CareQuality Commission

University Hospitals Birmingham NHS Foundation Trust

Birmingham Heartlands Hospital

Inspection report

Bordesley Green East
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Ratings

Overall rating for this service	Inspected but not rated ●
Are services safe?	**Requires Improvement** ●
Are services effective?	**Inspected but not rated** ●
Are services responsive to people's needs?	**Inspected but not rated** ●
Are services well-led?	**Inspected but not rated** ●

Our findings

Overall summary of services at Birmingham Heartlands Hospital

Inspected but not rated ●

Birmingham Heartlands Hospital (BHH) is part of the University Hospitals Birmingham NHS Foundation Trust which is one of the largest teaching hospital trusts in England, serving a regional, national and international population. The combined organisation has a turnover of £1.6 billion and provides acute and community services across four main hospital sites:

- The Queen Elizabeth Hospital Birmingham

- Birmingham Heartlands Hospital

- Good Hope Hospital

- Solihull Hospital

The trust also runs Birmingham Chest Clinic, a range of community services and a number of smaller satellite units, allowing people to be treated as close to home as possible.

The trust has 2,366 in-patient beds over 105 wards in addition to 115 children's beds and 145 day-case beds. The trust operates 7,127 outpatients' and 304 community clinics per week. The trust has over 20,000 members of staff.

At the time of our inspection, the trust was 10 months into the pandemic response to COVID-19 with over 450 COVID-19 inpatients. A number of changes to services and ward specialties had taken place since March 2020 in response to the emergency to ensure the trust was able to provide care and treatment as appropriate to the increasing number of COVID-19 patients. Throughout the pandemic, University Hospitals Birmingham NHS Foundation Trust has had a consistently high number of COVID-19 inpatients.

Concerns have been raised through enquiries and serious incident reporting about medical care services at BHH in relation to:

- Discharge processes and communication

- Venous thromboembolism (VTE) assessment and management

- Incident reporting and sharing of learning including Never Events

- Support, care and treatment for patients with learning difficulties

- Staffing

- Poor culture

- Infection control procedures

- Nutrition and hydration

These concerns led to a decision being taken to complete an unannounced (staff did not know we were coming) focused inspection on 2 December 2020. We inspected elements of our safe, effective, responsive and well led key lines of

Our findings

enquiry. The inspection was carried out by two CQC inspectors and one specialist advisor. During our inspection we visited eight wards and spoke with 36 members of staff including ward managers, registered nursing staff, healthcare assistants, medical staff and discharge co-ordinators. We reviewed 32 sets of records, including reviewing the electronic patient record. Following our inspection, we held a virtual interview with managers for the medical care.

Following this inspection, we did not re-rate all key questions inspected. We have only re-rated key questions where we identified a breach of regulation. Our rating of this location stayed the same. We rated it as requires improvement because:

- The service did not always control infection risk well. Control measures to protect patients, themselves and others from infection were not always used. However, equipment and the premises were visibly clean.

- Venous Thrombosis Embolism (VTE) risk assessments were not always completed on admission or by the time of the first consultant review. However, where indicated staff usually prescribed medicines to prevent the risk of a patient developing a VTE whilst in hospital within 24 hours of admission. Where VTE risk re-assessment was not indicated following the initial risk assessment, staff did not document this decision and the rationale for it on the electronic patient record. This meant staff may not be able to see the most up to date clinical information when reviewing the electronic patient record. VTE risk assessments were not always reviewed by consultants in line with national guidance.

- The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix to mitigate risks.

- Staff recognised and reported incidents. Managers investigated incidents. However, there were not consistent processes on all wards for sharing lessons learned with the whole team and the wider service.

- Staff gave patients enough food and drink to meet their needs and improve their health. However, this was not always documented in patient records where required. They used special feeding and hydration techniques when necessary. However, staff did not assess risk of malnutrition for patients admitted to the acute medical unit who had been in more than 24 hours.

- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions. Medical staff took time to consult family when making important decisions about a patient care where they lacked capacity. However, we did not always see evidence mental capacity assessments had been documented where indicated in patients where a do not resuscitation decision had been agreed.

- The service had systems and processes in place to safely discharge patients in a timely manner. However, we did not find these systems were always effectively implemented by staff. Discharge planning was not always commenced upon admission and completed in a structured way.

- Governance structures were in place; however, they were not always effective throughout the service. Staff at all levels were clear about their roles and accountabilities, however, not all staff had regular opportunities to meet, discuss and learn from the performance of the service.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Our findings

- The service had systems in place to provide an inclusive service which took account of patients' individual needs and preferences. Staff were aware of these systems; however, we did not see evidence of them always being implemented. Staff described making reasonable adjustments to help patients access services. They coordinated care with other services and providers.

- Staff generally felt respected, supported and valued. They were focused on the needs of patients receiving care. However, some staff on wards where there had been significant changes did not feel supported by senior managers.

- Leaders and teams generally used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Medical care (including older people's care)

Inspected but not rated ●

Is the service safe?

Requires Improvement ● ➜ ⬅

We re-rated our safe key line of enquiry as we identified a breach of regulation. Our rating of safe stayed the same. We rated it as requires improvement because:

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Following the inspection, the service provided us with mandatory safeguarding training data which demonstrated the service achieved the 90% target for safeguarding adults and children level two.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were able to describe examples where they had raised a safeguarding concern with the trust team who took it forward. Staff we spoke to during the inspection knew how to make a safeguarding referral and who to inform if they had concerns.

Staff provided examples of making referrals to specialist teams to support vulnerable patients. For example, we saw patients had undergone specialist assessment by dementia nurses where appropriate to identify needs and support required. Staff also referred to the Older Patients Assessment Advisory (OPAL) team to support staff in ensuring more vulnerable patients' needs were met in hospital and to support a safe discharge.

The service produced a quarterly safeguarding newsletter. We saw the spring 2020 edition contained information and guidance to staff about safeguarding. In this edition we saw information relating to discharge and safeguarding with key messages to staff to improve practice around discharge.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Control measures to protect patients, themselves and others from infection were not always used. However, equipment and the premises were visibly clean.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE) to control infection risk. For example, we saw four staff members on ward one not wearing a surgical face mask or not wearing it in a way to protect themselves or patients. We saw staff members on several wards leaving staff rooms unmasked and not putting one back on in a timely manner. On ward 20 we saw staff did not use a face shield when entering bays to provide care to patients. However, in general most staff wore face masks in line with national guidance whilst providing patient care. We found social distancing in the clinical environment was not always considered and saw staff not adhering to social distancing at the nurse's stations across most wards we visited.

Medical care (including older people's care)

All staff and visitors to the hospital were required to wear face masks on entering the hospital building and to keep these on whilst moving around the hospital. We saw that staff wore appropriate PPE when providing patient care including gloves and aprons in addition to face masks. We saw that all staff were bare below the elbow and we observed good hand hygiene during our visits to the ward, with staff adhering to the five moments for hand hygiene (World Health Organisation). These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. We saw hand gel was widely available on all wards.

Ward areas were generally clean and had suitable furnishings which were clean and well-maintained. However, some wards we visited contained clutter from equipment and stores in the ward area to create additional space in bays.

Assessing and responding to patient risk

Venous Thrombosis Embolism (VTE) risk assessments were not always completed on admission or by the time of the first consultant review. However, where indicated staff usually prescribed medicines to prevent the risk of a patient developing a VTE whilst in hospital within 24 hours of admission. Where VTE risk re-assessment was not indicated following the initial risk assessment, staff did not document this decision and the rationale for it on the electronic patient record. This meant staff may not be able to see the most up to date clinical information when reviewing the electronic patient record. VTE risk assessments were not always reviewed by consultants in line with national guidance.

Venous Thrombosis Embolism (VTE) risk assessments were not always completed on admission or by the time of the first consultant review. However, where indicated staff usually prescribed medicines to prevent the risk of a patient developing a VTE whilst in hospital within 24 hours of admission. An electronic risk assessment tool was used by medical staff to assess a patient risk of developing a VTE. NICE guideline [NG89]: Reducing the risk of hospital acquired deep vein thrombosis or pulmonary embolism (2018) recommends that all medical patients are assessed to identify the risk of VTE and bleeding as soon as possible after admission to hospital or by the time of the first consultant review. Hospital Acquired Thrombosis (HAT), covers all VTE incidents that occurred in hospital and within 90 days after a hospital admission. All medical patients should be reassessed for the risk of VTE and bleeding at the point of consultant review or if their clinical condition changes.

Medical staff we spoke to were aware of their responsibilities in assessing risk of developing a VTE and where indicated prescribed VTE prophylaxis medicines and mechanical aids. Nursing staff we spoke to understood their role as administering medicines and hosiery and to refer patients to physiotherapy to improve mobility where required.

We reviewed 32 patient records and found in 16 records there was no evidence that a VTE risk assessment had been completed on the electronic system. Twelve of these patients had been admitted longer than 24 hours and four under 24 hours. This meant 38% of the electronic patient records we reviewed, did not have a VTE risk assessment recorded within 24 hours or more of admission.

Following our inspection, we asked the trust to review the 12 patient records where a VTE risk assessment was not recorded upon admission. Feedback from the trust provided some assurance these patients had undergone a clinical review of their risk of developing a VTE as follows:

Medical care (including older people's care)

- Four patients were admitted on a COVID-19 rapid treatment pathway. All underwent a VTE clinical review by a doctor as part of the COVID-19 rapid treatment pathway. The trust provided assurance that for the patients who were on a COVID-19 pathway, all had a VTE clinical review as part of this pathway. This was not included on the electronic patient record.

- Three patients were admitted on anticoagulant therapy. These patients underwent a VTE clinical risk review which the trust advised was documented in the patient notes. However, this had not been recorded on the electronic VTE risk assessment.

- One patient was on an acute coronary syndrome pathway which included the use of enoxaparin to manage the risk of developing a VTE. A risk assessment was not recorded on the electronic system.

- Four patients had undergone clinical VTE review of their VTE risk on admission and documented in the on-going clinical notes, however, this was not recorded on the electronic system.

Whilst the service did not complete an electronic risk assessment upon admission, the trust provided some assurance a clinical review had been undertaken and these patients had where indicated been prescribed mechanical or chemical prophylaxis. Prophylaxis is treatment given to prevent a patient developing a VTE whilst in hospital. This can be medicines or use of hosiery such as stockings. Furthermore, the service advised they could have documented this using the online VTE risk assessment tool.

Following the inspection, the service provided us with VTE audit data which indicated VTE risk assessments were not always completed within 24 hours of admission. For example, an audit of 38 patient records in September 2020 showed only 71% of patients had a VTE assessment within 24 hours of admission. Six patients did not have a VTE risk assessment recorded but there was evidence these patients were prescribed prophylaxis or were already on anti-coagulant medicines. Anti-coagulants are medicines to help prevent blood clots. They are given to patients at high risk of getting blood clots to reduce their chances of developing serious conditions such as strokes and heart attacks. The audit demonstrated that 31 out of 38 patients had been prescribed prophylaxis medicines and hosiery. Out of the seven who did not have a prescription, two patients were identified as high risk and prophylaxis was recommended, however were not prescribed any form of prophylaxis. One record audited showed the clinician had not assessed the risk correctly.

Where VTE risk re-assessment was not indicated following the initial risk assessment, staff did not document this decision and the rationale for it on the electronic patient record. This meant staff may not be able to see the most up to date clinical information when reviewing the electronic patient record. During our inspection we found VTE risk had not been re-assessed following admission in 19 out of 32 records we reviewed. However, whilst there were no concerns found the patient's condition may have warranted a re-assessment, this was not documented. For example, if the patient was fully mobile and assessed as low risk or was already on anticoagulant therapy.

VTE risk assessments were not always reviewed by consultants in line with national guidance. We found there was an inconsistent approach to consultants reviewing VTE assessments with most wards saying they did not think these were reviewed. We saw no evidence of this being recorded on the electronic patient record. However, during our inspection we observed a ward round on one ward we visited where discussions took place regarding VTE risk and prophylaxis medicines review. Junior Doctors on ward 30 told us their consultant regularly reminded them about completing VTE risk assessments and ensuring where indicated prophylaxis had been prescribed.

We were not assured that processes for risk assessment, documentation of decision making and management of identified VTE risk was always completed in a way that ensured patients were kept safe from the risk of harm. Before our inspection, the trust had reported several serious incidents relating to VTE management through the trust's electronic reporting system which indicated that patients had experienced avoidable serious harm. However, none of these

Medical care (including older people's care)

occurred at Birmingham Heartlands Hospital location. Furthermore, from August 2019 to June 2020 we identified six VTE related incidents linked to the medical care core service at Birmingham Heartlands Hospital, all of which resulted in low harm. These incidents were potentially avoidable thrombosis. Some of the concerns identified following review were clinicians not assessing the risk correctly (two), delays in completing risk assessments and delays prescribing appropriate prophylaxis. Following the inspection, we requested the number of VTE related incidents that occurred three months before our inspection. The service identified one incident resulting in low level harm in November 2020 of a possibly preventable HAT which was under investigation. However, there were delays in completing the VTE risk assessment and prophylaxis was not always prescribed.

We were not assured systems provided to staff for recording VTE assessments were always effective and consistently used by staff. Whilst the trust provided some assurance patients had undergone a clinical review of their risk of developing a VTE upon admission, we were not assured there was a consistent process for recording VTE risk assessments at the point of admission. Following the inspection, it became apparent there were different processes for recording VTE risk depending on the pathway the patient was on. For example, a COVID-19 and coronary care pathway. These reviews were not included on the electronic patient record. Medical staff we spoke to were aware VTE assessments should be recorded on the electronic record, however, they were unable to tell us the reasons the admission VTE was not recorded on the system when asked. We were therefore not assured that all staff were aware of the different processes for documenting VTE assessments. Furthermore, we were concerned the variation in the process could lead to assessments being missed, risk not being appropriately assessed and clinicians not having the most up to date information on the electronic patient record.

Senior managers advised us they were in the process of implementing a new electronic record system across the trust. At the time of the inspection we were told this would be completed in February 2021 at Birmingham Heartlands Hospital. The system would provide medical staff with prompts to complete the assessments and re-assessments in line with guidance. We were informed the implementation of this system would mitigate some of the concerns we identified, such as one process for recording VTE assessments and improved documentation of decisions making and documentation where reassessment was not indicated.

Senior managers also provided assurance they had shared learning following incidents and had acted as follows:

- Training sessions had been delivered to clinicians by the VTE Trust Lead and this was intended to continue. The VTE nurse lead and her team delivered VTE prevention workshops across all sites. The training sessions had an emphasis on the importance of VTE prevention in terms of using the Department of Health VTE assessment tool correctly. An update of the latest NICE guideline on VTE management was given along with learning lessons from VTE-related incidents. This provided some assurance that there were processes in place to ensure staff were trained to complete VTE risk assessments.

- Trust wide concerns had prompted deeper dives into specific issues and at the time of the inspection audits were planned. Routine VTE audits were completed quarterly.

- A trust wide quality improvement project was underway focusing on VTE risk assessment, prevention and pausing and restarting anticoagulants.

- A new joint thrombosis committee had been established. The purpose of this group was to develop and oversee the implementation of interventions for the prevention of hospital associated venous thromboembolism within the trust and to ensure that national guidelines and recommendations on best practice were followed.

During the inspection we saw key messages to staff relating to VTE were on staff notice boards. For example, on ward one we saw a poster on the notice board reminding staff about VTE responsibilities for different roles.

Medical care (including older people's care)

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix to mitigate risks.

The service did not always have enough nursing and support staff to keep patients safe.

Staff on all wards we visited during our inspection told us they were regularly short staffed. Staff told us the wards were very busy with high acuity which on occasions impacted on the level of care they provided. For example, delays in updating records or delays in completing medicines rounds. Some wards told us on occasions this can impact on safety. For example, staff on ward one told us they were not always able to have a staff member present in a bay to supervise vulnerable patients. This meant there was an increased risk of patients falling as staff were not always present to supervise. However, this was mitigated by placing more vulnerable patients in more visible bays. During our inspection we did not see any evidence of delays in care.

Managers and staff told us systems were in place to escalate staffing concerns and staff felt able to do so. Staff told us if there were concerns about staffing levels impacting patient safety, they reported it as an incident. Following the inspection, we asked for information about incidents reported related to staffing concerns within medical care. There had been 27 incidents reported from September 2020 to November 2020 which related to staffing issues.

The actual number of registered nurses on shift did not match the planned on the wards we visited. Managers told us this was due to vacancies and unplanned absence. Managers told us where they were short of registered nurses, this was risk assessed and additional staff would be requested, or additional health care assistants provided to support.

Following the inspection, we requested planned versus actual staffing levels from September 2020 to November 2020. The data showed that on average 91% of qualified nurse shifts across medical care during the day were filled and 102% during the night. By comparison, health care assistant shifts were over-filled during this period by 119% during the day 133% and night.

Managers reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. Staffing was regularly reviewed across the hospital by the matrons, deputy director of nursing and the divisional director of nursing who met together three times daily to mitigate risks as they arose. Information about staffing levels was collated in a staffing dashboard so managers could easily identify the areas of greatest need. Acuity levels were considered alongside staffing numbers, but managers told us all areas were experiencing high acuity at the time of our inspection as a result of the impact of the COVID-19 pandemic and winter pressures.

Senior managers told us there had been significant changes to staffing at Birmingham Heartlands Hospital due to the site absorbing the medical provision from Solihull hospital as part of a system change in response to COVID-19 pandemic. The service absorbed an extra 123 beds. Managers told us this had impacted on staffing levels at Heartlands and had been reviewed throughout to ensure the staffing levels were safe.

The ward manager could adjust staffing levels daily according to the needs of patients. Managers told us they could request additional healthcare assistants to meet the acuity of the ward. Managers told us, they often got cover when requested although this was not always the grade nurse they request. For example, they may be allocated a health care assistant rather than a qualified nurse.

Medical care (including older people's care)

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The service used the safer staffing tool to review staffing requirements every six months which considered the number of patients and level of acuity.

Managers were aware of the staffing concerns and told us they had a range of actions in place to mitigate the risks as follows:

- Senior managers told us they submit 16 daily requests for additional staff to work across the division and support areas where acuity is high, or the actual levels did not meet the planned levels. These staff were allocated to the area of greatest need identified in the divisional directors of nursing's daily meetings.

- In response to the COVID-19 pandemic, student nurses in their last 6 months of training were deployed into paid placements as pre-registration nurses. They were added to the health care assistant section of the roster and there to mitigate any registered nursing gaps and support health care assistants in patient care.

- Trainee Nursing Associates (TNA) were also deployed to provide further skills to help mitigate the registered nursing gaps. A TNA is a highly trained, generic, nursing support role designed to bridge the gap between healthcare assistants and registered nurses to deliver hands-on, person centred care as part of the nursing team.

- A band six nurse in charge role was supernumerary on most wards we visited. They were in charge but also supported the team with clinical work where staff was low and acuity high.

We saw the service had mitigations in place to manage shortfalls in planned staff levels. Staff told us shortfalls in registered nurses were often filled with health care assistants if a registered nurse could not be booked. Some wards had flow and discharge co-ordinators to support nursing staff to manage discharges. Where required, the nurse in charge role would also include management of patients.

The service had increasing sickness rates. From September 2020 to November 2020, the service reported a sickness rate of 6.8% for qualified nursing staff and 10.5% for support staff in medicine. During the inspection, staff told us sickness was higher than normal due to staff being off with COVID-19. This was mitigated through daily staffing review meetings, requests for additional temporary staff and movement of staff to support areas with lower staff numbers. Senior managers told us there were higher rates of COVID-19 in the area surrounding the hospital which had impacted on sickness levels, staff shielding and self-isolation. Divisional Directors of Nursing held three live staffing meetings per day to mitigate staffing risks as they arose.

Incidents

Staff recognised and reported incidents. **Managers investigated incidents. However, there were not consistent processes on all wards for sharing lessons learned with the whole team and the wider service.**

All staff knew what incidents to report and how to report them. All staff we spoke to were aware of the process for reporting incidents and had access to the online reporting system. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff were able to describe incidents they had reported. For example, a staff member told us they had reported a medicines administration error they had made. Staff told us they felt comfortable reporting incidents. Following the inspection, the trust provided data on incidents reported in relation to staffing levels and Venous Thrombosis Embolism (VTE) related incidents. This provided some assurance that staff report incidents.

Staff were also able to describe the most commonly reported incidents such as pressure ulcers and falls. However, they were unable to describe the most common incidents across the hospital or trust. We found staff meetings were not

Medical care (including older people's care)

consistently held on wards and where they were held, there was no fixed agenda relating to governance. Senior managers told us face to face meetings were suspended during COVID-19 which left a gap in sharing of information consistently. Staff told us learning was shared through ward handovers, however this relied on staff being on shift to receive the feedback verbally. Wards set the meeting agenda according to issues of current concern and did not routinely include incidents, risk or performance. Some wards used a 'shift expectation' approach to sharing information at shift handover, others noted discussions on handwritten documents. Following the inspection, the service sent us some examples of meeting minutes from ward meetings, these were inconsistent, and we did not find evidence that learning from incidents was shared in a robust and consistent way across the service.

Learning about serious incidents and never events that happened elsewhere was shared with staff, however staff did not always read it. Sharing of learning was generally localised to the ward. We saw limited learning from directorate or trust wide serious incidents or never events. During our inspection, staff were unable to tell us about recent serious incidents or never events that occurred on other wards or across the trust. However, staff could tell us about incidents that occurred on their ward and the learning taken from this. For example, ward one was able to describe their last serious incident which was a fall and learning taken from this.

We saw systems were in place to share learning from these incidents. For example, staff told us they received information about never events through email, however, not all staff we spoke to accessed and read these emails due to workload.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. The service had processes in place to identify and share lessons learnt however the methods were not always effective in ensuring staff read and understood them. For example, following the inspection, the trust provided us with recent examples of published patient safety and safeguarding briefings. We saw evidence of incidents raised that were linked to concerns which prompted the inspection. For example, communications to staff about discharge and VTE. During the inspection we saw some evidence of lessons learnt and patient safety briefings attached to some staff room notice boards. However, most staff were not able to tell us about them and we were not assured there was a local and consistent process for sharing this learning at ward level. Staff told us they were able to access information on the trust intranet and through email but rarely had the time to do this or read information.

During our inspection, we asked staff whether they received feedback from incidents. Most staff told us they received feedback when they reported the incident through email or direct from their manager. However, staff told us they did not always receive feedback following incidents in general or incidents that happened on other wards.

Some staff told us that they received feedback verbally or by email following submitting an incident report. However, not all staff described receiving feedback following reporting incidents.

Staff did not always meet to discuss the feedback and look at improvements to patient care. Each ward we visited had a huddle folder which contained information about incidents and safety alerts. The manager kept folders updated and used staff notice boards to display incident learning. For example, on ward one we saw learning from hospital acquired thrombosis incidents and learning for staff. However, there was not a consistent approach to sharing learning verbally to ensure all staff were provided with the information and had an opportunity to discuss it. Staff told us this was impacted by COVID-19 restrictions for maintaining social distancing rules.

Medical care (including older people's care)

Is the service effective?

Inspected but not rated ●

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. However, this was not always documented in patient records where required. They used special feeding and hydration techniques when necessary. However, staff did not assess risk of malnutrition for patients admitted to the acute medical unit who had been in more than 24 hours.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Red trays were used as a visual aid to identify patients who needed assistance. We saw staff assisted patients who needed help to eat and drink at meals times. Fresh water and warm drinks were provided to patients.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. We saw evidence in patient records of referrals being made and patients being assessed where required.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We reviewed 24 patient records and found these were completed and reviewed where required in 19 records. However, these were not completed for any of the five patient records we reviewed on the acute medical unit (ward 23). We were advised that as this was a short stay medical ward, a nutritional assessment was not completed, however, of the five patients reviewed, two had been admitted for more hat 24 hours and a further one for more than 48 hours.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. We reviewed the fluid and nutrition charts of 12 patients and found only five had been completed consistently and fully throughout their admission. Therefore, staff were not always able to review a patient's intake and ensure they were receiving enough nutrition and fluids to keep them healthy.

Regular audits were undertaken to assess compliance against standards for assessing nutritional and hydration risk as well as ongoing monitoring. Following the inspection, the service provided us with nutrition and hydration audit data. Fluid monitoring audits demonstrated, in September and October 2020 an average 92% compliance was achieved against a target of 95% which dropped to 89% average in November 2020. Nutrition screening on admission audits demonstrated in September and October 2020 an average 98% compliance was achieved against a target of 95% which dropped slightly to 95% average in November 2020. Furthermore, for September and October 2020 92% of patients audited had their nutrition risk re-assessed which increased slightly to 94% in November 2020. The service was aware of wards that were not achieving targets and had processes in place to improve practice. We saw examples of hydration and nutrition displays during the inspection and following the inspection the service provided us with examples of communication campaigns to improve staff practice and compliance.

Nutrition and hydration performance was monitored through the divisional quality meeting and individual discussions between ward mangers and their respective matrons took place to discuss performance. Senior managers told us action plans were in place with spot checks to monitor improvement where any domain was not met.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Medical care (including older people's care)

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions. Medical staff took time to consult family members when making important decisions about a patient where they lacked capacity. However, we did not always see evidence mental capacity assessments had been documented where indicated in patients where a do not resuscitation decision had been agreed.

Staff we spoke to during our inspection understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could describe how they gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff made sure patients consented to treatment based on all the information available.

Medical staff contacted family and carers to discuss important decisions about their relative's care and treatment where they lacked capacity. For example, on ward 30 we observed several positive and supportive discussions from clinical staff to family in discussing Do Not Attempt Resuscitation (DNAR) status. Although very clear about the diagnosis and prognosis, this was completed in a sensitive and informative way. They gave the relatives they were talking to many opportunities to ask questions and checked their understanding.

We did not always see evidence mental capacity assessments had been documented where indicated in patients where a DNAR decision had been agreed. The service used ReSPECT forms to assess a patient's wishes and DNAR status. The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. Staff completed documentation to record the conversations held with patients, and discussions had with family and carers. During our inspection, we reviewed 12 ReSPECT forms and found:

- Three of the forms were completed for patients who were deemed to lack capacity. However, there was no evidence of a formal capacity assessment being completed in two of the patient records. We found in one case; the patient had a community ReSPECT form which had not yet been received by the ward. A letter from the patients GP provided confirmation of this and of a capacity assessment having been completed in the community.

- Nine forms were completed well and there was evidence of discussion with patients/family.

Following the inspection, we requested audit data to demonstrate compliance with the ReSPECT process. We were advised the service was unable to undertake these audits due to the COVID-19 pandemic and requirement to reduce footfall in clinical areas. However, managers confirmed they intended to restart them again in December 2020.

Is the service responsive?

Inspected but not rated ⬤

Meeting people's individual needs

The service had systems in place to provide an inclusive service which took account of patients' individual needs and preferences. Staff were aware of these systems; however, we did not see evidence of them always being implemented. Staff described making reasonable adjustments to help patients access services. They coordinated care with other services and providers.

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Systems were in place to provide an inclusive service which took account of patient's who lived with a learning disabilities individual needs and preferences. The trust had a strategy for meeting the needs of patients living with a learning disability and a set of standards for patients which had been written based on national standards. A link worker system had been developed across the trust to support the learning disabilities team. One hundred and twenty link workers had been trained in additional competency-based skills around supporting the needs of patients living with a learning disability.

All staff we spoke with were aware of any patients on their ward who was living with a learning disability. Information about any patients with additional support needs were communicated at each shift handover. A learning disabilities specialist team visited wards to provide additional support and advice to staff caring for patients living with a learning disability. This team worked across the hospital and community which enabled information to be shared between services.

Patients living with a learning disability were flagged at the point of admission. The learning disability team were automatically made aware when a patient was admitted to the hospital. Staff told us they were easily accessible and very responsive when support was required.

Staff on the ward could also email the team or make a referral to the team through the electronic patient records system. The team offered an advice line for staff. Staff we spoke to were aware how to get in contact with them.

Communication boxes were available for staff to access aids such as picture charts and communication books. These helped patients and staff to communicate with each other more easily. Most staff we spoke to were aware of these boxes. Staff also described using technology such as mobile phones to access communication aids.

Staff supported patients living with learning disabilities by using 'all about me' documents and patient passports. The document helped patients identify their likes and dislikes, normal routines for personal care, and any communication support needs so that staff could provide appropriate individualised care. We did not see any being used during our inspection, however, most staff were able to provide examples of where they have used them in practice. Staff told us family and carers normally inputted into them, but this had become more challenging through the COVID-19 pandemic.

Staff did not always make sure patients living with learning disabilities, received the necessary care to meet all their needs. We reviewed one set of records of patients living with a learning disability. We saw the patient had their hospital passport with them which included likes and dislikes. One of the top likes was being alone. We observed the patient was alone at the time we visited. On review of the patient record, we did not see evidence of a specific care pathway for this patient and no evidence the patient had been seen by a specialist nurse.

Access and flow

The service had systems and processes in place to safely discharge patients in a timely manner. However, we did not find these systems were always effectively implemented by staff. Discharge planning was not always commenced upon admission and completed in a structured way.

Processes to support a safe discharge were not always documented in patient records we reviewed. A discharge checklist document was available to staff on most wards we visited, and staff knew how to use it. There were two versions of the checklist, one for complex patients and one for simpler discharges. The checklists required staff to tick boxes to indicate actions had been completed. Actions included providing information to patients and family about their ongoing care, removing peripheral vascular devices, making referrals on to appropriate community services,

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arranging any care package required and providing any equipment or dressings. The checklist had been implemented to ensure discharges were safe and timely. We identified five patients who were deemed as medically fit for discharge, however there was no evidence of discharge care planning or a discharge checklist being completed. In one of these records we found there was a discharge checklist proforma, but it had not been completed. One patient was due for discharge the previous day; however, the discharge medicines were not ready, and no evidence the discharge checklist had been started.

From January to November 2020 we received six enquiries of concern about unsafe or poor discharges at Birmingham Heartlands Hospital. Five related to poor communication at the point of discharge about medicines, health conditions and changing needs. One related to a cannula being left in situ after discharge. Following the inspection, we requested the number of incidents reported the three months before our inspection, in relation to discharge. The trust reported eight incidents from September to November 2020 in relation to discharge. Five were categorised as no harm and three low harm. Furthermore, from August to November 2020, there had been 100 patients readmitted to hospital within 72 hours due to failed discharges. This equalled 2.48% of all discharges over that time period. Senior managers told us they recently closed the discharge lounge as there was a significant number of failed discharges associated with this ward. Since the closure, managers told us this had positively impacted on failed discharges. The nurse in charge role was responsible for checking discharge check lists were fully completed before the patient left.

Following the inspection, the service provided examples of recent patient safety alerts and safeguarding communications in relation to discharge. For example, there was information on roles and responsibilities around discharge. Discussions with staff confirmed they understood the importance of safe and timely discharge and whilst we did not see evidence of a discharge checklist being used, staff could tell us the checks they undertook and the reasons for them.

Whilst we had some assurance the service had taken steps to improve systems and processes in place to mitigate for failed discharges in the form of a discharge checklist, we were not assured staff always used them effectively.

Systems were in place to support staff in starting the discharge process as early as possible. Senior managers told us there was a strong focus within the hospital to start the discharge process early through a multidisciplinary approach. During our inspection we saw effective multidisciplinary meetings were held to discuss and plan the discharge of patients with complex health and social care needs. Staff told us these meetings occurred daily. We saw the meetings were attended by medical, nursing, therapy and discharge team staff members who all contributed to the decisions making process.

A complex discharge team offered further support in planning the discharge process for patients with additional support needs. This included patients whose care was transferring to another service. For less complex patients, doctors and nurses discussed patient's medical fitness to be discharged on daily ward rounds. We saw nursing staff appropriately challenged medical staff where discharge needs of a patient had not been met before a decision to discharge had been made.

Nursing staff we spoke to across all wards we visited were aware of the requirement to begin the discharge process early. Nursing staff were able to describe the areas which impacted on delayed discharges. For examples, we were told take home medicines sometimes delayed discharges. Nursing staff told us they mitigated this by submitting requests for medicines to pharmacy as early as possible to avoid delays

We did not always see evidence of a structured approach to discharge planning. Assessment documentation did not demonstrate a patient's full health and social care history, and needs had been obtained. We reviewed 21 records and

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found the social circumstances section of the admission paperwork either not completed or only partially. This meant that staff did not have a full picture of the patients individual needs to support personalised and effective discharge planning. Furthermore, we did not see evidence that discussions had always taken place with family and carers. Evidence of discussion with family/carers regarding discharge was found in only two out of 21 records we reviewed.

Where patients were not ready for discharge, we did not see evidence that discharge planning had commenced in a structured way as part of the admission documentation. However, we did find evidence of staff referring patients with more complex needs for assessment to aid discharge planning. We found referrals had been made to:

- Physiotherapist and occupational therapists.

- OPAL (Older Patients Assessment Liaison) service to support effective discharge planning. We saw evidence of patients being assessed by the OPAL team.

- Dementia nurses and we saw evidence of assessments being completed to support the care/treatment provided whilst in hospital and upon discharge.

- Transfer of care referral if social care needs require assessment for discharge planning.

Managers and staff worked to make sure patients did not stay longer than they needed to. Some wards had discharge coordinators to support nurses with planning the discharge process such as arranging transport, care packages or referrals to community services. All patients were reviewed by a consultant before the decision to discharge was made. Doctors completed a discharge summary and any prescriptions for medicines required to take home. Staff told us there were sometimes delays with pharmacy but there was a live pharmacy tracker and they could see where the medicines were ready.

Staff told us there was a pressure to discharge patients to maintain flow in the hospital, however, this was appropriate to the needs of the service and patients. All staff we spoke to felt comfortable escalating concerns if they felt the discharge was inappropriate or unsafe.

Senior managers told us they have worked with the local system to create wider accessibility to local beds. This meant that patients awaiting social care packages could be referred to care homes to reduce delayed discharges where social issues were impacting on discharge. Managers told us they have also improved communication channels with social care providers so that any issues could be escalated.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. Systems were in place to review stranded and super stranded patients. Stranded and super stranded patients were those who were medically fit yet had been in hospital more than seven and 21 days respectively. Flow co-ordinators and ward managers regularly reviewed patients to see what the barriers to discharge were. Length of stay multidisciplinary meetings were held twice daily and quality improvement work had been undertaken to improve the ward round process to include a discharge focus. Reasons for delayed discharges commonly included waiting for social care packages or residential care placements.

Delayed Transfer of Care (DToC) meetings took place daily, attended by senior practitioners, clinical leads and administrative staff to discuss delays and blockages with discharges to other care providers. This process supported staff to resolve issues where there were blockages to discharge. Weekly meetings took place with trust executives where staff could escalate any concerns with complex discharges.

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Is the service well-led?

Inspected but not rated ⬤

Culture

Staff generally felt respected, supported and valued. They were focused on the needs of patients receiving care. However, some staff on wards where there had been significant changes did not feel supported by senior managers.

We found the culture was centred on the needs and experience of people who use services. During our inspection, most staff we spoke to told us team working was what they liked most about where they worked. We observed some positive interactions between staff of different roles such as medical, nursing and therapy staff. This included effective multidisciplinary meetings which demonstrated a strong focus on the needs of the patient. We noted some particularly good team working on ward 30 which was a care of the elderly ward. Medical and nursing staff were complimentary of each other.

Staff generally spoke highly of their immediate managers and described being able to escalate concerns and felt supported to do so. Whilst staff described experiencing significant pressures due to staffing levels and the pandemic, almost all staff we spoke to described being motivated by providing an excellent service to patients. Staff told us 'I love my job' and were driven by doing the best they can for their patients.

There were mixed responses about the communication and support from senior leaders. Some staff felt very well supported by matrons and more senior leaders whereas other staff told us they did not see managers other than their ward manager. Some staff told us there had been changes in matrons which had led to uncertainty and others, that matrons supported them clinically when required.

During our inspection, staff on ward 20 told us they had undergone a significant change. The ward had been affected by the merging of medical care wards from Solihull hospital. Staff had transferred to Heartlands from Solihull and felt there was a lack of visibility and support from senior managers. Staff did not feel included in the change process and felt it impacted their morale.

Senior managers acknowledged they did not follow normal change management processes as ward merges had to be completed quickly due to system wide changes as a result of COVID-19. Following the inspection, we shared some of the concerns with managers who provided some assurance about actions they had taken to support staff with the changes as follows:

- Staff engagement and listening sessions to provide staff with a rationale for changes and hear their concerns and anxieties.
- Consultation sessions were held with staff. A designated human resource staff member was available for support.
- Staff were given an opportunity to move and if they did not feel it was right for them, they were given an opportunity to go back. Managers told us some staff who moved from a specialist area to general medicine felt deskilled. Staff were also given an opportunity to stay with their speciality.

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- A training needs analysis was completed across the services. Clinical education teams were based on the ward to support staff with new skills and competencies such as cannulation.

- Recruited an additional matron from 8am to 8pm to provide more out of hours cover.

In contrast to ward 20, we visited ward two which had undergone a similar change. Staff acknowledged they initially found the changes challenging which impacted morale but at the time of the inspection felt they worked together as a team very well. They generally felt listened to and supported by management. We were told the trust had invested in a psychologist who was available to support staff through the COVID-19 pandemic and change process.

Staff were encouraged to report incidents and we saw an open culture where most staff felt able to raise concerns without fear of retribution. Most staff we spoke to told us they felt there was an open culture where reporting incidents was encouraged and supported. Staff described how they had been supported to improve when they had done something wrong. Managers told us they wanted to get the best out of staff and described using tools such as reflective accounts to help staff to learn from incidents. This was reflected in staff accounts of how managers had responded to incidents that had occurred where there was learning identified.

Governance

Governance structures were in place; however, they were not always effective throughout the service. Staff at all levels were clear about their roles and accountabilities, however, not all staff had regular opportunities to meet, discuss and learn from the performance of the service.

Following our inspection, we met virtually with senior managers who told us they have adapted their normal governance structures in response to the COVID-19 pandemic. Normal structures for governance meetings have changed format to virtual meetings where possible. Managers told us they have continued with quality and governance processes and used information technology to share information with staff such as sharing through the use of the intranet and email. Following the inspection, the trust sent us information which demonstrated key patient safety messages which related to key concerns which triggered our inspection including discharge and Venous Thrombosis Embolism (VTE) assessment had been shared with staff. During the inspection, we found some wards had this information on staff notice boards.

Senior managers recognised that there was a gap in dissemination of information from board to ward as many ward-based meetings had been suspended due to pressures of the pandemic and social distancing. During the inspection we found that staff meetings were not consistently held on wards and where they were held, there was no fixed agenda relating to governance. Senior managers acknowledged this left a gap in sharing of information consistently.

We reviewed ward meeting documents sent to us following the inspection and did not see a clear and consistent approach to meetings across the medical division. Wards set the meeting agenda according to issues of current concern and did not routinely include incidents, risk or performance. Some wards used a 'shift expectation' approach to sharing information at shift handover, others noted discussions on handwritten documents.

During the inspection we found sharing of learning was generally localised to the ward. We saw limited learning from directorate or trust wide serious incidents or never events. During the inspection, staff were unable to tell us about recent serious incidents or never events that occurred on other wards or across the trust. Staff told us they could access information on the trust intranet and through email but rarely had the time to do this or read information.

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Most staff we spoke to were clear about their roles and who they were accountable to. However, some staff had experienced recent changes in wards and managers and had not yet got to know them. The service had introduced a sister meeting during the pandemic which met on a regular basis. The purpose of the meeting was to discuss performance and safety issues. During our inspection, staff we spoke to were unable to tell us about performance and safety incidents which occurred outside of their ward, we were therefore not assured this meeting was yet effective in sharing cross directorate information with staff.

In summary the service did have governance systems in place; however, we were not assured there was a consistent approach to ensuring all staff from board to ward had access to relevant information relating to incidents, risk and performance.

Management of risk, issues and performance

Leaders and teams generally used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The service had systems and processes in place to monitor performance and risk issues. Following our inspection, we requested audit information in relation to concerns we identified during the inspection in relation to Venous Thrombosis Embolism (VTE) risks. We found the service undertook audits to provide an overview of performance against specific measures related to VTE best practice and local snapshot VTE prophylaxis audits to identify trends in prescribing. In response to these audits the service told us training sessions had been undertaken with medical staff to improve performance and practice. The VTE lead nurse facilitated regular VTE prevention sessions across the trust sites. Sessions focused on the importance of VTE prevention in terms of using the department of health VTE assessment tool correctly. An update of the latest clinical guideline on VTE management was given along with learning lessons from VTE-related incidents.

The trust had also identified VTE prevention and management as a key priority area for quality improvement, focusing on VTE risk assessment, prevention, pausing and restarting anticoagulants. A new joint thrombosis committee had also been established in October 2020. The purpose of the group was to develop and oversee the implementation of interventions for the prevention of hospital associated VTE within the trust and to ensure that national guidelines and recommendations on best practice were followed.

During the inspection we saw key messages to staff relating to VTE were on staff notice boards. For example, on ward one we saw a poster on the notice board reminding staff about VTE responsibilities for different roles.

VTE risk, compliance and hospital acquired thrombosis was monitored by the clinical quality monitoring group. The group received regular reports on performance, incidents and signed off actions to improve where required.

Areas for improvement

The provider MUST ensure that:

- The provider must ensure that Venous Thrombosis Embolism (VTE) risk assessments are completed and recorded for all patients in line with guidance and prophylaxis is prescribed where indicated. Regulation 12 Safe care and treatment (1) (2).

The provider SHOULD ensure that:

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- The provider should ensure all staff are wearing Personal Protective Equipment (PPE) such as face masks and face shield in line with policy and national guidance. Regulation 12 Safe care and treatment (2)(h).

- The provider should ensure all clinical areas are adequately staffed to ensure safe patient care. Regulation 18 Staffing (1).

- The provider should ensure staff act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice; where a person lacks mental capacity to make an informed decision or give consent about decisions in relation to resuscitation. Regulation 11 Need for consent (3).

- The provider should consider implementing a consistent approach to ward-based team meeting content and documentation.

- The provider should ensure all patients receive an assessment of their risk of malnutrition and where indicated nutritional and fluid monitoring is consistently completed. Regulation 12 Safe care and treatment (2) (a)(b).

- The provider should ensure staff are documenting that discharge planning is taking place and discharge checklists are used to ensure a safe discharge. Regulation 12 Safe care and treatment (2) (a)(b).

- The provider should consider reviewing its process for sharing trust wide learning from incidents so that all staff receive this information in a consistent way.

Our inspection team

The inspection was carried out by two CQC inspectors and one specialist advisor.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment