty of candour requirements.
- Colchester General Hospital had the highest rate for Never Events in England at the time of the inspection with 11 Never Events, however none of the never events had occurred on the wards inspected.
- On each ward there was information about incidents that had been reported displayed including the number of falls that had occurred. There was a folder on each ward which detailed incidents that had occurred and what was to be learnt from each incident.
- We could not find any evidence of improvement from incidents learning primarily due to the high use of agency staff on the medical wards who were not aware of the incidents that had occurred or lessons that were to be learned from incidents.
- Mortality and morbidity meetings occurred monthly within the medical service amongst medical staff and minutes of meetings were available. A member of medical staff informed us that the meetings were a 'work in progress' and whilst they felt the meetings had improved more was needed to look at mortality.
- Mortality for the hospital on 01 June was 110 which was higher than expected for a medium sized acute hospital.
- Where incidents had been identified as having a moderate impact on patients staff did undertake duty of candour and inform the patient and/ or their family of the incidents and that an investigation would take place.

Safety thermometer

- Safety thermometer data was displayed on each ward on the main information board. The medical wards visited showed staffing, pressure ulcer, patient falls and cleanliness indicators. All of these areas showed that they were meeting trusts targets.

Cleanliness, infection control and hygiene

- Peldon ward had been closed during May 2015 due to an outbreak of diarrhoea and vomiting. An incident form completed by staff raised concerns that the staff on duty were not able to effectively barrier nurse the infected patients and minimise the spread of infection to non-infected patients due to insufficient staffing levels.
- The wards had diagnosed cases of C-difficlle over the past twelve months and overall the trust was performing worse than expected on the C-difficlle rates. The ceiling for the number of cases was 20 and the trust had 25 cases recorded.
- MRSA infection rates were within the expected limits for the medical wards.
- We observed throughout the medical wards that hand hygiene and personal protective equipment procedures were not always being adhered to by staff. We observed four instances of medical staff not washing their hands or using hand gels between patients. We observed five incidents of nursing and support staff not washing their hands, using hand gels or using the aprons as required for infection control reasons.
- The labels for intravenous cannulas were not dated they were labelled with a day sticker i.e. 'Monday', 'Tuesday'. The records did not evidence what date the cannulas had been inserted or changed. This was a consistent theme found throughout the medical wards and was a potential risk for infection.

Environment and equipment

- The wards had limited storage space which resulted in equipment and supplies being stored in a bathroom and in the corridor areas. This was particularly evident on the night duty with Birch ward where we observed equipment, linen, chairs and other items stored along the corridors in the ward area. This presented a risk of trips or falls to patients who were walking through the ward.
- On Birch ward we found the door to the roof terrace to open during our inspection. This door led from the ward

of the roof terrace area which was not well lit. Patients were at risk of falling and sustaining injury on the roof terrace if unobserved by staff. Staff on the ward observed that we were by the open door and then on the roof terrace but did not challenge us about this. We were unable to lock the door prior to leaving due to the way it had been left open. We escalated this to the duty matron on site as well as the staff for their immediate attention to keep patients safe.

- The lights on Birch ward at night do not turn off in the main areas because they are on motion sensor timers, which due to the staff and patients moving on the ward continuously, meant that the lights were on at all times of the day and night.
- The resuscitation trolley on Birch ward had not been checked on five days during May, one day in June and one day in July.
- Resuscitation trolleys on D'Arcy, Tiptree and Peldon wards were checked daily in line with trust policy, however a requirement of the checklists was to check the trolleys twice each day and we found instances where this had not been done.

Medicines

- We observed medicines were administered and recorded as administered, however we observed that the administration of medicines on rounds was delayed and this was linked to the staffing levels not being sufficient on the wards. We spoke with seven nurses on the medical wards who informed us that the medicines were not always on time as there was not enough staff on duty to administer medicines in a timely way.
- On Birch ward we were not assured by the quality of the daily controlled drugs records checks. The ward sister had identified that a controlled drug was missing from the cupboard however this had not been identified during the daily checks by nursing staff.
- Fridge and room temperatures for the medicines on Birch ward had not been routinely checked in May June and July despite recent heatwave. There were also gaps in monitoring checks on D'Arcy ward.
- There was an inconsistent approach to the agency staff on duty administering IV medicines. On two of the wards agency staff were administering IV medicines, Birch ward provided evidence that they observed their regular agency to ensure they were competent to administer IV medicines. There was no evidence available on the wards that the agency staff had been trained by the trust or through their agency. On Birch and Peldon wards low numbers of trust staff meant that to ensure patients received their medication in a timely manner agency staff would have to administer IV medicines.
- Following our inspection on 8th July the trust provided us with assurances that agency staff would be assessed as competent to safely administer IV medicines. On Birch ward during our inspection on 14th July we asked to see the competency checks and induction forms which would cover medicines for all agency staff on duty. These were not available to the nurse in charge or available on the wards so we were not assured that the staff on duty were competent to safely manage and administer medicines.
- The trust policy on IV medicines is that all staff including agency staff, must be trained through the trusts internal training course on IV medicines to be deemed competent, however we found no evidence that any agency staff member on duty throughout our inspection had received this training but were still providing IV medicines to patients.
- We were concerned that on Birch ward we observed that the Nurse in Charge had delegated the responsibility of holding the medicines keys to one of the agency workers on duty. There was no evidence on the ward available to the nurse in charge to determine whether this was safe or not.
- We observed a member of staff on duty on Birch ward retrieve intravenous medicines from the medicines cupboard and go to a patient's bedside. We did not see that intravenous medication was signed by two nurses as required by trust policy on intravenous medicine administration.
- On the Emergency Assessment Unit (EAU) two patients whose records we examined both were delayed in receiving their intravenous medicines and fluids. One of those patients was delayed in receiving medication by nearly three hours.
- Of the four medicines records examined there were discrepancies in three of those records. One demonstrated that there was a gap in administration of medicine. A further one showed that medicines were being given with the tablets being crushed and placed in the patient's food. There was no record of consent to this practice. The third record demonstrated that the flow rate of an intravenous fluid which was flowing two slowly.

Medical care (including older people's care)

Records

- The completion of 20 records examined on the medical wards was poor. Gaps and inconsistencies were noted throughout all records we examined. Whilst the completion of records was marginally better on Tiptree and D'Arcy wards of the 20 records examined we identified issues with 15 sets.
- Five nurses we spoke with raised concerns about the completion of records by agency staff. They stated that coming on duty following a shift with agency staff was challenging as the records were not well completed.
- Nutrition and fluid charts were poorly completed and did not demonstrate how nutrition or hydration needs for patients were being met. Of the five patients who required food and fluid monitoring we examined their records and found limited entries or recording for each one. For example we saw only cornflakes, Weetabix or roast dinner recorded with no amount to inform staff of how well patients were eating.
- One patient who required a soft mashable diet on Birch ward did not have detailed plan in place which demonstrated how support would be provided to this person in the nursing records. Records did not demonstrate how the food met the requirements identified by the Speech and Language Therapy (SALT) review. There was insufficient detail to demonstrate how the risk from dysphagia was being managed.
- On Birch ward we examined one patient record and noted that a medical care plan had been written on a scrap piece of paper. This was not on a trust identifiable document. There was no patient details listed nor were there details for the medical person who wrote the plan. This piece of paper did not have dates on it and the level of detail provided caused us concern. We requested for this patients plan to be reviewed by a member of the medical team as a priority to ensure that this was the right plan for that patient and that it completed appropriately on a trust formatted care plan.
- On the Emergency Assessment Unit, we examined six records and noted that two had limited entries recorded in the admission booklet for food and fluid intake despite being required as part of the admission plan. One patient was recorded as refusing food in their records. However, there was no escalation or steps taken to support this person, who lacked capacity, to intake the required amount of food and fluids.
- Of the six patients records we examined one required a falls risk assessment. The falls assessment was completed however it did not contain the lying or standing blood pressure reading, which would be a relevant factor as the patient had a known heart condition.
- On the Emergency Assessment Unit one of the DNACPR forms we examined was illegible. We could not read the reasons why resuscitation would not be successful or what had been discussed with the family. We requested that this be reviewed by the medical teams as soon as possible.

Pressure ulcer care

- Of the 20 records examined eight patients were recorded to have a pressure ulcer and required care to minimise the risk of further skin deterioration. In six of the eight records we saw that there were gaps in the pressure ulcer care provided. For example when the dressings were changed there was no new size, shape depth or grade recorded, or the area was called a 'red area.' In two cases there was no clear plan for pressure ulcer care and what care was provided was not always documented or recorded as given.
- Turn charts were used in the adult nursing care records. The records were 'ticks' in boxes with reference to the patient's position. Turn charts ensure that the patient's position is changed to relieve pressure and reduce the incidence of pressure sores. We asked three members of staff specifically about turning patients, all were not assured that patients were routinely turned, particularly by agency staff.
- On observation of four patients turned throughout our inspection they remained in the same position but were 'ticked' as being turned. One patient with a Grade III on the sacrum was recorded as on their back for several days continuously. We were therefore not assured that patients were receiving their turns to minimise the risk of pressure ulcer development.
- On the Emergency Assessment Unit (EAU) of the six records examined four required pressure ulcer care. One patient did not have appropriate care plans, treatment plans or assessments in place. The patient, admitted with leg ulcers, had no body map, care or treatment plans in place. The patient was not on an air mattress and we found no evidence of turns being provided or recorded and no rationale for the lack of pressure reliving equipment being provided.

- On Birch ward we observed a patients position throughout the duration of our inspection time on the ward and at a later time. We noted that the patient was recorded with a 'tick' for being turned however they remained in the same position. We were not assured this patient received their turns when required.

Safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- Of the medical staff in the hospital 91% have received safeguarding adult level 2 training, 68% have received training in Deprivation of Liberty Safeguards level 2 and level 3, 52% have received training on learning disability and autism at level 1 and 50% have received level 3 training and 73% have received Mental Capacity Act training to level 3.
- Of the nursing staff in the hospital 91% have received safeguarding adult level 2 training, 60% have received training in Deprivation of Liberty Safeguards level 3, 57% have received training on learning disability and autism at level 1 and 40% have received level 3 training and 62% have received Mental Capacity Act training to level 3.
- The medical wards were using the Essex template for mental capacity assessments and Deprivation of Liberty Safeguards. However the implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards practice was inconsistent and could place patients at risk of harm.
- On Birch ward a patient who was subject to a Deprivation of Liberty Safeguards for risk of falls and leaving the ward was left unattended fell sustaining an injury. The Deprivation of Liberty Safeguards for this patient was issued urgently and had expired however we found no evidence that a further application had been made to continue the Deprivation of Liberty Safeguards through a routine application route.
- The same patient had been administered a sedative based medicine to minimise the risk of wandering. The original Deprivation of Liberty Safeguards application had not specified this as form of allowed restraint. We found no evidence that a mental capacity act form, for decisions in the best interest of the patient, had been completed to authorise this as an appropriate form of treatment. However the trust state that should this have been a recurrent event a new DoLS application would have been sought.
- On the Emergency Assessment Unit a patient who had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) completed was identified as not having mental capacity and therefore the decision not to resuscitate had not been discussed with them. However the best interest decision around this had not been completed.
- A patient who was refusing food and fluids and required a Deprivation of Liberty Safeguard to ensure that they received appropriate nutrition and hydration for their wellbeing had not been assessed for a Deprivation of Liberty Safeguards despite being in the Emergency Assessment Unit for almost 12 hours.

Assessing and responding to patient risk

- The wards used the National Early Warning Score (NEWS) system. The forms were part of the initial medical and nursing assessment and where a patient was identified as at risk their enhanced observation requirement was written on the patient board and on the board outside the bay.
- We identified three cases, two on Birch and one on Peldon, where nursing staff had escalated to medical staff concerns that a patient had triggered the NEWS score. The medical staff had not responded to the escalation in line with trust policy which specifies that attendance is required within one hour.
- On the Emergency Assessment Unit two of the six patients required monitoring for sepsis and the risk of deterioration. One patient did not have a sepsis care bundles started despite being admitted with sepsis, another patient who had triggered the NEWS had their sepsis bundle started however this had not been completed.
- On Tiptree ward concerns were raised to us about the location of the side rooms for the ward and the distance they were away from the main ward which meant patients could not easily be observed. They reported that the found it challenging to place appropriate patients in the rooms. This was not noted on the risk register.
- On Peldon ward we found that during a night shift medical staff did not respond to a patient escalated by nursing staff for a high NEWS of 10. It was recorded in the patients record that the doctor, 'Does not feel the need to review patient.'
- On Birch ward we found two patients where there were challenges with getting medical support to attend to

patients who were escalated with high NEWS during a night shift. One patient with a NEWS of 10 had an entry in their records which said, 'Patient not a priority since this is the patient's normal range.' Medical staff are to respond within one hour as per trust policy, nursing staff further escalated this patient's condition and the doctor arrived 4.5 hours after original call. The patient was subsequently started on IV antibiotics for sepsis.

- We were concerned that patients with high NEWS scored were not being seen in a timely manner. The trusts policy states that once alerted to a patient with a high NEWS score medical staff should respond within one hour. We saw evidence that this was not occurring on three occasions. On Peldon ward we found in the records for one patient with a NEWS score of 10 that the doctor 'Does not feel the need to review patient' with no further rationale documented.
- On Birch ward we found two patients where there were challenges with getting medical support to attend to patients who were escalated with high NEWS during a night shift. One patient with a NEWS of 10 had an entry in their records which said, 'Patient not a priority since this is the patient's normal range.' Nursing staff escalated this patient's condition and the doctor arrived four and a half hours after the original call.

Nursing staffing

- We found that there was a high use of agency staff to fill the vacant shifts on EAU, Peldon, Birch, Tiptree and D'Arcy wards. The use of agency, we found, through examination of the rotas, was prevalent at nights and on weekends. The trust policy was to ensure that a member of trust employed nursing staff was on duty to act as the nurse in charge of each shift. This involved moving staff around the hospital from different specialties to meet this requirement.
- During the day shifts during our inspection the wards were led by the band 7 senior sister or band 6 junior sister or deputy charge nurse. At night time, through examination of the rotas and observed on our inspection, the inpatient wards were led by band 5 nurses. On the EAU the ward was led by band 6's but it was acknowledged that at times it was led by senior band 5 staff due to the availability of senior staff.
- On EAU the staffing levels met the establishment defined by the trust with vacant shifts filled by agency staff. At the time of the inspection of the 15 nurses on duty eight were agency staff and of the six health care assistants on duty three were agency staff.
- Prior to the inspection we received information of concern that the conditions placed on the trusts registration in December 2015 were not being met, due to the staffing numbers available to meet patient demands including senior staff availability. Based on the patient dependency and acuity seen on the ward at the time of the inspection there was a sufficient number of staff on duty to comply with the imposed conditions however we found through the examination of the rotas that there was not a sufficient number of band 6 or band 7 staff available to provide the appropriate skill mix and leadership to the team.
- On Birch ward the staffing levels consisted of six nurses and four healthcare assistants on the early shift, five nurses and four healthcare assistants on the late shift, and three nurses and three healthcare assistants on the night shift. We were informed that the numbers were determined by a staffing establishment review undertaken in December 2014 and a review had been undertaken again in June 2015 though the results of this were not yet known.
- On Birch ward we found that the night time staffing was as in line with the review in December 2014. However, during our inspection there was one additional nurse on duty providing one to one care to a patient. The nurse in charge was a trust employed bank nurse who was supported by agency staff. Of the 30 patients on the ward, eight lacked mental capacity of which four were on being deprived of their liberty for their own safety. Of the other patients four were at high risk of falls, seven on intravenous antibiotics, one required specialised feeding and 13 had triggered the National Early Warning Score (NEWS) and required a higher level of observation. Thus the patient group was complex medical, some with challenging behaviour and as a result the staffing numbers on duty did not meet the acuity and dependency requirements which placed patients at risk.
- Across the medical wards we visited, with the exception of EAU, the wards did not undertake acuity or dependency assessments daily to inform whether or not the staffing ratios required increasing. This is not in line with best practice guidelines on safer staffing.

Medical care (including older people's care)

- The EAU was assessing dependency twice daily. We were told that should dependency require it they were able to request for additional staff. However when we looked at how the dependency of the unit was calculated it was high level care only and did not include other patient needs such as pressure ulcer care or intravenous antibiotic monitoring.
- On Peldon ward (medical and care of the elderly) the ward has seen a 50% reduction in permanent nursing staff. The ward had previously had 20 nurses employed but this had reduced to 10, since April 2015. Staff had been seconded to other wards, taken up roles in other areas of the trust or left the trust entirely. This was a significant reduction of staff for one ward and the rota was now mostly support by agency and bank staff.
- With the exception of EAU when we asked to see competency assessments and induction checklists for the agency staff on duty these were not available on the ward. We were therefore concerned that the trust could not be assured that the staff on duty from agencies were competent or safe to undertake the tasks they were assigned to do.
- During the night inspection on Birch ward the nurse in charge did not observe the agency staff. We observed examples of poor practice around medicines management and also examples of poor care and interactions when patients required assistance.
- During the time of our inspection two agency staff members were sat talking whilst call bells sounded and patient asked for assistance. We observed one patient ask for assistance and they were told they had to wait. When one staff member went over to see what was required the other walked away from the patient. The patient was not spoken to in a respectful manner and the staff attitude was poor towards the inspectors and to the patients we observed them interact with. We reported this to the trust for their attention and action as appropriate.
- Prior to each inspection we had received information of concern from staff who were concerned for the patients and staff in these wards and chose to report those concerns to CQC for action with one of the reasons being that they were 'afraid' to raise concerns interlay for fear of what would happen to them.
- During the inspection staff spoke with us openly but were concerned what would happen once they had spoken to us. We were informed during the afternoon of our inspection 08 July 2015 that staff were being asked to attend a meeting with the trust senior management team to speak about what they had been asked during our inspection. The inspection team believed that staff were intimidated by this approach and during the afternoon staff spoke to us in a scripted way with messages that they were 'told' to give us.
- Staff in medical wards were committed to their patients and dedicated to the care they provided however they did not want to speak with us openly following being spoken to by the trust. Subsequently following the inspection we were contacted by staff who were afraid to speak with us on site whilst the management team were present.

Surgery

Safe	Not sufficient evidence to rate
Overall	Not sufficient evidence to rate

Information about the service

The trust provides a surgical service with a range of specialties including ENT, Vascular and Urology general surgery.

For the inspection on 08 July 2015 we inspected the orthopaedic ward Aldham and the general surgery wards Brightlingsea and Mersea. Each ward has between 28-34 patients some and the service also provided care to medical outlying patients due to a lack of available medical beds in the hospital. Mersea provided care to general surgery, orthopaedics, cardiology and urology patients. Brightlingsea also provided care to patients with ear nose and throat health complaints.

On 14 July 2015 we returned to inspect Brightlingsea Ward in response to concerns received regarding staffing and patient care at night.

We examined the records of 23 patients. We spoke with 19 members of staff including nurses, support staff and allied health professionals, six patients and three relatives.

Summary of findings

Safety systems, processes and standard operating procedures did not operate in a way that protected patients from the potential risk of harm. Patients were at risk of deterioration were not monitored in accordance with trust policy. Records of patient care were in some cases poorly completed, disorganised and difficult to navigate and did not provide a clear picture of the care patients required.

Medicines were often delayed in administration and there were concerns that IV medicines including antibiotics were not provided in a timely way. There is insufficient attention to safeguarding adults and safeguarding required significant improvement in surgery.

There were substantial and frequent shortages of permanent staff which required the high use of bank and agency staff however there was poor management of agency staff which increased risks to people who use services. Staffing levels on the inpatient wards were not sufficient to meet the dependency needs of patients. There was an inconsistent approach to providing local induction to agency staff and the competency and induction checklists for staff were not available on the wards.

There was a notable culture throughout the areas we inspected with staff being afraid to speak up and raise concerns and during the inspection concerns were formally raised to us by five members of staff who feared what would happen should they raise concerns formally.

Following the inspections we requested assurances of what actions the trust would be taking immediately to ensure that effective systems for the management of agency and staff shortages were in place. The trust did not have the evidence available to provide us with

assurances and we therefore took urgent enforcement action to place conditions on the trust's registration to ensure that patients were protected from the risk of harm.

Are surgery services safe?

Not sufficient evidence to rate

Safety systems, processes and standard operating procedures did not operate in a way that protected patients from the potential risk of harm. Patients were at risk of deterioration were not monitored in accordance with trust policy. DNACPR was not always undertaken in line with national guidelines because patients were not informed of the DNACPR decision in two cases examined. Records of patient care were in some cases poorly completed, disorganised and difficult to navigate and did not provide a clear picture of the care patients required.

On Brightlingsea ward and Aldham ward we noted concerns with the provision of oral care and hygiene to patients, there were no care plans in place for patients to support that they received appropriate oral care. Medicines were often delayed in administration and there were concerns that intravenous medicines including antibiotics were not provided in a timely way. There were delays in undertaking patient observations which meant that patients may be at risk of deterioration through inappropriate monitoring.

There is insufficient attention to safeguarding adults. We identified concerns regarding the undertaking and completion of assessments relating to mental capacity and Deprivation of Liberty Safeguards. Safeguarding and the understanding of safeguarding adults required improvement in surgery and we subsequently raised safeguarding alerts to the local authority for two surgical patients following our inspection to ensure that patients were safe.

There were substantial and frequent shortages of permanent staff which required the high use of bank and agency staff however there was poor management of agency staff which increased risks to people who use services. Staffing levels on the inpatient wards were not sufficient to meet the dependency needs of patients. The numbers on the wards we inspected met the trust defined establishment however there was a high use of agency and bank staff with some shifts operating between 60%-90% bank or agency staff. There was an inconsistent approach

to providing local induction to agency staff and the competency and induction checklists for staff were not available on the wards for the shift leads to review to ensure that safe care was provided to patients.

There was a notable culture throughout the areas we inspected with staff being afraid to speak up and raise concerns and during the inspection concerns were formally raised to us by five members of staff who feared what would happen should they raise concerns formally. Senior staff told us that they raised concerns regarding staffing on a regular basis but felt that those concerns were not listened to in all cases and that the high use of agency was accepted.

Following the inspections we requested for information from the trust together with assurances of what actions would be immediately taken to ensure that patients received care from suitably skilled and competent bank and agency staff, also that staff moved around the hospital to provide substantive staff cover were appropriately supported. The trust was unable to provide us evidence or assurances which removed the risk of harm to patients and we therefore took urgent enforcement action to place conditions on the trust's registration to ensure that there is a safe effective process in place relating to the use of bank and agency staff that ensured that patients were not exposed to the risk of harm.

Incidents

- Between 1st January 2015 and 28th May 2015 Brightlingsea ward, Aldham ward and Mersea ward reported 280 incidents. The most reported incidents were low staffing levels, pressure ulcers and patient falls.
- Between 1st January 2015 and 28th May 2015 Brightlingsea ward, Aldham ward and Mersea ward reported had reported no never events, though the surgery service overall had reported nine never events since January 2014.
- Brightlingsea ward, Aldham ward and Mersea ward reported four serious incidents. Two related to deteriorating patients, one patient fall and one related to delayed treatment.
- The trust was not grading the classification of harm from incidents appropriately. Of the incidents reported between 1st January 2015 and 28th May 2015, 30 of 280 were graded as low 'no harm' or 'low harm' which was not appropriate. The trust stated that they will not declare harm level until the investigation had concluded (up to 45 days) which is not in line with duty of candour requirements for patients to be told as soon as possible after an incident occurs.
- Where significant harm was identified or a serious incident declared soon after the incident the trust did undertake duty of candour in line with requirements.
- Where incidents had been identified as having a moderate impact on patients staff did undertake duty of candour and inform the patient and/ or their family of the incidents and that an investigation would take place though we are not assured that this is always undertaken in a timely way.
- For example a patient was found to have three pressure ulcers and bruises on their body when assessed, there were no risk assessment in place for the patient but this incident was classed as 'no harm' . A patient prescribed with a blood thinning medication for their condition was not given the medicine for two days. This was graded as 'no harm'.
- Mortality and morbidity meetings occurred monthly within the surgery service amongst medical staff and minutes of meetings were available for staff to read.
- Mortality for the hospital on 01 June was 110 which was higher than expected for a medium sized acute hospital.

Safety thermometer

- Safety thermometer data was displayed on each ward on the main information board. The medical wards visited showed staffing, pressure ulcer, patient falls and cleanliness indicators. All of these areas showed that they were meeting trusts targets.

Cleanliness, infection control and hygiene

- We were informed by two patients that they felt the environment was not as clean as it could be and cleaning could be improved however, at the time of our inspection the wards were visibly clean.
- During the inspection we observed three incidents of staff going between patients on Brightlingsea ward with the same apron on. We also observed two incidents of staff not washing their hands or using hand gels between patients. This meant that infection control procedures were not always followed.
- The surgical wards inspected had not had any recent cases of C. difficille or MRSA.
- The labels for intravenous cannulas were not dated they were labelled with a day sticker i.e. 'Monday', 'Tuesday'.

The records did not evidence what date the cannulas had been inserted or changed. This was a consistent practice throughout the surgical wards inspected and was a potential risk for infection.

Environment and equipment

- The wards had limited storage space which resulted in equipment and supplies being stored in a bathroom and in the corridor areas which was particularly noticeable on Brightlingsea and Aldham wards.
- The resuscitation trolley on Aldham ward was not recorded as checked on two days during June 2015. On Brightlingsea ward the resuscitation trolley had not been checked on one day between 01 and 14 July 2015.
- On Brightlingsea ward the information in the folder for the management of emergencies had not been updated since 2010. We also found that the adrenaline that was ordered for the resuscitation trolley on 10th July had not been provided four days later and staff on duty were not aware that it was missing.
- Within Brightlingsea there was a strong smell of urine at one end of the ward. This was consistent with the information of concern we received prior to the inspection that there were malodours on this ward. We raised our concerns regarding the odour on the unit with the nurse in charge who requested for house keeper support. However the smell of urine was care related. When we returned on 14th July we note that there were no malodours present.
- The ward environment on Brightlingsea ward was very warm and this was acknowledged by staff that the temperature for the ward had regularly been above 28 degrees Celsius. The trust had subsequently hired a portable air conditioning unit for the ward to reduce the temperature.

Medicines

- During the inspection on Brightlingsea ward on 08 July 2015 the staff were delayed in giving the prescribed medicines. We were told that this was due to staffing shortages and the number of patients who required intravenous medicines and support. At the time of inspection there were seven patients receiving intravenous antibiotic treatment.
- A patient who had been admitted had not been given their regular heart medication for three days. The patient had asked for staff for the medicine but it had not been provided. The patient asked the CQC inspector if they could use their phone to call a relative to bring the medication in from home they told us that staff had refused them permission to use the ward phone. We raised the issue of this patient's medication with the nurse in charge.
- On Aldham ward during our day inspection on 08 July we observed that the trust policy for administering intravenous medicines was being adhered to with two nurses and the nurse in charge signing off the administration of IV medicines.
- On Brightlingsea we identified two patients who had problems with their intravenous fluids. One patient's intravenous catheter was blocked and the other had stopped working which meant that their prescribed medicine was not being given. We raised this with the nurse in charge when identified, these were changed however it took over two hours to do so. Both patients told us that they were in pain as a result of the intravenous catheters not working and one was quite distressed by the pain and crying. We escalated our concerns regarding intravenous care to the associate director of nursing for surgery.
- There was an inconsistent approach to the agency staff on duty administering intravenous medicines. On all wards agency staff were administering intravenous medicines. There was no evidence available on the wards that the agency staff had been trained by the trust or through their agency.
- Following our inspection on 8th July the trust provided us with assurances that agency staff would be assessed as competent to safely administer intravenous medicines. On Brightlingsea ward during our inspection on 14th July we asked to see the competency checks and induction forms which would cover medicines for all agency staff on duty. These were not available to the nurse in charge or available on the wards so we were not assured that the staff on duty were competent to safely manage and administer medicines.
- The trust policy on intravenous medicines is that all staff, including agency staff, must be trained through the trusts internal training course on intravenous medicines to be deemed competent. However we found no evidence that any agency staff member on duty throughout our inspection had received this training but were still providing intravenous medicines to patients.
- On Mersea ward on 5th May 2015 an incident was reported that agency nurses were not administering

intravenous medicines safely or in line with trust policy. The action taken to deal with this incident was to speak with the staff involved. No lessons were learnt to make the intravenous administration process safer.
- On Brightlingsea ward during our inspection on 14th July we asked to see the competency checks and induction forms which would cover medicines for all agency staff on duty. These were not available to the nurse in charge or available on the wards so we were not assured that the staff on duty were competent to safely manage and administer medicines.

Records

- The completion of records 23 records examined on the surgical wards varied. Of the 23 records examined we identified issues with 15 sets because the records were difficult to navigate and there were gaps and discrepancies.
- Two nurses who were bank or agency spoke with us and said that the notes were not easy to understand as they were different on each ward. One staff member on Aldham ward raised concerns that they could not understand or clearly identify what care and treatment their patients had received or now required due to the disorganisation of the records.
- Nutrition and fluid charts were vaguely completed and did not demonstrate how nutrition or hydration needs for patients were being met. Of the six patients who required food and fluid monitoring we examined their records and found in five cases that there were issues with the recording of food and fluids. For example a patient receiving intravenous fluids had no fluid monitoring recorded for three days. For another patient the amount of food they were eating was inconsistently being recorded with vague entries such as 'jelly'. This patient was also recorded as refusing food however there was no escalation around their food intake recorded and the nurse in charge of the ward was unaware of the issues with food and hydration for this patient.
- In three other records where patients were on food or fluid charts the input of fluids were not being routinely recorded. We asked the staff how the three patients on fluid charts were drinking and were told that they were drinking well however the records did not evidence this. For example in one record a patient who was reported to be drinking well had an intake of 250mls recorded for one day.
- Of the six patients who required a falls risk assessment, in all six cases the falls assessment had not been completed at all or had not been fully completed with a safe plan of care implemented. For example a patient admitted to hospital following a fall did not have a falls risk assessment in place despite falling twice since their admission.
- On Aldham ward one patients record we examined was mixed with the records of another patient.
- On Aldham and Brightlingsea wards we observed that records were left out open on trolleys and on the side which could have been read by members of the public. This meant that records were not always kept securely.

Safeguarding, Consent and DNACPR

- Of the medical staff in the hospital 91% have received safeguarding adult level 2 training, 68% have received training in Deprivation of Liberty Safeguards level 2 and level 3, 52% have received training on learning disability and autism at level 1 and 50% have received level 3 training and 73% have received Mental Capacity Act training to level 3.
- Of the nursing staff in the hospital 91% have received safeguarding adult level 2 training, 60% have received training in Deprivation of Liberty Safeguards level 3, 57% have received training on learning disability and autism at level 1 and 40% have received level 3 training and 62% have received Mental Capacity Act training to level 3.
- The surgical wards were using the Essex template for mental capacity assessments and Deprivation of Liberty Safeguards; however the implementation of MCA and DoLS practice was inconsistent and could place patients at risk of harm.
- On Aldham ward we observed a patient who was on a DoLS due to their behaviour on the ward. The reasons for the behaviour of the patient had not been fully explored by the staff who subsequently placed security to watch the patient. There had been no consideration for other sources of behaviour changes including postoperative delirium. We raised our concerns regarding the care of this patient to the nurse in charge, the associate director of nursing for surgery and the local safeguarding authority.
- On Brightlingsea ward we identified a patient who had a lumbar puncture procedure without the appropriate mental capacity assessment for a best interest decision to be made before the procedure was undertaken. This

patient also had a DNACPR in place which had been completed during a period of confusion. The patient had not been informed of the decision for DNACPR. A mental capacity assessment for supporting the rationale for not informing them was not present.
- In a second case we found a patient who was recorded in their records through discussion as having mental capacity had a DNACPR in place which had not been discussed with them. We raised this with the staff to undertake a review swiftly to ensure the patient was aware of the DNACPR and reasons why this decision was taken, or to remove it entirely.

Oral Care

- On Brightlingsea ward we identified three patients who had not received oral care. Their oral hygiene was observed to be in a physically poor state. Two of the three patients had capacity to provide their own care but had not been provided with the oral products to clean their mouths. We examined the records of all three patients and found no evidence that oral care or hygiene had been assessed or was being provided.
- On Aldham ward we observed one patient with poor oral care who was potentially dehydrated. On examination of this patient's records we found no evidence that oral care or hygiene had been assessed as part of their care plan.
- We were not assured that patients on these wards received appropriate provisions or support to maintain good oral health whilst an inpatient in the hospital. We found no evidence in the records we examined that the needs of oral care had been factored as part of the basic nursing care requirements.

Assessing and responding to patient risk

- The wards used the National Early Warning Score (NEWS) system. The forms were part of the initial medical and nursing assessment and where a patient was identified as at risk their enhanced observation requirement was written on the patient board and on the board outside the bay.
- Of the records we examined 10 patients required monitoring due to having scored more than one on the NEWS. Of those 10 the NEWS was correctly undertaken in seven cases. In the three cases where it was not undertaken correctly. The assessments were not undertaken in a time that was in line with trust policy, i.e. every two, four or six hours. This meant that patients were placed at risk of deterioration due to a lack of consistent monitoring.
- Surgical medical staff were available on call and in the hospital 24 hours per day. However, agency staff were unfamiliar with their work environment and were not informed of the arrangements at night time. We were not assured that staff were fully familiar with the arrangements for accessing medical support at night time.
- We examined the theatre records for safe surgery which were completed in all three cases. In one case we identified that consent for two procedures was written on the same form, with different dates, signed by two different doctors. This meant that appropriate consent was not taken. This was not picked up by the theatre teams. This should have been picked up by theatre teams if the safer surgery checklist was used correctly. However we found that the safer surgery checklist had been signed off. This meant that the patient had a procedure that they may not have consented to. We raised our concerns relating to this to the nurse in charge.

Nursing staffing

- We found that there was a high use of agency staff to fill the vacant shifts on Aldham, Brightlingsea and Mersea wards. The highest use of agency we found, through examination of the rotas, was at nights and on weekends. The trust policy was to ensure that a member of trust employed nursing staff was on duty to act as the nurse in charge of each shift. This involved moving staff around the hospital from different specialties to meet this requirement.
- During the day shifts during our inspection the wards were led by the band 7 senior sister or band 6 junior sister or deputy charge nurse. At night time, through examination of the rotas and observed on our inspection, the inpatient wards were led by band 5 nurses.
- On Brightlingsea ward on 8th July the staffing numbers met the establishment listed; however the dependency levels were high which had not been taken into account. On 14th July there were three nurses and two healthcare assistants on the night shift for 30 patients. The acuity on the ward was high with 13 patients scoring on the NEWS with score between one and seven, which

meant they required monitoring. Seven patients were on intravenous antibiotics, four patients had been stepped down from Intensive care and required monitoring. Two patients were identified as 'at risk' of falls, six patients had stoma or tissue viability needs and two patients were receiving end of life care.

- In the surgical wards we inspected the staffing numbers were based on the establishment. This was assessed twice a year and took into account acuity and dependency of patients at the time of review. Additional staff were booked for one to one care or additional support. However we found that staffing numbers, based on the assessment undertaken biannually, were not always sufficiently flexible to meet the needs of patients on the wards on a day to day basis as acuity and dependency was not undertaken daily.
- On Mersea ward staffing for the day of our inspection, 8th July, showed that the ward was one nurse short in the morning and one healthcare assistant short in the afternoon. There were 32 patients on the ward. Mersea ward was a newer environment and was a different layout to the other surgical wards inspected. The ward layout was large and meant that observation of patients was not as easy as it would be on the wards with a smaller layout. The ward layout being larger was not reflected in the staffing numbers and the need to provide additional staff to support the size of the ward as well as the acuity and dependency of patients.
- We were informed that the staffing levels on Mersea ward had been a concern for several months. We saw through minutes of meetings that this had been escalated to the trust executive and senior management team. Staff on the ward told us that they were beginning to see improvement in staffing levels but more work on this was still required.
- On review of the incidents reported between 1st January 2015 and 28th May 2015 Mersea ward had reported 58 incidents of which 8 were related to staffing levels not being sufficient or issues with agency workers. During our inspection on 8th July we found no evidence of local induction for agency staff in place. We were assured following this inspection that the agency staff on duty would receive a local induction prior to working their shift.
- When we returned on 14th July to Brightlingsea ward there were two agency nurses and one agency healthcare assistant on duty and we asked to see competency assessments and induction checklists for the agency staff on duty these were not available on the ward. We asked them if they had received a local induction to the ward. All three confirmed that they had not had one but one staff member had worked on the ward previously on multiple occasions. We were therefore not assured that the staff on duty from agencies were competent or safe to undertake the tasks they were assigned to do.
- We asked a nurse in charge if they were aware if the agency staff on duty were competent to safely administer intravenous medicines or if they had received an induction to the ward. They were not aware of this ward was not their regular ward, the nurse in charge had been moved to provide cover from another ward. The nurse in charge had received no handover on the patients, no induction and no information about general surgery procedures for night cover prior to taking the lead as nurse in charge. This meant that the staff were placed at risk by working in an unfamiliar environment with a patient group they are not familiar with.
- We spoke with patients on Brightlingsea ward during our inspection on 8th July in one of the bays. Two of the patients in this bay expressed their concerns about the nursing staff attitude and whether or not they were competent. One patient told us that they felt the care received by the staff on duty the night before our inspection was, "Dangerous". They told us that they did not want to go to sleep until their medicines had been given because they did not trust the nursing staff as they made mistakes. One patient said, "I wouldn't want to be in a side room with X caring for me".
- We raised our concerns on behalf of the patients about nursing staff on Brightlingsea with the associate director of nursing for surgery and the director of nursing for immediate action. Following the inspection we were informed that appropriate action had been taken in relation to the staff member's attitude towards patients.
- Several patients on Brightlingsea commented to us that staff attitude on the unit was poor with staff being "rude" and "short" with patients when they asked for support at night. This was consistent with patient experiences shared with us prior to our inspection.
- The culture of openness in the service was a concern; as with the teams in medical wards the trust staff were committed to their patients and the care they provided however they did not want to speak with us openly

following being spoken to by the trust. Subsequently during and after the inspection we were contacted by five members of staff who were afraid to speak with us on site due to the presence of the management team.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- That the staffing numbers on inpatient wards take into account the acuity and dependency needs of patients.
- That the agency staff, bank staff and trust staff who work on a ward for their first shift receive a local induction to the ward.
- That the medicines policy in place is adhered to in that only staff who have completed competency training on IV medicines are able to administer IV medicines and the responsibility for the keys remains with the nurse in charge.
- That the door to the roof terrace on Birch ward is secure at all times.
- That improvements are made with regard to the awareness and understanding of mental capacity and deprivation of liberty safeguards.
- That patients are informed of decisions not to resuscitate where appropriate to do so and where this is not possible that the Mental Capacity Act 2005 has been adhered to.
- That staff adhere to its policies including resuscitation, consent and moving and handling.

Action the hospital SHOULD take to improve

- That the resuscitation trolleys are checked in accordance with the trust policy.
- That it improves the culture of openness throughout the trust so that the staff can speak without fear of consequences for doing so.
- That observations of patients at risk of deteriorating are undertaken in a more timely way.
- That agency and bank staff on wards are appropriately observed and provided with support during their shifts.
- That prescribed medicines are administered in a timely way.
- That a review of the culture around care on Brightlingsea ward is undertaken.
- Review the lighting on Birch ward to ensure that that patients' are able to rest at night time.
- Ensure that lessons from incidents are learnt and shared amongst all staff.

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
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Section 31 (2) (a) The trust has failed to demonstrate that it is implementing an effective system in place so as to ensure that bank, agency and redeployed staff are inducted and assessed as suitably competent, skilled and experienced to work on the wards upon which they are deployed. The Care Quality Commission has urgently imposed conditions on the trust's registration, in respect of the location Colchester General Hospital, in order to protect patients who will or may be exposed to the risk of harm.