

# University Hospitals Coventry and Warwickshire NHS Trust

## University Hospital Coventry










### Quality Report

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Date of inspection visit: 10–13 March 2015  
Date of publication: 06/08/2015

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

### Ratings

Overall rating for this hospital	Requires improvement	
Urgent and emergency services	Requires improvement	
Medical care	Requires improvement	
Surgery	Requires improvement	
Critical care	Requires improvement	
Maternity and gynaecology	Good	
Services for children and young people	Requires improvement	
End of life care	Requires improvement	
Outpatients and diagnostic imaging	Requires improvement	

# Summary of findings

## Letter from the Chief Inspector of Hospitals

University Hospitals Coventry and Warwickshire NHS Trust is one of the UK's largest trusts and serves a population of about 1,000,000 across Coventry, Warwickshire and beyond. Inpatient services are provided from two hospital sites, University Hospital Coventry (the main site) and Hospital of St Cross, Rugby. In total, the trust has 1,250 beds and provides both elective and emergency care. A major trauma centre, University Hospital Coventry specialises in cardiology, neurosurgery, stroke, joint replacements, in vitro fertilisation (IVF) and maternal health, diabetes, cancer care and kidney transplants.

We carried out this inspection as part of our comprehensive inspection programme between 10 and 13 March 2015.

Overall, we rated University Hospital Coventry as 'requires improvement'. We have judged the service as 'good' for caring. We found that services were provided by dedicated, caring staff. Patients were treated with dignity and respect and were provided with appropriate emotional support. However, improvements were needed to ensure that services were safe, effective, responsive to people's needs and well-led.

Our key findings were as follows:

### Cleanliness and infection control

- Patients in children's services, the emergency department (ED) and maternity received care in a clean, hygienic and suitably maintained environment. Staff were aware of and applied infection prevention and control guidelines.
- We observed good practices in relation to hand hygiene and 'bare below the elbow' guidance and the appropriate use of personal protective equipment, such as gloves and aprons, while delivering care in children's services, the ED and maternity. These practices were not so well embedded in the critical care, medical and surgery departments, where examples of poor infection control practice were observed.
- There was a pre-admission service within the outpatients department; however, no preoperative MRSA screening was undertaken during this consultation. Screening was done by the preoperative nurse, who only saw those patients who were a higher anaesthetic or operative risk, for example, patients with co-existing morbidities. Women were also not routinely screened for MRSA before elective caesarean section in maternity. This meant that not all patients undergoing elective surgery were screened preoperatively. Screening has been a Department of Health recommendation since 2007.
- Examples of poor infection control practices were observed in the radiology department. These included:
  - Poor hand hygiene with staff not washing hands between touching patients, bedpans and clean linen.
  - No robust training in scrub skills for nurses to support advanced interventional procedures. The nurses confirmed that although they had 'on the job' training, they were not aware of any advanced scrub practitioners from the operating department auditing or supervising the radiology staff's scrub skills. This meant that there was no assurance that best practice with regards to infection control was being complied with and could have increased the risk of patients being exposed to an infection.
  - No robust procedure for identifying and isolating patients who attended the department who had a known infection that could contaminate other patients.
  - The bed wait area in CT and MRI was just large enough for three beds, separated by curtains. Again this was an infection control risk for patients who were in such close contact with another patient.

### Records

- The standard of record completion varied across the services. In emergency services, critical care, surgical, neonatal and maternity services, we found that medical and nursing notes were structured, legible, complete and up to date.
- On the medical wards we found gaps in the completion of records relating to sepsis recognition, venous thromboembolism assessments, fluid balance charts, comfort rounds and individualised care plans.

# Summary of findings

- Records in most departments were stored securely in line with requirements. However, on some medical wards we found records to be easily accessible to others visiting. For example, on one ward, we saw that five sets of care records were left on a table in one of the bays, instead of being kept in a secure area.
- 44% (13 out of 29) of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms were incorrectly completed or had information missing. Incomplete or incorrect DNA CPR forms can lead to patients being subjected to attempts to resuscitate them when this is not appropriate or in line with their wishes.

## Staffing levels

- The trust used the nationally recognised Safer Nursing Care Tool along with National Institute for Health and Care Excellence (NICE) guidance to assess required nursing staff levels.
- Vacancy rates, staff turnover and sickness were audited monthly. Daily checks were completed across all areas to check staffing requirements and availability against gaps in the rota. Vacant shifts were offered to bank or agency staff.
- All staff we spoke with, from the management team to healthcare assistants, recognised nursing recruitment as a major safety risk to the service. It was captured on the directorate risk register. Vacancy rates across the core services ranged from 13% in the surgical teams to 17% in the Cardiac Critical Care Unit (CCCU).
- The trust told us they were currently undertaking significant investment in attracting the right nursing staff to its hospitals and becoming an employer of choice. A rolling recruitment programme was ongoing with advertising websites, local media and universities. Plans were also in place to widen the recruitment drive internationally. All ward-based staff were aware of these initiatives and supported them. There was general agreement that recruitment and retention of nursing staff were seen as a priorities by the trust.
- We spoke with two medical students, who told us, "It's a really positive experience working here. We get high-quality training and are integrated into the team."
- In the ED, consultants were available and visible, and junior medical and nursing staff confirmed that this was usual.
- There was appropriate consultant obstetric cover on the labour ward weekly. This was consistently reported as 96 direct cover hours. The maternity service staffing levels for obstetric anaesthetists and their assistants were in line with Safer Childbirth (RCOG, 2007) recommendations.
- Care and treatment within the CCCU were led by consultant cardiac surgeons with support and advice, when required, from intensive care consultants. However, the arrangements for senior medical cover did not meet the requirements of core standards in intensive care.

## Mortality rates

- Our 'Intelligent Monitoring' report of December 2014 showed that there was no evidence of risk for summary hospital mortality level indicators or for hospital standardised mortality ratio indicators. However, there was risk in: in-hospital mortality associated with dermatological conditions and trauma and orthopaedic procedures and conditions, and elevated risk for nephrological conditions.

## Incidents

- The trust used a centralised web-based reporting system for staff to report incidents and near-misses. Staff who we spoke with during our visit included newly appointed junior staff who confirmed they knew how to use the system to report incidents.
- The trust's attitude to the reporting of incidents was one of learning. Staff were encouraged to report incidents in the hope that lessons could be learned and further incidents prevented. This led to a high volume of incidents being recorded.
- Staff in the GP assessment unit said that, although they were aware of the incident reporting system, they did not feel confident in completing incident reports because they felt that "nothing gets done".

# Summary of findings

- The trust told us each incident was managed through the trust's significant incident group, which met on a weekly basis to review all serious incidents, monitor ongoing investigations and approve investigation reports. Trust root cause analysis leads were appointed to manage the investigations and actions were assigned to address the issues.
- Mortality and morbidity reviews were undertaken and discussed at the quality improvement and patient safety meetings. Minutes of meetings we reviewed showed that, when needed, actions were taken to improve practice.

## Nutrition and hydration

- The trust had a rotational menu offering a wide variety of hot and cold choices and cultural needs were catered for: menu sheets took account of cultural and dietary requirements.
- Patients with specialist needs in relation to eating and drinking were supported by dieticians and by the speech and language therapy team. Red tray liners were used to help staff identify those patients who required support.
- The patient records we reviewed included an assessment of patients' nutritional requirements based on the malnutrition universal screening tool (MUST). We observed on the medical wards that fluid balance charts were used to monitor patients' hydration status. However, the records seen on two wards did not include the totals for ease of information for staff reviewing details on the MUST.
- The trust used national guidance for parenteral and enteral nutrition. Policies were in place to help patients who were unable to take oral nutrition or fluids to be given specialist feeds until they could be seen by a dietician. Patient records we looked at confirmed that these policies were in use. This meant that patients were protected against the risk of malnourishment.
- We noted that drinks and sandwich packs were available to patients in the ED. Patients admitted to the observation ward were provided with a full meal service in line with other ward areas within the trust. We saw patients waiting on trolleys in corridors in adult majors being offered drinks.
- As well as mandatory training, catering staff received annual training from the dieticians.

## Medicines management

- The systems in place for the management and storage of drugs, including controlled drugs and oxygen, were inconsistent throughout the trust. In children's and young people's services, outpatients, critical care, medical services and the ED, drugs were stored and maintained in line with regulations.
- In maternity we saw that community midwives were carrying medication without proper storage facilities, and that epidural drugs were overstocked and had been stored not only in an 'epidural-only cupboard' but also in a neighbouring cupboard.
- There were particular medicines management issues in the surgery wards and theatres, where we saw a drugs cabinet in one theatre had been forced open and could not be secured. This cabinet had been taken out of use. We saw packs of medication, which should have been in drugs cabinets, left out in theatres because there was insufficient space in the cabinets for the quantities to be stored. We asked a member of staff how they would know if drugs had gone missing because the area was unattended during operating procedures; they told us there would be no way to tell if stock had been taken. We also observed out-of-date intravenous fluids ready for use, and oxygen cylinders attached to anaesthetic trolleys that were out of date.
- On the surgical wards we also found some patients who were in pain and had not been given their prescribed drugs when they needed them. Staff reported having been unable to give a diabetic patient insulin because the drug was not available.
- Anticipatory prescribing in end of life care was common, in line with best practice. This meant that pain relief and other medication could be started quickly if patients became unwell.
- In the critical care unit we observed that intravenous fluid bags were used for preparing intravenous injection/infusions for more than one patient and used for up to 24 hours. This process had not been risk assessed and no

# Summary of findings

protocol was available. There was a risk that the bags could be contaminated by poor infection control practices, or maliciously while left unattended on trolleys on the units. This practice was escalated to the trust executive team during the inspection and we were assured that this practice had stopped and would not recommence until there were suitable and appropriate assurances in place.

We saw several areas of outstanding practice including:

- Outstanding practice in respect of trauma care: for example, the fracture patient pathway that encompassed effective pain management, and integrated daily and weekend physiotherapy sessions to develop improved outcomes for patients.
- The trust was working to improve the experience of older patients. Initiatives included blue pillowcases for patients with dementia, the screening of all patients aged 75 and over for dementia and the development of a 'care bundle'.
- The trust was using the 'M' technique as a means of holistic communication by touching the hands and feet of older people. It included the repetition of stroking and conventional massage through slow, constant and rhythmical pressure.
- The head of midwifery had won the Healthcare Hero and Lifetime Achievement Award 2013/14 at the Coventry Telegraph's Pride of Coventry and Warwickshire Community Awards ceremony.
- The specialist bereavement midwife had received the National Maternity Support Foundation Award for Bereavement Care at the Royal College of Midwives Annual Midwifery Awards 2015. They had provided sensitive photographs for parents who had lost their baby in late pregnancy or soon after birth.
- The trust had a well-developed research programme and good links with local universities. There were excellent multidisciplinary education facilities that we observed being well used

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

## **Importantly, the trust MUST:**

- The trust must improve the ability of the emergency department to consistently respond safely to the demands placed on it and to respond to patient needs in a timely way once they have arrived at the hospital and in a way that promotes patients' privacy and dignity.
- The trust must ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance, including Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training.
- The trust must ensure all staff have a clear understanding of Mental Capacity Act 2005 and deprivation of liberties as they apply in practice to the service provided.
- The trust must review and reinforce staff knowledge of the 'Assessing mental health in ED' policy in order to better support staff to protect the rights of patients when any restraint power is used.
- Review medicines management within the medical division to ensure that controlled medicines are stored securely.
- The trust must ensure the practice of multi-use administration of intravenous infusions is stopped until assurance can be made that it is safe and appropriate practice.
- The trust should ensure that people who use services and others are protected against the risks associated with the unsafe management and storage of medicines. The trust should ensure that there is a system in place to prevent medicines of different patients being confused and/or ensure that patients receive or have access to all their medication when it was required.
- The trust should implement robust processes in place to ensure that intravenous fluid expiry dates were checked to ensure that they were within date prior to be administered.
- Ensure all patients attending for elective operations, including caesarean section, are routinely screened for MRSA before surgery.
- Ensure that its systems to review equipment and audit compliance are effective so far as they relate to checking resuscitation equipment and medical gases.

# Summary of findings

- Ensure there is a robust policy for transporting patients with an infection or who may be at risk of acquiring an infection in the hospital, so that staff are aware that special precautions need to be put in place to protect the patient and the public.
- The trust should ensure that 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms are completed accurately.

## Action the trust SHOULD take to improve:

- The trust should manage the expectations of the ambulance services in respect of corridor nurse assessment and care while they are queuing for clinical handover with patients.
- The trust should adopt a more effective approach to keeping patients informed while they are waiting in the emergency department.
- Should take suitable arrangements are in place to respond appropriately to any allegation of abuse in order to safeguard service users against the risk of abuse and that safeguarding concerns are reported to the local safeguarding authority in line with best practice requirements.
- Should ensure consistency in the use of the World Health Organization (WHO) surgical safety checklist, including standardising practice in posting identification of patients and procedures within theatres. This is something that is required as part of regulation 9(1)(b)(ii) and (iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. (ii) Planning the delivery of care and where appropriate treatment in such a way as to ensure the welfare and safety of the service user and (iii) to reflect published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice. However it was considered that it would not be proportionate for the finding to result in a judgement of a breach of the Regulation overall at the location.
- Ensure that planning of care reflects all the needs of the patient, including any comorbidities or pre-existing issues. This is something that is required as part of regulation 9(1)(b)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. (ii) Planning the delivery of care and where appropriate treatment in such a way as to ensure the welfare and safety of the service user. However it was considered that it would not be proportionate for the finding to result in a judgement of a breach of the Regulation overall at the location.
- Review the admission process for the GP Assessment Unit to ensure that patients are appropriately referred to the service.
- Ensure that the access and flow of medical patients are improved, and delayed patient discharges managed appropriately.
- CCCU should contribute data to the Intensive Care National Audit & Research Centre (ICNARC), to ensure that comparisons and assurances could be made that the unit performed favourably with other critical care units.
- Improve arrangements for the handover between the critical care outreach team and the hospital at night team to ensure that deteriorating patients receive safe care.
- The number of practice development nurses should be increased to reflect core standards for intensive care units.
- Medical staffing in the cardiac critical care unit should meet the requirements of the intensive care core standards.
- Ensure all outpatient staff complete their mandatory training.
- Review discharge procedures for both rapid discharge, (in particular to Warwickshire) and routine discharge procedures for palliative care patients in the last year of life.
- Consider clearly defining medical and nursing management roles in the supportive and specialist palliative care service.
- The trust should support staff and develop their skills in promoting and creating personalised care plans for end of life care based on the individual preferences of patients and their families.
- Ensure that doctors (outside of the palliative care team) feel confident in discussing end of life care and DNA CPR decisions with patients.
- Consider how the waiting areas, particularly for radiology 'bed' areas could be used more appropriately.
- Consider the need for a more suitable waiting area for ambulatory patients whilst awaiting a CT/MRI.
- Plan caesarean section lists before the day of operation whenever possible.

# Summary of findings

- Ensure that staff carry out and document assessments of patients' needs so that the planning and delivery of care meet those needs.
- Ensure that there is handover of 'bed' patients to staff when they arrive from the ward into the radiology department.
- Ensure there is a process in place so that vulnerable patients waiting for imaging are cared for as their needs dictate and this is recorded.
- Ensure the nurses in imaging receive adequate scrub training from someone qualified to do so and that it is maintained.
- Ensure all staff complete their mandatory training, particularly child safeguarding training, level 3 in the ED. Ensure that community midwives receive regular and formal safeguarding supervision.
- Ensure that fluid scores are completed and recorded appropriately so that patients who are at risk of dehydration are correctly escalated.
- Provide information leaflets and signs in other languages and easy-read formats.
- Develop robust processes to meet the estimated discharge dates.
- Ensure they have robust arrangements in place to meet referral-to-treatment times.
- Make sure that learning from incidents is shared across all staff groups.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**



# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

Requires improvement

### Rating



### Why have we given this rating?

The trust had responded well to an increase in demand within the paediatric emergency department (ED), but there was no effective strategy for the needs of a growing elderly population. Access to services and patient flow through the ED to wards in the hospital were poor and patients experienced long waits in the majors area, including on trolleys in corridors. The waiting time for minor injuries had been reduced but services were not planned effectively in conjunction with other local services such as GP services. Arrangements were good for supporting individual needs, such as patients with mental health conditions, and the paediatric ED had its own entrance and waiting area. Patients and relatives were encouraged to submit any comments and complaints about the service so the trust could learn from them.

The trust's vision and strategy for the ED did not improve the department's ability to cope with the daily demands placed on it and the department frequently became overcrowded. The risks created by overcrowding were dealt with by the department, which could not influence the wider organisational issues. Nurses and doctors were managing on a shift-by-shift basis, keeping patients safe using the monitoring systems put in place by the trust, but the wider organisational issues were not being addressed. The ED operated in an open, friendly and inclusive manner. Staff were proud of their ability to keep patients safe in overcrowded conditions. The leadership of the shift and team was good and staff at all levels were keen to learn from complaints, incidents or errors.

### Medical care

Requires improvement



Patients were positive about the care and treatment they had received from the trust. We observed that patients were treated with compassion and kindness by dedicated, professional staff.



# Summary of findings

When patients were infectious or were suspected of having an infection, practices and procedures did not always protect against the risk of the spread of infection.

The storage of controlled drugs, which need extra security storage arrangements, did not always ensure that they were stored following good practice in NHS hospitals.

We found variable record keeping with regard to people's care planning and observations. Patients said they were kept informed and felt involved in the treatment they received. Discharge arrangements for medical patients needed to be better organised, and many patients were being discharged later in the day than planned, however the trust had implemented several initiatives to improve patient flow

The arrangements for identifying and managing risks were not robust. Poor recording of care plans and concerns about the management of medicines had not been identified by any audits undertaken by the trust.

## Surgery

### Requires improvement



Overall, we found that the service required improvement. Sustained capacity issues over prolonged periods had led to excessive numbers of cancelled procedures. Staff had come to expect cancellations as normal and accepted practice. A degree of complacency existed where issues had been identified and escalated, and interventions applied, but with little or no improvement seen. We saw that 'Never Events' were properly investigated and information from them was shared both within individual departments and also across the division and the trust as a whole. However, the learning from them was not always embedded in practice. Interpretation of theatre practice, such as the completion of whiteboards and instrument counts, were not consistent in all areas, and there was therefore the potential for further incidents. We found breakdowns in communication and liaison between surgical and medical services. The services worked in isolation, which meant that patients did not always receive a holistic approach to their care and could be left without medication or appropriate treatment.

# Summary of findings

## Critical care

### Requires improvement



The critical care units were clean and there were mostly appropriate systems in place to minimise the risk of cross-infection, although further improvement could be made. The availability and use of equipment was found to be appropriate. There were appropriate arrangements for the safe administration and storage of medicines. A need to review the practice of multi-use administration of intravenous infusions to ensure that patients were protected from potential harm was identified and was being addressed by the trust. Critical care services were obtaining good results for patients and treatment was based on national guidelines. The hospital had seven-day working and effective multidisciplinary working, which positively affected patient care and recovery. Critical care staff were caring and compassionate.

## Maternity and gynaecology

### Good



Overall, we found the service to be good, but with the 'safe' domain requiring improvement. Ward storage of medication, handling of medication by community midwives, checking of resuscitation equipment on the labour ward, and elements of infection control and prevention practice were found to be in need of improvement. Women we spoke with were mostly happy with the care they had received, and we heard staff offering compassionate care and clear explanations. Ward staff told us they felt well informed about the trust, and that they regularly met and spoke with senior management. Community staff had recently been based at the hospital to improve their integration with hospital staff and management.

## Services for children and young people

### Requires improvement



There was an incident reporting system in place. A trend of medication errors had been identified, and actions had been taken to raise awareness and facilitate learning. However we found learning was not demonstrated from a previous medication error relating to the administration of out-of-date intravenous fluids. During our inspection we found intravenous fluids available for use that were past their expiry date. The records for the resuscitation trolley in the transitional care unit did not demonstrate that they

# Summary of findings

had been checked on a daily basis. If not checked, there was a risk that, if it was needed in an emergency, the equipment may be incomplete or out of date.

Children and young people's needs were assessed appropriately, and care and treatment was planned and delivered in line with current standards and evidenced-based guidance.

There was an effective system in place for young people to be supported in their transition from children's to adult services.

Staff were kind, and had a caring, compassionate attitude, and built positive relationships with children, young people and their families.

Children were seen in purpose-built environments, which included their own designated children's emergency department.

## End of life care

### Requires improvement



End of life patients were not always able to be in their preferred place of care because the discharge planning process was not fully effective. We reviewed 29 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms in patient records and found 13 had errors or information missing. We found 12 DNA CPR forms where doctors had identified patients as lacking capacity but who had not had a Mental Capacity Act assessment form completed. Doctors were reluctant to discuss end of life care and DNA CPR decisions with patients. Leadership roles within both medicine and nursing in the specialist palliative care and support service were not clearly defined. Interpersonal issues between staff and reports of bullying were affecting the effectiveness of the multidisciplinary team.

## Outpatients and diagnostic imaging

### Requires improvement



Although overall the hospital was clean, bright and tidy, we were not assured that there were practices to ensure that infection was controlled when moving patients around the hospital. There was no robust system for screening patients for Methicillin Resistant Staphylococcus Aureus. (MRSA). We saw some poor compliance with hand washing in the radiology department. Scrub practices within the radiology department were not aligned to best practice to ensure patients were protected from a hospital-acquired infection.

# Summary of findings

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Most staff had attended mandatory training. However, no outpatient staff had attended safeguarding training. Medicines were stored and administered safely.

Many patients complained to us about waiting times in outpatient clinics.

We saw evidence of kind, compassionate care, despite less than ideal circumstances, in radiology, where activity had outgrown the department. Staff were reporting incidents, and these were discussed at the clinical governance meetings within the directorates.

The trust had met its national targets and consistently performed higher than the national average with regard to radiology waiting times. There had been a backlog in reporting results from investigations for several months, but there was evidence at the visit that these were being resolved. The hospital was undergoing a management reorganisation. However, the reporting structure was unclear, and even some of the more senior staff were unsure of who their line manager was.

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# University Hospital Coventry

## Detailed findings

### Services we looked at

<Delete services if not inspected> Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

# Detailed findings

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## Background to University Hospital Coventry

University Hospitals Coventry and Warwickshire NHS Trust is one of the UK's largest trusts and serves a

population of about 1,000,000 across Coventry, Warwickshire and beyond. Inpatient services are provided from two hospital sites, University Hospital Coventry (the main site) and Hospital of St Cross, Rugby.

## Our inspection team

Our inspection team was led by: Chair: Peter Turkington, Medical Director, Salford Royal NHS Foundation Trust

Head of Hospital Inspections: Helen Richardson, Care Quality Commission

The team included 12 CQC inspectors and a variety of specialists including junior doctors, medical consultants,

senior managers, child and adult safeguarding leads, trauma and orthopaedic nurses, paediatric nurses, an obstetrician, midwives, surgeons, an end of life care specialist and experts by experience who had experience of using services.

## How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before visiting, we reviewed a range of information we held about University Hospitals Coventry and Warwickshire NHS Trust and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning groups, the trust development authority, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

## Detailed findings

We held a listening event in Coventry in the week leading up to the inspection where people shared their views and experiences of services provided by University Hospitals Coventry and Warwickshire NHS Trust. Some people also shared their experiences by email or telephone.

We carried out this inspection as part of our comprehensive inspection programme. We undertook an announced inspection of University Hospital Coventry and the Hospital of St Cross, Rugby between 10 and 13 March 2015.

We also undertook an unannounced inspection to University Hospital Coventry on 19 March 2015

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, health visitors,

trainee doctors, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatients services.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at University Hospitals Coventry and Warwickshire NHS Trust.

## Facts and data about University Hospital Coventry

In total, the trust has 1,250 beds and provides both elective and emergency care. A major trauma centre,

University Hospital Coventry specialises in cardiology, neurosurgery, stroke, joint replacements, in vitro fertilisation (IVF) and maternal health, diabetes, cancer care and kidney transplants.

## Our ratings for this hospital

Our ratings for this hospital are:









# Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Inadequate	Not rated	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

## Notes

# Urgent and emergency services

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

## Information about the service

University Hospitals Coventry and Warwickshire (UHCW) NHS Trust is one of the largest in the UK and serves a population of 1,000,000 people from across Coventry, Warwickshire and beyond. It specialises in cardiology, neurosurgery, stroke, joint replacements, in vitro fertilisation (IVF) and maternal health, diabetes, cancer care and kidney transplants.

The trust provides services at the University Hospital Coventry and the Hospital of St Cross in Rugby, North Warwickshire. University Hospital Coventry provides both emergency and elective care and the Hospital of St Cross provides elective care.

The emergency department (ED) at University Hospital Coventry is a busy 24-hour, seven-day comprehensive emergency service with resident senior accident and emergency staff, providing trauma care, medical care and paediatric resuscitation.

The department has its own CT scanning facilities, decontamination facilities and on-site specialist opinion from all major specialties. The service includes:

- An ambulance triage unit for patients who are transferred by ambulance, which has two patient bays.
- Two walk-in purpose-built triage assessment rooms.
- A 24-hour dedicated children's ED with a separate entrance and waiting area.
- A dedicated five-bed resuscitation unit, with one paediatric resuscitation area.
- A REACT Team (social care) that provides intermediate care for patients with ongoing care needs.

- A 17-bed observation ward.
- A nurse-delivered see-and-treat minor injury service.
- Dedicated eye assessment rooms.
- A purpose-built specialist mental health assessment room, with two further specialist rooms on the ED observation ward.

The trust is a designated receiving hospital for major incidents requiring chemical, biological, radiological and nuclear (CBRN) decontamination.

There were 180,347 attendances between January 2014 and December 2014; approximately 20% of these were by children up to 16 years who attended through the children the ED.

We visited the ED at University Hospital Coventry over three weekdays, including a Thursday evening. We spoke with over 30 patients and their relatives, approximately 47 trust staff at different levels and in different roles including cleaners and consultants, and five ambulance service trust staff. We looked at records and observed how the ED functioned and how patients were managed and cared for. We tracked the care of ten adults and four children through the ED and hospital admission.

# Urgent and emergency services

## Summary of findings

We found ED services required improvement.

The staff within the department took no responsibility for patients arriving by ambulance while they were queuing to be 'handed over' to the hospital. There was no process in place between the trust and the ambulance service to as to how patients were being managed or assessment for risk of deterioration whilst waiting.

There were high levels of vacancies within the department resulting in high usage of temporary staff, although all shifts requiring temporary staff were filled.

There was an open culture about safety and we saw good examples of clearly embedded systems for keeping patients safe and minimising errors. The ED was clean and staff followed hygiene procedures.

We found ED services were effective. Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Patients' needs were assessed and reviewed when they had to wait for treatment, and they were offered food and drink and pain relief. Staff were qualified, had the skills to carry out their roles effectively and had access to the training and development they needed. This included staff in the paediatric ED. There were arrangements in place to protect patients' rights.

We found the ED services were caring, but could improve if the management of overcrowding was more effectively addressed by the trust. Staff at all levels and in all roles were kind and caring to patients and relatives and treated them with respect. Patient feedback about the way staff treated them was very positive. Although caring for patients on trolleys in corridors was not unusual in busy periods, staff worked hard to maintain patients' privacy and dignity. Patients were generally given good information when they first arrived, but the level of communication reduced the longer they waited in the department. There was good provision of emotional support for people who were mentally unwell and for bereaved parents of young children.

We found the responsiveness of the ED required improvement. The trust had responded well to an increase in demand within the paediatric ED, but there was no effective strategy for the needs of a growing elderly population. Access to services and patient flow through the ED to wards in the hospital was poor and patients experienced long waits in the majors area, including on trolleys in corridors. The waiting time for minor injuries had been reduced but services were not planned effectively in conjunction with other local services such as GP services. Arrangements were good for supporting individual needs, such as patients with mental health conditions, and the paediatric ED had its own entrance and waiting area. Patients and relatives were encouraged to submit any comments and complaints about the service so the trust could learn from them.

We found leadership of ED services required improvement. The trust's vision and strategy for the ED did not improve the department's ability to cope with the daily demands placed on it and the department frequently became overcrowded. The risks created by overcrowding were dealt with by the department, which could not influence the wider organisational issues. Nurses and doctors were managing on a shift-by-shift basis, keeping patients safe using the monitoring systems put in place by the trust, but the wider organisational issues were not being addressed. The ED operated in an open, friendly and inclusive manner. Staff were proud of their ability to keep patients safe in overcrowded conditions. The leadership of the shift and team was good and staff at all levels were keen to learn from complaints, incidents or errors. The trust encouraged ED patients to rate their experience through the NHS Friends and Family Test.

# Urgent and emergency services

## Are urgent and emergency services safe?

Requires improvement



We found emergency department (ED) services required improvement.

The staff within the department took no responsibility for patients arriving by ambulance while they were queuing to be 'handed over' to the hospital. There was no process in place between the trust and the ambulance service to as to how patients were being managed or assessment for risk of deterioration whilst waiting.

There were high levels of vacancies within the department resulting in high usage of temporary staff.

Mandatory Training was variable with some areas not having training completed to the levels required by the trust. There were systems and processes in place for child protection and vulnerable adult safeguarding, including mandatory staff training, and staff used these processes. Not all ED staff had undertaken safeguarding training to the recommended level, with only 53% of staff trained to level 3 for children's safeguarding.

There was an open culture about safety and reporting medication errors. Staff at all levels understood their responsibility to raise concerns and report incidents, and were supported to do so. Local leaders were confident that the trust's board was made aware of incidents.

Systems were in place within the ED to monitor and review activity levels. Staff including local leaders had access to current information on safety and were enabled to understand and evaluate risk.

There was a good track record in safety and we saw examples of how lessons learned led to improvements in practice.

There were clearly embedded systems for keeping patients safe and minimising errors and we saw good examples of these in record keeping, medicines management and in hygiene and infection control.

Staffing levels and skill mix were planned and adjusted to keep patients safe and handovers were effective.

Although the ED was frequently overcrowded and patient flow through the rest of the hospital was blocked, patients

who had passed through the ambulance handover point were monitored for signs of deterioration while they waited. Staff recognised and responded to changes in risk to patients.

The trust's board was assured in the annual report of 2013/14 of the EDs readiness to respond to a major incident and the ED had been involved in a major incident exercise in October 2014 that was set up by partner agencies.

### Incidents

- No pressure ulcers, falls or urinary tract infections were reported in the emergency department (ED) from July 2013 to July 2014.
- The adult ED reported seven serious incidents for January 2014 to December 2014. These included a hospital transfer issue, a delayed diagnosis, a communication issue, *Clostridium difficile* and healthcare-acquired infections, an unnecessary caesarean section, an unexpected deterioration in a patient's condition and a safeguarding issue.
- The trust told us each incident was managed through the trust's significant incident group, which met on a weekly basis to review all serious incidents, monitor ongoing investigations and approve investigation reports. Trust root cause analysis leads were appointed to manage the investigations and actions were assigned to address the issues. The ED consultant governance lead was a member of the significant incident group.
- We looked at the root cause analysis for one ED incident and noted an action plan and learning points, including improving the protocol for response and support from maternity services. Local leaders confirmed this work had been carried through to improve the service.
- The trust used a centralised web-based reporting system for staff to report incidents and near-misses. Staff who we spoke with during our visit included newly appointed junior staff who confirmed they knew how to use the system to report incidents.
- The trust told us incidents were discussed at ED board, quality improvement and patient safety (QIPS) meetings and staff meetings, which included discussing actions, outcomes and recommendations. A quarterly summary analysis of incidents and trends was reviewed at the specialty multidisciplinary QIPS meetings. Staff who we spoke with during our visit confirmed that this happened.

# Urgent and emergency services

- We saw noticeboards throughout the ED identifying the top two incidents and a recent innovation, the QIPS newsletter, which were both updated monthly.
- Local nursing leaders confirmed that the ED consultant governance lead worked closely with the clinical site manager to monitor trends. Staff were encouraged to fill in incident reports. However, one band 7 nurse said she had not completed an incident report in 15 years. The ED consultant governance lead said nursing staff were encouraged to come to him to report quality concerns or incidents and he would complete the incident form. Junior doctors could report concerns through their forum.
- Junior doctors and band 3 nurses who we spoke with in the ED confirmed there was an open culture to reporting concerns. Nurses said they got feedback when they reported an incident.
- The trust told us each incident submitted was reviewed and graded by the clinical nurse manager and lead consultant for governance, and they confirmed this when we spoke with them during our visit.
- The trust told us themes of inappropriate transfers and handovers emerged from incident reporting and there had been discussion and changes made to address these. The inter-hospital transfer issue and the communication issue cases were jointly investigated with the other hospital involved, with the support of the local commissioners; joint learning and actions were agreed.
- We observed recent learning from incidents.. Clinicians to use handheld devices such as an iPod touch to record inpatient observations (such as pulse, blood pressure and temperature) at the bedside. The system used the data input to calculate an early warning score (MEWS; a measure of risk) for each patient. This meant clinical staff could access patient observations from any computer, tablet PC or mobile device with access to the hospital network.
- The trust told us infection control nursing audits were undertaken monthly in the ED and on the observation ward.
- We noted during our visits that the ED was a clean environment in which to receive care. The design of the space and the surface materials enabled effective cleaning. With the exception of a large number of patient trolleys in the corridors in the majors unit, the department was free of clutter.
- Equipment, including patient trolleys, was clean and cubicles were cleaned and labelled as serviced by housekeeping staff after use. Cleaning staff we spoke with confirmed that the escalation process into 'Black Alert' when the ED was crowded included extra cleaning staff being deployed to the ED.
- We observed medical and nursing staff regularly cleansing their hands using the disinfectant gel that was provided in dispensers in multiple locations on the walls around the department.
- Personal protective clothing was available in wall dispensers around the department and we saw staff wearing it.
- All of the staff we saw during our inspection followed the trust policy and were bare below the elbow. Doctors wore short-sleeved shirts as uniform.

## Environment and equipment

- There was a five-bedded adult resuscitation area within the ED; each bed space was set up identically allowing staff to become familiar with their working environment. However this floor space in this area was cramped, which meant there was a risk of staff colliding with moving trolleys and each other when they were very busy. The trust had recognised this as an issue before our inspection and had plans for improvements.
- The trust told us there was sufficient equipment in the ED and staff had been trained in its use. The private finance initiative contract ensured that equipment was on a replacement life cycle and so was replaced and upgraded on a regular basis. Staff we spoke with during our visit confirmed this.
- Resuscitation equipment was checked daily within the ED and the GP assessment unit, in line with trust policy. We noted that cardiac arrest trolleys throughout the department were appropriately stocked with equipment, clean and regularly checked.
- There was a CT scanner located within the resuscitation department, minimising the need for patient transfer.

## Cleanliness, infection control and hygiene

- The trust shared with us its November 2014 performance dashboard before the inspection. This showed both the ED and observation ward were rated green in the red/amber/green (RAG) report for MRSA bacteraemia and Clostridium difficile.
- The ED had nominated link nurses and champions for infection control.

# Urgent and emergency services

- The trust told us the ED had a person working in materials management, who was responsible for ordering and streamlining stock, and identifying equipment that required servicing or repair.
- The trust had redesigned the designated mental health assessment rooms in the ED and the observation ward to provide a more appropriate environment for assessment. Alterations to the triage rooms had been made to minimise the risk to staff and patients, with appropriate entry and exits, alarms, furnishings and visibility.
- We noted there were two dedicated family/visitors rooms within the adult ED.
- We saw that the paediatric ED was a clean, bright and pleasant environment with its own entrance and reception area. Equipment was new, accessible to staff when they needed it and where relevant, in date.
- We noted an observation area and also a quiet family room for parents and family members to be with a deceased child and for speaking with families and breaking bad news.
- We observed on the first morning of our visit there was traffic queuing from the ED car park. At one point this delayed an ambulance blue-lighting a patient into the resuscitation suite. The trust had commissioned contractors to remodel part of the access area to the main entrance of the hospital and this was in progress during our visit.

## Medicines

- Controlled drugs were stored according to legal requirements and staff carried out twice-daily routine checks within the ED.
- When we visited the hospital we found there was a well-established pharmacy team within the trust who supported the safe use and management of medicines. The pharmacy team was actively involved in all aspects of a patient's individual medicine requirements.
- Any medicine errors were recorded directly on to the electronic incident reporting system. We were told by nursing and pharmacy staff that there was an open culture of reporting medicine errors. These were scrutinised and monitored by pharmacy and were discussed further at the Medicine Management Committee.
- We found the ED had a dedicated pharmacist and the trust pharmacist team carried out audits of drugs.
- The pharmacist audit for January 2015 found no level of risk of non-compliance for ED majors, but minors and resuscitation services were rated at an overall high risk.
- The majors areas of the ED used a storage system for drugs that automatically tracked drug usage and was accessed by fingerprint data. The clinical director told us that this had greatly reduced drug loss in the ED.

## Records

- The trust told us it had an electronic clinical result reporting system that was available where required in all clinical and non-clinical areas; all images and pathology results were available on this system.
- When physical notes were required there was an electronic note tracking system in place to assist traceability.
- We reviewed four sets of patient notes in the children's ED and found they were legible, demonstrated interventions such as observations and included treatment plans.

## Safeguarding

- The trust had systems and processes in place for child protection and vulnerable adult safeguarding, including mandatory staff training. We noted compliance for adult safeguarding at the time of our visit was at 84% for level 1 and 79% for level 2, against a target of 90%.
- We noted that although 98% of staff had received children's safeguarding training at level 2, only 53% were competent at level 3 therefore not meeting the intercollegiate guidance 2014.
- The trust told us that safeguarding children level 3 and adults level 2 were deemed mandatory and have been reported to the board as such since September 2014.
- However we noted the current version of the mandatory training policy had not been updated to reflect safeguarding children level 3 as a mandatory topic. This was rectified by the trust during our inspection.
- We saw there was an information child protection folder in the ED for staff to refer to.
- Nursing staff in the ED were aware of what to do if they had a safeguarding concern and of the policies and procedures in place.
- We saw in adult patients' notes that the need for a safeguarding referral to be considered was prompted and responded to by nursing staff.
- We spoke with the medical safeguarding lead, who was an ED consultant in paediatric emergency medicine.



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There was no paediatric liaison nurse in the ED to complete safeguarding referrals for children to health visitors and school nurses. These referrals were being completed by ED staff.

- We noted from looking at a sample of four care records in the paediatric ED that safeguarding consideration was not routinely documented if staff had no concerns about the child.
- The ED had an identified link nurse for domestic violence and adult safeguarding, who attended multi-agency forums and passed on information to staff in the department. The domestic violence pathway was available for all staff to consult on the trust intranet.
- Paediatric safeguarding alerts were discretely displayed within the ED patient management computer system, flagging children at risk to the staff on duty.
- All staff who we spoke with, including housekeeping staff and new starters, understood their responsibility to escalate any concerns they had about a child or vulnerable adult to senior staff.
- The trust told us staff new to the ED undertook safeguarding vulnerable adults training as part of the trust's induction programme and this was confirmed by new staff who we spoke with during our visit.
- The safeguarding vulnerable adults policy contained information relating to mental capacity, consent and DoLS. Information on how to contact independent mental capacity advocates was also in this policy.

## Mandatory training

- Trust data showed that within the emergency service department (trust-wide including the Rugby urgent care service) staff compliance with mandatory training was 87% at January 2015.
- There was 88% compliance with mandatory training across the acute medicine group for all staff (at December 2014), including the GP assessment unit.
- There was a dedicated nurse who delivered training and ensured that staff were up to date with mandatory training. Performance was reported monthly at the Quality Improvement and Patient Safety meeting.
- Trust data as of November 2014 showed the ED was red/amber/green (RAG) rated as green for uptake of the following training: hand hygiene 79%; mandatory CPR (registered nurses) 89%; mandatory CPR (healthcare support workers) 84%, and mandatory handling and moving 94%.

- The level of compliance was lower for the observation ward, which was RAG rated as amber for hand hygiene (65%) and handling and moving (70%). CPR training was rated as green for both registered nurses (86%) and healthcare support workers (86%).

## Assessing and responding to patient risk

- The trust scored better than other trusts for one question in the Care Quality Commission A&E survey 2014 regarding care handed over from ambulance crew to A&E staff. The other four questions all scored similar to other trusts. Themes included waiting for medical professionals, how clean the department was and if you ever felt threatened.
- There was no system of rapid early senior assessment of patients. The clinical director told us it had been tried but had not been considered worthwhile.
- There were nominated tissue viability link nurses for the ED.
- We observed a corridor queue of patients who were being managed by the hospital ambulance liaison officer and not by the trust's nursing staff. We saw that the roster indicated a supernumerary nurse on duty in the ED to manage patients waiting in corridors if necessary. However, reception staff and ambulance crews told us there was no 'corridor nurse' on duty on that morning despite ED majors being overcrowded.
- Patients were not being assessed by ED staff while they were waiting in the ambulance reception corridor with ambulance crew.
- Ambulance crews were staying with their patients, although they had been 'off loaded' and were technically the responsibility of the hospital, because they had not been 'handed over' to a clinician and were under no clinical supervision in the corridor.
- The clinical director told us that the hospital did not provide care and treatment to patients before the ambulance crew had handed them over to a clinician. This suggested some lack of clarity about expectations in this corridor.
- The trust developed an Over Capacity Operating Policy in January 2015 which outlined the approach to be used, and the standards of nursing and medical care that should be applied, to situations where the use of corridor areas is required. This did not include any reference to patients who were remaining in the care of ambulance staff.



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- We noted that this policy's starting point was triage of patients at the ambulance handover point. This meant that the trust was not taking responsibility for its patients who had arrived within the ED and were waiting in a queue for triage at the ambulance handover point.
- There was no process in place between the trust and the ambulance service to as to how patients were being managed or assessment for risk of deterioration whilst waiting.
- This document also does not make it clear, in the event of a patient being cared for in a corridor needing resuscitation before they were formally handed over, whether this responsibility would fall to the ambulance crew or the ED staff.
- The trust told us that it had an ED trigger sheet that was used to record each hour the number of patients in each area, along with patients who were being cared for outside of national standards (such as waiting for more than 15 minutes to be assessed, being cared for on a trolley for more than four hours).
- These triggers identified trends in the emergency medicine pathway that informed operational decision-making. An example of this related to the 15-minute ambulance handover trigger, where staffing levels are augmented to reflect expected activity. We noted during our visits that there was ongoing collection of 'real-time data' available to staff.
- We noted that patients waiting on trolleys and chairs in a corridor inside the majors area were receiving regular attention from nursing and medical staff. Notes for a sample of 10 adult patients that we looked at about midday on that day, including three 'corridor patients' at that time, showed that they had all had observations taken, and these observations were reviewed periodically where appropriate.
- We noted one patient in a corridor within the majors area having blood pressure, pulse and pulse oximetry measured by a nurse, and a consultant undertaking a 'trolley walk around'. Another consultant looked at patients (glancing in observation records with patients next to them) and they informed us that this was a regular and planned activity.
- In this area we observed that staff were working in a dynamic system to get patients into cubicles for assessment and treatment when they could and then free up the cubicles by moving them back out to the corridor to wait for test results or a vacant bed on a ward.
- The minor injuries stream was staffed by emergency nurse practitioners at grade 6 and these nurses could discharge patients without always needing a consultant's sign-off. There were no delays in this stream, although it was busy.
- There were security personnel on site and panic buttons on the reception desks. Staff told us that security personnel were very supportive and generally responded quickly, but were not sufficiently present in the ED at night or over weekends.
- The nurse manager in the paediatric ED confirmed that all nurses in the PED had advanced paediatric life support training.

## Nursing staffing

- The trust told us at the time of our inspection there were 18.94 whole time equivalent registered nurse and 5.86 whole time equivalent healthcare support worker vacancies in the ED. This had reduced from 44 whole time equivalent vacancies in October 2014 as a result of a phased recruitment plan that will conclude in June 2015.
- The nursing vacancy rate for January to March 2015 was between 26 and 30%.
- There was a significant reliance on temporary staff and agency usage for that period was between 238 and 249 shifts per month.
- There was a temporary staff fill rate of 39.5%, however all shifts requiring agency support were filled
- We noted there was a duty patient flow manager at the centre of the ED. They told us their role was to oversee and track patients and interventions through the ED. They explained that their role had developed into a patient safety one to deal with waiting patients and prevent breaches.
- The trust told us the acuity tool was used within the ED. Nursing numbers were flexed to ensure sufficient numbers at peak times. Volunteer staff helped support the department by providing food and drink to patients.
- We found the roster showed named nursing staff and healthcare assistants allocated to the resuscitation bays and sections of eight cubicles, minor's stream and triage including ambulance triage.
- There were 14 registered nurses rostered on duty on the early shift and 17 on the late shift, with 15 overnight. We

# Urgent and emergency services

noted from the roster that the overnight shift booking exceeded the usual complement by two qualified nurses and one healthcare assistant. There also was a named 'corridor' nurse for each shift.

- We observed that there were sufficient nursing staff on duty at the times of our visits given the amount of space that was available to treat patients and the wait for beds in the hospital that clogged up the ED.
- The clinical director told us the ED booked to 14 qualified nurses and five health care assistants for the early shift; 17 nurses and six assistants for the late shift and 13 nurses and five assistants for the night shift.
- We looked at rosters for a sample of days in the last week of December 2014 and the first week in April 2015 which included weekends and public holidays. We noted that the ED generally achieved its full staffing complement and that flexibility was built into the roster to cover extra capacity.
- The ED provided an emergency nurse practitioner service from 7.30am until midnight, seven days a week.
- There was a healthcare worker rostered in the ED dedicated to performing tests (ECG, blood tests) during the initial stages of assessment to help plan appropriate care and treatment.
- The paediatric ED was staffed by only paediatric trained nurses. They told us there was no expectation that they would cross cover for staff in adult ED. The trust used its own bank to cover for staff absence and did not use agency nurses.
- The trust told us that because of the increase in children's attendances in the children's ED, a business case to increase staff had been successful and staff were being recruited at the time of our inspection.
- Staff in the children's ED confirmed this when we spoke with them during our visit: "staffing could be better, this is better than before, it feels generally adequate". They said there was a good relationship between the staff in the ED and children's ED.
- Every case of a paediatric resuscitation involved contacting a paediatric bleep holder who was a general paediatric ward nurse. Staff in children's ED told us they felt this support was very helpful and they now felt well supported in resuscitation.

## Medical staffing

- The trust told us the ED employed 15 emergency medicine consultants. Of this group two were paediatric emergency medicine specialists, two were pre-hospital

emergency medicine specialists, with dedicated time on the local air ambulance service, and one had a combined role between emergency medicine and intensive care.

- They provided supervision for the adult and children's EDs, with further support given to the children's ED by a paediatric emergency medicine consultant from the paediatric team.
- Medic consultant vacancies were at 8.25% for January to March 2015 and speciality doctor vacancies were 3.75%.
- Consultants were in the ED between 8am and at least midnight, with greater cover during the week than the weekend. Between 9am and 10pm there were at least two consultants providing in-department supervision and review of cases.
- The roster showed consultant cover for early, late and night shifts during weekdays, with a consultant sleeping in the hospital on call after 1am. At weekends consultants covered two long shifts each day on call, including overnight.
- Consultants were supported by middle-grade doctors and junior doctors. Local leaders told us that there was a high staffing level overnight of one registrar and five junior doctors because of the usual patient flow backlog, "We generally don't struggle hugely with staffing".
- Local leaders told us that there were three acute physicians on duty each day over the weekends covering 12 hours, with one general physician who was also on call overnight.
- We noted during our visits (over three days including one evening) that consultants were available and visible and junior medical and nursing staff confirmed that this was usual.
- The trust told us consultants sign-off all majors and resuscitation cases, and all admissions that occurred between 8am and 10pm on weekdays. Where practical this also occurred after 10pm and at weekends.
- Care on the ED observation ward was led by the consultant team, which conducted a ward round every morning, seven days a week, and a board round each week day afternoon at 3pm.
- We observed there were sufficient medical staff on duty at the times of our visits.

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- We looked at the consultant roster for February and March 2015 and found that it was generally filled as planned. There was only one locum used over that period.
- Agency use for medics generally for ED in February 2015 was 21 shifts as compared with only three shifts in January and four in March 2015.
- The trust told us acute medicine had expanded its contribution to hospital services over the 12 to 18 months before our inspection. As a result, it had gone from 7.6 to 13.4 whole time equivalent consultants, with some posts 50% in a specialty and 50% in acute medicine.

## Major incident awareness and training

- The trust told us they had an emergency planning department that was responsible for the delivery of major incident planning, training and exercises. The trust board received assurance about the trust's emergency preparedness and approved the annual report for 2013/14.
- A major incident policy for the trust contained relevant sections relating to the roles of ED staff, preparedness and immediate actions.
- Training in dealing with hazardous materials exercises were delivered bi monthly.
- The ED had been involved in a major incident exercise in October 2014 that was set up by partner agencies.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good



We found emergency department (ED) services were effective.

Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.

The trust had put in place monitoring arrangements to ensure consistency of practice, collected data to demonstrate patient outcomes and contributed to national audits.

Patients' needs were assessed and reviewed when they had to wait for treatment. There were arrangements in place to protect patients' rights, but not all staff clearly understood the complexities of patient consent. Patients' hydration and nutrition needs were met and pain relief was addressed.

Staff were qualified and had the skills needed to carry out their roles effectively and had access to the training and development they needed.

Multidisciplinary working was good within the ED and with partnership teams such as REACT, but some improvement was needed with other departments in the wider hospital.

The ED, including the paediatric ED, provided a 24-hour, seven-day comprehensive emergency service. However, lack of a comprehensive seven-day service within the wider hospital system contributed to blockages in patient flow that had a disproportionate negative impact on the EDs ability to respond to demands on its services and to plan timely care pathways.

## Evidence-based care and treatment

- The trust told us guidelines were based on local need and practice, and on nationally produced best practice guidance from the National Institute for Health and Care Excellence (NICE), the Resuscitation Council and Royal College of Emergency Medicine. These were all available on the e-library on the trust intranet and therefore to the ED, acute medical unit and the GP assessment unit. Staff who we spoke with during our visits confirmed that they had access to this guidance.
- We were told that the ED had worked with other specialties to produce guidelines, for example 'Head injuries, providing a locally agreed pathway of care'. The trust guidelines for the management of adult head injury and traumatic brain injury were based on NICE's head injury guidelines (2007). The ED had employed a dedicated risk and governance manager within the group, to organise quality improvement and patient safety (QIPS) meetings, track audit and guideline production, and establish strong governance arrangements. Local leaders who we spoke with during our visits confirmed this.
- The trust told us the ED had a dedicated clinical audit lead who worked with the clinical audit facilitator to develop and approve the ED audit programmes and monitor clinical audit performance. This person acted

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as a champion for clinical audit within their clinical area, setting a culture for clinical improvement and encouraging involvement in clinical audits by staff of all levels working within the specialty.

- Local leaders confirmed that clinical audit findings were presented at the ED QIPS meeting in order for them to be debated within the clinical team, any lessons learnt to be shared and any improvements to practice identified and action agreed.
- The trust told us the ED participated in a local trust-wide audit of documentation on an annual basis to ensure documented information relating to the care of patients was completed in accordance with both national and local recommendations. We noted that documentation we looked at during our visits was complete and legible.
- The ED had participated in three College of Emergency Medicine audits since 2012, which included standards relating to pain relief: renal colic, fractured neck of femur and pain in children. The trust told us actions in relation to these audits included raising awareness about the importance of re-evaluation of pain in patients with renal colic and fractured neck of femur and the inclusion of information about management of and re-evaluation of pain in children in nursing and medical induction programmes.
- The trust had made patient data submissions to the three College of Emergency Medicine audits for 2014/15: initial management of the fitting child, mental health and assessing for cognitive impairment in older people. These audits were ongoing and the trust had not had results at the time of our inspection.

## College of Emergency Medicine consultant sign-off

- The trust told us since the audit the department had introduced a new system of consultant working to sign off particular types of patients before they were discharged from the ED. The supervising senior team signed off every result through the electronic results diagnosis system in the department with the consultant responsible for conducting the ward round.
- A mechanism for continuous monitoring of sign-off was being explored with the department's updated IT system..

## Pain relief

- The trust told us it identified a number of areas for improvement following the College of Emergency Medicine audit of pain in children. Actions in response

to the findings included the addition of information about management of and re-evaluation of pain in children in nursing and medical induction programmes and emphasis on the importance during QIPS meetings. We noted that distraction therapies had also been introduced in the children's ED, including a sensory room.

- We looked at a sample of 10 patients' notes in the adult majors stream. We noted that there was a record of analgesia offered in eight cases, including three patients who were at that time waiting in the corridor on trolleys. The remaining two cases did not record why it was not offered.
- A sample of four patients' notes in the paediatric ED recorded that analgesia was offered in three cases with no indication of why it was not in the fourth case.
- Patients who we spoke with in the minors stream who had been through x-ray told us their pain had been well managed.

## Nutrition and hydration

- The trust scored the same as other trusts for the Care Quality Commission 2014 A&E survey. The themes for these questions included food and drinks.
- We noted that drinks and sandwich packs were available to patients in the ED. Patients admitted to the observation ward were provided with a full meal service in line with other ward areas within the trust.
- We saw patients waiting on trolleys in corridors in adult majors being offered drinks.
- We saw that on the GP assessment unit drinks were available for patients from a self-service trolley. The trust told us sandwiches were also provided or hot meals on request.
- There was a hot and a cold drinks machine in the ED reception area. At the time of our visit we noted the hot drinks machine was out of service.
- We noted 'React to Red' tissue viability team posters on display in the ED.

## Patient outcomes

- The unplanned re-attendance rate in ED within seven days is higher than the England average. The trust told us the local reporting methodology had assessed this indicator to be significantly lower. Review of the data measure and capture process was taking place at the time of our inspection.

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- In the Trauma Audit and Research Network national audit, the trust reported that 95% of patients meeting NICE head injury guidelines received a CT within 60 minutes (national average 88%) and 100% of patients received tranexamic acid when given blood products within six hours of an incident compared with the 88.5% national average.

## College of Emergency Medicine renal colic

- The majority of indicators in the renal colic (kidney stones) College of Emergency Medicine (CEM) audit 2012/13 that looked at evaluation of the severity of pain and administration of appropriate analgesia in a timely way, were between the upper and lower England quartiles.
- Of patients who presented to ED during 2012/13 complaining of pain as a result of renal colic, 88% had a pain score recorded, an improvement from 86% in 2010 (CEM standard 100%).
- The provision of analgesia to patients who presented in severe pain with renal colic was noted as an area for improvement and the trust told us actions had been undertaken to raise awareness of this within the ED. For example, information had been passed on within the group, and prioritisation of analgesia clearly identified at junior doctor education and nurse handover.

## College of Emergency Medicine fractured neck of femur

- The fractured neck of femur College of Emergency Medicine (CEM) audit 2012/13 had eight out of 15 indicators in the upper England quartile. This measured the time taken to offer pain relief to patients arriving at the ED with suspected hip fracture. The trust had improved its adherence to the standards for the management of patients with fractured neck of femur since 2009.
- The 2012 audit demonstrated that 64% of patients with moderate pain received analgesia within 30 minutes compared with 23% in 2009 (CEM standard 75%, national median 22%); 71% of patients with moderate pain received analgesia within 60 minutes compared with 38% in 2009 (CEM standard 98%, national median 43%).
- The trust told us it had implemented actions to improve the fractured neck of femur pathway and raise awareness regarding the re-assessment of pain.

## Competent staff

- All staff who we spoke with, including healthcare assistants, told us they had access to training and development in the ED and were up to date with their mandatory training. "I feel part of the team [here] and I always get a break, I left the ward [I worked on previously] because my training wasn't progressing".
- We observed staff shift handover meetings at various times of the day and evening and noted they were constructive and efficient.
- The trust told us the advanced nurse practitioners also performed a teaching function for junior nurses and assisted junior staff in managing patients who were unwell.
- Trust data showed that within the ED 95% of non-medical staff and 76% of medical staff had completed appraisals in 2014/15. Staff who we spoke with during our visit confirmed they had regular appraisals.
- The trust told us within acute medicine supporting the advanced nurse practitioners supporting the GP assessment unit (GPAU), had all completed (or were undertaking) an MSc in advanced practice and were required to complete non-medical prescribing training. Their education was supplemented by in-house problem-based learning sessions. Advanced nurse practitioners that we spoke with confirmed this.
- The trust told us all patient flow coordinators who interacted with the GPAU had undertaken training to enable them to request chest x-rays and many were completing arterial sampling training.
- In the resuscitation suite we noted staff using specific templates for notes for patients with specific conditions/ interventions to act as guidance documents. These included sections to identify the agreed lead team/ consultant and any changes to this.
- All paediatric ED (PED) nursing staffing were paediatric trained and the trust was developing further advanced practitioner competencies for the PED. PED staff received appropriate clinical support from the paediatric medical and specialist nursing staff in the general paediatrics department of the hospital.

## Access to information

- We noted that all staff had good access to the information they needed to treat and care for patients and carry out their role.



# Urgent and emergency services

- Information was available in paper from patient's notes and assessments, on the electronic patient care tracking system and through the E library. We saw staff using all of these forms of information access throughout our visit.

## **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- We noted information and flow charts displayed on walls within the ED for staff to consult on the deprivation of liberty safeguards (DoLS).
- The trust had recognised before our inspection that the system put in place to reduce the risk to patients without capacity and other patients around them was not always effective during busy periods.
- Staff believed they meant to phone security when any patient was put under any restraint power, however this was not always done as there were not always enough security personnel in the trust during busy times. This, however, was not in line with the trusts 'Assessing of mental health patients in ED' policy. ED consultants confirmed they attended quarterly meetings with safeguarding teams and hospital security to discuss how to improve this situation.
- The trust had consent to treatment policy and an information-sharing policy. These policies included the process for consent, consent refusal, lasting power of attorney guidance, and children giving consent to treatment. Information on the use of interpreters was incorporated within the consent policy.
- We observed in the ED that nursing and medical staff did ask patients explicitly if they understood their treatment plans and for their consent for tests and treatment. This included patients who had been identified as experiencing dementia. We saw no indication however that staff were acknowledging that these patients may not have capacity to give informed consent or understand the explanations they were given of treatment.
- The trust told us there was a programme of training for Mental Capacity Act, DoLS and mental health to be delivered by UHCW NHS Trust staff and the CCG. The adult mental health team would also deliver one of the sessions in the programme. The agenda also included PREVENT awareness-raising about protecting young people from the influence of religious radicalisation.

- We noted that not all staff we spoke with could articulate an understanding of the Mental Capacity Act requirements and the meaning of deprivation of liberties safeguards.
- An ED consultant showed us some software they had developed with a member of the IT department to help assess mental capacity. It was due to be launched within weeks after our visit, initially in the ED and then rolled out across the trust. It had an assessment flow chart within it that gave different outcomes depending on the data inputted.

## **Multidisciplinary working**

- Nursing leads told us the ED had difficulty obtaining surgical advice and beds, and that a surgical assessment unit was needed. We observed a nurse having difficulty contacting an orthopaedics ward by phone.
- Nursing staff in the adult and paediatric EDs confirmed that multidisciplinary working was good.
- We observed good handover between ambulance crews and clinicians. It was informative, well-structured with attention given to detail.
- Ambulance crews spoke highly of the department and the staff and said they worked well with the ambulance services.

## **Seven-day services**

- We noted 'lack of seven-day working' was identified on the corporate risk register as a gap in controls for managing the high 'red'-rated risk of patient flow through the hospital. Blockages in patient flow had a disproportionate negative impact on the ED's ability to respond to demands on its services and plan timely care pathways. Local leaders told us they could not ever consider 'closing the front door' because other local trusts would not be able to cope with the number of extra patients that would be diverted to them.
- The trust told us it provided a 24-hour, seven-day comprehensive emergency service with senior accident and emergency staff, emergency nurse practitioners, trauma team, operating department technicians, CT scanning, cardiac arrest team, decontamination facilities and specialist opinion from all major specialities. Staff we spoke with confirmed this but we did not visit the department over a weekend as part of the inspection.

# Urgent and emergency services

- Consultants were rostered and available to the ED overnight, sleeping on-site after 1am. The roster showed consultants on call only, over the weekends. The trust told us there was an onsite resident on call after midnight and the third consultant rostered did ward rounds. There was also one middle-grade doctor on duty in the department from 8am to 4pm on Saturday and Sunday. Staff who we spoke with confirmed they had no difficulty with access to consultants when needed.
- A GP assessment unit had been introduced within the trust and opened five weeks before our visit. The aim of this unit was to support the management of referrals from GPs and it was therefore open from 10am to midnight Monday to Friday, and 10am to 6pm at weekends.

## Are urgent and emergency services caring?

Good



We found the emergency department (ED) services were caring, but that they could be improved if some hospital-wide operational changes were made.

Staff at all levels and in all roles were kind and caring to patients and to relatives and treated them with respect. Patient feedback about the way staff treated them was very positive.

Caring for patients on trolleys in corridors had become normalised. However, staff in the ED worked hard under difficult circumstances to maintain patients' privacy and dignity as far as reasonably possible.

The main ED reception area provided little privacy for people to communicate their personal information when they booked in. Reception staff did what they could to improve this.

Keeping patients informed was a challenge to the ED and the trust had recognised this before our inspection and was working to improve it. We found that patients were generally given good information when they first arrived, but the level of communication reduced the longer they waited in the department.

There was good provision of emotional support for people who were mentally unwell and for bereaved parents of young children.

## Compassionate care

- For the Care Quality Commission accident and emergency national survey in November 2014, the trust was around the national average on most of the questions (33) and better than average on two of the questions. The questions for this core service were about privacy and length of stay.
- The NHS Friends and Family Test results for the ED in December 2014 reported a response rate of 14.9%, with 83% reporting 'recommended' (people ticking extremely likely and likely to recommend the trust as a place of care to their friends and family), and 12% reporting 'not recommended'. The majority of responses were gathered by using SMS/TEXT or smart phone app.
- All of the staff at different levels and across various roles who we observed working with patients during the three days of our visit were friendly, kind and interested in their patients.
- Almost without exception, all of the patients and relatives/friends who we spoke with during our visit confirmed this and highly praised of the quality of care they received from staff.
- When we arrived at the majors unit of the ED at 8.45am on Wednesday 11 March 2015, we observed patients being assessed and treated on trolleys in the corridors within the majors area because all the treatment cubicles were full. This situation continued for most of the day.
- Although staff generally lowered their voices, we and other patients could clearly hear the consultations that doctors were having with these patients.
- Although staff and local leaders told us they felt very uncomfortable about caring for patients in corridors, we noted that it had become normalised. Local leaders told us that nursing staff were rostered to care for corridor patients and it happened routinely.
- We did not at any time during our visit see patients immodestly clothed or positioned in public view, therefore their dignity was protected.
- We sat in the main reception area and noted that ineffective arrangements for privacy were provided for patients checking in for the adult ED. The two receptionist workstations were very close to each other



# Urgent and emergency services

and despite the background music we could hear patients' personal details from the seating rows as they booked in. Reception staff raised this with us as an issue of concern to them. They said they took some people to the rear of their workstation area to speak with them and they had got a radio installed to provide some background noise to cover conversations.

- We noted that the estimated waiting time was displayed in reception to provide patients with some level of assurance.
- In the observation ward we noted that patients' names and the relevant receiving speciality were displayed on whiteboards in full view of the visiting public.
- We noted across a range of roles, except nursing, that the combination of fashion and the preference for male staff to wear their identity badges clipped to their belts, required patients to gaze below the hip line to see staff names and roles. This was not dignified for patients and visitors.

## Patient understanding and involvement

- The trust told us that ED users had advised the trust that improvements could be made in communication with patients around treatment, plans and progress within the ED. In response, staff had been reminded of the importance of keeping patients and families informed. Notes had also been placed in the ED's communication folder so this was passed on at each change of shift.
- Some patients told us during our visit they were kept well informed. However other patients, including parents of a child in the paediatric ED, said that although they were happy with the level of care they received, the facilities and the staff, they felt unhappy about the information they were given. They said that initially it was good but became poor as time went on. "Staff are friendly, but what am I waiting for?"
- We heard specialisms staff such as cardiologists clearly explaining to patients about the tests they proposed to carry out.
- We saw reception staff leave their desk to accompany relatives into the majors area to see patients so they had some support to find them.

## Emotional support

- We noted a dedicated room in both the adult ED and on the observation ward to treat people who presented with mental health problems. These rooms offered patients privacy.

- The trust had a bereavement room in the paediatric ED that had been enabled through private donation.
- No private dedicated space was provided in the adult ED for bereavement.
- The trust told us the ED was a supportive environment for staff. Members of the hospital chaplaincy spent time in the ED offering emotional support to staff, patients and carers. They followed critically ill patients to the ITU in order to support families.

**Are urgent and emergency services responsive to people's needs?**  
(for example, to feedback?)

Requires improvement



We found the responsiveness of the ED required improvement.

We found that although the trust had responded to an increase in demand within the paediatric ED, the trust had not fully taken into account the needs of a growing elderly population. There was no effective vision to address this strategically.

Access to services and patient flow through the ED to other parts of the hospital was poor and patients experienced long waits in the majors area, including on trolleys in corridors. This had been normalised and staff worked hard to keep patients safe within this system. Local leaders told us the national target of patients being seen, treated and admitted or discharged within four hours was largely being disregarded while the ED was under such pressure and executive action and support was put into achieving the 12-hour target.

The trust had successfully reduced the waiting time for minor injuries and put in place a number of other strategies to attempt to take pressure off the flow of majors. These were not effective at addressing the problem of bed management in the wider hospital and the dysfunctional relationship with acute medicine that was causing the backlog and subsequent crowding in the ED. Services were not planned effectively in conjunction with other local services such as GP services.

# Urgent and emergency services

There were good arrangements in place to address individual needs, such as patients presenting with mental ill health, and the paediatric ED had its own entrance and waiting area.

We found there was a proactive approach in the ED to encouraging and learning from patient complaints.

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

- There had been an increase in nurse staffing within the children's ED to meet the increase in attendees over the last six years from 27,000 to above 36,000 in 2014.
- The trust told us a redevelopment of the resuscitation area was planned, to increase the number of beds to 11, with two dedicated children's areas and one isolation/infectious diseases room.
- A business case was under development to recruit a team that provided a paediatric emergency nurse practitioner seven days a week for 12 hours a day.
- The trust had decided against using a GP service within the ED, although local leaders indicated that this decision may now be under review.
- The corporate risk register in April 2014 showed as a red risk that the ED reception department had significant vacancies. This had left the reception staff unable to complete additional tasks beyond providing reception duties for the ED, children's ED and main reception. This meant referral letters for GPs and health visitors for children attendances had not been completed on time and the commissioners had raised concerns because this could compromise children's safety. The trust had taken action to address this, including recruiting to posts. However, the October 2014 review of the risk showed renewed staffing shortages because of promotion and resignations.

## **Taking account of the needs of individual people**

- The trust told us an eLibrary had a wide range of patient information leaflets available for staff to print and give to patients. Patients could also ask the health information centre (by email, phone or face to face) to search for further information if required.
- We noted a good range of leaflets and posters in waiting areas for patients providing information on health-related issues, but we noted that information leaflets and posters were only in English.

- The trust had a contract with a telephone translation service. ED senior leaders told us that this was not used in the ED, but that pictorial translation books were available in the department. They said it was unusual to see someone who needed ED point of care translation.
- Two patients who were followed through admission to wards whose first language was not English confirmed they had no access to interpreter services while they were in the ED. They did have sufficient English language knowledge to respond to our questions, however.
- A 'quiet and calm room' facility had been provided to enable patients with mental ill health to use ED services safely while they waited for psychiatric assessment.
- The paediatric ED had its own entrance and waiting area to protect children from inappropriate or distressing behaviour in the adult ED. The waiting area had been decorated to provide a child-friendly environment.
- Paediatric ED staff told us they had good access to the child and adolescent mental health service teams (CAHMS). Children presenting with mental ill health, for example self-harming, were not admitted to the observation ward adjacent to ED but to ward 14 in the hospital. Where a child had come in overnight they generally waited there for a CAHMS review next morning.
- We noted a trust-wide equality and diversity plan identified objective for 2014/15 was to consult within the community on how the trust could improve frontline staff's understanding of people with learning disabilities.

## **Access and maintaining flow through the department**

- The trust scored the same as other trusts in the Care Quality Commission 2014 A&E survey. The questions for this core service were regarding privacy and length of stay.
- The trust shared data with us that showed the ED's compliance with the four-hour wait target for patient arrival to being seen, treated and admitted or discharged was at 90% in October 2014.
- We noted trust data showed that between January and December 2014 the 12-hour target was breached each week on average between one to six times. There were spikes in July 2014 when the number of breaches was 16 in one week and in December 2014 when there were 19 breaches in one week.

# Urgent and emergency services

- The system to record, track and monitor patient flow through the ED informed predictions of the number of available beds required in the hospital at 8.30am on the following day. Local leaders told us that it was fairly accurate.
- The trust told us that the ED had developed a minor injury stream provided by specialist nurse practitioners and medical staff. This had protected this group of patients against delays caused in the major injury stream of the service (97% seen within standard on average during 2014/15).
- We noted that the minor injury stream was staffed by advanced nurse practitioners; patients experienced a responsive service and were not kept waiting for more than 15 minutes on average on the days of our visit.
- A GP assessment unit (GPAU) had opened five weeks before our visit. This was situated some distance from the ED. The purpose of the unit was to for a senior nurse to accept GP referrals of patients over the phone. Staff told us the GPAU saw approximately 40 patients each day, and it was infrequent that any of these were inappropriate to be treated in the unit.
- Some local leaders expressed the view that if they had a rapid assessment consultant system in ED they could identify more patients who could be seen in the GPAU in the mornings when it was less busy, thus taking some further pressure off the ED. Others told us the ED had experimented with a rapid assessment system but it only drove up the rate of admission to the hospital,
- A seventeen-bed observation ward was part of the ED. Local senior leaders told us that the ED had no control over these beds and could not use them to alleviate the overcrowding in the minors stream caused by patients waiting for beds in the wider hospital. Nursing leaders told us the observation ward did not always receive short-stay patients.
- The trust told us the paediatric ED (PED) consistently achieved the ED target for 95% of patients to be seen within four hours, despite increasing activity levels.
- There were four-hour breaches in the PED, however. We tracked back seven patients from wards to the PED during the week of our visit and according to their records 50% had breached the four-hour target
- On the days of our visit activity levels were low in the PED, with fewer than five patients at any one time. Staff told us this was unusually quiet. Senior nursing staff confirmed the trust's view that the department was 'getting busier' and that patients presented throughout the night. They said despite this the PED did not breach targets while waiting for specialists, such as plastics consultants, to come and review patients.
- The trust told us a joint course had been developed to train paediatric emergency nurse practitioners (PENP) with Coventry University and children's services, which provided minor injuries and minor illness modules as well as non-medical nurse prescribing. A PENP was trialled for six months within rigorous triage criteria, which showed that a PENP could see approximately 25% of all children.
- PED staff confirmed that all nurses had advanced paediatric life support training regularly updated. Senior nurses told us that they did struggle to fill all nursing shifts but they generally managed to do so and staff retention was good.
- Before our visit the trust told us it played a significant and leading role in the health economy to improve patient flow within the acute setting. The trust said it had initiated many improvements in the emergency care pathway, in particular with the Getting Emergency Care Right initiative. This hospital-wide initiative was designed to improve flow of patients by facilitating early discharge, achieving early specialist input and daily senior review and eliminating early diagnostics.
- However, we found there was no acute healthcare hub that would encourage collective responsibility for the care of patients across professions and healthcare teams. There was no system of early senior review. Local leaders told us this would be of benefit, but patients would still have nowhere to go when the rest of the hospital was full.
- There was a flow coordinator (band 7) available 24/7 to take referrals to medicine and to signpost patients to the correct area, for example ambulatory emergency care, GPAU or acute medical unit. GP referrals were taken by a GP liaison nurse during weekdays 8am to 5pm.
- Flow into and out of all areas of the GPAU service were overseen by the nurse coordinators across acute medicine. There were six advanced nurse practitioners who covered GPAU and ambulatory emergency care that were able to complement medical staff in assessing and managing undifferentiated patients through advanced clinical skills, including prescribing.

# Urgent and emergency services

- However we found the GPAU underutilised and serving largely as the clinical decisions area but off bounds to the ED.
- Local leaders acknowledged that the ED was still struggling with patient flow problems.
- We found at 8.35am on the first day of our visit that the majors stream was crowded and there were more than 13 patients waiting in the corridors on trolleys. All of the cubicles were in use. Ambulance-transported patients were also queuing on trolleys with paramedic crews in the corridor to the handover suite.
- Inside the ED area we observed that staff were operating a dynamic process of moving patients in and out of cubicles, where this was possible, for medical assessment and treatment and waits for test results or specialist review. Team/shift leadership in the ED was good and staff were kept busy despite the lack of flow.
- During our visit even when some cubicles were vacant, empty trolleys remained lined along walls ready for use, meaning corridor care had become normalised.
- The ED majors had been on Black Alert status since lunchtime on Monday 10 March 2015. This alert was not scaled down until the morning of Thursday 12 March 2015.
- Local nurse managers told us that this was a normal day in ED: “patients always wait”. They said the problem was with the wards and medical management within the wider hospital but that it was viewed as an ED problem and that was not helpful. On average during the three days before our visit there had been 20 patients waiting in the ED for a bed in the hospital at any one time through the day.
- Hospital bed management meetings were held in the control room near the ED. We attended the meeting at midday on the first day of our visit. This reported there had been 84 four-hour breaches on the previous day and 46 breaches so far that day.
- Staff working in and managing the ED confirmed our impression from looking at the patient flow tracker board that 12-hour target breaches for time from admission to discharge or admission were rare. The four-hour target was largely ignored however and executive action and support was put into achieving the 12-hour target.
- Local nurse managers told us the ED had a good medical referral system in place. Staff were able to identify a medical patient early and flag them for admission before the formal doctor review took place.
- Staff said that surgical referrals had improved recently with the implementation of the nurse practitioner role. These nurses attended and saw patients in the ED. Before this system it was very difficult to admit patients because of the lengthy waits for a surgical doctor’s review.
- ED consultants did not have admitting rights to hospital wards for their patients

## Complaints handling and learning from feedback

- We noted that information was available for patients on how to raise concerns or make a complaint. Leaflets and the information contained on the website sign posted patients and carers to advocacy services and the Parliamentary Health services Ombudsman. There was a dedicated phone in reception to allow patients to contact the patient advice and liaison service (PALS) from the ED.
- The trust told us an ED complaint had been presented to the trust board in 2014/15 as part of the patient story programme where actions were discussed. Following the complaint, the ED implemented a system of emergency nurse practitioner peer review of notes. This was where a set of notes was identified, randomly and anonymously, for the ENPs to review and reflect on as a group.
- The ED and children’s ED had a dedicated complaints and PALS officer, and received information on monthly complaints.

## Are urgent and emergency services well-led?

Requires improvement



We found leadership of emergency department (ED) services required improvement.

We found the trust’s vision and strategy for the ED did not have an impact on its ability to cope with the demands placed on it on a daily basis. ED staff had given up looking for trust-wide solutions because they felt they got little strategic support for this approach.

# Urgent and emergency services

The trust's approach to improving the overcrowding in the adults ED was reactive and largely focused on short-term issues.

Risk management was pushed down to the department, which had neither the resources nor span of control to change it. Nurses and doctors were getting by on a shift-by-shift basis, keeping patients safe in often overcrowded conditions.

ED leaders were not leading effectively in engaging the executive team in the need for trust-wide solutions.

The trust had systems in place to oversee planning, delivery and monitoring of care provided by the ED and the PED and to identify, monitor and assess risk. However, we found these systems were not sufficiently effective to mitigate the risk of overcrowding in the adults ED.

The ED and PED operated in an open, friendly and inclusive manner and staff were happy to be at work despite the pressure they were under. Staff in the adults ED were proud of their ability to keep patients safe in overcrowded conditions.

Shift and team leadership and collaboration between roles was effective including with respect to learning from complaints, incidents and errors.

The trust engaged the public through proactive use of the NHS Friends and Family Test in the ED and staff were supported to develop innovation in practice.

## Vision and strategy for this service

- The newly developed GP assessment unit (GPAU) and the expansion into ward 3 to create an observation ward enabled the service to become more efficient and supported the acute medicine group's strategy of expanding its services to support safe and responsive care for its patients.
- We found there was no realistic or credible vision for the ED. There was a mixture of developments that did not work together that had been experimented with or actioned 'in the last few weeks' or would be actioned 'in the next few weeks', such as the GPAU, the purpose of the observation ward and adoption of an early senior ED consultant assessment.
- The 'Getting Emergency Care Right' initiative was one of the key priorities set by the board for 2015/16. The trust audit plan showed it was scheduled for an audit to

begin in October 2014 but no actual start date had been subsequently entered on the plan. We heard no evidence that it was under audit by the time of our visit in March 2015.

- Local leaders told us that the Getting Emergency Care Right initiative worked when it was put into action. Clinical directors had been allocated to a group that met four or five times each day to administer a plan to address flow in the rest of the hospital. However, this had fallen away after three months and clinical directors outside of the ED did not sustain a proactive involvement in patient flow. ED leaders said they wanted it to be re-established.
- The level of cooperation between acute medicine and emergency medicine was not sufficiently effective and resources had been put into these only weeks before our inspection. The trust's inability to effectively manage acute medicine had a detrimental effect on the ability of the ED to respond safely to the demands placed on it.
- There was no vision for an acute care hub.
- Local nursing and medical leaders in the ED told us they were aware of a trust vision but were not sure how or whether it translated to the ED.
- Staff in the ED were proud of and defended their skill in reducing waiting times for patients but felt let down by senior leaders "somewhere above them" in the trust.
- Administration staff told us that senior leaders did not "have a feel for the shop floor problems"; they were distant and didn't understand "real life". Reception staff felt isolated and unsafe on occasions.

## Governance, risk management and quality measurement

- The trust told us that the ED was part of the emergency medicine specialty group and that acute medical physicians were managed through the renal and acute medicine specialty group. Both were led by a senior management team, comprising a clinical director, modern matron and group manager.
- Urgent and emergency care risks were identified through a variety of sources (for example, risk assessment, service changes and incident trends) and a log was maintained on the trust's risk register, held centrally on a web-based software system.



# Urgent and emergency services

- The teams reviewed their risks at the monthly quality improvement and patient safety (QIPS) meetings, updating controls and risk ratings as appropriate and informed by their quality and performance data, to ensure that risks were being managed.
- Local risks that could not be managed within the group were escalated to corporate level.
- Acute medicine also held a monthly QIPS meeting. The department was developing a safety team that intended to feed into QIPS and pass on information and learning. Acute medicine representatives also attended the ED QIPS meetings to ensure shared learning and continued service development.
- We found that risk management was pushed down to the department which did not have the resources or span of control to change it.
- Senior leaders and the executive were seen to be reactive rather than proactive. Local leaders in the ED told us senior leaders did react to safety warnings about crowding in ED and clear beds within the hospital to facilitate flow. However, they took less action if the average waiting times were below 12 hours.
- The response then was often to move additional staff into the ED, which did not effectively address the problem of flow. “Escalation is permanent, the Black Alert is useless, ED doesn’t need more staff arriving from other parts of the hospital to solve the problem, we need beds and discharge”.
- We noted that the ED risk register at the time of our visit had the three top red (high) rated risks as: patients in corridors; use of the observation ward corridor and nurse staffing levels. The review in October 2014 of the use of the observation ward corridor for ED patients noted ‘no change, continued pressure on ED leading to normalising of this’. It was dated for further review at the end of March 2015.
- An Over Capacity Operating Policy was signed off for ED by QIIPS in January 2015. This addressed only the treatment of patients who had been triaged and handed over by ambulance staff in majors. The trust took no responsibility to deteriorating patients while they queued for triage and handover; this was left to the ambulance personnel.
- We noted that the pressures generated through the ED featured as a red risk on the risk register for the surgery department, but was not on the risk register for acute medicine, where it was not considered at all.
- Local senior leaders gave us conflicting views about whether the overcrowding risks in the ED were considered to be a trust-wide problem; “we do what’s in our gift, but there are things outside of it. What you see is a symptom of overcapacity in the whole hospital. It is acknowledged as a trust-wide issue but we don’t have a trust-wide answer”; “there is no risk share in the organisation – we [ED] hold all the risk. This has been said to executive level managers numerous times but there is no response”.
- The Over Capacity Operating Policy made clear that risks associated with overcrowding were to be managed by the ED. Although an overcrowding situation should be escalated by local managers it was not operational site manager’s responsibility to manage those risks.

## Leadership of service

- The trust told us the ED was led by the clinical director, group manager and lead nurse forming the emergency medicine group. The GP assessment unit was part of the renal and acute medicine group with a similar leadership structure.
- The children’s ED was jointly managed by emergency medicine and paediatrics.
- Local leaders acknowledged that bed flow management was poor and “the system was not working” because the ED generated 60 to 80 medical admissions each day.
- We found that there was a tension between the chief officers and local leaders on the use of the observations ward corridor for ED patients to wait when the major’s flow was overcrowded. Local leader considered it an unacceptable risk as this corridor was outside of the ED, “Patients are happy to wait within the ED because ED is excellent. The corridor within ED is safe because it’s adequately staffed (although it’s [waiting in a corridor and not a cubicle] not the right thing to do)”.
- Staff told us that the Getting Emergency Care Right initiative had worked to reduce ED waiting times when it was put into action during 2014, but that compliance with it had fallen away after three months. Local leaders told us they needed the initiative re-established with a hospital-wide commitment to support it. The ED needed the support of other clinical directors to make it work.
- The observation ward had empty beds on occasions when patients were waiting in the corridors in adult’s majors. ED consultants and site managers did not have any control over use of observation ward beds and local

# Urgent and emergency services

leaders believed that they should have this control in order to reduce the pressure on ED waiting times. There seemed to be no commitment at trust level or effective challenge at local leadership level to address this.

- We found team and shift leadership was strong within the ED and the PED. Despite the blockage in flow in adults ED and the challenge to cover the nursing roster in PED, staff were highly motivated and were kept busy.
- The band 7 flow nurses carried out a challenging job with great skill.
- There was good staff morale and staff were happy at work, and junior doctors were happy with their education.
- Nursing and consultancy staff were clear about their roles in every area and there was good leadership.
- The ED senior leadership did not effectively challenge the lack of executive response to proactively deal with the challenges the ED faced on a daily basis and the risks associated with overcrowding.

## Culture within the department

- The trust told us the ED operated in an open, friendly and inclusive manner. There was a no-blame approach used with respect to complaints, incidents and errors. This was confirmed by the nursing and medical staff, including juniors who we spoke with during our visit.
- All of the nursing staff we spoke with at various levels in the ED told us they felt proud to work for the department. However, shift-leading nursing staff also told us that they “just got on” with treating patients and making the department as safe as possible when they were very busy; they had stopped expecting others outside of the department to solve their problems. They could not tell us how the risk register operated for the ED. They told us they were not sure other departments/wards appreciated the impact in the ED of a one- or two-hour delay in a discharge: “it may feel inconsequential to them but it could mean a breach for the ED”.

- Consultants in the ED did not have the right to admit patients into other speciality’s care.
- We noted positive professional interactions in the children’s ED between junior and senior nurses, for example over escalating concern about analgesia.

## Public and staff engagement







- The trust encouraged public engagement through feedback cards, the NHS Friends and Family Test, and the trust’s impressions survey.
- We found in the ED that the NHS Friends and Family Test was displayed through an interactive installation and that patients used this.
- The trust told us the ED QIPS meeting was open to all staff and medical and nursing groups had information and feedback meetings.
- The trust told us on NHS Change Day 2014 (3 March) it launched Together Towards a World Class Service.
- The trust had held a number of Listening Events for staff in April and May 2014 to get the views of staff about achieving this. Staff were also asked to volunteer themselves to be ‘change makers’ for the programme.

## Innovation, improvement and sustainability

- The trust told us the ED had recently employed a research nurse. There were several portfolio trials underway at the time of our inspection, and the ED was one of the most successful recruitment sites to the CRASH3 head injury study.
- The ED had collaborated with IT services within the trust to develop software to help assess mental capacity. It was initially to be launched in the ED and then rolled out across the trust if it worked effectively.
- The trust had plans in place to enlarge the resuscitation area floor space to enable staff to move around more easily and safely.



# Medical care (including older people's care)

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Requires improvement	
Overall	Requires improvement	

## Information about the service

University Hospitals Coventry and Warwickshire NHS Trust (UHCW) has 616 inpatient beds and 13 day-case beds within the medical specialties (which include cardiology, neurology, haematology, nephrology and oncology). Hospital of St Cross, Rugby, has 69 beds and University Hospital, Coventry, 547. Medical services provided by UHCW are located on the two hospital sites. Services at Hospital of St Cross are reported on in a separate report.

An acute medical unit (AMU) incorporates assessment areas, a short-stay ward, an acute ambulatory clinic and a recently opened GP assessment unit (GPAU).

Both stroke thrombolysis and primary percutaneous coronary intervention are delivered 24 hours, seven days a week, on the University Hospital site in Coventry.

The medical services include specialty rotas for cardiology, neurology, nephrology, haematology, respiratory medicine, gastroenterology (including an acute upper gastro-intestinal bleed service) and oncology.

During our inspection, we visited ten medical wards, two of which were elderly care wards. We also visited patients who were being looked after by medical consultants but were accommodated on other wards in the hospital because of lack of capacity on the medical wards.

We spoke with over 70 members of staff, including nurses, doctors, therapists, administrators and housekeepers. We spoke with 55 patients and 18 relatives. We reviewed 22 care records and observed interactions between staff and patients.

Before, during and after our inspection, we reviewed information sent to us from the trust.

# Medical care (including older people's care)

## Summary of findings

Overall, we found that the service required improvement.

Patients were positive about the care and treatment they had received from the trust. We observed that patients were treated with compassion and kindness by dedicated, professional staff.

When patients were infectious or suspected of having an infection, practices and procedures did not always protect against the risk of the spread of infection.

The storage of controlled drugs, which need extra security storage arrangements, did not always ensure that controlled drugs were stored following good practice in NHS hospitals.

There was a shortage of nursing staff on all the medical wards. The trust was using large numbers of agency and bank nurses.

All staff we spoke with were able to define a safeguarding concern, and were aware of their role and responsibilities to safeguard vulnerable adults from abuse.

We found variable record keeping with regard to people's care planning and observations.

Staff had access to specialist training that included training to support people with dementia.

Multidisciplinary working was evident to coordinate patient care.

Patients said they were kept informed and felt involved in the treatment they received. Discharge arrangements for medical patients needed to be better organised, and many patients were being discharged later in the day than planned.

The arrangements for identifying and managing risks were not robust. Poor recording of care plans and concerns about the management of medicines had not been identified by any audits undertaken by the trust.

Staff felt under pressure, mainly due to poor staffing levels. This was affecting staff morale.

## Are medical care services safe?

Requires improvement



We found that medical services required improvement in relation to safety. Staff understood their responsibility to report concerns and record safety incidents. We saw evidence of learning from incident reporting. All staff we spoke with were able to define a safeguarding concern, and were aware of their role and responsibilities to safeguard vulnerable adults from abuse.

However, we found that controlled drugs were not stored in line with good practice guidance. The quality of record keeping was variable in relation to care planning and observations. There was a shortage of nursing staff on all the medical wards, which resulted in the trust using large numbers of agency and bank nurses.

### Incidents

- Between February 2014 and January 2015, medical services reported 77 serious incidents through the National Reporting and Learning System (NRLS). Grade 3 pressure ulcers and slips, trips or falls accounted for the highest number of these incidents.
- Staff we spoke with were aware of, and had access to, the incident reporting system. This allowed them to report all incidents, including 'near misses', in which patient safety may have been compromised. We reviewed safety records, and incident and accident reports, and saw evidence that these were reviewed and action taken when necessary. For example, the ward manager on Ward 40 told us that they reviewed all incidents weekly and fed back by letter to the relevant person. This was confirmed by staff we spoke with.
- Staff in the GP assessment unit (GPAU) said that, although they were aware of the incident reporting system, they did not feel confident in completing incident reports because they felt that "nothing gets done".
- The trust investigated every serious incident through a root cause analysis (RCA) process. We looked at a selection of RCAs, which involved pressure ulcers, falls and incidence of infections, and saw that required actions were being addressed. For example, in response to a high number of incidents relating to pressure ulcers, the trust had introduced the intentional rounding (or

# Medical care (including older people's care)

'comfort rounds') system on all the medical and care of the elderly wards. This is a system where nursing and healthcare assistant staff regularly check on patients every 2 hours.

- Staff carried out various checks on patients, such as comfort, hydration, nutrition, continence, equipment, positioning, mobility and skin condition. Patient records we looked at showed that 'intentional roundings' were undertaken every two hours.
- The trust had robust systems and processes for action and dissemination in the event of Central Alerting System (CAS) alerts. CAS is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety-critical information and guidance. CAS alerts were sent from the trust's central source to medicine care groups. The health and safety lead nurse logged them on a database and took the specified action (for example, informing all the ward managers and giving instructions). Each ward manager detailed the actions required regarding the alert and any outcomes for their ward.
- Mortality and morbidity reviews were undertaken and discussed at the quality improvement and patient safety (QIPS) meetings. Minutes of meetings we reviewed showed that, when needed, actions were taken to improve practice.

## Duty of Candour

- Senior staff we spoke with were aware of the Duty of Candour legislation and able to describe the responsibilities involved.
- Senior staff said they had been involved in root cause analysis meetings with the outcomes being cascaded to staff during team meetings. This meant the trust had established processes to address concerns and complaints openly and honestly.

## Safety thermometer

- The NHS safety thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections (C.UTIs), venous thromboembolism (VTE) and falls.
- The safety thermometer information was displayed at the entrance to each ward so that all staff were aware of the performance in their ward or department. This

included information about infections, new pressure ulcers, new urinary tract infections (UTIs) and VTE. For example, the display board showed that Ward 34 was 100% harm free and Ward 41 97% in February 2015.

- For medical services, rates of all grades of pressure ulcers and C.UTIs remained low with a steady prevalence rate, despite a small peak in October 2013.
- Falls had remained low from July 2013 to July 2014 with none reported between November 2013 and January 2014. There was a small rise between March and May 2014, with a steady decrease thereafter.
- In response to the number of falls, the trust had developed a 'falls care bundle' for all patients identified as being at risk of falls. This included early identification by using the Falls Risk Assessment Tool (FRAT) and developing comprehensive action plans. Throughout our inspection, we saw that patients at high risk of falls were clearly identified and actions taken (for example, the use of low-level beds) to minimise the risk.
- Ward staff told us that, if any concerns arose from audits, they would be contacted by the relevant department. For example, if the ward had an incidence of hospital-acquired infection, they would be visited by the infection control team.

## Cleanliness, infection control and hygiene

- We saw that care environments were clean and well maintained. All wards we visited were clean and cleaning schedules were clearly displayed on the wards. Equipment was cleaned and marked as ready for use with 'I am clean' labels.
- Staff followed the trust's infection control policy. Staff were 'bare below the elbow'. This means that all staff in contact with patients will be able to wash their hands and wrists effectively without the restriction of cuffs, watches or jewellery. Staff had access to personal protective equipment that included aprons and gloves.
- Instructions and advice on infection control were displayed at the ward entrances for patients and visitors. Personal protective equipment was available in sufficient quantities.
- We found that between April 2014 and February 2015 there had been 13 MRSA bacteraemia (in 11 patients) 9 of which had developed in patients under the care of the trust.
- We reviewed the records for four of the reported MRSA bacteraemia.

# Medical care (including older people's care)

- We found that post infection reviews' (PIR) had been completed. However investigations did not in all cases provide assurance of effective investigation and lacked detail. For example, there was also no reference to MRSA screening rates within most of the investigations other than the individual patient concerned. There was lost opportunity for identifying the root cause and any actions required.
- We reviewed an incident on Ward 50 when a patient who had been diagnosed positive for *Clostridium difficile* was nursed in a side room. The patient was discharged and another patient admitted to the room. This patient was also diagnosed with *Clostridium difficile*.
- We were informed that although the room had been cleaned between patients, a 'deep' clean had not been undertaken. We were informed that this was because the ward staff had been told that bed needed to be used immediately. This was not in accordance with the trusts own policy and placed the patient admitted into the bed at risk of cross infection.
- We were informed that no detailed investigation had been undertaken to ascertain if the infections were related because the infection prevention link nurse was on unavailable. This demonstrated lack of ownership by the clinical team caring for the patient in ensuring this was addressed and any actions taken.
- One of the records we read on the acute medical unit (AMU) identified that a patient had had a cannula inserted that was out of date. We saw that this had been acknowledged by a doctor who had allowed it to remain. However, we did not find any guidance for staff with regard to checking for infection at the cannula site.
- We observed a healthcare assistant working on Ward 23. They attended to three patients, helped them to drink and held hands with each one. They then gave a patient a tablet that had been left on the patient's table. They did not clean their hands between patients or check that the tablet was for the patient concerned.
- On Ward 40, we found that the surfaces under the pressure cushions were dirty with the remains of food. We brought this to the attention of the ward sister. We revisited the ward the next day and observed that they had attended to our concerns and all surfaces under the pressure cushions had been cleaned.
- We found a bad odour under the waste bin in one of the bathrooms on Ward 40. On investigation, we found a disposable pad wedged under the bin. This meant that

cleaners were not moving items to ensure the cleanliness of rooms. This was brought to the attention of the ward sister. We revisited the ward and observed that the items in the bathroom had been moved and the surfaces were clean, tidy and odour free.

- We observed a member of domestic staff cleaning patients' tables in one of the bays on Ward 42. The staff member swept all the debris from the tables on to the floor. The accumulated rubbish was swept away about 15 minutes later when all the tables had been cleared. We noted various staff members step across, or sidestep, the rubbish while entering or leaving the bay.
- We also observed this practice on Ward 23 where medical patients were being cared for. It was unhygienic as well as unsafe, because a patient could potentially slip on the debris on the floor. We raised these concerns with the senior sister on duty in both wards.

## Environment and equipment

- We observed that each ward area had enough moving and handling equipment to enable patients to be cared for safely. Equipment was maintained and checked regularly to ensure that it was still safe to use. It was clearly labelled with the date of when the next service was due.
- The ward sister on Ward 40 said the ward had 'falls' alarms for patients who were at risk of falls. The records showed that falls risk assessments had been undertaken.
- Staff said there were no issues or concerns in obtaining equipment, and they could access bariatric equipment when needed.
- We inspected the resuscitation trolleys on Wards 10, 21M, 23, 34, 40, 41 and 42 with no issues or concerns identified. We saw the equipment had been checked daily. We noted the checks on Ward 50 had not been completed on five occasions in January 2015 and seven occasions in February.
- There was enough equipment to maintain safe and effective care on the wards. Staff told us if they needed equipment, for example, pressure relieving equipment, they made a request to a local company who responded quickly and efficiently.
- The trust used blue pillowcases to identify dementia patients. During our visit, we saw that patients had blue pillowcases allocated appropriately.

## Medicines

# Medical care (including older people's care)

- To Take Out (TTO) medicines were ordered when patients were deemed medically fit for discharge. Staff said they did not have any issues with obtaining medicines because the ward had access to a satellite pharmacy. A satellite pharmacy is when a smaller pharmacy is located elsewhere from the main pharmacy.
- We reviewed the stock list and checks within the areas visited, with no issues or concerns identified.
- We visited the clinical room in the GPAU. There was a stock check in use for all medicines that was overseen by the pharmacy. The fridge temperatures had been checked daily with no issues or concerns identified. The clinical room was clean and tidy. There were clear processes and procedures on display for the mixing of intravenous fluids.
- In the GPAU, there was a drugs trolley that was used for the storage of needles. We found the drugs trolley open on the ward. This meant that the equipment was not stored safely and securely to prevent theft, damage or misuse.
- We looked at medication management on the oncology Wards 34 and 35. A pharmacist visited the wards each weekday. We saw that pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date. Interventions by a pharmacist were recorded on medicine administration record charts to help staff administer medicines safely. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed that patients were getting their medicines when they needed them. If they were allergic to any, this was recorded on their medication administration record.
- We found that controlled drugs, which require extra security storage arrangements, were not always stored in line with good practice in NHS hospitals. All four controlled drugs cupboards we looked at were too small for the number of controlled drugs needing to be stored. This meant that some controlled drugs were not stored safely.
- The service was able to provide a range of different treatments and care. We saw that records had generic care plans. Most of these had been customised to take into account specific patients' needs.
- We found that completion of documentation varied between wards and patients. Assessments were available (for example, for pain, nutrition, falls, pressure ulcers, skin condition, mobility and personal care).
- Two of the records we read did not contain enough information to help staff in caring for and treating the patients. For example, one record indicated that the patient had back pain. We found no evidence that this had been addressed and it was not mentioned in the handover notes we read.
- Another patient's records stated that they had a mental health disorder. However, we found no guidance for staff to support the patient should they become distressed or show symptoms pertinent to the disorder.
- The trust used a sepsis early recognition tool, called 'Sepsis Six', for patients identified as having an acute infection. A triage assessment for a medical patient on Ward 23 had identified that the patient had a suspected community-acquired infection and asked ward staff to 'think sepsis'. We found that a 'Sepsis Six' form had not been completed for the patient.
- The care records for another patient on Ward 23 identified that they were receiving **medication** to prevent and treat harmful blood clots. There was no venous thromboembolism (VTE) assessment evident in their records. There was also no nutrition and hydration plan and the chart to record intentional rounding had last been completed at midnight the previous night.
- We found the daily fluid totals were not all completed in the records read. For example, a record we reviewed on Ward 50 indicated that the patient should be restricted to one litre of fluid a day. There was no evidence of a fluid balance chart being maintained for them. On Ward 42, we found input and output for the day for one patient had been entered, but not balanced. We also found that, out of six records reviewed for medical patients on Ward 23, only two fluid balance charts had been completed. This meant that staff overseeing the records could not identify adequate hydration and report any abnormalities in patients' fluid records.
- The Matron for Older People Care told us that fluid balance charts were not routinely audited by the trust.
- Comfort rounds (intentional rounding) were undertaken every two hours. These included change of position and

## Records

- We looked at the paper records of 22 patients. These showed that information about the patients, including their medical history and allergies, had been collected.



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pressure area care as needed. However, the documentation for these rounds did not consistently record all aspects of the care provided. We saw, for example, that one patient's intentional rounding had not been recorded within the 2 hours before we assessed their care plan. On Ward 23, a patient had been identified as needing hourly rounding. We saw that a round had not taken place for four hours.

- A patient transfer checklist was completed for all patients transferred internally, and this information was filed in the patient's notes. We saw a checklist that had been completed; this included information to ensure that the patient continued to receive appropriate care and to minimise any risks.
- The medical records identified that patients were reviewed regularly by medical consultants and junior doctors.
- Patient information and records were available by the nurses' station. However, on some wards, we found records to be easily accessible to others visiting. For example, on Ward 23, we saw that five sets of care records were left on a table in one of the bays, instead of being kept in a secure area.

## Safeguarding

- The ward sisters said the trust had a rolling programme to ensure that staff kept up to date with their deprivation of liberty safeguarding (DoLS) training.
- The training records within the wards we visited identified that nursing staff had attended safeguarding adults and children training at levels 1 and 2 respectively. This was confirmed by staff we spoke with.
- Staff were able to describe situations in which they would raise a safeguarding concern, and how they would escalate any concerns.

## Mandatory training

- Staff were aware of the need to attend mandatory training and were able to book their training online themselves. The trust also provided face-to-face training when applicable.
- The ward managers kept accurate records of the training needs of staff, and employed a quality officer to manage any outstanding training. This was recorded on the electronic staff record (ESR) system.
- In acute medicine, we were told that a small team of specialised nurses delivered in-house training and ensured that staff were up to date with mandatory

training, which was reported monthly at QIPS meetings and discussed at senior nurse management meetings. Mandatory compliance was 88% across medical care services for all staff in December 2015.

- We looked at the mandatory training records at ward level and found that most staff had completed their training. For example, 90% of staff on Ward 40 and 87% of staff on Ward 34 had done so.
- Mandatory training covered a range of topics including moving and handling, hand hygiene, safeguarding adults and children, and health and safety. Staff also completed extra training, which included dementia awareness, tissue viability and drug assessments.
- Staff on Ward 42 said they had completed multi-agency public protection arrangements (MAPPA) training.
- Staff in the GPAU said they had completed percutaneous endoscopic gastrostomy (PEG) training. This is a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and oesophagus.
- The trust had a 10-minute power training available for staff called 'FOCUS ON FIVE – ASKIN (Assess, Surface, Keep Moving, Incontinence and Nutrition)', which related to preventing pressure ulcers. This was provided at a time that suited the demands of the wards. We saw posters and processes on display in the wards we visited.
- Occasionally training was cancelled because of staffing shortages, but staff were given choices in how to complete their annual mandatory training, for example, e-learning, face to face or ad-hoc practical sessions.

## Assessing and responding to patient risk

- Three patients on Ward 41 said they did not feel safe in the evening because of slow response to call bells. The ward sister said this was due to two staff having to be available to attend to a patient's needs when behind closed curtains. When we revisited the ward, the sister told us they had reviewed the patients' concerns and amended their protocol to allow patients to be attended by one member of staff when behind closed curtains, should the call bell ring. This meant they could attend to other patients as needed. We saw in a handover meeting that this change in protocol had been implemented. The ward sister said they would also address the change in protocol at the next staff meeting.

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- Patients who required a nasogastric (NG) tube were given mittens. An NG is a tube that is passed through the nose, past the throat and into the stomach. The mittens supported patients who became restless and might inadvertently remove their feeding tubes or other essential access lines.
- Some staff said patients could be challenging and “flare up” with staff. Senior staff said they completed Antecedent–Behaviour–Consequence (ABC) charts in response to the patient risk. These were identified in the records read.
- Senior staff said they were working alongside staff to support a change in culture and approach to people with challenging behaviour. They said this was a “work in progress” and there had been visible improvement over the past 6 months. Healthcare assistants confirmed that the atmosphere on the ward had improved over the past few months.
- Staff in the GPAU said they had access to a panic button to summon security in the event of an emergency. Some said security responded instantly while others said it took about 20 minutes for them to arrive. Staff confirmed that they would not complete an incident report when calling security to their aid.
- Patients’ records contained early warning score (EWS) charts completed by appropriately trained personnel (NICE clinical guideline 50 - Acutely ill patients in hospital: recognition of and response to acute illness in adults in hospital). These charts are designed to identify changes in patients’ observation and wellbeing that indicate a deteriorating condition. The records we read on the wards identified that routine changes had been appropriately actioned. This meant that staff took the required action when a EWS observation indicated that a patient’s condition was deteriorating.
- All patients diagnosed to be FAST positive strokes were assessed by a stroke registrar and stroke nurse immediately on arrival at the hospital. FAST is a process of recognising the most common signs and symptoms of a stroke. All new admissions to the neurology and stroke unit were reviewed by a consultant within 24 hours of admission.
- The trust had replaced the paper-based observation system with the VitalPAC recording system. This touch screen technology enabled quick and reliable recording of observations and automated EWS calculations at the bedside. If a patient’s deterioration was detected, an urgent alert was generated to enable appropriate escalations to be made to duty clinicians and hospital-wide teams.
- Nursing staff felt well supported by doctors when a patient’s deterioration was severe and resulted in an emergency.
- The records showed that patients had MRSA screening on admission.
- Risk assessments were undertaken for individual patients in relation to VTE, falls, malnutrition and pressure sores. These were documented in the patient’s records and included actions to mitigate the risks identified.
- There were clear strategies for minimising the risk of patient falls. Staff on the wards showed a good understanding of the causes of falls and how to avoid them. However, we found that not all falls and bed rail risk assessments had been completed and signed by the patient and/or their relative or representative.
- Clinical professionals told us they supported the Commissioning for Quality and Innovation (CQUIN) goal, which was to improve dementia and delirium care, including sustained improvement in ‘Finding people with dementia, Assessing and Investigating their symptoms and Referring for support (FAIR)’. We saw that 90% of patients aged 75 years and over had been screened.

## Nursing staffing

- Nursing numbers were assessed using the national Safer Nursing Care Tool and there were identified minimum staffing levels. The safe staffing levels were displayed at the entrance to every ward, including planned and actual numbers.
- All staff we spoke with, from the management team to healthcare assistants, recognised nursing recruitment as a major safety risk to the service. It was captured on the directorate risk register. The management team told of various measures, such as open recruitment days and overseas recruitment initiatives, that they had put in place in an effort to decrease the vacancy factor. All ward-based staff were aware of these initiatives and supportive of them. There was general agreement that recruitment and retention of nursing staff were seen as a priorities by the trust.
- When shortfalls in nursing numbers were identified, temporary staff from the National Healthcare Service



# Medical care (including older people's care)

Professionals (NHSP) or from an agency were used to ensure that there were adequate numbers of registered nurses to meet patients' needs. When bank and agency staff were used they received local induction prior to working in the department and their competency was checked. We saw evidence of the induction for one agency staff nurse during our unannounced visit to the trust.

- Staff on the wards said they had a flexible shift rota that took into account their work-life balance by ensuring that they had time with family and friends.
- Patients told us that the staff and the wards were busy but the nursing staff looked after them well and they did not have to wait long for help or care.
- We observed nursing handovers on a number of wards, both during the day and at night time. We saw nursing handover sheets that contained information about care needs, past medical history and plans for discharge. There was a thorough discussion of each patient, which included information about their progress and potential concerns.
- Staff said they felt the night staffing levels were poor but confirmed that they conformed to the patient-staff ratio. This was confirmed in the rotas seen.
- We saw the rotas for nursing staff on most of the wards we visited. Both agency and bank staff were used on a daily basis. We looked at actual versus rostered staffing levels on wards. We found them to be identical on the day of our visit for all three shifts, and saw them displayed on whiteboards near the entrance to the wards for visitors to see.

## Medical staffing

- Staff told us there were enough consultants and doctors on the wards during the week. Junior doctors, too, felt there were adequate numbers of doctors on the wards.
- We viewed the staffing rotas for medical care services and enough medical staff were on duty.
- There was an established medical team for medical patients placed on other specialty wards, such as gynaecology or surgery. These patients are called 'outliers'. They were reviewed by doctors from the medical directorate in a timely manner.
- Consultant ward rounds took place daily. During the day all new patients were seen by a consultant after admission. Consultants were contactable by phone if a doctor needed extra support.

- Handovers were consistently formal and structured. During our unannounced visit, we observed a staff handover. The handover covered care of patients based on the severity of their condition and any anticipated problems.

## Major incident awareness and training

- Staff were aware of the procedures for managing major incidents, winter pressures on bed capacity and fire safety incidents.
- Emergency plans and evacuation procedures were in place and on display. Staff were trained in how to respond to major incidents.
- There was a bed management system that aimed to ensure that patients' needs were met when there was an increased demand for beds.

## Are medical care services effective?

Good



Medical care services were provided in accordance with evidence-based national guidelines. National guidelines and pathways were used extensively, so that best practice was used to manage patients' care.

Policies and procedures were accessible to staff and they were able to guide us to the relevant information. Care was monitored to show compliance with standards and there were good outcomes for patients.

There were arrangements for ensuring that patients received timely pain relief. Patients were assessed for their nutritional and hydration needs and referred to a dietician if required.

Staff had access to specialist training that supporting people with dementia.

Multidisciplinary working was evident to coordinate patient care. Overall, staff had access to training and had received annual appraisals.

## Evidence-based care and treatment

- The medical service participated in all national clinical audits that it was eligible for. The directorate had a

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formal clinical audit programme where compliance with the National Institute for Health and Care Excellence (NICE) guidance was assessed, areas with only partial compliance were reviewed and action plans were made.

- There were care pathways based on NICE guidance for stroke patients, heart failure, diabetes and respiratory conditions. The trust had a pathway for patients with sepsis to enable early recognition, prompt treatment and clinical stabilisation.
- Local policies, such as for pressure ulcer prevention and management, were written in line with national guidelines and staff we spoke with were aware of these policies. The trust launched a '100 days free from pressure ulcer' initiative. Each ward and department was given a target of 100 days without a pressure ulcer. Particular emphasis was placed on nursing and therapy staff who had a direct role in assessing risk factors and repositioning patients. We saw the wards visited had achieved their target.
- As part of the Commissioning for Quality and Innovation (CQUIN) framework, the trust was required to sustain frequency in the reduction of pressure ulcers. It launched 'React to Red Skin', which was overseen by the trust's tissue viability nurses. This campaign was aimed primarily at patients, families and carers.
- All documentation and information relevant to pressure ulcer prevention had been adapted to incorporate FOCUS ON FIVE – ASKIN (Access, Surface, Keep Moving, Incontinence and Nutrition) which represented the five elements of pressure ulcer prevention, (NICE clinical guidance 29, Pressure Ulcer Prevention). This meant the trust had ensured and adapted a consistent message to all staff, patients and carers.
- The trust met the national dementia CQUIN that identified all patients with a diagnosis of dementia. It achieved this by giving staff dementia and delirium training and developing a 'forget-me-not' champions group to share good practice. The forget-me-not care bundle focused on critical elements of nutrition, hydration, communication and the environment for those living with dementia and their carers.
- We saw completed 6-monthly acuity audits. The trust monitored the importance of workforce planning to ensure that there was adequate staffing with the correct skill mix on each ward.
- We saw completed catheter, cannula and sluice machine audits that showed the wards were 100% compliant.

- The Infection Control Nurses Association (ICNA) audit had been completed with no issues or concerns identified. The ICNA audit tool was used to monitor infection control guidelines. The records seen provided objective data on compliance with trust policies.

## Pain relief

- Patients were assessed pre-operatively for their preferred pain relief.
- The VitalPAC records showed that patients' pain relief had been risk assessed using the pain scale found within the early warning score (EWS) system.
- Patients told us they were given pain relief when they needed it, and nursing staff always checked if it had been effective.
- Staff could access support from the pain management team when required.

## Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess and record patients' nutrition and hydration when applicable. We observed that fluid balance charts were used to monitor patients' hydration status. However, the records seen on two wards did not include the totals for ease of information to staff reviewing the MUST tool.
- Patients had access to drinks by their bedside. When necessary, care support staff checked that regular drinks were taken.
- Patients said they were given choices of food and snacks. However, they had mixed views regarding the quality of the food available.
- Staff said they monitored patients' nutritional state and would make a referral to the dietician when needed. We saw evidence of a referral to the dietician in some of the records we read.
- The wards we visited had an 'at a glance' board that provided an overview of the patients on the ward. The areas identified included support with feeding and whether the patient was diabetic.
- The wards had introduced protected time when visiting was not allowed. This was during meal times. However, during our inspection, we observed visitors on wards during these times. They told us they came during lunchtime to help their relative to eat. They were

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concerned about how much assistance was given patients to drink, and reported that they often visited their relative and saw that hot drinks left on the bedside table had gone cold.

- Cold snacks were available for patients outside meal times.
- A catering assistant said they used a 'cook chill' system and that patients were able to choose their lunch and evening meals the previous day. They could access differently textured food (for example, mashed or puréed) and meals suitable for different cultures, such as halal food.
- There were 'red trays' to identify patients who needed support with eating. We observed one patient with a red tray being helped by staff. When we asked two members of staff on the ward what the red tray system meant, they were able to tell us.

## Patient outcomes

- The trust took part in the Sentinel Stroke National Audit Programme and in the most recent audit; data showed the trust had improved from category E to category D. It performed well in meeting physiotherapy and discharge standards for stroke patients. It performed below the national average in speech and language therapy, and specialist assessments.
- In response to the SSNAP results the trust developed an ongoing action plan that included recording patients earlier onto the SSNAP database. Other actions taken included ensuring a 'hyper-acute stroke' bed was made available on ward 41, the stroke ward, every night and that senior stroke nurses could request CT brain scans, carotid ultrasound and chest x-rays.
- Trust data for the period July to September 2014 demonstrated improvements made. For example, 51% of stroke patients had a CT scan within an hour compared to the England average of 44%.
- The trust's performance in 2012 and 2013 was better than the national average in the Myocardial Ischemia National Audit Project (MINAP), a national clinical audit of the management of heart attack.
- The cardiology specialty participated in the 2011 Dr Foster Global Comparators project which highlighted timeliness of Primary Percutaneous Coronary Intervention (PCI) to a corresponding low mortality rate. The trust undertook a local initiative to improve timeliness of Primary PCIs. The percentage of Primary PCIs being administered within 150 minutes of receiving

an emergency call has risen to 90%, which has consistently been maintained since 2012. The most recent Adult Cardiac Interventions Audit (2013) recognised UHCW as an outlier good performance.

- The trust participated in the National Parkinson's Disease (PD) Audit 2012. The report was published in July 2014 and demonstrated that the trust was performing better than the national average for most standards. Examples of action taken by the trust as a result of the audit included the implementation of an Impulse Control Questionnaire tool and development of nurse led PD clinics to ensure patients are fully informed about impulse control disorders (ICDs).
- The trust is investigating the possibility of introducing a new Best Practice Tariff (BPT) clinic to assist with ensuring new PD patient referrals are seen within six weeks. BPT is a Government initiative and outlines the standards of care people with Parkinson's need and also ensures greater access to services, including therapy and mental health services.
- The trust participated in the National Review of Asthma Deaths (May 2014), and told us that an action plan was in progress to meet the recommendations of the review. Actions included the trust investigating the possibility of the trust Asthma Lead being notified of all asthma deaths which would allow each asthma death to be reviewed and investigations being undertaken, if appropriate. The trust was working in partnership with the local Clinical Commissioning Group (CCG) to develop an asthma network in the city.
- Overall, the trust performance in the National Diabetes Inpatient Audit (NaDIA) was worse when compared with the England average for 16 of the 21 indicators. Examples included visits by the specialist diabetes team, insulin errors and foot risk assessments during a patient's stay. However, staff awareness of diabetes and patients' satisfaction was better than the England average.
- In response to the NaDIA report, a steering group had been developed to aid with driving improvement in diabetes care. An action plan is being developed in conjunction with the local CCG. Examples of actions they have already implemented or intend to implement included:
  - A consultant and specialist registrar ward based team specifically for inpatient care. Daily ward round will be undertaken which will also include visits to AMU and ED.

# Medical care (including older people's care)

- A diabetes specialist nurse post is being advertised by the trust.
- An inpatient 'foot pathway' has been developed and awaiting approval by the board.
- Monthly staff education sessions are provided for nursing staff.
- The trust also had a specialist diabetes team within the hospital based Warwickshire Institute for the Study of Diabetes, Endocrinology and Metabolism (WISDEM). WISDEM was set up to help improve the care of individuals with diabetes and other hormonal illnesses through excellence in clinical care, education and research. The staff included doctors, specialist nurses, dietitians and other healthcare professionals.
- The trust's emergency readmissions were within the expected range. The standardised readmission rates compared favourably with national rates except for general medicine and gastroenterology where they were above national rates.

## Competent staff

- Staff told us they did not receive formal supervision. However, they felt that handovers, ward rounds and board rounds provided them with learning opportunities. They also told us that they could address any concerns with informal support from their managers, who were generally accessible.
- The records for 2014 showed that 89% of staff had received an annual appraisal. This was slightly higher than the England average of 85%.
- Care of the elderly wards had regular input from a dementia specialist nurse. Most staff on these wards had attended dementia training. A selective number of staff were trained as dementia champions on the medical wards we visited. We saw the trust had extended the dementia training programme to June 2015.
- New members of staff told us that they had been well supported since joining the hospital. They had completed a trust-wide induction programme. The nursing staff had also been supernumerary on the ward for two weeks, giving them an opportunity to understand the processes and procedures.
- We discussed revalidation of doctors in the directorate with a clinical director. We were informed that the

process was working well and that all medical staff were up to date. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise.

## Multidisciplinary working

- We observed multidisciplinary meetings on two wards. Most of these were attended by a full range of staff, including medical staff, nurses, therapists and social workers.
- Expected discharge dates were discussed at the meetings and all decisions agreed by the multidisciplinary team members. The types of assessment and therapy a patient needed were identified at meetings and steps taken to arrange these.
- We saw minutes of monthly multidisciplinary meetings included a psychologist, ophthalmologist, and a speech and language therapist.
- During our visit to the wards, we observed a good working relationship with the dietitians.
- A daily ward round was held to review care, treatment and discharge planning. Staff informed us that there were good relationships between nursing and medical staff.
- Doctors and nursing staff told us that nurses and doctors worked well together within the medical specialty. We saw evidence of this on the wards we visited.
- Speech and language therapists attended the wards. We saw evidence of this in the records we read.
- Staff said the tissue viability nurse visited the ward when patients with pressure ulcers were identified. They then visited the ward weekly.
- Patients' records across the medical services showed they were referred, assessed and reviewed by physiotherapists, dietitians and the pain team.
- There was dedicated pharmacy support on all the wards we visited.
- On the medical wards, patients with dementia were assessed and reviewed by dementia specialist nurses. A dementia care pathway was used to treat people with dementia.

## Seven-day services

- Consultant ward rounds took place daily on all the wards we visited. Over the weekend, all new and deteriorating patients were seen by a doctor.

# Medical care (including older people's care)

- Staff had access to on-call pharmacists to dispense urgent medications at weekends and out of hours.
- The medical services had access to a consultant over the weekend if needed.
- The 'hospital at night' model of care had been adopted at the trust. This is an out-of-hours team of doctors and nurses who work across the trust to ensure that quality and safe care is delivered to patients at all times.

## Access to information

- Staff told us they had good access to patient-related information and records whenever needed. The agency and locum staff also had access to the information in care records to enable them to care for patients appropriately.
- Nursing staff told us that, when patients were transferred between wards, staff teams received a handover about their medical condition. We saw that ongoing care information was shared appropriately in a timely way.
- Discharge summaries were given to GPs to inform them of a patient's medical condition and the treatment they had received before discharge.
- The trust used the VitalPAC to record the vital signs of patients and monitor EWS recognition. We saw this being used by the nursing staff. It was seen as vital to ensuring patient safety on the wards.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had awareness of the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards (DoLS). The trust ensured that decisions about the living arrangements of a person without capacity did not amount to a deprivation of liberty.
- Patients were asked for their consent to procedures appropriately and correctly. We saw examples of patients who did not have capacity to consent and the MCA was adhered to appropriately with documented assessments.
- The records, when applicable, showed clear evidence of informed consent that identified the possible risks and benefits of care.
- When patients did not have capacity to consent, staff said they would apply for best interest decisions in deciding the treatment and care they required.
- Ward staff were clear about their roles and responsibilities regarding the MCA.

## Are medical care services caring?

Good



Patients received compassionate care and we observed a number of positive interactions between patients and staff. One patient said they felt patronised by the terms used by staff.

Patients were happy about how they had been looked after and complimented the staff. They told us "The nurses are fantastic", and "I can't fault the care I've had here". They said staff were supportive, although they could be busy at times and this reduced their availability to help patients.

Patients said they were kept informed and felt involved in the treatment they received.

The NHS Friends and Family Test showed that over 78% of the respondents for December 2014 said they were likely to recommend the trust to friends or family.

## Compassionate care

- The patients and relatives we spoke with were pleased with the care provided. They told us that doctors, nurses and healthcare assistants were caring and compassionate, treated them with dignity and respect, and responded quickly to their needs.
- One patient on Ward 41 said they felt staff patronised them by using the terms 'sweetheart' and 'darling'. We brought this to the attention of the nurse in charge.
- Privacy and dignity were maintained on the wards we visited. We observed curtains were closed round a patient's bed if personal care was required.
- We checked if patients were able to reach their call bell in five of the medical wards we visited. We found that 14 of the 15 patients we checked had their call bell within reach. This meant that most patients were able to call staff using the call bell if they needed help. We drew to the attention of the staff the patient who was unable to reach their call bell.
- The trust used the NHS Friends and Family Test to record and report on patient feedback. This was a single question survey that asked patients whether they would recommend the service they have received to friends or family who needed similar treatment or care. Between April 2013 and July 2014, the average hospital-wide response rate was 22%, compared with the England



# Medical care (including older people's care)

average of 30%. The average response rate for the medical wards was 27%. The monthly results of the Friends and Family Test in December 2014 showed that over 78% of patients receiving medical care would be either likely or extremely likely to recommend the service.

- Feedback from patients and relatives on 'Impressions', an online survey operated by the trust, showed that for the quarter ended December 2014, 95% of respondents had had a positive experience at the trust.
- The Patient-led Assessment of the Care Environment (PLACE) 2014 scored the trust as 96 for privacy, dignity and wellbeing compared with the England average of 87.

## Understanding and involvement of patients and those close to them

- We heard staff introducing themselves to patients and explaining the treatment and care they were giving. They asked patients if they had any questions and gave them time to reply.
- There was evidence of when a patient's family had been involved in their relative's care and discharge plans. For example, discussions with family members were documented in patients' notes on the oncology ward. These discussions detailed information about the care and support patients would require when discharged from hospital.
- Patient information packs were available. These contained information about the hospital and what patients should expect in terms of care. They also included details of the staff member to contact if a patient or their family had any concerns about their treatment while on the ward.
- We looked at six patients' records on Wards 40 and 41. We saw that four had the patient's surname recorded with no hospital number or date of birth. This meant there was the risk of a patient with the same name being given the incorrect treatment and care.
- The national Cancer Patient Experience Survey 2013/14 showed that 71% of patients were involved in decisions about their care and treatment, which placed the trust in the middle 60% of trusts that had completed the survey.

## Emotional support

- The Cancer Patient Experience Survey 2013/14 showed the trust was in the middle 60% of trusts for 'patient being able to discuss worries or fears with staff during their visit'.
- Patient feedback on the cardiology and respiratory wards regarding the support they had received from staff was very positive. The Cardiac Rehabilitation and Heart Failure team gave patients emotional support, both in hospital and in the community.
- Patients had access to further support from clinical nurse specialists. For example, a liver nurse specialist was available to support patients with liver disease both on the wards and when they visited the medical day unit.

## Are medical care services responsive?

Good



There was support for vulnerable people, such as people with dementia or mental health problems. Flexibility with visiting hours was given to carers of patients with mental health disorders.

There was a proactive approach in medical care services to encouraging and learning from patient complaints. Patients reported that they were satisfied with how complaints were dealt with by the trust.

Discharge arrangements for medical patients needed to be better planned and many patients were being discharged later in the day than intended. The trust had developed several initiatives to improve patient flow. For example, a daily board round was introduced each morning and afternoon to coordinate patient care and prioritise discharge when appropriate.

There were also a large number of patients who had their discharge delayed because they were awaiting care home or care packages, the trust had identified this and were working with external partners to address it.

Information leaflets and consent forms were not available in easy-to-read formats. An interpreting service was available and used.

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

# Medical care (including older people's care)

- The GP assessment unit (GPAU) was being trialled to see if the project was beneficial to people who used the service. It had been open for 5 weeks. All GP referrals were now signposted to the GPAU instead of the emergency department. Staff said the service was beneficial because patients were seen more quickly and it reduced the pressure on the emergency department. This meant that patients were directed more quickly to staff who were best able to treat their individual needs.
- The GPAU was situated alongside the acute medical unit (AMU). The AMU's primary role was to provide rapid assessments, investigations and treatment for patients admitted urgently or as an emergency from the emergency department. The AMU admitted patients 24 hours a day, 7 days a week. Patients stayed in the AMU for up to 48 hours, during which time a management plan was instigated by the consultant-led acute care medical team. A specialist care of the elderly team looked after elderly patients with acute illness who needed admission to hospital for a few days.
- Staff said the arranging of scans could be difficult. All scans had to be validated and vetted. Validation is the process of checking to see that patients who are due to have appointments still need them. Vetting a request was an important part of ensuring robust governance methods for the delivery of a scan. Staff said the vetting process caused long delays because they were not automatically on the electronic system and staff had to obtain the correct authorisation.
- We saw the service had acknowledged that discharge planning was an area of concern. The clinical staff were assisting acute care by looking at delays in discharge and actions to take to facilitate discharge. We saw this was identified in the trust's quality strategy report.
- When patient experiences were identified as poor, action was taken to improve them. For example, staff caring for elderly patients explained how they had responded to a higher than expected number of patient falls. Patients had falls risk assessments that identified the high risk of falls.
- We were informed that discharge planning started soon after admission. However, it was difficult to identify when a patient's discharge planning began in some of the patient records we read.
- During our visits, we saw that planned discharge days for each patient were displayed on the whiteboard on each ward. We noted that some patients had not been discharged on the planned day. The board used the 'red, amber, green' system: 'red' represented patients who were not medically stable, 'amber' indicated patients requiring attention, and 'green' meant that patients were ready to be discharged and leave the ward.
- Discharge was sometimes delayed because of a lack of suitable accommodation for people to move on to, or funding for specialist placements. For example, we saw that 50% of patients on Ward 40 were fit for discharge but did not have an established package of care. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and the service overall.
- Across the hospital, bed capacity meetings were held six times a day to establish the availability of beds on the wards. We observed such a meeting. Immediate decisions were made to manage the bed situation across the trust. We saw there was a list of medical outliers and discussions were held to ensure that patients were in the best place for their care. The aim was to discuss the availability of beds and the flow of patients, and to instigate any changes that might facilitate more timely patient discharge.
- Senior managers spoken with acknowledged that bed flow management was poor and told us that the Emergency Department generated 60 to 80 medical admissions each day.
- The trust had developed several initiatives to improve patient flow. These included a daily board round each morning and afternoon to coordinate patient care and prioritise discharge when appropriate.
- There was an established medical team for medical patients placed on other specialty wards, such as gynaecology or surgery. The team was comprised of four consultants and six junior doctors and specifically looked after medical patients being cared for on non-medical wards, for example surgical or gynaecology wards, across the hospital.
- There was an integrated discharge team within the trust to help facilitate patient discharges. The team consisted

## Access and flow

- The average bed occupancy for the trust was 97%. This was above the England average of 87% and the 85% level at which it is generally accepted that bed occupancy can start to adversely affect patient care.



# Medical care (including older people's care)

of nurses, physiotherapists, occupational therapists and social workers. Members of the team attended daily ward rounds to ascertain which patients were ready for discharge.

- An early supported discharge team provided an early, intensive rehabilitation service for stroke patients. The team helped patients to leave hospital more quickly and return to their own homes so that they could maximise independence as quickly as possible.
- There was a weekend discharge team of a consultant and a junior doctor who reviewed all potential weekend discharges as identified by the medical teams on Fridays.
- There was a small discharge lounge with chairs. This was adjacent to the newly opened GP Assessment Unit. The lounge was open from 9am to 7pm. If a patient was medically and clinically discharged from a ward, they could transfer to the discharge lounge while awaiting final arrangements to be made (for example, transport, or medication to take home). We were told that waiting times for transport sometimes delayed a patient's discharge until very late in the evening, or resulted in the patient being unable to go home and having to remain overnight on a ward.
- We saw the figures of attendance for the period 4–19 February 2015 on display within the AMU. This showed that 441 patients had attended the unit, of whom 253 had been admitted. The figures showed that 164 of the patients admitted had been discharged.
- Bed pressures were compounded by high numbers of delayed transfers of care. Delayed transfer of care is when patients are in hospital, fit to be discharged but unable to leave the hospital because of external factors. The data provided by the trust showed that, between March 2013 and November 2014, there was an increasing number of delayed transfers of care.
- Between March 2013 and November 2014, the service had decreased its 18-week referral to treatment time (RTT). The specialty groupings were consistently meeting the England average target of 95%. Neurology, gastroenterology and rheumatology had a success rate of 99% while geriatric medicine and general medicine had a compliance rate of 100%. We saw the overall referral to treatment time for the service was above the England average.
- There was an arrangement with the local NHS mental health services to provide a liaison service for people with learning disabilities and mental health disorders. Staff were able to access support and advice from a learning disability nurse for individual patients and there was relevant information and tools on the trust intranet.
- Patient information leaflets on pressure ulcer prevention had been updated to include FOCUS ON FIVE – ASKIN (Access, Surface, Keep Moving, Incontinence and Nutrition), and provide pictures and diagrams so that patients were aware of pressure ulcers and how they could prevent them.
- The service had developed care pathways for dementia and delirium to improve the service for patients and their carers or relatives.
- The trust had introduced a 'This is me' booklet for patients with dementia. This had been developed by the Alzheimer's Society to alert and inform staff about identifying and meeting the needs of these patients. This was identified in the records we read.
- A 'forget-me-not' symbol and blue pillowcases were used to identify people with dementia on all the medical wards.
- On Ward 40, we saw that a memory lane and 'forget-me-not lounge' had been provided for reminiscence and as a calm, quiet space for people with dementia and their carers or relatives. The memory lane was made of 210 tiles which depicted local scenes from around Coventry and Warwickshire from the past 100 years.
- A wide range of patient literature was displayed in clinical areas giving disease- and procedure-specific information, health advice and general information relating to health and social care, and services available locally. Patient information leaflets were not displayed in any languages other than English.
- Patients' diverse needs relating to religion and ethnicity were recorded and we saw these were being met (for example, through specific diets and access to religious services).
- The hospital chaplains visited the wards on a regular basis. A multifaith room was available in the hospital for patients or relatives to access.
- There was adaptive cutlery to help patients with dexterity problems.
- Staff on Ward 40 were introducing the 'M' technique as a form of relaxation procedure with patients. This

## Meeting people's individual needs

# Medical care (including older people's care)

technique is a structured touch method. Each movement and sequence is done in a set pattern at a set pressure and set speed, which never change. It is suitable for the very fragile, critically ill and actively dying. We saw four case studies of patients who had used the technique. Feedback was positive, and one patient said their breathing and asthma had improved. A relative said they were “amazed” to see their relative more relaxed.

- The trust had also endorsed the ‘VERA’ technique. This is a communication procedure for a person with later-stage dementia. It is based on four key elements: Valuing what the patient says, looking at the Emotions and feelings behind the patient’s words, Reassurance by staying calm and finding an Activity that is helpful to the patient.

## Learning from complaints and concerns

- Complaints were handled in line with the trust’s policy. Staff directed patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with their concerns directly, and advised them to make a formal complaint.
- Literature and posters were displayed advising patients and their families how they could raise a concern or complaint, formally or informally.
- Staff told us ward sisters investigated complaints and gave them feedback about complaints in which they were involved.
- Information was sent directly from the complaints department to senior leadership on a monthly basis, informing them of the complaints received and giving brief descriptions of the concerns with a ‘due date’ for response to each. Complaints information was also included on Quality Improvement and Patient Safety (QIPS) dashboards for information and discussion.
- The dashboards on each unit encouraged people to provide feedback to improve services and reported on practice changes learning from complaints and concerns. For example, following feedback from the family of patient, we saw that more wheelchairs had been purchased for patients’ use. The trust was also setting up a dedicated ‘wheelchair service’ later in the year.
- Patients we spoke with felt they would know how to complain to the hospital if they needed to.

## Are medical care services well-led?

Requires improvement



The trust had systems in place to oversee planning, delivery and monitoring of care provided by the clinical group and speciality level and to identify, monitor and assess risk. However, the arrangements for identifying and managing risks were not robust. For example, we found poor care plan record keeping and concerns with the management of medicines had not been identified by any audits undertaken by the trust.

Staff felt under pressure, mainly because of poor staffing levels. This was affecting staff morale.

Staff were confident that immediate line managers would listen and support them. The trust board members were visible but staff felt they did not understand the day-to-day pressures they faced.

Patients were engaged through feedback from the NHS Friends and Family Test, the online trust feedback system and complaints and concerns. Clinical governance meetings showed patient experience data was reviewed and monitored.

Innovation was encouraged from all staff members across all disciplines. Staff said they were encouraged to develop new ideas and to make continuous improvement in the service provided.

## Vision and strategy for this service

- University Hospitals Coventry and Warwickshire NHS Trust (UHCW)’s vision was to become an organisation that was a national and international leader in health care.
- UHCW aimed to achieve this with a 10-year clinical strategy to be a regional, national and international leader in world-class health care for the local populations of Coventry and Warwickshire.
- UHCW’s mission was to be caring and innovative. This was to be achieved by delivering the best care for patients through staff education and training, and innovation through research and learning.

# Medical care (including older people's care)

- The senior leadership team in medical care services had a clear vision of the future of the service, but was aware that having enough beds, increasing nursing recruitment, and ensuring that staff were delivering safe and quality care to all patients were imperative.
- All speciality strategies had been developed in line with the trust framework to ensure consistence with the overall organisation vision, strategy and key performance targets. For example, acute medicine and gerontology strategies included the development of a frail elderly/acute medicine unit at UHCW to improve the emergency pathway.
- Each speciality strategy group was part of the trust's operational delivery plans and had given specific objectives, key performance indicators and cost improvements targets. Monitoring was undertaken internally through speciality group meetings and through the chief officers trust operational delivery meetings.

## Governance, risk management and quality measurement

- The wards we visited had regular team meetings at which performance issues, concerns and complaints were discussed. When staff were unable to attend ward meetings, steps were taken to communicate key messages to them via emails and team meetings.
- The medical services had a quality dashboard for each service and this was available on the trust's intranet. It showed how the services performed against quality and performance targets. The ward areas had visible information about the quality dashboard. Staff said they were aware of the dashboards but had not discussed the outcomes at team meetings.
- The medical services had an established governance structure. There were quarterly clinical governance meetings in which the results from clinical audit, incidents complaints and patient feedback were shared with staff. Minutes of clinical governance meetings showed patient experience data was reviewed and monitored.
- We were told that the mortality review committee (MRC) was multidisciplinary and held fortnightly meetings chaired by the trust's chief medical officer (CMO). Its membership included three deputy CMOs, the mortality lead for the trust, the clinical coding manager, a junior doctor representative, acute nurse representation and

lead clinicians for medicine. All new mortality alerts such as Dr Foster's were reported to the MRC and a clinical lead was assigned to undertake an investigation if deemed necessary.

- The service produced a monthly governance newsletter that was shared with staff. Patient stories and lessons learned were included in these newsletters. We were given an example of when a medical consultant had written their reflections on a complaint that had resulted from poor communication with the patient's family, and how practice could be improved in future as a result of the complaint.
- The service had a risk register that included all known areas of risk identified in the medicine directorate (for example, staffing concerns). These risks were documented together with a record of the actions being taken to reduce them.
- The pressures generated through the Emergency Department was not identified as a risk in medical care services, however it featured as a red risk on the risk register for the surgery department.
- Compliance with infection control procedures was variable throughout medical care services. This put patients at risk of a hospital-acquired infection because trust policies and procedures were not uniformly followed.
- We found medication concerns and a range of gaps in care records across medical care services. Quality audits and checks undertaken by the trust to monitor services were not robust.

## Leadership of service

- There were 17 medicine speciality groups within medical care services, for example Gerontology, Cardiology, Rheumatology, Clinical oncology and Respiratory medicine. Each group was led by a clinical director supported by a modern matron and general manager.
- Staff said the chief executive officer (CEO) was visible within the trust but they were unaware of the middle management staffing.
- Regular team meetings took place and staff on the wards and the GP assessment unit (GPAU) told us that they felt supported by colleagues and managers. Daily clinical leads' meetings were held each morning to review any issues. Staff in the GPAU said the consultant nurse was very good and often helped out when there were staff shortages.

# Medical care (including older people's care)

- The wards had a folder that staff could access regarding the monthly operations meeting with the lead consultant and group manager.
- Staff spoke highly of the leadership within their teams and felt respected by senior nurses. They said the wards worked together as a team. We saw that senior managers and clinicians were visible and approachable to staff and patients.
- Staff told us they felt that managers listened and acted on any issues raised, and they could discuss any concerns with them.
- The managers said that they felt supported and enabled to manage poor staff performance and/or competencies.
- The managers said there were low levels of sickness in the service and staff could be referred to occupational health services when applicable.
- While there were challenges with recruitment and retention of staff for the medical services, we saw evidence that the provider was taking action to proactively recruit and retain staff. This included reviewing the reward package for experienced registered nurses. Some staff said they felt morale was low on the wards because of the high level of staff shortage.
- Staff also recognised that, while their immediate managers were supportive, they too were under pressure. For example, on one of the wards we visited, we were told of an occasion when the ward was short-staffed at night. The trained staff were told they could not leave the ward until a "UHCW nurse was found". The staff member felt unsupported by both the night sister and night manager, and did not finish their shift until after 10pm that night.
- Junior doctors felt well supported by consultants and senior colleagues. Medical staff felt supported by the medical leadership in the division and the trust.
- Staff told us the CEO was often visible within the trust and was approachable.

## Culture within the service

- We asked staff across the wards about the culture within the trust. A number spoke positively about the high-quality care and services they provided for patients, and were proud to work for the trust. They described the trust as a good place to work and as

having an open culture. Other staff told us they were under pressure because of staff shortages and morale was low. Some staff told us they were looking for other jobs and others were leaving without jobs to go to.

- Staff told us their immediate managers, at ward level, were accessible and approachable. Above this level, however, some staff regarded the management as remote and failing to recognise the pressures they were under.
- Staff were committed to their work and to providing high-quality care for patients, although at times they told us they felt under "extreme" pressure because of the volume of patients in the hospital. We observed many examples of caring and compassionate care that was provided even when staff were stressed and under pressure.

## Public and staff engagement







- Results of the NHS Friends and Family Test were displayed on every ward, and there were posters encouraging patients to feed back so that staff could improve the care provided. Overall, these showed satisfaction with the service provided. The average response rate was above the England average. We saw the results for Wards 40, 41 and 42 were between 80%, 100% and 87% respectively.
- Each ward displayed clearly key performance data, for example hand hygiene audit and infection rates, and staffing numbers so that patients and their visitors as well as staff could see how well the ward was performing. There were also examples displayed of how the ward had responded to both positive and negative feedback.
- Clinical governance meetings showed patient experience data was reviewed and monitored.
- The medical divisional leads held monthly 'listening clinics' for all staff in which staff could raise any concern or share any experience.
- The junior doctors told us they were able to raise concerns, and the trust conducted junior doctor forums in which they could express their views and share new ideas.
- Staff were updated on the work the trust had conducted in the 'Intouch plus' magazine. This included the results of the 2014 NHS Friends and Family Test, which showed that 88% of patients were happy with their overall impression of the trust.

# Medical care (including older people's care)

## **Innovation, improvement and sustainability**

- Senior professionals told us the trust followed the national dementia strategy identified by the Department of Health. The aims of this strategy are to transform services for people with dementia and their carers. Staff were committed to providing the best service available for people with dementia.
- The frail older people's team was presented with 'The Best Dementia Friendly Hospital' award at the 5th National Dementia Care Awards of 2014.
- The Neuroendocrine Tumour service was accredited as a European Centre of Excellence in March 2015 and is one of only eight centres in the United Kingdom to achieve this accreditation.
- The trust won an award in February 2015 from the Faculty of Medical Leadership and Management for their 'e-handover'.
- A framework for improvement had been set out. Key performance indicators were discussed at the service's monthly clinical governance meeting, for example, safeguarding, incidents and complaints.
- Periodic reviews had taken place to monitor the quality of the service, with actions identified as necessary.

# Surgery

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

## Information about the service

University Hospitals Coventry and Warwickshire NHS Trust provides both elective and emergency surgery to the population of Coventry and Warwickshire with a wider catchment for specialist services.

Different surgical specialities were managed by different clinical groups of the hospital, and had different clinical directors. This provided clear management structures for the specialities but did not always provide an integrated approach to patient care. Surgical services have around 670 staff.

The trust has 27 operating theatres at the Coventry site. There are 337 beds which are designated for surgical patients. The trust completes over 44,000 operations a year.

The surgery inspection team consisted of 7 staff and was conducted over 3 days. We visited 10 wards, the surgical day unit and the surgery on day of admission (SODA) unit, and we observed practice in five theatres.

We spoke with 83 staff ranging from housekeepers and porters to departmental leads, and 29 patients or their family members. We held trust-wide focus groups to capture the experience of staff in different disciplines and at different levels within the organisation. We held listening events in Coventry and Rugby to gather information and experiences of patients past and present.

## Summary of findings

Overall, we found that the service required improvement. There was the potential for the service to perform to a much higher level, however sustained capacity issues over prolonged periods had stifled it, with excessive numbers of cancelled procedures. Staff had come to expect cancellations as normal and accepted practice. A degree of complacency existed where issues had been identified and escalated, and interventions applied, but with little or no improvement seen.

Staff within the surgical specialties were passionate about the care they gave patients. Staff at all levels had a desire to provide safe, effective, caring and responsive care. State-of-the-art equipment and training were available to enable them to do this. Unfortunately, we found that, despite the passion of the staff and availability of equipment, a large number of issues had been allowed to develop over time, and these had the potential to affect patient safety.

While the trust had completed in excess of 44,000 operations during the past 12 months, with the vast majority resulting in positive outcomes for the patients concerned, 1,500 operations were cancelled during the same period.



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We saw that 'never events' were properly investigated and information from them was shared both within individual departments and also across the division and the trust as a whole; however, the learning from them was not always embedded in practice.

Interpretation of theatre practice, such as the completion of whiteboards and instrument counts, were not consistent in all areas, and there was therefore the potential for further incidents. In particular we were concerned that lack of consistency in relation to the WHO checklist could lead to further never events.

We found breakdowns in communication and liaison between surgical and medical services. The services worked in isolation, which meant that patients did not always receive a holistic approach to their care and could be left without medication or appropriate treatment.

## Are surgery services safe?

Requires improvement



We found that surgery services required improvement in relation to their safety. While some practice we observed was good, we identified a number of safety lapses that could potentially have serious consequences for example, infection control breaches and failure to check equipment. The number and spread of these issues prevented the service being graded as good, as safety was not given a sufficient level of priority.

The trust had policies and procedures that were designed to keep patients, visitors and staff safe. Unfortunately, through a combination of factors, these policies and procedures were not always followed or as effective as they could have been.

We observed several instances in which infection control measures were compromised: for example, staff not complying with 'bare below the elbow' guidance, not following hand hygiene policies, and failing to use or obstructing access to hand gel dispensers.

There was evidence of staff complacency regarding the checking of equipment, including missed checks to resuscitation trolleys in many areas. There was also a failure to identify over several months that emergency back-up supplies of oxygen had expired.

We saw excessive numbers of medical outliers on surgical wards, causing confusion for both nursing and clinical staff.

The use of the World Health Organization (WHO) surgical safety checklist and the practices that accompany it were not embedded. There were different practices in different theatres, rather than strict adherence to one set of rules.

We observed isolated or 'silo' working within specialties, with staff not recognising and addressing pre-existing medical issues of surgical patients during their hospital stay.

We saw that nursing and medical staffing levels were good, and recognised tools were used to determine staffing levels. Systems were in place to ensure continuity of services.

## Incidents



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- Staff reported all incidents and 'near misses' through a centralised web-based reporting system (DATIX). This system automatically escalates incidents according to their type and the department affected. All surgical incidents were reviewed by a senior nurse or consultant within the surgical department.
- The Datix system generated an email providing feedback when an investigation had been completed. A number of staff confirmed that they had received email updates, and that knowing that they would get a response motivated them to make reports. Some staff said they were not aware of email updates, but thought this might be due to the type of incident reported.
- The trust had a Quality Improvement and Patient Safety (QIPS) group within each specialist department. Less serious incidents were assessed and managed locally by these groups.
- A large number of incidents reported within surgical services were minor and 'no harm' incidents.
- Serious incidents were reported to the trust's significant incident group, which met on a weekly basis to review new incidents, monitor ongoing investigations and approve investigation reports. Significant incidents were also presented at surgery QIPS meetings for discussion and learning. We saw minutes of these meetings, which confirmed that incidents were discussed.
- The trust had reported three surgery specialty-related 'never events' in 2014/15; one concerned a retained surgical swab and one a retained portion of a resectoscope. Never events are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken. There was also a displaced nasogastric (NG) tube incident, which occurred on a vascular surgery ward and was reported as a never event. We saw that the trust completed comprehensive root cause analyses of these events and produced action plans.
- We met with the clinical lead for theatres who described how the trust had initiated a series of actions. These included innovation workshops, the planned implementation of an audio prompt system within theatres, a review of the theatres by the West Midlands Quality Review Service and the creation of a theatre safety training video.
- Other interventions had included changes to the NG feeding guidelines to make them clearer and more specific, and communication of the NG never event to all staff as a patient safety alert.
- The trust's attitude to the reporting of incidents was one of learning. Staff were encouraged to report them in the hope that lessons could be learned and further incidents prevented. This led to a high volume of incidents being recorded.
- Information provided by the trust for the 4 months before the inspection indicated that 1,041 serious incidents were reported in the surgical department; 72% of these incidents were classed as negligible or no harm; 20% related to skin or tissue injuries, such as pressure sores. The remaining 8% related to more serious incidents. There were 40 moderate harm incidents and 5 severe harm. Two incidents had been recorded as resulting in death.
- One death was identified as not being a patient safety incident. It related to a patient with severe trauma injuries who died despite surgical intervention. The other was the NG tube never event.

## Safety thermometer

- The trust used the nationally recognised NHS safety thermometer as one of its improvement tools for measuring, monitoring and analysing care. Performance was measured for all specialties within the trust, including surgery, against four possible harms: falls, pressure ulcers, venous thromboembolism (VTE) and catheter-associated urinary tract infections.
- **Harm-free care** is defined by the NHS Institute for Innovation and Improvement as the absence of pressure ulcers, **harm** from falls, urine infection (in patients with a catheter) and new VTE. General surgery at the trust had achieved harm-free care for 95% of patients during the 2013/14 period and the percentage was 99% at the time of our inspection.
- The trust's results for VTE risk assessment for the year to date (April through December 2014) were over 96% against a target of 95%. The VTE assessment uptake was reported through the Datix system.
- We saw that the safety thermometer was displayed on the wall charts inside the wards, together with details of 'harm-free days', which indicated how long it had been since particular types of incident had occurred in that area.
- The trust provided information regarding their trust-wide Houdini project, which was designed to reduce the already low incidents of catheter-associated urinary tract infections.

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## WHO Safety Checklist

- The World Health Organization (WHO) has produced guidance to increase safety for patients undergoing surgical procedures. The guidance sets out five steps that should be undertaken during every procedure to help prevent errors.
- The guidance forms a basis from which organisations are able to adopt and adapt practice to reflect the needs of their service.
- The trust developed its surgical safety checklist from the WHO guidance.
- Surgical and theatre staff we spoke with were all familiar with the checklist; however, we found that not all areas were applying the system in the same way. There was a lack of consistency between theatres. All theatres were recording the system electronically, but some did this at the time while others completed a paper version first and then copied it onto the computer.
- We saw that the elements of the checklist were followed in all the theatres: patient identification and procedures were verbally checked and agreed, and patient issues, such as allergies, were highlighted and re-emphasised.
- We saw how the use of the surgical safety checklist prevented an operation being carried out on the wrong eye of a patient. The initial team brief identified that the booking list referred to the wrong eye. This showed how following the WHO guidance can prevent serious mistakes from occurring.
- In one area, the team brief (the first step in the checklist) was completed correctly but not recorded until later. The details were copied from the operation list as opposed to recording the conversation that had taken place.
- Trust data in respect of the safety checklist suggested that there was over 99% compliance; however, this was the result of analysis of information entered into the computerised patient record system, and this did not always reflect practice.
- The theatres lead explained how a new system was being incorporated that included an audio logging facility. This system was designed to instruct staff on the next required step of the safety checklist; it then paused to allow that information to be confirmed and entered into the computer. The next step of the checklist could not be completed until the preceding one had been recorded. The pauses in the system were timed so that a

minimum period of time had to elapse before the next entry could be made. This meant that there was less opportunity for mistakes to be made and information entered before the task had actually been done.

- We also saw that different theatres had different practices regarding the use of whiteboards, which was a visible check for operating staff to see that the correct patient was being treated, to identify the procedure that was being done and to enable counts of equipment, such as swabs, needles, instruments and other items that were counted as they were used. The information on the board was then used at the end of the procedure to check that everything used had been accounted for.
- In one instance, we saw that the whiteboard was not used to count swabs and items of equipment.
- Other practices included not putting the patient's name on the board, or not identifying the procedure. Staff had various reasons for the different practices. In some areas, the operating list was attached to the whiteboard. This meant that no one could read the details unless they left the patient and moved to within reading distance. The list had more than one patient and more than one procedure, which meant that there was more opportunity for errors to be made in respect of patients or procedures.

## Cleanliness, Infection Control and Hygiene

- The hospital appeared clean and bright, and housekeeping staff were observed completing various tasks throughout the course of the inspection. Patients told us that they were impressed with the cleanliness of the wards and public areas. Some patients explained that they had had previous stays in the hospital and had always found the same level of cleanliness.
- We saw many instances of staff observing infection control measures by washing their hands and using protective gloves and aprons when providing care or coming into physical contact with patients. This included observing staff care for a patient who needed a higher level of protection. The patient was in a side room and signs had been put up to remind staff and visitors that extra precautions were required. We saw that staff used red aprons in the area, bagged contaminated materials appropriately and documented their activity.
- Infection control procedures were not always consistent. In the same areas where we had seen good practice, we also witnessed staff entering and leaving

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the ward into the main hospital corridor without using the hand gel by the entrance and exit doors. On one occasion, we saw a trolley had been parked next to a wall-mounted gel dispenser so that it was not possible to reach the gel.

- We observed two instances of doctors on the surgical wards who were not following the 'bare below the elbow' guidance. One involved a doctor wearing a wristwatch and the other with sleeves to the wrists. We also saw interactions between doctors and patients when doctors had not washed their hands before examining the patient.
- The trust highlighted that the infection, prevention and control team (IPCT) had won the Infection Prevention society's (IPS) team of the year in 2013, and that the team had a successful Twitter account with almost 2,000 followers.
- The trust also had IPC healthcare assistants who were roving educators for all staff. They covered all trust areas over a 2-week period, providing education and reminders to staff about cleaning, decontamination and IPC practices. A monthly report was fed into the 'saving lives' and operational cleaning meetings. While issues were highlighted in the reports, such as those we had seen with watches or other jewellery being worn, we did not see evidence that staff were challenged or that improvements were made.
- Staff we spoke with were aware of infection control procedures and were able to describe training and guidance they had received. However, the knowledge was not always evident in their practice.
- Cleaning staff described the process for dealing with contaminated waste. Numbered tag seals were allocated to individual staff who used these to seal the contaminated waste sacks before placing them in trolley skips that were collected by porters. The tags meant that any contamination from incorrectly bagged waste could be tracked.
- Cleaning staff said they felt supported and valued by most of the medical and nursing staff; however, odd instances had occurred that were demeaning. We were told how a member of staff had been cleaning an empty bed bay when a nurse came through with a bed. The cleaner had said they were "nearly done" and would be out of the way soon, to which the nurse replied, "You need to move. I have to look after patients, which is more important than a bit of dust." Staff thought this

rude but it also showed that the nurse did not understand the importance of cleanliness. We asked if such comments were reported and staff said they didn't feel there was any point.

- We saw documentation that showed that compliance with *Clostridium difficile* (C. difficile) and MRSA management was monitored and reviewed monthly. During the period March 2014 to March 2015 The trust had reduced the number of infections by 19%.
- The trust had set a target to ensure that fewer than 54 cases of C. difficile occurred between the end of March 2014 and the end of March 2015. At the time of our inspection (11 March 2015), the reported cases were 34.
- There had been an increase in MRSA infection rates. The trust provided information to show that the increases in infections had been analysed, with the involvement of the Trust Development Agency (TDA) to assist with a thematic review. The analysis failed to identify any cause, but it showed that the outbreaks were not connected because they concerned different strains of the bacteria.
- All patients admitted to hospital were routinely screened for MRSA so that anyone who was found to be carrying the bacteria could be treated and, when required, isolated. During our inspection, we saw several examples of emergency surgical patients, whose MRSA test results were not yet available, being placed adjacent to other patients on wards and in the day units. This meant there was the potential for a patient with MRSA to infect others.

## Environment and equipment

- Major pieces of equipment in the hospital were provided under contract to the trust and were repaired or replaced as part of the contract. This included replacement of equipment with the latest version when appropriate, which meant that staff had state-of-the-art equipment available and maintained ready for use.
- Smaller items of equipment were maintained by the hospital's technicians. Staff told us that they did not experience difficulties in obtaining repairs or replacements for faulty equipment.
- Equipment that might be required for short periods was available through the trust's equipment library, and included such items as syringe drivers and specialist

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mattresses. We saw that the trust had invested in some bariatric equipment and further items could be hired. There was a system for requesting these out of hours if necessary.

- Trust policy required equipment, such as oxygen cylinders, be checked regularly and that the outcome be recorded on the trust safety matrix which was completed monthly. The safety matrix is comprised of information which senior managers use to monitor that patient safety is being protected. However, when we visited in March 2015, two oxygen cylinders on an operating theatre anaesthetics trolley were seen to have expired: one 6 months and one 5 months earlier.
- Portable appliance testing (PAT) had been completed in some areas; however, it was not consistent throughout the theatre areas and some equipment had not been tested since October 2013. PAT testing ensures that electrical equipment is safe to use, therefore this we could not be assured that all equipment was safe
- Theatre staff completed an electronic stock update during surgical procedures. This meant that any items used were accounted for and stock re-ordered automatically as appropriate.
- Resuscitation trolleys in theatres and wards were all found to be appropriately stocked, however, trolleys were not locked to prevent tampering or loss of equipment. Plastic tab locking systems enabled staff to see that trolleys had not been used or tampered with, without having to check every individual item. This saved time and increased staff confidence when they needed to use the trolleys. Trust policy dictated that resuscitation equipment was checked daily and checks monitored for compliance.
- However we found a number of examples of when trolleys had not been checked. On two trolleys in one area, we saw that the defibrillator had not been checked a total of 53 days out of the preceding 6 months, including several sets of consecutive days e.g. 1, 2, 3 and 4 December 2014. The second trolley in the area had not been checked on four occasions during February and its defibrillator had not been checked for 50 days during the past 6 months, which also included several consecutive periods.
- When asked about the lack of checks, the ward manager did not appear surprised or concerned. We were told

that the checks were completed by the staff on night duty and that, if agency staff were on duty, they might not be aware that it was their job to complete the checks.

## Medicines

- Staff reported having been unable to give a diabetic patient insulin because the drug was not available. This had been escalated to the ward manager but the next day there was still no medication for the patient and the nurse completed an incident report. The patient subsequently became ill and needed emergency dialysis. We asked the trust for a copy of the root cause analysis of this incident.
- We found that the drugs cabinet in one theatre had been forced open and could not be secured. The cabinet had a note attached to say the keys had gone missing. The cabinet had been taken out of use and was repaired shortly afterwards.
- We saw packs of medication, which should have been in drugs cabinets, left out in theatres because there was insufficient space in the cabinets for the quantities to be stored. We asked a member of staff how they would know if drugs had gone missing because the area was unattended during operating procedures; they told us there would be no way to tell if stock had been taken.
- Stocks of intravenous sodium chloride in one theatre were checked and the whole batch had expired in February 2015. This was highlighted to staff and the expired fluids disposed of.
- Anaesthetics trolleys in operating theatres were connected to piped oxygen supplies, and the trolleys also carried emergency bottled oxygen. Two cylinders were carried on the trolleys. One was attached and ready to operate automatically in the event of failure of the piped system, and the second was ready to be used if the first failed or ran out. When we checked the expiry dates of the two emergency cylinders in one of the theatres, we saw that one had expired in September 2014 and the other in October 2014. Staff explained that the piped oxygen system had never failed and because of this they had become complacent. They demonstrated how they would be able to use bottled oxygen from the patient transfer bed with a manual face mask if an emergency arose, and we saw that the alternative oxygen was within date.

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- We saw that staff involved in drugs rounds wore 'do not disturb' tabards to enable them to concentrate on the task at hand.

## Records

- Patients' notes and records were maintained to a high standard. We checked 20 sets of notes and saw that entries were legible, concise, timed and signed. Risk assessments had been completed when required to inform staff and help keep patients safe.
- We saw that care plans were based on individuals' needs and reflected the care pathway relative to their condition.
- The trust used an electronic monitoring system called VitalPac for patients' vital signs. The system raised an alert if a patient's vital signs had not been recorded within the expected time for their care plan. It also alerted nursing staff if a patient's scores fell outside expected parameters, which could indicate incorrect readings or that the patient might be deteriorating and need further intervention. Staff we spoke with had confidence in the system and believed it had much improved accuracy of information.
- A new electronic notes system was being purchased for ophthalmology to enable improved recording of patient information and outcomes; the system was unique to that department. We were told it was due to become operational in May 2015.
- We saw that assessment booklets for risks were completed for all patients in trauma and orthopaedics. These covered aspects of care such as pressure sores, handling and moving, and malnutrition, as well as other risk factors.
- Safeguarding training formed part of the trust's mandatory training. Staff we spoke with were fully aware of their responsibilities to identify and report safeguarding issues.
- Nursing staff received safeguarding training at either level 2 or level 3, depending on their role.
- Healthcare workers were able to describe the different types of abuse people might be subject to, and how they would escalate any concerns to senior nurses.
- The trust had a safeguarding team; staff were aware of the team and knew who to approach if they needed advice or guidance on safeguarding issues.
- Level 3 training for safeguarding children was 93% compliant. Level 2 was 88%. Training was available as

an online package or a face-to-face session. Joint adult and children training sessions had been co-delivered by the safeguarding team and the clinical commissioning group. The events included learning from recent serious case reviews.

- The ophthalmology department had a best interest lead who arranged specialist training for nurses involved in best interest meetings before obtaining consent to operate. The Mental Capacity Act (MCA) 2005 states that, if a person lacks mental capacity to make a particular decision, then whoever is making that decision or taking any action on that person's behalf must do this in the person's best interests. Best interest meetings may involve relatives, guardians or advocates as well as medical professionals.
- At the daily bed meeting when reviewing elective patients for the next day, there was a specific question as to whether the patient had had a best interest meeting or was vulnerable. Vulnerable patients were prioritised and protected from cancellations when there were bed availability pressures.

## Mandatory Training

- Training was delivered in a number of ways including online learning, classroom-based sessions and individual face to face support.
- Monitoring was undertaken at both local level and corporately through quarterly performance meetings. The nursing and midwifery care quality forum monitored and reviewed nursing performance on a monthly basis.
- Mandatory training rates were extremely good for theatre staff who had achieved 98% compliance, but fell far short of the trust target for ward-based nursing staff who achieved only 64%. The directorate had introduced a number of interventions to improve compliance; these included support for staff with the e-learning system, one-to-one support if needed, email reminders that training was due and training boards on the wards to act as a reminder to staff.
- A clinical education lead had recently been appointed to support both the monitoring and delivery of mandatory and specialist training.

## Assessing and responding to patient risk

- The trust followed National Institute for Health and Care Excellence (NICE) guidance to identify deteriorating patients.



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- Electronic monitoring systems helped staff to recognise when patients were deteriorating. The system included prompts and advice to staff on what actions were needed.
- The trust had a hospital-wide approach to managing deteriorating patients. This included a critical care outreach service whose team provided services to patients outside the critical care unit. These included visiting surgical patients on wards to help with interventions to stabilise them and prevent them becoming more ill.
- A high dependency unit skills training course was in place for all trained staff. An acutely ill management course had also been rolled out to trained ward staff across the trust, to equip them to manage deteriorating patients.
- We had to request that a doctor intervene when at 2pm in the afternoon we identified a patient on a ward who had had a chest drain removed that morning. They were clearly in pain and distress. They told us that they had not been examined nor had an x-ray since the procedure, although both of these were recommended best practice.

## Nursing staffing

- The trust used the nationally recognised Safer Nursing Care Tool along with NICE guidance to assess required nursing staff levels. This included surgical areas.
- Vacancy rates, staff turnover and sickness were audited monthly. Daily checks were completed across all areas to check staffing requirements and availability against gaps in the rota. Vacant shifts were offered to bank or agency staff.
- Trust data showed that the surgery group had experienced a high level of vacancies during the past 12 months. The current shortfall was 13% of trained nurses. This had been as high as 19% before very recent ward reconfigurations.
- Agency staff had an induction process to follow if they were new to the department. We spoke with one agency nurse who confirmed that they had completed an induction programme.
- Nursing handovers occurred at the change of shifts and were based on an electronic e-handover that enabled the process to be monitored.
- The trust's theatres had invested in a staff development in-house programme that included advanced

practitioner training, theatre nurse accreditation, and a theatre practitioner recruitment and retention plan. This had resulted in a significant increase in recruitment of theatre and anaesthetic practitioners.

## Medical staffing

- Doctors within the surgical department had a broad range of experience. The skill mix was similar to the England average for surgical departments. It consisted of 40% consultants, 12% middle-career doctors, 38% registrars and 10% junior doctors.
- Medical vacancy levels against establishment were low in the surgery groups. Rotas were managed by specialties and planned in advance. Each sub-specialty within a surgery group had a consultant on-call rota covering 24 hours, 7 days a week. A number of consultants were on call with no elective commitments (colorectal, neurosurgery, vascular and trauma).
- Middle-grade rotas were overseen by the trust rota team; gaps were identified and filled by temporary staffing services either through backfill by internal staff or through locum staff.
- The trust had recently increased the consultant workforce in plastics and colorectal surgery. There were plans to increase the number of consultants in thoracic surgery in line with national guidance. Extra junior doctors for neurosurgery had been recruited over the past 2 years.
- Out of hours (overnight and weekends), staff were supported by additional middle-grade doctors to deal with outlier patients and provide specialty care. The hospital at night team supported the middle-grade team, with all unstable patients handed over from the day to the night team.
- An e-handover system had been implemented to ensure that tasks were carried forward from out-of-hours to day teams.

## Major incident awareness and training

- The trust had a major incident policy. The response plan specified actions to be followed in the event of a major incident. Action cards were available for specific areas of the hospital.
- Staff were aware of how to access the policy online, and they understood that they would be given specific tasks to complete in the event of an emergency.
- Protocols for deferring elective activity to prioritise unscheduled emergency procedures were in place.



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## Are surgery services effective?

Good



Surgery services provided a wide variety of procedures following nationally recognised care pathways. Outcomes for those patients who received surgery were good.

Engagement with national audits was good, and local audits were used to monitor outcomes and identify opportunities for improvement.

We saw that the surgical department followed National Institute for Health and Care Excellence (NICE) guidance and nationally recognised best practice.

Nursing staff had received appropriate specialist training and understood their role. Clinical staff were supported to complete their revalidation.

Multidisciplinary team (MDT) meetings took place, which identified how different specialties could support patients through their treatment. We were concerned about patients with pre-existing medical conditions and how these were managed during their surgical stay.

### Evidence-based care and treatment

- Trust policies and procedures were available on the trust intranet and staff reported that they could access them easily. We saw the trust policies were reviewed and updated at regular intervals, and were based on NICE guidance and recommendations from national registration bodies and societies.
- The trust maintained theatre discipline, such as using appropriate theatre wear and minimising movement of people in and out of the operating areas, although one operating department practitioner (ODP) who was agency staff, was seen to enter and leave a theatre twice during the course of one operation. The ODP was in scrubs but did not announce their presence or play a part in the procedure. After the operation, staff were asked about the ODP entering and leaving. They confirmed that the ODP should have announced their presence and the ODP's presence should have been recorded in the theatre notes which it was not.
- Effective hand hygiene and decontamination were used to reduce the risk of infection occurring during a procedure.

- Theatre 6 did not have a separate scrub room, which meant that staff scrubbed and prepared for theatre within the operating area. We were told that risks were minimised by ensuring that only less invasive operations were undertaken in that theatre, thereby mitigating the risks involved.
- We saw how pathways of care were based on NICE guidance and recommendations from national registration bodies and societies.
- Clinical audits were completed within each surgical specialty supported by a clinical audit facilitator. Results of audits were reviewed at surgical Quality Improvement and Patient Safety (QIPS) meetings. Examples of audits provided by the trust included the following.
  - Ophthalmology – audit of the NICE interventional procedure guidance for corneal endothelial transplantation (NICE IPG304, 2009), which resulted in unifying the follow-up procedure for patients.
  - General surgery – audit of the Royal College of Surgeons (RCS) Emergency Surgery Standards, which had helped to ensure that all emergency surgical patients received correct and timely venous thromboembolism (VTE) assessment.
  - Local audit – complications in tracheostomy undertaken by the maxillofacial department, which confirmed the safety of the procedure and that low complication rates were partly due to strict compliance with guidelines on post-operative care.
  - Carotid endarterectomy and elective repair of abdominal aortic aneurysms (AAAs) were reported as part of the National Vascular Registry by four named consultants working at the trust. The surgical outcomes for each of the consultants were within the expected range for their level of activity.
  - General surgery – audit of compliance with the RCS standards for unscheduled surgical care and emergency surgery. The audit showed that the trust was compliant and had effective arrangements in place.
  - Patient outcomes for the three bariatric surgery procedures performed, which included gastric bypass, vertical sleeve gastrectomy and gastric banding, were reported as part of the National Bariatric Surgery Registry. The surgical outcomes for patients having bariatric surgery at the trust were within the expected range nationally for all these procedures.

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- The National Joint Registry (NJR) identified the trust as an 'outlier' (falling outside expected results) having a high number of revision knee operations. The trust investigated the findings and found that the NJR statistics were analysed separately for the Coventry and Rugby sites. Because most of these operations were carried out at Rugby, the statistics appeared very high. When taken as a trust, the figures were in line with national figures and the trust was not seen to be an outlier. The NJR was notified and asked to consider future data at trust level.
- The Dr Foster Unit at Imperial College London informed the trust of its second alert for intracranial injury on 30 January 2015. Alerts draw attention to where there has been significant divergence from expected levels of mortality for diagnosis and procedures, and suggest areas for further investigation.
- The previous CQC mortality outlier alert for intracranial injury included patients from July 2012 to August 2013. An investigation, action plan and written response were produced by the trust and the alert was subsequently closed by the CQC in July 2014.
- The January 2015 alert refers to the period between November 2013 and October 2014. There were 56 deaths compared to 38.24 expected. Twelve specialties were involved in the alert with the highest number of deaths from critical care medicine, 22 deaths versus 2.51 expected. A thematic trend analysis led by the clinical lead in neurosurgery has been completed. The reviewers did not find any evidence of poor care amongst the patients treated by the neurosurgery team. An action plan has been produced to improve outcomes, with recommendations such as improved identification of palliative care treatment for patients not suitable for surgical intervention ongoing. CQC will continue to monitor the alert and the trust's progress against the action plan.

## Pain relief

- We found some patients who were in pain and had not been given their prescribed drugs when they needed them.
- We saw that patients were given pre-operative assessment for post-operative pain relief. Most told us that they had been kept pain free. One patient we spoke with told us they were in pain. They said they had been given their required medication but they had also been prescribed extra pain-killing drugs that they could take

'as required'. Although the drugs had been prescribed, the patient had not understood that they could request them and they were waiting for staff to offer them. We brought this to the attention of nursing staff so that the medication could be provided.

- The trust had a dedicated acute pain management service. This service was nurse led with consultant input.
- Daily ward rounds were completed, and education, advice and support were given to nursing staff with direct intervention if required.
- Referrals could be made to the acute pain team from nurses, doctors or therapists.
- The team used an acute pain software package that was accessed from portable devices; it managed all activity in relation to pain management patients.
- The acute pain service did not operate at weekends, although we were told that weekend working and consultant dedicated hours were being reviewed.

## Nutrition and hydration

- Patients received a malnutrition universal screening tool (MUST) assessment on admission, and those with complex dietary needs were referred to and seen by dietitians. We saw evidence of the MUST assessments and dietitians' comments in the patients' notes we examined.
- We saw meals being served to patients for breakfast and lunch. Patients had choices and were able to select from a range of items.
- The trust had a rotational menu offering a wide variety of hot and cold choices.
- Patients' comments about the meals rated them from good to poor.
- We spoke with a number of hostesses who served food to patients. They described how they ensured that patients received the correct type of food for their needs. We were told that the service differed in different areas: in some, ward staff provided a written list that identified issues such as 'nil by mouth', 'clear fluids', 'fork mash'. The hostesses said they found this system helpful and it enabled them to provide a better service. Other areas required the hostesses to check the information board for each patient, which caused extra work and slowed the process, resulting in some patients waiting to be served.

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- We saw that cultural needs were catered for: menu sheets took account of cultural and dietary requirements.
- Patients who needed assistance with eating were identified during the admission process and red tray liners were used to help staff identify those requiring support. Assistance with meals was provided by relatives, healthcare workers and nurses.
- The hostesses told us they wanted to highlight the usefulness of the written lists and pass on other ideas, but they did not know who to speak with or how to pass the information on.
- As well as mandatory training, hostesses received annual training from the dieticians.

## Patient outcomes

### National Hip Fracture Database (NHFD)

- The trauma and orthopaedics department had a multidisciplinary care pathway specifically for hip fracture patients. It was started within the emergency department and centralised all records in one document.
- The National Hip Fracture Database (NHFD) 2013 and 2014 audits showed that mortality rates were within expected rates for the size of the service. The trust improved its performance in 6 of the 10 measures audited, and performed significantly higher in some areas than the England average. The high-performance areas were surgery on the day of, or day after, admission, where the trust achieved 85% against an average of 74%; the rate of patients suffering pressure sores where the trust's result was 0.9% against an average of 3%; and falls assessments where the trust achieved 100% against an average of 97%. The data also identified that the trust performed poorly in respect of pre-operative assessment by geriatricians (75% against an average of 87%) and overall length of stay at 23 days against an average of 19 days.
- The trust's target for discharge was 30 days and the current average was 23.4 days; however, the England average was only 19 days. This meant that, while the trust was ahead of its own target, hospital stays were much longer than in most other hospitals.
- The trust had recognised the areas for improvement and responded by introducing a number of activities and innovations to address issues. These included:

- A recently established hip fracture area on one ward with extra nursing staff employed.
- A daily orthogeriatric ward round.
- A quarterly hip fracture governance group MDT meeting, creating more dedicated hip fracture theatre lists.
- Improving the nutrition of patients with the help of dietetics and voluntary services.

### National Lung Cancer Audit

- The latest national report, published in December 2014 and containing data from 2013, demonstrated that the trust's outcomes were generally better than the England average. The percentage of cases discussed at MDT meetings at the trust were 99% against an average of 96% for all England, and the percentage of patients receiving computerised tomography (CT) scans before bronchoscopy was 97.5% for the trust and 91% across all England.
- The trust submitted data for all patients diagnosed with either lung cancer or mesothelioma, and data on positron emission tomography (PET) scan dates was captured for all relevant cases.
- Examples of action taken in response to this audit included a review of the specialist nurse service to ensure that all nursing posts were staffed and that clear referral pathways existed.
- Best practice histological diagnostic techniques including immunohistochemistry were followed, so that patients received appropriate chemotherapy treatment.

### National Bowel Cancer Audit

The latest national report, published in December 2014 and containing data from 1 April 2012 to 31 March 2013, showed that the trust performed well in 7 out of the 10 areas audited, although it had lower than average results for patients discussed at MDT meetings.

- One patient described how they had been receiving treatment for some time from their GP but had become progressively less mobile over time. They could only walk very short distances and then only with a cane. The deterioration had been attributed to their medical condition. They described how, after being admitted to the hospital, they had received further diagnoses and, after treatment, they were now able to leave the ward

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and make their way, without a cane, to the hospital restaurant to meet with relatives. They said, “They have given me my life back. It’s the first time I’ve been able to walk like that for 5 years.”

- The trust’s theatres used a computer system to schedule and manage theatre cases. Real-time management of theatres was achieved using the system, which tracked patient pathways and allowed accurate and detailed information to be captured.
- Robotic surgery had been introduced in one theatre. Robotic surgery can greatly increase the surgical accuracy of delicate procedures, thereby improving patient safety and outcomes. This type of surgery is far slower than conventional surgery: robotic operations can take three times longer than conventional procedures. This meant that increases in safety and outcomes had had an impact on the number of operations that could be performed, and this in turn had had an impact on waiting lists. We were told that patients who had used this service required less repeat and follow-on treatment.

## Competent staff

- Nursing and clinical staff we spoke with were knowledgeable and understood their role within the organisation. Nurses and healthcare workers described the induction process and support they had received when they first started at the trust.
- Staff told us they had been supported to undertake extra training that complemented their role.
- The trust was host to the West Midlands Surgical Training Centre (WMSTC). Surgeons from all specialties learned to perform operations in a safe environment, either as trainees learning basic principles or expert consultants learning new techniques. The trust’s surgeons worked at both the Coventry and Rugby sites.
- Specialist nurse training was supported among, for example, orthopaedic clinical nurse specialists, pain nurses, urology nurses and trauma coordinators. Advanced nurse practitioners undertook extra duties, such as prescribing medications and blood products.
- Theatres had recently introduced education facilitators and a series of video-based training products to support staff and encourage development.
- As well as mandatory training, some surgery group staff received additional competencies in order to perform

their roles effectively. These included epidural training, total parenteral nutrition (TPN) training, central line management and nasogastric (NG) tube placement and management.

- Ophthalmology had led nationally in training optometrists in enhanced roles, such as eye casualty, and in corneal, vitreo retinal (VR) and medical retina clinics. Paediatric ophthalmology had trained orthoptists in advanced roles.
- Revalidation of medical staff was monitored and completed as required.

## Multidisciplinary Team (MDT) Working

- We saw how different therapists were used to provide a multidisciplinary approach to patient care. Physiotherapists were based on the trauma and orthopaedic wards, and other wards could refer patients to the service.
- We saw excellent entries in patient records from tissue viability nurses, which showed their input to patient care.
- MDT meetings were an embedded feature of patient management, with weekly meetings to agree patient management and to plan treatment.
- We observed ward rounds and saw how people’s care was discussed between clinicians, nursing staff and the patient.
- We did not always find clear pathways between services to support patients on wards. We observed two instances when there did not appear to be a coordinated approach to patients with pre-existing medical issues. The patients had undergone or were waiting for surgical procedures. One patient’s medical condition appeared to have been considered from the perspective of how their illness might affect the surgical procedure; however, little or no notice appeared to have been taken of the patient’s medical needs by the surgical team. This led to their not receiving appropriate support for their diabetes.
- When medical issues were raised by a patient during a surgical ward round, we heard a surgeon’s response, “We do our thing and they do theirs.” There was no offer to consider the issues or to ensure that a suitable clinician would be alerted. The patient was unable to have one conversation about their overall health with

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one clinician. Patients told us they did not expect specialists to be experts in other areas but they did expect them to have an understanding of a patient's overall health and to coordinate all their care.

- Surgery staff were involved in a number of MDT meetings. Most covered cancer care (breast, colorectal, head and neck, upper gastrointestinal, hepatobiliary and pancreatic, and urology), but there were also others, such as bariatric, vascular and inflammatory bowel disease MDTs, at which non-cancer patients' care was discussed.

## Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- The trust had a comprehensive consent to treatment policy. Staff we spoke with understood the policy and we observed them requesting consent.
- The safeguarding vulnerable adults policy contained information relating to mental capacity, consent and DoLS. Information on how to contact independent mental capacity advocates (IMCAs) was also in the policy.
- We saw signed consent documents and observed a number of instances of patients being spoken to and their consent checked before they were anaesthetised for theatre.
- Staff we spoke with were aware of their obligations to ensure that patients consented to all aspects of their care and treatment. We saw how staff explained processes to patients and waited for them to respond before providing care.
- The trust used pale blue pillows on the beds of dementia patients. These helped staff to recognise when a patient might need more support when dealing with aspects of consent and understanding.

## Seven-day services

- Emergency theatres operated on a 24 hour, 7 day a week basis, with associated imaging services also available.
- A second emergency theatre had been funded at Coventry and included the provision of extra staff. Use of the theatre was being phased in over time. It was currently available two evenings a week and on Saturdays. We were told that it was already having a positive impact for the trust by reducing delays for urgent cases and avoiding elective cancellations.

- Ward staff were aware of the medical cover available, and the out-of-hours imaging and pharmacy services.
- On-call consultant rotas covered 24 hours, 7 days a week.
- We were told that the trust planned to recruit an extra thoracic surgeon during 2015/16 to support extended cover arrangements for trauma on call, ward-based services and therefore patient review across the 7 days.
- Ophthalmology operated an out-of-hours on-call service that was available 24 hours, 7 days a week. The eye casualty department was open on Saturday mornings as well as weekdays.

## Access to Information

- The trust used electronic patient records, which meant that information was accessible.
- Theatre list were prepared in advance and provided information regarding number of cases, type of procedure and identified potential complications or considerations such as allergies.
- Theatres and recovery areas used monitoring equipment during and where appropriate following procedures which provided visual and audible information which assisted staff to monitor patients.
- Trust intranet and email systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust, and access guides to policies and procedures to assist in their own role.
- Audit information was shared during meetings and copies were available in managers offices if staff wished to review them.

## Are surgery services caring?

Good



All areas of surgery services portrayed a calm and relaxing atmosphere. Staff were professional and knowledgeable, which gave them confidence when dealing with people.

We observed how staff were friendly towards patients and their families and we saw how patients responded to this. The staff concerned included housekeepers, hostesses, porters, doctors and nurses.

Patients told us that the staff were excellent.



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Staff told us they were proud to work at the hospital. They said they had already recommended, or would if required, the services to their own families and friends. Many staff described having had treatment at the hospital, and others were waiting to have treatment there.

## Compassionate care

- We noted that all areas of the surgical service (wards, theatres, recovery rooms and day units) had a calm atmosphere.
- We saw how staff interacted with patients in their care. Patients were happy to see and speak with staff; we saw smiles and pleasantries exchanged during these interactions. Nursing staff were professional while recording information or providing care, but they also took time to ask how people felt and if they needed anything.
- All patients told us that nursing staff were very attentive. They said they were rarely kept waiting if they needed to call for assistance.
- During one extended observation period on a ward, we noted that no call bells were heard for over an hour. We checked to ensure that call buttons were within reach of patients and functioning correctly. We found that the system was working correctly but the staff had been so attentive that the patients had not needed to call.
- Patients and their relatives described being involved in conversations with doctors. They said they were treated well and spoken to as equals, and that they had been able to influence the decisions about their care and treatment.
- Patients' privacy and dignity were supported by staff of all disciplines. We observed numerous instances of good practice with curtains being closed before discussions or care being given, clothing being adjusted, and other simple but important aspects of support being given. Isolated incidents of poor support were seen: one was when two junior doctors walked past an elderly patient who was walking through the ward with their gown completely open at the back. Neither doctor offered assistance. The same patient was seen by the ward sister who immediately went over, helped tie the gown and restored the patient's dignity.
- The NHS Friends and Family Test response rate for the trust showed that patients were happy with the services provided.
- The surgical day unit had been using the Friends and Family Test since October 2014. Patients were able to

respond electronically or by completing a paper questionnaire. While there had only been a 20% response rate, 94% of those responding said they would recommend the service.

- We spoke with a number of staff who were not only proud to work at the trust but also told us how they had recommended friends and family members to request that their treatment be carried out there. One member of staff described how they were personally waiting to have an operation and had chosen to have it done at the trust; they said, "I wouldn't have it done anywhere else."
- We saw that Friends and Family test results were displayed on the noticeboards on the wards.
- We were told that matrons completed random 'night safety' visits to monitor and support staff, and to assess issues such as levels of noise during the night.

## Patient Understanding and involvement

- Patients told us that they had been able to influence decisions about their care and treatment. Some said they had not been offered alternative types of operation, but they had not expected that: they saw the discussion more about suitability for the operation than about options.
- Patients told us that on the whole they were treated as equals by clinicians and nursing staff, and things had been explained in terms they could understand.
- We saw there was a wide selection of information available to patients and visitors on the wards. All of them had document stands with information leaflets about the trust and its facilities, specialist information on specific conditions, and other material. Some items were available in multiple languages.
- All nurses in charge on the wards wore yellow epaulettes for ease of identification by staff and patients. Table mats had pictures of staff uniforms to help patients identify who various staff members were and what their role was.
- Whiteboards were placed at the entrance of each bay giving the name of the nurse and surname of the consultant looking after the patient.
- Safety boards on ward performance were routinely displayed in patient and family areas so that care performance was understood.

## Emotional support



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- Patients and relatives confirmed that staff had been compassionate and thoughtful in their interactions with them.
- Some disciplines had dedicated staff to assist patients and their families during difficult times. These included the trauma and orthopaedic service, which had a counsellor who visited 1 day a week. An increase in healthcare support workers was expected to enhance the support available. Ophthalmology had an eye care liaison officer and advocacy at the point of diagnosis. Neurosurgery had introduced a quiet room where bad news could be broken; this ensured that privacy and dignity were maintained at all times.
- Staff from a number of disciplines described how appointments were routinely extended when patients or family members needed more time to come to terms with upsetting news.
- Staff told us they were supported by their local managers and also supported each other in difficult emotional situations.
- We observed how managers and staff supported each other through difficult and emotional issues. We saw how staff remained professional and continued to provide a compassionate and caring service.

## Are surgery services responsive?

Requires improvement



Surgery services were not meeting the 18-week standard referral to treatment targets. This was reflected in the surgical risk register. Overnight admissions and medical outliers had been constant issues for the past 12 months, adding pressure to the surgical wards.

The service was being responsive to the needs of the organisation by supporting the high volume of inpatients, but this was having an impact on its ability to perform and meet its own targets. Senior managers in the department were confident that new initiatives, which had recently started, or were about to start, would improve this long-standing problem and help to improve patient flow. At the time of our inspection, it was not possible to say if these measures would be effective.

During the 12 months from January through December 2014, a total of 1,237 patients had their elective surgery cancelled at short notice.

Over the same period, 7.2% of patients who had operations cancelled were not offered an alternative appointment within 28 days.

In the 12 months before our inspection, over 1,500 operations had been cancelled; 23% of these were cancelled on the day of surgery.

Over half the cancelled operations, 58% were cancelled for non-clinical reasons.

We found that patients did not always receive appropriate support in respect of pre-existing medical conditions when they were admitted for unconnected surgical procedures. There did not appear to be a holistic approach to a patient's health, which in some cases had led to patients becoming ill.

Theatre staff told us there was a culture among clinical staff to arrive late for theatre. They believed this had come about because theatres rarely started on time because of pressures on beds.

Large numbers of medical outliers, and the extended period over which this had applied, meant that medical and nursing staff were not as effective as they would have wished.

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

- The trust was not routinely meeting the national 18-week referral to treatment target. Some specialties were meeting the target while others were not, the overall result being that between November 2013 and November 2014 the trust as a whole consistently failed to meet the target. In particular, from January 2014, when the trust almost achieved the 90% target, there had been a downward trend to October 2014 when the trust achieved only 79% of cases referred within 18 weeks.
- Data showed that the services that performed well during the period were urology, ophthalmology, oral surgery and cardiothoracic surgery. Poor performers were general surgery, trauma and orthopaedics, ear nose and throat, plastic surgery and neurosurgery.
- Patients scheduled for operations on the afternoon list were required to arrive at 7.30am. This appeared to be due to the hospital's inability to make firm plans for the day until bed space and other resourcing issues had been identified and addressed.

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- When elective operations were cancelled, we saw that the trust met the 28-day re-booking target in most cases. For the period October to December 2014, 296 operations were cancelled and 31 patients did not receive a new appointment within the required period. This equated to 10.5% of patients. Over the previous 12 months, the average had been 7.2%.
- In 2014, the trust launched a new vascular access service. This enabled trained staff to insert feeding tubes or drug administration lines directly into a patient's bloodstream. The service was set up in response to delays in inserting lines. Within a year, the service had transformed vascular access, reducing time from request to insertion from 7 days to fewer than 3. The service had also introduced ward based peripherally inserted central catheter (PICC) insertions. These can be a safer option for some patients because they carry less risk of infection and other side effects. The team was expanding to accommodate patients from other local hospitals.

## Access and flow & Cancelled Operations

- Capacity to balance the demands of both elective and non-elective activity meant that the cancellation of operations had become almost routine. A member of staff commented, "We are cancelling operations right, left and centre."
  - Medical outliers in virtually all surgical wards, including day surgery areas, meant that patients who were scheduled for operations were being sent home because beds they would have needed post-operatively were taken by medical patients.
  - The high number of medical outliers on one ward had become so embedded that nursing staff had become concerned and raised the issue of availability of medical doctors. The trust response had been to appoint a medical doctor to the ward to support the nursing staff, rather than taking steps to reduce the medical outliers.
  - In April 2014, the trust board agreed investment of £8.4 million for staff to operate the second emergency theatre. At the time of our inspection, this theatre was in operation and being phased in over time. Managers told us that it was already starting to have an impact. When fully operational, staff were confident that it would have positive benefits for patients:
    - Elective operations would not be cancelled to accommodate emergency cases.
- We saw data showing that during the previous 12 months over 1,500 operations had been cancelled. Almost a quarter, 23%, were cancelled on the day of surgery for clinical reasons that included patients not having received pre-operative assessments in a timely manner.
  - Over half the cancelled operations, 58%, were cancelled for non-clinical reasons such as non-availability of post-operative beds.
  - Issues with capacity and medical outliers leading to cancelled operations had been reported and entered in the surgical and trust risk registers.
  - We were told that theatres regularly started late, often due to capacity issues. Operations could not start until staff were confident that there were post-operative beds of the right acuity to accommodate patients after their surgery. We were told the frequency of late starts due to capacity had a knock-on effect in that clinicians often turned up late in anticipation of late starts. This meant that on some occasions operations that could have started on time were still delayed. This had been raised at the surgical team meetings and improvements made, but it was still a culture within the department.
  - The average length of stay for surgical patients across the trust was 23 days; the average for the country was 19 days.
  - Senior departmental managers highlighted a number of interventions had been started, or were planned for the near future, to address the issue of patient flow. Those started included:
    - A second emergency theatre.
    - Moving theatre capacity to the trust's St Cross, Rugby, site.

recruiting over 50 extra nursing and operating department practitioners over the past year.

- Introducing robotic surgery, dramatically reducing post-operative length of stay.

We saw evidence of other planned Interventions that had yet to be introduced. These included the following:

- Further use of the second emergency theatre.
- Changes to theatre rotas, including further transfer of services to Hospital of St Cross, Rugby.
- Reviewing theatre start times, including monitoring clinician attendance times.

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- A new day surgery lounge, which was due to open shortly after our inspection; this was designed to free up bed space by providing a monitored seating area for patients who did not need to remain in bed, thereby improving patient experience and increasing day case activity.
- The trust used a system of identifying patients with dementia or similar issues by giving them pale blue pillow cases. While this had a slight impact on patient confidentiality, it enabled staff to easily identify dementia patients and reminded them that those patients might need extra time or explanation of what was happening. Porters told us that the system worked really well because they understood better how to speak with patients when transporting them, and this helped to reduce patients' anxiety.
- Nursing staff in the surgery on day of admission (SODA) unit monitored the progress of patients through theatres using the electronic patient record system, Opera. They used the information to identify when patients needed to undress ready for their treatment. This meant patients could remain in their day clothes and did not have to spend long periods in gowns.

## Meeting people's individual needs

- The trust had learning disability champions who undertook extra training and supported staff on the wards.
- Interpretation services were available for patients whose first language was not English. There were posters in several languages advertising this service.
- The trust website offered users the facility to view content in any one of 91 different languages.
- Staff had received dementia training and trialled the forget-me-not challenge which covered patients with multiple needs, not just a diagnosis of dementia. The trust had comprehensive information for dementia patients and their carers on its website.
- The trauma and orthopaedic department had employed a healthcare worker as a dedicated activities coordinator to provide therapeutic activities in small and large groups and to visit patients' bedsides for one-to-one interactions. Patients told us how effective this service had been in reducing boredom.
- The therapeutic arts coordinator and the activities coordinator had developed links with the community,

which was now providing arts, music and storytelling from a variety of groups. The charitable funds team had funded an activities centre complete with bespoke mural artwork.

- The trust was implementing a personalised knee improvement programme (PKIP). This was an alternative to arthroscopy. Surgeons would refer directly from their clinic. It was evidence based, with a focus on exercise and weight loss using a multidisciplinary team (MDT) of physiotherapists, dieticians and orthopaedic surgeons. The programme had been approved and the implementation date was set for 1 June 2015.
- Bedside booklets were available to help patients understand aspects of their care and treatment as well as facilities around the trust.
- Outcomes were good for patients who underwent surgery at the trust. Figures compiled by NHS England showed that for the period from January through December 2014, 1,237 patients who were due to undergo elective surgery had their operations cancelled. In January/March there were 318 cancellations, April/June 361, July/September 262 and October/December 296. Having had their operations cancelled, an average of 7% of patients did not receive an alternative appointment within 28 days.
- When we visited the female surgical day case unit, we saw that planned procedures were interrupted because beds that should have been available for patients in recovery after surgery were occupied by medical patients. Of the 15 beds available, 6 were taken up by medical outliers.

## Learning from complaints and concerns

- The trust had a complaints policy. Complaints were handled by the trust's Patient Advice and Liaison Service (PALS). Staff we spoke with understood how to support people to make complaints, and the trust website had information about how to complain.
- Staff told us that they tried to address concerns for patients or their families as they arose, and thereby prevent the issue escalating into a complaint.
- Information was sent directly from the complaints department to senior leadership on a monthly basis, informing them of the complaints received and giving

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brief descriptions of the concerns with a 'due date' for response to each. Complaints information was also included in Quality Improvement and Patient Safety (QIPS) dashboards for information and discussion.

- Evidence of learning from complaints and concerns included:
  - Refurbishment of a day room and waiting area.
  - Seating along corridors for relatives and carers who may have mobility or health problems.
  - Establishment of a neurosurgery quiet room where bad news could be broken, thereby ensuring that privacy and dignity were maintained at all times.
  - Privacy frosting on the main windows in the SODA unit.
  - Introducing a new policy restricting the number of family or friends patients could bring with them, so as to avoid uncomfortable environments.
  - In ophthalmology, improvements in signage to yellow on black after feedback from a patient adviser, making the department easier to find for partially sighted patients.
  - Also in ophthalmology, putting up curtains across an internal door in the previously open-plan suites, in response to two patient complaints about dignity.

## Are surgery services well-led?

Requires improvement



The leadership of surgical services required improvement.

We saw that clinical leads, senior nursing staff and managers were enthusiastic about the breadth and depth of services provided. They were justly proud of the staff they worked with and senior staff were liked and respected by the teams.

The trust had identified 100 risks relating to surgical issues. These were being monitored and investigated, indicating a culture of raising and addressing issues. However the volume of incidents meant that management of risks was not as effective as it should be.

Whilst managers had plans to introduce further systems to monitor compliance with the WHO safety checklist,

including recorded systems which prevented entries being completed until a specified period had elapsed; the proposed systems could not provide assurance that checks were actually completed.

The local leadership had a clear vision for the service and many innovative practices had been or were being introduced.

With 670 staff and over 44,000 operations conducted each year in the trust, managers needed to delegate responsibility for monitoring different aspects of the workforce and service. The increase in emergency surgery cases and unprecedented volume of medical patients required earlier positive interventions if the issues described within the safe, effective and responsive domains were to be avoided.

Services worked independently of each other, Surgical services had a departmental culture working in isolation from other divisions of the trust. Patients could not receive a seamless service for all their health issues.

Some nursing staff reported difficulty in approaching consultants. We witnessed one encounter between a consultant and a senior nurse that had the potential to affect patient care.

## Vision and strategy for this service

- The staff we spoke with were familiar with and engaged with the trust vision, 'Together towards World Class'. The service had strong leadership with an open culture and robust management of quality. Key issues and lessons learned from investigation of incidents were discussed at Quality Improvement and Patient Safety (QIPS) group meetings and circulated across the units via email.
- Strategies of the surgical specialties supported the corporate strategy to develop the trust as the hub for specialist and non-elective services, with 'spokes' elsewhere for elective and less complex services. For example, the general surgery strategy included the development of an integrated network for emergency surgery. The theatres strategy made provision for a second emergency theatre.
- Plans were being developed in collaboration with neighbouring cancer centres to secure compliance with 'improving outcomes guidance' for rare cancer surgery.

## Governance, risk management and quality measurement

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- Surgical team meetings took place weekly when group managers, matrons, human resources and business managers came together to discuss issues.
- There was a clear structure for the escalation and investigation of never events and serious incidents.
- An information governance manager had recently been appointed to support staff in the surgical department; they had introduced a surgical newsletter to highlight the good work of the department and to raise awareness of issues among the 670 surgical staff across the trust staff.
- Surgery risks were identified through a variety of sources, such as risk assessment, service changes and incident trends, and logged on the trust's risk register, which was held centrally on the web-based software system. There were 100 items listed by the trust which related to surgical issues at the time of our inspection. Risks were managed by the appropriate manager within teams and most risks were either low or moderate. Specialities discussed risks at QIPS meetings. The list identified when risks had been reduced and the interventions that had been made.
- The trust-wide mortality review process applied to all inpatients aged 18 years or more who died at UHCW. The primary review forms were completed by the consultants responsible for caring for the patient at the time of death.
- The trust website provided information to the public with comprehensive guidance for patients and visitors. The website had the facility to be viewed in any one of 91 different languages.
- The Patient Advice and Liaison Service (PALS) provided information and guidance to patients and visitors.
- Performance information, details of staffing levels and other useful information were posted on noticeboards on the wards.
- The trust had a patient engagement and experience committee.
- Staff had access to the trust's intranet where newsletters and general information were disseminated. Some support staff such as housekeepers, porters and hostesses said that they did not know if they could access the intranet and their roles did not give them access to computers. They told us they received information about the trust from their line managers and noticeboards.
- All nursing and clinical staff had access to the trust email system, which was used to distribute information and for general messaging.

## Culture within the service

- There appeared to be a distinct departmental culture within the hospital. Surgical patients who also had medical conditions found that they could only discuss their surgical problems with surgeons and their medical problems with medics. We saw two instances when this apparent lack of joined-up working directly affected patients who required medical interventions in addition to their surgical needs.
- Nurses reported that some senior consultants were not approachable, which had in some cases led to grievances. We observed one discussion between a consultant and a ward sister, when a patient's care was being discussed; the discussion ended with them agreeing to disagree. It is difficult to understand how staff caring for patients could know what was required of them when senior staff agreed to disagree about a care plan.

## Public and Staff Engagement

### Innovation, improvement and sustainability







- Within the surgery group, there were some notable innovations, including:
  - Development of KingMark, a radiographic scale marker that had been commercially developed and marketed globally since 2013 by an international medical innovation company.
  - Collaboration with the University of Warwick including providing a chair in surgery for a number of projects:
    - Development of removable bone cement.
    - A cervical collar designed specifically for use on intensive care patients.
    - Development of graphical methods to display trainee surgeon performance data (currently under discussion with the Royal College of Surgeons for potential integration into national trainee portfolios).
  - A proposed clinical trial of 3D-printed orthotics.
  - Use of iPads to access clinical systems at a patient's bedside.
  - Trialling wifi tracking systems to allow localisation of critical equipment.
  - Purchase and use of a Da Vinci robot, which enabled minimally invasive robotic surgery.

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- Imminent implementation of a secure clinical photography app to enable safe capture of images on mobile phones.
- Development of a novel 'non-surgical' treatment package for patients with moderate knee arthritis.
- Procurement of an innovative 'patient outcomes' software tool.
- Introduction of collagen crosslinking in ophthalmology; this is a new procedure that uses riboflavin and UV-A light to enable new bonds to form between collagen strands.
- A large UK Orthopaedic Trauma Research Unit. The trust hosted four out of seven of the National Institute for Health Research (NIHR) programmes, Health Technology Assessment (HTA)-funded multicentre clinical trials in orthopaedic trauma and contributed to all other major UK clinical trials in orthopaedic trauma. It had the largest NIHR clinical academic training programme in the country.
- Transformation of the vascular line service, which involves inserting feeding or drug administration tubes directly into a patient's vein. Reducing referral to treatment time from 7 to 3 days.
- The trust's theatres had a reputation for being innovative. Examples of the initiatives were as follows:
  - A reference site for the theatre management systems – hosting a number of UK and internal hospitals each year, showcasing the real-time patient tracking and materials management capabilities at UHCW.
  - Video-training packages that complemented policies and procedures.
  - Information portal for theatre statistics.
  - Electronic surgical safety checklist documentation monitoring.
  - Clinical education facilitators.
  - Introduction of an electronic stock management system.



# Critical care

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Requires improvement	
Overall	Requires improvement	

## Information about the service

University Hospitals Coventry and Warwickshire NHS Trust has two critical care units: a general critical care unit (GCCU) and a cardiothoracic critical care unit (CCCU). The GCCU provided up to 20 level 3 beds (beds for critically ill patients, who are ventilated and have other complex care requirements), which could be flexed between 14 level 3 beds and 12 level 2 beds (high dependency beds, but non-ventilated patients), as patient need required. Patients were admitted to the GCCU from the emergency department, theatres, wards and departments in the hospital.

The CCCU was separately managed and had 13 beds, which were generally configured as seven level 3 beds and six level 2 beds. The CCCU was primarily used as a surgical postoperative unit with capacity reduced at weekends to reflect this. At weekends, there were five level 3 beds and six level 2 beds funded. The CCCU beds were also flexed in response to patient need and dependency.

The GCCU had admitted 1,547 patients and CCCU admitted 1,237 between 1 March 2014 and 28 February 2015.

The trust are members of the regional critical care and trauma networks.

We visited both the GCCU and CCCU during our announced inspection. We spoke with five patients, seven relatives and 68 staff: nurses, doctors, therapists, domestic staff and managers. We observed care and treatment, and looked at the records of 14 patients on the critical care units. Before the inspection, we reviewed performance information about the hospital.

## Summary of findings

Critical care services were found to require improvement. Improvements were needed primarily in the safety and leadership of cardiac critical care. Critical care services were found to be caring, effective and were responsive to patient needs.

There was sufficient and appropriately experienced nursing staff available within the critical care units. Medical care and treatment in GCCU was led by consultants with qualifications and experience within intensive care medicine, which met core standards in intensive care. Care and treatment within the CCCU was led by consultant cardiac surgeons with an interest in intensive care with advice, when required, from intensive care consultants. However, the arrangements for senior medical cover did not meet the requirements of core standards in intensive care.

The critical care units were clean and there were mostly appropriate systems in place to minimise the risk of cross-infection. Improvements such as ensuring effective hand washing takes place by all staff, including cardiac surgeons, were required. The availability and use of equipment was found to be appropriate. There were appropriate arrangements for the safe administration and storage of medicines. A need to review the practice of multi-use administration of intravenous infusions to ensure that patients were protected from potential harm was identified and was being addressed by the trust.

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Critical care services were obtaining good results for patients and treatment was based on national guidelines. The hospital had seven-day working and effective multidisciplinary working, which positively affected patient care and recovery. Critical care staff were caring and compassionate.

Bed capacity of critical care services was a challenge to the hospital. However, the ability to 'flex' beds in response to patient need within both the GCCU and CCCU reduced the risk of patients not receiving timely or appropriate critical care.

Whilst the leadership (both medical and nursing) of general critical care was good, medical leadership of cardiac critical care required improvement. Staff reported that leaders were supportive and supported innovation. Staff were aware of, and committed to, the trust's vision and demonstrated commitment to its objectives and values. Staff were proud of the standard of care they provided and said that their achievements were recognised by their senior managers. All managers said how proud they were of their staff and their commitment to patient care.

## Are critical care services safe?

Requires improvement



The safety of critical care services was found to require improvement. Improvement was primarily needed on cardiac critical care with the lack of medical cover by intensive care doctors which did not meet intensive care core standards.

There were appropriate systems in place to highlight risks, incidents and near misses, although these systems were not always fully utilised. This may mean that appropriate actions were not taken to ensure lessons were learned.

The general critical care unit had sufficient and appropriately experienced staff. Nursing arrangements for cardiac critical care were also found to be appropriate and met intensive care core standards.

The critical care units were clean and there were generally appropriate systems in place to minimise the risk of cross-infection. Hand washing by doctors in the cardiac critical care needed to be improved.

The availability and use of equipment was found to be appropriate to meet patient's needs. Resuscitation trolleys were accessible on each critical care unit and had been checked and signed as being 'in order' on a daily basis, as per trust policy.

There were appropriate arrangements for the safe administration and storage of medicines. A need to review the practice of multi-use administration of intravenous infusions to ensure that patients were protected from potential harm had been identified and was being addressed by the trust.

### Incidents

- There were five serious incidents reported to the Strategic Executive Information System (STEIS) from February 2014 to January 2015 for GCCU and one incident relating to CCCU within University Hospitals Coventry and Warwickshire NHS Trust. Five incidents related to patients with grade 3 pressure ulcers and one incident of *Clostridium difficile* (C. difficile) and a healthcare-acquired infection. The trust investigated every serious incident through a root cause analysis

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(RCA) investigation process. We looked at a selection of RCA investigations, which included pressure ulcers, falls and incidence of infections and saw that when required actions had been, or were being, addressed.

- The trust had an established system for reporting incidents and near misses through a centralised web-based reporting system. The GCCU had reported 117 incidents and CCCU had reported 35 incidents between 1 August 2014 and 30 November 2014. Each incident submitted was reviewed and graded by a senior nurse or consultant and the investigation was proportionate to the grading and any harm to the patient involved.
- When the staff member completed an incident report they received immediate acknowledgement that the report had been submitted. The initial acknowledgement was then followed up with an email to them from the system, which detailed the outcome of any subsequent investigation. Staff confirmed they always received feedback from incidents they had reported. All staff, including bank staff were able to report incidents. Agency staff required a permanent staff member to complete the form for them online. Staff (both medical and nursing staff) we spoke with said that they had reported incidents, such as pressure ulcers or general concerns about care.
- We discussed the reporting of incidents or near misses with both nursing and medical staff. Nursing staff told us they would report a pressure ulcer, but would not report grade 1 pressure damage (which would present as non-blanching skin or skin not affected by light finger pressure). Medical staff told us that they would not complete an incident report for a delay in discharge or a non-clinical transfer to another hospital. This meant there was a risk of some issues that affected the service being under reported and potential opportunity for learning lost.
- Incidents including clinical adverse events (CAEs) were reviewed by medical and senior nursing staff depending upon the nature of the incident. Incidents and CAEs were discussed at the monthly quality improvement and patient safety meetings (QIPS). Specific cases were selected by the clinical leads for inclusion in the CAEs presentation so that lessons could be shared and feedback given to the teams. A quarterly summary analysis of incidents and trends was also reviewed at the specialty multidisciplinary QIPS meetings to see if

further learning could be identified. Feedback on the outcome of investigations and learning was given by email, with staff information files. This information was visible for all staff to see.

- Mortality and morbidity reviews were undertaken and findings were discussed at the QIPS meetings. Minutes of meetings we reviewed showed that, when needed, actions were taken to improve practice.

## Safety Thermometer

- The hospital safety information was updated monthly. It showed that, within the critical care units, between July 2013 and June 2014, there had been three pressure ulcers (two in GCCU and one in CCCU), zero patient falls, and two reported catheter-related urinary tract infections. This demonstrated care that had minimised the risk of patient harm.
- The Safety Thermometer was in use on both GCCU and CCCU with the information displayed for patients and relatives to view. The information on display showed the number of falls, pressure ulcers and infections and time since their last occurrence.
- The “Nurse KPI” (key performance indicators) was a management tool and contained information about each ward or unit’s performance against agreed targets. It included: staffing information (such as sickness, vacancy rates and bank and agency staff usage), incidence of infections, incidence of pressure ulcers, slips, trips and falls and patient feedback and compliance with mandatory training. The critical care units were mostly performing well compared to the rest of the trust in relation to pressure ulcers, mandatory training, patient feedback and patient falls and was reviewed by ward and senior managers.
- Risk assessments for patient pressure ulcers and venous thromboembolism (VTE) were being completed appropriately on admission.

## Cleanliness, infection control and hygiene

- The wards we inspected were clean and well maintained. There were cleaning plans in place, which included the frequency that cleaning should take place. Staff did not sign to confirm that they had cleaned identified areas and this was confirmed by domestic staff. We saw that ‘weekly maximiser audit’ were undertaken to check the cleanliness of the unit. The audits identified when areas required additional

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cleaning or were “dusty” and this was addressed.

However, we were not assured that all areas were cleaned at the required frequency as staff did not sign to confirm when they were cleaned.

- The Infection control audit for GCCU in January 2015 scored 90% and CCCU scored 97%.
- The GCCU and CCCU submitted data to monthly ventilator-associated pneumonia (VAP) and central venous cannula (CVC) audits. Both units achieved high compliance in these audits, but, if required, would ensure that corrective actions were undertaken.
- Staff compliance with hand hygiene was checked monthly by the matron or a senior nurse on both units.
- We observed that the majority of staff washed their hands appropriately and wore appropriate personal protective equipment (PPE). However, we saw that the CCCU doctors did not always wash their hands before or after each patient contact. We also observed minimal use of either gloves or aprons by doctors. Hand washing and use of gloves and aprons reduce the risk of cross-infection. There was 88% staff compliance with infection control training and 90% compliance with hand hygiene training in February 2015.
- Hand sanitising gel was available at the entrance to the each critical care unit, at each bed space and throughout each unit. Signs to remind both staff and visitors about hand hygiene were visible throughout the units.
- GCCU had better MRSA infection rates compared to other comparable hospitals in the 12 months prior to the inspection. There had been one case of *C. difficile* within GCCU and one incident of MRSA in CCCU between January 2014 and February 2015. Information provided by the trust showed that incidents were investigated, with root cause analysis (RCA) undertaken. When needed, required actions were identified such as an independent investigation of the infection.
- Findings into the root cause of the MRSA infection had been inconclusive and this case formed part of the external review that the trust had commissioned for all MRSA infections within the trust over 2014/15.
- Side rooms were used, where possible, as isolation rooms for patients identified as having an increased infection control risk (for example patients with MRSA). There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room. These rooms were also used to protect patients with low immunity.

- Staff told us and this was confirmed by records we looked at that patients admitted for planned surgery were screened for MRSA infection, and patients admitted as emergencies were isolated until it was confirmed that the patient did not have an MRSA infection.

## Environment and equipment

- We saw that storage within critical care units and particularly in the GCCU was problematic. The apparent lack of storage had necessitated that areas (side wards during our visit) were used for storage of equipment, such as beds and mattresses. Corridors within the GCCU were cluttered with trolleys storing equipment. This might adversely affect emergency access. We also observed fluids used for renal dialysis were stored on (staff) corridors. There was a need to ensure that the units had sufficient and appropriate storage facilities available.
- Staff told us that there was no shortage of equipment to meet patient needs. The private finance initiative (PFI) project ensured that equipment was replaced and upgraded on a regular basis. In addition, as the service had developed the flexibility to acquire new equipment to meet changing patient needs. Patient safety and appropriate checks on equipment were undertaken. For example, we observed checks to portable capnograph monitors (capnographs measure expired carbon dioxide to confirm correct placement of breathing tubes).
- The critical care units used the same equipment, which enabled continuity in staff training and use. When new equipment was purchased, it was only introduced into the critical units when a minimum of 70% of staff had been trained in its use.
- We saw that the resuscitation equipment was regularly checked and, when needed, restocked. There was a record of when someone had undertaken this check, as well as who it was.
- A buzzer system was used to enter the critical care unit, to identify visitors and staff, and ensure that patients were kept safe.

## Medicines

- Medicines were securely stored. We observed that medicines rooms and cupboards at patients' bed spaces were locked.
- We observed that intravenous fluid bags were used for preparing intravenous injection/infusions for more than

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one patient. The intravenous fluid bags (glucose and normal saline) were used for up to 24 hours. There was a risk that the bags could be contaminated by poor infection control practices, or maliciously while left unattended on trolleys on the units. Despite staff telling us that both pharmacy and infection control had agreed this practice, there was no protocol available. We spoke with pharmacy, who confirmed it was not an agreed safe practice and should not be undertaken. The matron assured us that this practice had stopped and would not recommence until there were suitable and appropriate assurances in place. This was brought to the attention of the Trust Executive team at the time of the inspection. This practice was not commented upon in the root cause analysis investigation of the MRSA bacteraemia and as such calls into question the robustness of that investigation in highlighting an infection control risk and an opportunity for learning.

- All controlled medication, high risk medication and associated paperwork were appropriately and safely stored.
- The medicines fridge temperatures, including the minimum and maximum temperatures were recorded daily. A regular check on temperature provided assurance that medicines are stored safely, and their effectiveness was not adversely affected.
- The critical care units used a paper-based medical prescribing and medication administration record system for patient. We saw that nursing staff signed to confirm that medicines had been given or the reason they were not given.
- Emergency medicines were available for use and there was evidence that these were regularly checked.
- There was a senior pharmacist available for each unit to advise doctors on medicines.
- There was a top up service for ward stock and other medicines were ordered on an individual basis. Staff reported that there was an effective on-call service, out of hours. This meant that patients had access to the medicines they needed.

## Records

- The critical care units used a combination of computerised and paper records. Records were completed and filed in a consistent manner to enable staff to easily locate required information about the patient, their treatment and care needs.

- Within the critical care units paper-based nursing documentation was present at each bed space. Each record covered 24 hours and included the frequency and type of observations and risk assessments required. These included pressure ulcer risk, nutrition risk, coma scale, and delirium assessments. We saw that observations were checked and recorded at the required frequency and any deviation from expected results were escalated to medical staff.
- There were clear records of the treatment that patients had received and any further treatment or follow-up they required.
- The trust has an electronic clinical results reporting system that was available in the critical care.

## Safeguarding

- The trust policies and procedures were in place for safeguarding children and vulnerable adults.
- Staff that we spoke with knew how to access safeguarding policies and procedures on the trust's intranet.
- The trust wide target for compliance with level 1 and level 2 safeguarding training was 90%. We noted compliance at the time of our visit was 91% of CCCU, staff and 100% of GCCU staff had completed safeguarding training. Staff confirmed that they had received safeguarding awareness training, and confirmed actions that would be undertaken to keep people safe.

## Management of the deteriorating patient

- The hospital used the National Early Warning Score (NEWS) to identify for acutely ill or deteriorating adult patients.
- A patient's NEWS was calculated from each observation recorded on the patient's computerised records. The score then identified deteriorating patients who required input from the critical care outreach team or the Hospital at Night team. The team then assessed the patient and a decision was made in relation to their ongoing management.
- There was a critical care outreach team available between 8am and 6pm and Hospital at Night team between 8pm and 8am, seven days a week for the management of critically-ill patients in the hospital. There was a plan to increase the availability of the critical care outreach team until 8pm. However, at the time of the inspection the critical care outreach team



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did not have a face-to-face handover with the Hospital at Night team. A handover sheet was posted under the Hospital at Night office door. We did not consider this to be a safe system of working.

- Staff inputted patients' observations results onto the electronic system. The electronic system then alerted either the outreach team, or the Hospital at Night team (dependent on the time of day) to patients who were deteriorating and required timely review. The critical care outreach team also reviewed all patients who were discharged from critical care within 12 hours of discharge to assess their progress. Some staff told us that there was sometimes a delay in putting patients' observations onto the electronic system, as sufficient handheld devices were not always available. This may cause delays in following up on deteriorating patients. The trust told us that this was a historical issue prior to September 2014 and now all staff have their own handheld device.
- The critical care outreach team undertook twice daily visits for patients with NEWS of six or above. The team ensured that wards were contacted for further information about the patient, to offer advice, ensure that the national guidelines were followed and, when appropriate, visited the patient.
- The hospital had a high dependency skills training course for all trained staff, including new staff within critical care. This course equipped staff to manage and identify deteriorating patients.
- The trust clinical staff had been nursing acutely ill patients in accordance with the NICE guidance using the National Early Warning Score (NEWS) CG35 Prediction and Detection of Impending Critical Illness in Adults. Records we looked at showed that critical care outreach staff responded quickly to deteriorating patients.
- There were care pathways in place to ensure appropriate and timely care for patients with specific conditions and in specific situations, such as ventilated patients, management of sepsis (infection) and the management of tracheostomies or types of breathing tubes.

## Nursing staffing

- The safer nursing staffing tool was completed daily by the senior nursing staff on both critical care units. The rotas were managed by the trust's electronic rostering system.

- The required and actual number of nursing staff on duty for each shift for both critical care units was identified and displayed within each critical care area.
- We found that nurse staffing numbers met core standards for intensive care units. Nurses on the critical care units were allocated to one-to-one care for level 3 patients. One nurse provided care for up to two level 2 patients. Healthcare assistants were also on duty to provide assistance with personal care.
- The GCCU had vacancies for 14 whole time equivalent (WTE) nurses, which was 10% of all qualified nurses for the unit. However, the vacancy rate had been halved over recent months.
- The CCCU had a 17% qualified nurse vacancy rate. The matron told us that this was due to an uplift of their staffing establishment, with a requirement for an additional five qualified nurses. The increase in staffing was part of their cost improvement plan to ensure sufficient staff were available to increase bed occupancy and consequently that this would lead to an increase in remuneration for critical care services. We observed that the number of staff on duty and duty rota's confirmed that even with a 17% vacancy rate, nurse to patient ratios were maintained by employing agency staff, who all had an induction to the area.
- When shifts could not be fully staffed from their own staff working their contracted hours, critical care staff could work additional hours on the hospital bank. Staff told us that the removal of enhanced rates for specialist staff had resulted in the increased use of agency staff.
- The critical care units used agency nurses and were able to block book with a single agency to ensure consistency of nursing expertise. Senior nurses said that they ensured that there were no more than 20% of agency nurses on each shift. Matrons told us that they had an ongoing advertisement for experienced band 5 nurses to work in critical care.
- All shifts within each critical care unit had supernumerary senior nurses (band 6 or 7). The GCCU had four supernumerary staff members on duty. Each nurse coordinated the three teams, with an overall nurse in charge to coordinate the shift. The CCCU had three supernumerary nurses on duty. Each nurse coordinated the two teams, with an overall nurse in



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charge. The matron was also supernumerary when on shift. We found that the availability of supernumerary nurses met best practice guidelines (core standards for intensive care units, 2013).

- Nursing handovers occurred at least twice a day, during which staff communicated any changes to ensure that actions were undertaken to minimise the risks to patients.

## Medical staffing

- Medical care in the GCCU was led by a team of eleven consultants, who were qualified to provide intensive care. The consultant to patient ratio varied between one consultant for every eight patients and one consultant to every 14 patients. At least one intensive consultant was present on the unit between 8am and 8pm, seven days of the week. This met the national recommendations of not having more than 15 patients to each consultant.
- Consultants in the GCCU were supported by a minimum of three trainee doctors, who provided medical cover for the unit during the day and throughout the night.
- In the GCCU, three consultants worked in seven day blocks to aid continuity of patient care.
- The GCCU had appropriate medical cover at night. At night, a registrar and two other junior doctors were on duty with a consultant on call who both provided telephone advice and, when needed, came in from home. This was also confirmed by the junior doctors we spoke with who stated that consultants were accessible and supportive.
- Evening and overnight medical cover on the CCCU was provided by a cardiac surgery registrar and a junior doctor with a consultant on call from home. Doctors we spoke with said they had concerns about emergency cover and, when required, escalating a deteriorating patient who may require intensive care advice. This could provide a significant risk that patients may not receive timely and appropriate review.
- If medical staffing was not adequate (for example, due to sickness), locum support was generally provided by doctors who were currently working, or who had previously worked on the units. Only if services could not be covered from within these groups were locum doctor agencies used. If medical cover could not be delivered by junior staff identified as above, the on-call consultant would remain on the unit until cover was resumed.

- The consultants on the GCCU had handovers and ward rounds twice daily. This meant that patients' health and recovery was regularly assessed to ensure they received appropriate and timely treatment.
- There was a daily consultant handover and ward rounds undertaken on the CCCU. In addition, there was an evening handover between the day and night registrars.
- All potential admissions to the GCCU were discussed with a consultant and new admissions were reviewed by a consultant within 12 hours of admission. However, we did find that there was a delay in assessing one patient, which we highlighted to the trust for further investigation.

## Major incident awareness and training

- As a major trauma centre, the hospital had to be prepared for the likelihood of a major incident. The major incident policy for the trust contained relevant sections relating to the roles of critical care staff, preparedness and immediate actions.
- The trust had in place a strategic business continuity plan to ensure that there was a clear process in managing the response to an event that would cause disruptions severe enough to impede on the delivery of essential services.
- The trust was reviewing the daily escalation plans to ensure that any fluctuations in demand and capacity were managed safely and effectively, along with managing the associated clinical risk, within acceptable limits.

## Are critical care services effective?

Good



People have good outcomes because they receive effective care and treatment that meets their needs. We found that the general critical care was progressive and innovative. There was a need for the cardiac critical care to replicate practice within general critical care that both met best practice guidelines and the innovative practice.

Arrangements were in place to ensure that both nursing and medical staff had appropriate training and development opportunities. However, the lack of practice development nurses meant that critical care may not be adequate in the future when it comes to ensuring that

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nurses have appropriate training opportunities and checks on their competence. Staff had mixed understanding of their responsibilities around the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The comprehensive multidisciplinary daily handover on GCCU and multidisciplinary working provided effective patient care within the general critical care unit. This comprehensive multidisciplinary handover was not replicated on the CCCU. Seven-day working was in place for all medical and nursing staff and for most other staff disciplines.

There were appropriate care pathways and clinical audit programmes in place to monitor adherence with guidance. The GCCU mostly performed well when compared to other units. CCCU did not contribute data to the Intensive Care National Audit & Research Centre (ICNARC) or similar. A failure to complete ICNARC or similar information meant that a similar benchmarking comparison with other critical care units and the effectiveness of care provided could not be made for cardiac critical care. This meant that assurance could not be made that cardiac critical care performed favourably with other critical care units.

## Evidence-based care and treatment

- Critical care used a combination of National Institute for Health and Care Excellence (NICE), Intensive Care Society, Faculty of Intensive Care Medicine (FICM) and Nursing and Midwifery Council (NMC) guidelines to determine the treatment it provided. Local policies were written in line with this.
- Care and services within the general critical care services met the requirements of intensive care core standards although this was not undertaken within cardiac critical care. Compliance with intensive care standards within general and cardiac critical care were reviewed by the senior management teams. This review did not include a review of medical staff in either general or critical care..
- The critical care units participated in an annual trust-wide audit of documentation to ensure patient information relating to the care of patients was completed in accordance with both national and local recommendations. We noted that documentation we looked at during our visit to the critical care units was complete and legible.

- Staff told us and we observed patient records that demonstrated that the hospital was largely meeting the requirements of NICE (83), which identified a need for an individualised, structured rehabilitation programme.

## Pain relief

- A standardised pain scoring tool was used in both critical care units and could be used for patients who were unable to express pain. The pain assessment included a check on non-verbal responses, or changes to the patient's observations. Patient records we looked at confirmed that staff were using this tool to assess patient's pain.
- The GCCU and CCCU were both supported by the acute pain nursing team who helped manage patients' pain relief.
- The records we looked at confirmed that patients had regular pain relief. Patients we spoke with told us staff ensured they had the pain relief they needed and they were kept comfortable.

## Nutrition and hydration

- Appropriate arrangements were in place to highlight the risk of dehydration within the critical care units.
- The trust used national guidance for parenteral and enteral nutrition. Policies were in place to enable patients who were unable to take oral nutrition or fluids to be given specialist feeds until they could be seen by a dietician. Patient records we looked at confirmed that these policies were in use. This meant that patients were protected against the risk of malnourishment.
- Patients we spoke with said that the food was tasty and appropriate for their needs. We observed that drinks were accessible for patients and that, when needed, nursing staff provided appropriate assistance.
- Dieticians provided individualised dietetic advice using their expertise in food, nutrients, drug interactions, and enteral feeding. Patient records we looked at confirmed that when required patients had been seen by a dietician. We observed during our visit that dieticians visited the critical care units daily and also took part in multidisciplinary team meetings. This meant that patients received appropriate nutrition to meet their needs.

## Patient outcomes

- The mortality rate for cardiothoracic surgery was slightly below other units. However, as the CCCU did not

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contribute data to the ICNARC database or undertake comparable local audit benchmarking, comparisons for the critical care component of coronary/cardiac care could not be made.

- The GCCU contributed to the ICNARC database. The data demonstrated that the GCCU performed similarly to other comparable hospitals.
- The ICNARC data for GCCU showed that non-clinical transfer, delayed discharges from GCCU and readmissions to GCCU were comparable with the national average. Out of hours discharges from GCCU were worse than the national average. (CCCU does not report into the ICNARC report).
- The critical care units collected data for a local audit of central venous catheters (CVC). The results were discussed at the monthly 'saving lives' meeting, which was attended by the infection control team, matrons, associate directors of nursing and the chief nurse. Compliance with standards was generally identified to be in excess of 95%. However, if satisfactory compliance was not identified, the matron for the clinical area affected was responsible for reinforcing the correct procedure.
- The critical care outreach team provided a trust-wide tracheostomy service. This involved the daily assessment and management of tracheostomy patients until their hospital discharge.

## Competent staff

- The CCCU was led by consultant cardiac surgeons. Staff told us that one consultant cardiac surgeon who had an interest in intensive care medicine was present on the unit five mornings a week. Staff told us that, when requested, intensive care consultants would visit the CCCU to provide patient advice. The medical arrangements of the CCCU did not meet intensive care core standards, which require that an intensive care consultant leads the care on all intensive care units.
- All band 6 and above nurses had a post registration qualification in critical care. The CCCU met the required standard of at least 50% of nursing staff with a post registration award in critical care nursing. The GCCU had 46% of nurses with a post registration qualification in critical care. The trust did not supply the percentage of cardiac critical care nurses with this qualification.
- All medical staff received a hospital and critical care induction. The doctors' induction was followed by weekly (one hour) critical care specific teaching for junior doctors with a monthly half-day teaching programme for middle grade doctors.
- Junior doctors we spoke with said they felt supported by their mentor and other staff.
- All new nursing staff had a hospital and local induction in critical care. They had a four week supernumerary period, with six weeks for newly qualified nurses. New staff were assigned mentors. Developed by the critical care network, the competency book supported the training and development of staff, and could be used in any of the critical care units within the region.
- All nurse competencies were checked against standards identified by the critical care network. Nursing staff had competency booklets that were completed and assessed to check their competency which we observed during our visit. This meant that there were assurances in place to ensure appropriate staff practice and competency.
- All new staff attended a three day "boot camp", which was an enhanced programme of lectures and practical sessions to aid their introduction into critical care. Senior staff reported that, due to the success of this initiative, this training experience would also be available to more experienced staff.
- Staff working within the CCCU had access to a variety of specialist courses, including cardiothoracic care, critical care, pain and end of life care. GCCU staff were also able to apply for the critical care course, but could also apply to undertake the neurosurgical course. This meant that staff had the opportunity to develop their knowledge and skills.
- The critical care outreach team provided a rolling programme of tracheostomy and suction training for ward nurses. This programme ensured that staff had the knowledge and skills to support patients with these needs.
- The GCCU had a clinical care practice development team consisting of four band 7 nurses (1.5 WTE), who organised and delivered training and supervised the practice of 130 staff. The CCCU had one band 7 practice development nurse working 11.5 hours a week overseeing 70 staff, a further practice development nurse had been on long-term sick leave. The practice development nurses told us it was a challenge to meet all the requirements of the role, particularly with the

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employment of newly qualified and inexperienced nurses. The critical care units did not meet core standards for critical care units, which require one WTE practice nurse for 75 nurses.

- At the end of January 2015, 82% of CCCU staff and 86% of GCCU staff had had an appraisal. All staff we spoke with confirmed that they received an annual appraisal.
- Critical care was supported by a dedicated clinical audit facilitator based within the clinical audit department. The clinical audit facilitator, in conjunction with clinical leads, was responsible for ensuring that a high standard of clinical auditing was conducted within the specialty.

## Multidisciplinary working

- There were excellent daily multidisciplinary team meetings on the GCCU which were held at 9am, there was input from doctors, nurses, physiotherapists, dieticians and, when available, speech and language therapists and specialist nurses for organ donation. We observed the multidisciplinary team meetings and found that staff discussed all patients and their treatment plans, the teams involved were invited to contribute. We found that the multidisciplinary team meetings demonstrated excellent effective multidisciplinary working, which enhanced patient care.
- It was disappointing that the effective multi-disciplinary meetings were not replicated in CCCU.
- There were separate pharmacy and microbiology ward rounds five days a week on both CCCU and GCCU, during which the patients' medication and microbiology treatment needs were discussed. At other times, staff could obtain telephone advice. This meant that advice was provided which reflected changing recommendations and immediate changes could be made in response to national guidelines.
- The critical care units had a dedicated team of physiotherapists. A recent rehabilitation pathway had been introduced so that rehabilitation needs were assessed within 24 hours of admission and then reassessed before discharge from critical care. A plan for the patients' rehabilitation needs was clearly documented in their notes and on a whiteboard at the patient's bedside so that everyone was aware of their rehabilitation goals.
- Doctors, nurses, physiotherapists and speech and language therapists contributed towards a plan to wean patients off ventilators. This met best practice guidance.

- A speech and language therapist reviewed all patients with a tracheostomy, with swallowing and speech difficulties and communication difficulties. Communication aids were available, with advice from the speech and language therapists. This met best practice guidance.
- Multidisciplinary team working within CCCU was supported by clinical nurse practitioners who provided cardiac rehabilitation and heart failure support across primary and secondary care departments.
- The critical care outreach team was a multidisciplinary team as well, with the inclusion of a dedicated physiotherapist.
- The CCCU used an integrated care pathway for patients who were admitted for care and treatment on an elective basis. The pathway included pre-assessment, admission, theatres, return to the CCCU, transfer to a step down ward, discharge and follow-up. Patients admitted on an emergency basis had a tailored multidisciplinary care pathway.

## Seven-day services

- There was at least one intensive care consultant present in the GCCU between 8am and 8pm (and frequently until midnight), seven days a week.
- Physiotherapy provided a seven-day service for the critical care units.
- Radiology and radiography services were led by a consultant who was available for urgent x-rays and scans seven days a week and during the evening and overnight.
- The hospital pharmacy was open seven days a week, although for reduced hours at the weekend. Urgent medicines could also be accessed by senior on-call staff.
- Speech and language therapists and dieticians were available five days a week, although we were told there were plans in place to increase their availability.

## Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- The trust had consent to treatment policy, and an information sharing policy. These policies included: the process for consent, consent refusal, lasting powers of attorney guidance and children giving consent to treatment. Information on the use of interpreters was also incorporated within the consent policy.
- The majority of patients treated in the critical care units lacked mental capacity to allow informed

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decision-making. Staff told us they had received training about the Mental Capacity Act 2005, but had mixed understanding of their responsibilities around it and Deprivation of Liberty Safeguards. For example, around the use of restraint, this may include the use of sedative medicines or equipment used to stop patients pulling out intravenous lines. Staff did not always understand that these 'best interest' decisions should be considered and recorded in these circumstances.

- Occasionally, a stable level 3 patient would be moved to another hospital to make space for an unstable level 3 admission. The medical team agreed that their process of best interest decision-making and consent was not always recorded and may not be considered in the stable patient's best interest. There was a need to record the use of best interest decisions for these patients.

## Access to information

- On the critical care units nursing notes were kept at the patient's bedside and were accessible by staff at all times
- Staff could access electronic care and treatment policies and procedures at all times.

The ward managers attended senior sister meeting with the critical care matron and shared the outcome of these meetings with staff. Information was mostly shared face to face or by email.

## Mandatory training

- Nursing and medical staff confirmed that they received annual mandatory training in areas such as: infection control, moving and handling, medicines management and information governance.

Mandatory training attendance for nursing staff was monitored by the unit managers and professional development nurses. Medical staff training was monitored by each doctor's mentor.

The CCCU and GCCU teams worked in a coordinated way to ensure regular opportunities were scheduled to allow staff to undertake mandatory training. Staff completion of required mandatory training at the end of January 2015 was:

- CPR for both GCCU and CCCU 97%
- hand hygiene – GCCU 90% and CCCU 85%
- handling and moving – GCCU 100% and CCCU 73%
- infection control – GCCU 88% and CCCU 92%

- Overall, compliance with mandatory training for GCCU and CCCU was 88% in January 2015.
- Senior medical and nursing managers told us that mandatory training was reviewed as part of each staff member's appraisal.

## Are critical care services caring?

Good



Patients and their relatives said that staff were caring and compassionate and were happy with the care they or their loved one had received within critical care.

All critical care patients who had completed the NHS Friends and Family Test said that they would recommend the service. Staff built up trusting relationships with patients and their relatives by working in an open and supportive way.

Patients and relatives were given good emotional support, and throughout our inspection we saw patients treated with compassion, dignity and respect.

Whenever possible patients and relatives were consulted and informed about the treatment they or their relative would receive. There was a critical care follow up clinic which was opportunity to discuss ongoing problems. Bereaved relatives also received support from the trust and critical care when required.

Staff provided good care by understanding what was significant to patients, and making arrangements to ensure they retained what was special in their lives.

## Compassionate care

- Patients were positive about staff and the care they received. One person told us: "The staff are angels." Two relatives told us: "We are very happy with the care."
- Throughout our inspection, we saw patients being treated with compassion, dignity and respect. We heard just one inappropriate reference to a patient when a nurse referred to them as "awkward", although in the medical handover doctors referred to the same patient more sensitively as "confused".
- Privacy and dignity arrangements for patients were acceptable. Privacy curtains were closed and staff were



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seen to ensure they remained closed to maintain patients' dignity. We observed staff tuck blankets and bedding around patients to protect their modesty and keep them warm and comfortable.

- We observed staff talking to patients and relatives in a respectful and friendly manner.
- All critical care patients who had completed the NHS Friends and Family Test said that they would recommend the service.

## Understanding and involvement of patients and those close to them

- The nature of the care provided in a critical care unit meant that patients could not always be involved in decisions about their care. However, whenever possible, relatives were consulted on the patient's preferences such as organ donation and their views were taken into account and this was sensitively undertaken
- Staff told us that explained that had a meeting with the patients relatives to discuss the benefits of treatment, treatment withdrawal and the futility of further treatment. This meeting was held with the patient's consultant with the Specialist Nurse for Organ Donation should the relatives wish to discuss organ donation.
- Whenever possible, patients were asked for their consent before receiving any care or treatment, and staff acted in accordance with their wishes.
- Patient diaries were used within GCCU. The diaries assisted patients to retrospectively reflect on their experience of critical illness.
- The critical care units had a good selection of patient information leaflets, which were available in visitor areas. Examples included: a 'Who's Who?' guide, a guide to follow-up services and a bereavement guide.

## Emotional support

- Staff built up trusting relationships with patients and their relatives by working in an open and supportive way. Patients and relatives were given good emotional support.
- After admission, a meeting between the consultant covering the unit and the patient's relatives would be arranged to update them on the patient's progress. When necessary, further face-to-face meetings were organised.
- The relatives we spoke with said they had been updated and had opportunities to have their questions answered.

- The hospital had a follow-up clinic for GCCU patients and relatives. Patients were able to speak about their critical care experiences and discuss unpleasant ongoing symptoms, such as hallucinations. This service had been invaluable to patients and their relatives. Staff all told us about how positive this service had been for patients and relatives.
- A chaplaincy service was available, which provided valuable support to patients and relatives.
- CCCU and GCCU had a bereavement follow-up service. A card was sent to relatives following the death of a loved one and they were offered the opportunity to visit the unit and talk to staff.
- GCCU offered an annual memorial service each January for the families and loved ones of patients who had died on GCCU.

## Are critical care services responsive?

Good



Critical care services were responsive to people's needs. There had been an increase in both general critical care beds and also cardiothoracic critical care in response to an increased demand for these services.

There was higher than national average occupancy of critical care beds in the trust. However the flexibility between the critical care beds had ensured that patients received timely care in those units.

Patients who were discharged from the units were aware of their discharge plans and had appropriate records or information given to them or to those providing ongoing care. Critical care also provided ongoing support to patients with tracheostomies (specialist breathing tubes) throughout their hospital stay and also to support their discharge home.

There were appropriate visitor facilities available. Within the critical care units, support for patients living with physical and learning disabilities, dementia, or those who had communication difficulties, was available, if needed.

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



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- The critical care units were funded to provide up to 27 (level 3) beds and were able to respond to local and national needs with the support and involvement of commissioners.
- Cardiothoracic beds had been increased during 2014/15 to increase the CCCU establishment to ensure bed availability could meet elective cardiac-surgical demand.
- Feedback was received from patient-centred groups, such as the cardiac rehabilitation and heart failure team to ensure that patients' views were represented in service planning and change.
- In 2014, funding was provided for an additional GCCU level 3 bed to support an increase in demand from major trauma patients.
- The critical care outreach team assisted patients requiring discharge with a tracheostomy to primary care or home. The team also provided teaching for families and care home staff to assist the patient discharges.
- All discharges from GCCU were agreed by a critical care consultant and also agreed by the accepting ward team. After discharge all patients, with the exception of those discharged for end of life care, were followed up by the critical care outreach team. Written discharge summaries were provided by medical and nursing staff.
- Staff told us that they were supported by hospital management to ensure that patients were discharged from critical care within six hours when they were assessed to no longer require a critical care bed. This also ensured that the hospital did not breach mixed sex accommodation standards.
- The critical care outreach service had a remit to: facilitate timely admission and discharge from critical care units, prevent readmission to critical care and promote continuity of care for patients who had been critically ill. The outreach team also had a role in educating staff about the management of critically-ill patients and those at risk of deterioration.
- The critical care outreach team assisted the multidisciplinary team to discharge patients with a tracheostomy to primary care or home.

## Access and flow

- Between May 2013 and November 2014, figures showed that the bed occupancy for GCCU beds was mainly around 92% to 93% and CCU was 72%. The national average critical care bed occupancy was 86%. Persistent bed occupancy of more than 85% suggests a unit is too small. However, the ability to 'flex' the number of critical care beds by utilising beds in CCCU for general critical care patients meant this was not an issue for the hospital.
- Despite an increase of overall capacity in critical beds, there were still times when critical care capacity was exceeded. The hospital had developed guidelines to ensure the potential risks to patients were minimised. These included the stipulation that patients will either be cared for in the emergency department or theatre/recovery with the constant presence of either an intensive care consultant or registrar until a suitable bed in critical care was available. If bed availability was unlikely, a suitable patient would be discharged (this would be a non-clinical transfer). However, transfers were not made after 10pm in line with the critical care network rules. In addition, to avoid non-clinical transfers, suitable GCC patients would be managed on the CCCU under the care of the GCCU team.
- There were regular bed management meetings that reviewed both elective and emergency hospital admissions, the demands of the critical care units and patients' risks. Between March 2014 and February 2015, 33 operations were cancelled due to the lack of availability of critical care beds.

## Meeting people's individual needs

- Support for patients living with physical disability, learning disability or dementia was available if needed. Relatives of patients with a learning disability and dementia were asked about patients preferences and understanding and were able to have longer visiting hours. Staff told us that they usually received assistance from families with care and were also able to use "the communication box", which provided aids for communication.
- There were a total of six visitor overnight rooms available (three rooms on both GCCU and CCCU). These rooms were also used as areas to break difficult news.
- Regular meetings were held with the patient and family members to ensure they were included in treatment decisions and, where necessary, interpreters/translation services was arranged.
- GCCU had a follow-up service for former patients. Patients were visited on the ward post discharge from GCCU and also invited to a nurse-led follow-up clinic. The aim of the clinic was to support the recovery and

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review the progress of patients who had been critically ill. It also gave them the opportunity to discuss any ongoing problems that they had. This service had been shortlisted for a Nursing Times award.

- An ICU steps (the intensive care patient support charity) support group was established for former patients of the GCCU in 2014.

## Learning from complaints and concerns

- There had been two complaints about the GCCU in the twelve months prior to the inspection. We found that there was an appropriate response to the complaints received. On both occasions, the matron had discussed the complaint face-to-face with the complainants and the complaints had been locally resolved. Feedback was provided to staff to show how their actions were perceived by others.
- There had been one complaint about CCCU in the twelve months prior to the inspection, which had been satisfactorily resolved. Following feedback from relatives, the waiting area of the CCCU was being refurbished.
- Complaints were handled in line with trust policy. If a patient or relative wanted to make an informal complaint, they would be directed to the nurse in charge. Staff would direct patients to the Patient Advice and Liaison Service if they were unable to deal with concerns. Patients would be advised to make a formal complaint if their concerns were not resolved.
- Complaints information was included on the specialty quality improvement and patient safety (QIPS) dashboards, which were discussed at departmental QIPS meetings. On a monthly basis, senior leadership received a report detailing any complaints received.
- Information on how to raise concerns and make a complaint was on posters displayed within critical care.

promoted the delivery of high quality person-centred care. However we found that there was a need to review cardiac critical care leadership to ensure it provided care that promoted and assured patient safety.

Staff working in critical care were aware of the trust's vision and demonstrated commitment to its objectives and values.

Quality received sufficient coverage within division meetings. There was an effective process in place to identify, understand, monitor and address current and future risks. However there was no identification by the cardiac critical care medical leadership to ensure that medical cover reflected intensive care core standards. Performance issues were escalated to the relevant managers and quality assurance meetings and to the board through clear structures and processes. However a lack of completion of ICNARC or similar data by cardiac critical care meant that cardiac critical care leadership were unable to fully reflect on the performance of the unit compared to other similar units.

The nursing leadership were knowledgeable about quality issues and priorities, understand what the challenges are and take appropriate actions to address them. Leaders prioritise high quality compassionate care and ensure that staff feel valued, respected and supported. Financial pressures were managed so that they did not compromise the quality of care.

Staff were supported by managers and were positive about the care they provided and that their achievements were recognised.

There was a focus on continuous learning and improvement. Safe innovation was supported

## Vision and strategy for this service

- Staff were aware of, and understood, the vision and values of the trust and the behaviours that would achieve these values.
- Strategies for the service were developed with the involvement of clinical directors, nurse managers and group managers. The specialties' strategy for critical care was to review capacity against demand and the possible integration of CCCU. This included: the reduction of on-the-day cancellation of surgery, due to bed pressures.

## Are critical care services well-led?

Requires improvement



The leadership of critical care services requires improvement, primarily due to the shortfalls within the medical leadership of the cardiac critical care unit and a failure to meet best practice guidance for critical care. We found that general critical care services were well led. The leadership, governance and culture of GCCU services

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- We were not made aware of an effective strategy to ensure that there were consultants in intensive care managing the care on the cardiac critical care unit. The clinical lead told us that currently there were not sufficient intensive care doctors to provide medical cover for cardiac critical care.
- Improved preoperative assessment and GCCU bed-booking processes.
- Increased level 2 bed capacity.
- There was a vision to improve co-working between GCCU and CCCU, starting with availability of a GCCU consultant on the CCCU daily ward round and increasing to twice daily consultant intensivist ward rounds.
- Critical care services were exploring how the critical care advanced nurse practitioner role could be developed and provide additional support to nursing and medical teams working within critical care.
- Risks inherent in the delivery of safe care were identified on the trust's risk register: the critical care risk register had 32 identified risks of which five were identified as high risk and included insufficient staffing levels in GCCU. Critical care risks were reviewed at a weekly team meeting and also at QIPS meetings, updating controls and risk ratings as appropriate, taking into account all of their quality and performance data, to ensure that risks were being managed.
- A root cause analysis was undertaken following each serious incident. Records of Investigations which we saw detailed identified actions to reduce the risk of further, similar incidents in the future.
- Dissemination of clinical audit findings was done via presentation at the critical care QIPS meetings. This enabled the audit results and any improvements to practice to be identified and action agreed.
- Cardiothoracic and cardiology held monthly mortality and morbidity (M&M) meetings to discuss CCCU patients treated over the preceding period. The governance and audit leads for the specialty reported to the quarterly trust M&M group and, as necessary, raised and discussed matters through the specialty QIPS.

## Governance, risk management and quality measurement

- Governance and performance management arrangements were reviewed and adapted to take account of best practice. There were monthly governance meetings where complaints, incidents, audits and quality improvement projects were discussed. The outcomes of these meetings were fed back to staff. However the shortfalls in cardiac critical care not meeting intensive care core standards had not been addressed.
- The performance of the critical care units was reviewed quarterly at face-to-face performance reviews, using an integrated performance report, which included information on quality, safety, finance and workforce metrics. The shortfalls in cardiac critical care meant that there were ineffective leadership for cardiac critical care.
- The critical care managers encouraged staff to report incidents and staff confirmed that they received feedback on the incidents they reported.
- GCCU consultants were motivated and committed to improving the quality of the service that general critical care provided. However there was a need to ensure that the same commitment was in place to ensure that the effective critical care was in place for cardiac critical care.
- A failure of the CCCU to contribute information to ICNAR meant that the leadership did not have full assurance of the performance of the unit in comparison with other comparable units.

## Leadership of service

- The CCCU were part of the cardiac and respiratory group. There was a clinical director, group manager and modern matron in place to provide leadership to the specialties. GCCU were part of the anaesthetic, critical care, and pain group, with the same leadership structure plus a clinical lead for critical care.
- Critical care had a consultant intensivist who was the medical clinical lead for critical care. This meets intensive care core standards.
- CCCU had a cardiothoracic surgeon who was the medical lead. The lack of involvement of an intensive consultant in the management/ leadership structure does not meet intensive care core standards.
- GCCU and CCCU had a modern matron (band 8) who had a specialist qualification in critical care in addition to a management qualification and had overall responsibility for the nursing elements of the services. This met core intensive care standards.
- We saw that, while there was a need for greater integration between GCCU and CCCU, this process had already commenced. We observed that the modern matrons for both specialties worked closely to ensure

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that the critical care units jointly responded to patient needs. We observed that to enable the hospital to respond to emergency trauma patients, patients had been moved from GCCU to CCCU to meet this need.

- There were supernumerary band 6 or 7 nurses in charge of each shift on both GCCU and CCCU.
- The leadership ensured that there was shared learning and support for all critical care staff.
- The leadership in GCCU drove continuous improvement in intensive patient care, sharing good practice and highlighting audit findings with staff and when improvements were needed. For example Staff told us about improvements made to ensure patients received an appropriate specialist feeding regime, or that they received optimum and safe treatment by ensuring their ulna (lower arm bone) was recorded for ventilated patients.
- We saw that nursing leadership in CCCU were also involved in quality improvement. We were not assured that the medical leadership in CCCU provided similar assurances of a modern critical care service that reflected intensive care core standards.
- We found that the leadership were responsive to suggestions for improving care outcomes, maximising resources and obtaining best value for money. For example, by negotiating contracts for supplies of specialist equipment and medicines.

## Culture within the service

- Staff spoke positively about working for the hospital. Staff told us they would recommend it as a place to work and that senior staff were supportive.
- Staff commented that they were “a good team”.
- All the managers told us that they were proud of their team and their commitment to high quality patient care.

## Public and staff engagement







- The trust used a combination of email, intranet messages and newsletters to engage with staff.

- Managers were visible on the critical care units and staff spoke positively about matrons and the support they provided.
- GCCU had a patient/relative support group, which was consulted about initiatives and their experiences of being a patient on GCCU.
- CCCU staff and patients were encouraged to assist in service developments. There were a number of patient groups in primary and secondary care, covering chronic obstructive pulmonary disease (COPD), heart failure and cardiac rehabilitation, which contributed to ensuring patient feedback and engagement with service development plans.

## Innovation, improvement and sustainability

- There were appropriate systems in place to reviewing service delivery and, when needed, ensure that lessons were learned and appropriate actions taken. As a consequence of medication incidents, nursing staff involved had to complete a reflective practice summary. Learning was shared from medication errors, for example, staff ‘READ’ files which were files located in the staff room that staff could refer to and detailed information for staff to be aware of.
- Critical care had a quality improvement plan which demonstrated a commitment to quality care while obtaining best value for money.
- In collaboration with the University of Warwick, the GCCU had secured three years of funding to conduct a multi-centre study of how the decision to admit critically unwell patients to intensive care was made. This study will take place in a total of nine sites across the UK and the intended outcome of this is to develop a decision-support framework that will ensure decisions made on behalf of critically-ill patients are made in a patient-centred, ethically justifiable, and consistent way and will take place over the next three years.

# Maternity and gynaecology

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

## Information about the service

The maternity service provided care for women with high- and low-risk pregnancies. It offered antenatal care, access to a foetal wellbeing unit with foetal medicine, a scanning department, maternity triage, antenatal and postnatal wards, a labour ward, the Lucina Birth Centre, a bereavement service and infant feeding support. Between April and November 2014, 4,176 births were recorded. There were 226 maternal admissions to the high-dependency unit in the same period.

The community midwifery team's main base was in the hospital maternity department with some community bases available. Eight teams of community midwives worked in partnership with GPs, health visitors, family nurses and children's centres, promoting good health during pregnancy and the early days after a baby's birth.

The gynaecology service offered inpatient, day care and assessment facilities, along with a Centre for Reproductive Medicine. A consultant-led, multidisciplinary service provided secondary care to the women of Coventry and Warwickshire, and tertiary care to those in the West Midlands. Outpatient, inpatient and day case care were integrated with the obstetric service, which had an outpatient department and a dedicated ultrasound service. Some integrated clinics were based at Hospital of St Cross, Rugby. In 2014/15, there were 1,400 gynaecology emergency attendances and 2,100 elective gynaecology procedures were carried out.

## Summary of findings

We inspected University Hospitals Coventry and Warwickshire NHS Trust (UHCW) gynaecology and maternity unit over 3 days. The team included an inspector and three specialist advisers who were practising obstetricians or midwives. We visited all wards and departments relevant to the service. We spoke with 16 women and 61 members of the nursing and midwifery staff, including eight community midwives and maternity staff who had attended a focus group. We also spoke with 21 medical staff and 17 relatives.

Overall, we found the service to be good, but with the 'safe' domain requiring improvement. Ward storage of medication, handling of medication by community midwives, checking of resuscitation equipment on the labour ward, and elements of infection control and prevention practice were found to be in need of improvement.

We found the service to be well-led with strong leadership and an open culture. The birth centre promoted a 'home-from-home' experience for women who wished to have the home birth experience with the reassurance of being in a hospital.

Wards and departments were clean and tidy with ample equipment and storage facilities.

Women we spoke with were mostly happy with the care they had received, and we heard staff offering compassionate care and clear explanations. Ward staff

# Maternity and gynaecology

told us they felt well informed about the trust, and that they regularly met and spoke with senior management. Community staff had recently been based at the hospital to improve their integration with hospital staff and management.

Safeguarding issues were well managed regarding women with special needs or specific medical conditions. A specialist bereavement midwife offered an exemplary service in supporting parents during difficult times.

In line with both national and local guidance, obstetrics and gynaecology staff participated in local trust-wide audits relating to the care of women. The maternity service and emergency gynaecology unit offered 24-hour, 7-day access to all women with gynaecological or early pregnancy problems.

## Are maternity and gynaecology services safe?

Requires improvement



We found that the 'safe' domain required improvement in two main areas. One related to medication and the other to the non-checking of resuscitation equipment on the labour ward and community midwives were non-compliant with trust policy in their handling and storage of medication.

Evidence of adherence to the policy for MRSA screening in maternity was lacking in patient records and in discussions with staff.

One 'Never Event' (a serious, largely preventable patient safety incident that should not occur if proper preventative measures are taken) reported in May 2014 that theatre personnel had not adhered to trust guidelines on intraoperative care. Lessons learned were that successful delivery of care in an operating theatre required the presence of an effective team. Non-application of trust guidelines produced errors that resulted in the delivery of unsafe patient care. When reviewing three sets of maternal medical notes, we identified that the women had not been screened for MRSA before undergoing planned caesarean sections.

Community midwives told us they had not received formal safeguarding supervision. Their caseloads were up to 1:130 women, with a planned ratio of 1:96. At times, they had to manage up to 17 safeguards alerts within their caseload.

The overstocking of epidural drugs on the labour ward had led to supplies being kept not only in an 'epidural-only cupboard' but also in a neighbouring cupboard.

We saw that community midwives were not supplied with suitable storage facilities to carry medication in their vehicles; consideration for stock control and suitable conditions for storage had been overlooked, for example hot weather.

The gynaecology ward had 28 beds; up to 20 of these had been consistently allocated to medical outliers in the previous 12 months. 'Outlier' is the term used to describe patients cared for in areas other than the appropriate



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location for their needs. This situation had had an impact on the effectiveness of the gynaecology service for some women, causing cancellations and delays in surgery; it also reduced staff morale.

## Incidents

- Escalation of risk was identified through an incident reporting system. The ward manager or supervisor of midwives on call was contacted when a serious incident occurred.
- Nineteen serious incidents had been reported since April 2014. Each was reviewed by the senior manager. The matrons discussed weekly any issues that had occurred, and a multi-professional meeting was held to discuss incidents in specific areas. A root cause analysis report was produced after an incident investigation. Review meetings were held, minuted and attended by those involved, including the senior management team.
- Between December 2014 and March 2015 there were 1494 vaginal deliveries resulting in 37 anal sphincter injuries (OASIS).
- Between December 2014 and March 2015 82 postpartum haemorrhages were reported >1000mls. Of those 57 were recorded as >1000mls, 20 were recorded as >1500mls and 5 were recorded as >2500mls.
- Data relating to unexpected admissions to NICU was requested and not received.
- In gynaecology, the most reported incidents related to slips, trips and falls. After robust nursing interventions, this trend reduced on Ward 23 with no serious injuries reported in February 2015. However, only 8 of the 28 beds were being used for gynaecology patients. The rest were occupied by medical patients who were managed by a separate medical team. Slips, trips and falls were attributed to this group of patients rather than the gynaecological ones.
- There were two category 3 pressure ulcers reported on Ward 23 at the end of 2014. Root cause analysis was undertaken and staff retraining implemented. Both these incidents involved medical outlier patients rather than gynaecological patients.
- An obstetrics and gynaecology performance and governance scorecard for 2014/15 recorded 17 neonatal deaths and 0.2% neonatal readmissions.

- The National Patient Safety Agency (NPSA) Intrapartum Toolkit was in place. NPSA had developed this to improve safety within maternity by providing guidance and resources to help staff monitor and investigate incidents.

## Safety thermometer

- The Royal College of Obstetricians and Gynaecologists (RCOG) Maternity Dashboard was populated each month to monitor maternity data. The information was then considered at the patient safety committee and at local quality improvement and patient safety meetings.
- The trust's target of 95% for harm-free care had been consistently achieved over the previous year for all harms in maternity and gynaecology. The maternity service planned to adopt the maternity-specific safety thermometer by April 2015. The national recommended maternity clinical outcomes were measured in line with the Maternity Dashboard: Clinical Performance and Governance Score Card (Good Practice No. 7) Royal College Obstetricians and Gynaecologists 2008. Between April and November 2014, there were no failed instrument deliveries and 456 emergency caesarean sections.

## Cleanliness, infection control and hygiene

- Between May and July 2014, 37 women sustained surgical site infection after their caesarean section. The infection rate of 10.1% was slightly higher than the national average of 9.6% (Health Protection Agency, 2012). During the same time, 20 women (5.5%) were excluded from surveillance because their signs and symptoms did not meet the reporting criteria for surgical site infection.
- We identified that, in three sets of maternal medical notes, women undergoing planned caesarean sections had not been screened for MRSA before surgery. We discussed this screening with midwives and reviewed the database, which confirmed that women were not being routinely screened. We found no evidence that the trust's policy and procedure were being followed. We were told that MRSA screening in maternity was not included separately in the audit system. Staff did not know the MRSA screening compliance rates in maternity or the criteria for screening. This practice was not in accordance with the trusts guideline.
- Hand hygiene audits were completed during April and May 2014. Ward 23 scored 94%, and Wards 24 and 25

# Maternity and gynaecology

each scored 97%. Availability of hand wipes at mealtimes, hand gel and hand hygiene posters were areas identified for improvement. Hand gel was placed throughout the ward areas but not in all bed spaces, and hand hygiene posters were not widely displayed. Staff used the hand gel and wore protective clothing when necessary. They all adhered to the 'bare below the elbow' policy. Wards and departments we visited were clean and well maintained. We saw that the birthing pool's maintenance and cleaning regimes were in place.

## Environment and equipment

- On the labour ward, we found that on 10 occasions since November 2014 the daily checks of the maternal resuscitation equipment had not been carried out and the compliance with these checks against trust policy had not been monitored. The defibrillator had not been checked on 57 occasions since August 2014, and the neonatal trolley on 2 occasions during March 2015. Failure to adhere to the trusts policy of completing daily checks was discussed with the ward manager.
- Environment audits were completed according to the trust's infection control policy. Most areas achieved above 88%. In January 2015, the labour ward theatre scored 53%, the labour ward 68% and the antenatal clinic 79%. To address these poor results, domestic staff had been retrained and ward staff reminded of their responsibilities.
- There was a trust-wide equipment library for syringe drivers and pressure-relieving mattresses. We saw that the trust had invested in some bariatric equipment and further equipment was hired as necessary. Ward staff requested items from the library 'in hours' and the helpdesk for mattresses and feed pumps 'out of hours'; the holder of the hospital bleep was contacted for syringe drivers out of hours.
- We discussed the evacuation procedures from the birthing pool in the case of an emergency. Midwives practised these within their 'skills and drills' programme. Skills drills are the accepted format by which healthcare professionals gain and maintain the skills to manage a range of obstetric emergencies.

## Medicines

- Medication was stored in locked cupboards within clinical rooms. We saw that community midwives were carrying medication without proper storage facilities, and we raised this with the pharmacist during our inspection.
- On the labour ward, we saw that epidural drugs were overstocked and had been stored not only in an 'epidural-only cupboard' but also in a neighbouring cupboard. This meant the stock control was not effective and led to confusion as not all staff were aware of this including the pharmacy technician we met with.
- No issues were raised about administering medication, Ward staff were supported during weekdays by a pharmacist and a pharmacy technician, whose key roles included chart review, medicines reconciliation and supply, patient counselling and review of patients' medicines.
- Venous thromboembolism scores were recorded and monitored. We saw that prophylactic treatment was prescribed and administered. The March 2015 audit showed compliance of 98% against a trust target of 95%.

## Records

- Nursing and medical records were kept secure and away from public view. Records were maintained in a neat order and the use of dividers aided the nursing and midwifery staff. The maternity service used the Perinatal Institute's pregnancy care records for all pregnant women and their babies. These were kept by the women during their care and filed in the hospital's main healthcare records once the period of pregnancy was over. Child health records, known as 'Red Books', were distributed to mothers for each newborn.
- The maternity service had a training programme on standards for records and record keeping. This involved a number of audits, a self-audit programme, spot checks, and training and education for all levels of staff. The maternity risk management team monitored the standards across the service. A gynaecology consultant was seconded to the trust-wide electronic patient record replacement team to support the implementation of a new maternity record system.

## Safeguarding

- All the staff we spoke with were aware of the trust's safeguarding policy and the reporting procedure. We met with the safeguarding, risk and bereavement

# Maternity and gynaecology

midwives to discuss their roles in the department. Working as a combined team, there was a dedicated lead nurse for safeguarding children and vulnerable adults, a named nurse for safeguarding adults and a support midwife.

- The community midwives told us that, on booking and throughout the course of antenatal care, they looked out for any safeguarding concerns and escalated as necessary. They told us they did not receive regular, formal safeguarding supervision. The trust lead for safeguarding received a weekly report that identified the unborn babies subject to child protection plans.
- 'Coventry Acting Early Intervention' meetings took place within weekly multi-professional meetings held in local children's centres. Attendees included community midwives, health visitors and social care staff. The purpose was to share information when there were professional concerns about families relevant to more than one person's case load. A consent process had been agreed and was in place; this allowed for early sharing of relevant information.
- Local FGM issues were discussed and monitored during the midwifery and gynaecology service (nursing and medical leads) weekly governance meeting. Staff we spoke with were aware of the issues surrounding such incidences and they showed us how this was documented and how safeguard alerts were raised.
- The gynaecology team had produced an escalation policy for all staff to follow in the event of any safeguarding issue. All staff were aware of the procedures involved in escalating adult safeguarding and deprivation of liberty issues. We heard that trust-wide processes were followed with support from matrons and safeguarding leads when necessary.

## Assessing and responding to patient risk

- **The modified early obstetric warning score (MEOWS) system was used to** record and document women's vital signs. This helped staff to recognise any change in a woman's condition. The use of MEOWS charts prompted early referral to an appropriate practitioner who would undertake a full review, order appropriate investigations and treat as required. Midwives undertook cardio-tocograph monitoring of the foetal heartbeat. Any incidents were reviewed by the supervisor of midwives with resulting action implemented and monitored accordingly.

- The theatre staff applied the World Health Organization (WHO) surgical safety checklist as part of the '5 steps to safer surgery' procedures at critical time points within a patient's care pathway to ensure their safety. In November 2014, the obstetrics and gynaecology theatres both scored 100% in the WHO checklist audit.
- An escalation policy was available for junior staff to read when they were considering calling in a consultant. We were told that senior staff were always available to be consulted. Evidence from the job evaluation survey tool (JEST) showed that junior doctors were comfortable asking senior staff for help.

## Nursing staffing

- As of November 2014, the maternity service had 199.2 whole-time equivalent (WTE) midwives, which is the total number of full-time staff that the full- and part-time staff combined would represent.
- Ward 23 and the gynaecology outpatient department combined were funded to employ 56.6 WTE nurses. However, on 31 January 2015, there were 50.4 WTE in post, which meant there were 11% vacancies. The Centre for Reproductive Medicine (CRM)'s funded establishment was 10.4 WTE and there were 9.18 WTE staff in post.
- From April 2014 to February 2015, the midwife to birth ratio was 1:28.9. This meant there was one midwife working in the trust to every 28.9 babies delivered. Band 3 maternity support workers were currently completing a training programme and, once the course was completed, they would support the midwives with basic observational support. The trust promoted one-to-one care in active labour. However, midwives told us that this was unlikely to be provided because of demand on the ward (for example, at times they could have up to three women in active labour in their care). Currently, one-to-one care was recorded as 87–90% on the labour ward.
- '24 hour on call' processes were in place on the labour ward. The band 7 midwife 'on call' was called in initially and then the community midwives, on call for home births, were called in when necessary. This process had an impact on the community workload, and some clinics had been cancelled because of it. Equality issues had arisen when staff had not been released from the

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birth centre, currently unoccupied, to support a busy labour ward. We were told that the policy may be revisited to ensure that support is available when needed.

- The trust had used a nursing acuity assessment tool since 2006, after participating in the original research programme with Leeds University. The Safer Nursing Care Tool (SNCT) had been used since January 2014 and an assessment of all wards undertaken; this also took account of professional judgement and guidance from the National Institute for Health and Care Excellence (NICE). A full and comprehensive assessment of nurse and midwife staffing and gap analysis was undertaken and presented to the trust board in May 2014 (in line with the National Quality Board standards and the NICE Safe Midwife Staffing in Maternity Settings guideline).
- The trust recognised the need for extra staffing on Ward 23 due to the presence of outliers. As a result, they agreed and funded an additional healthcare support worker per shift to help with any outlying patients. After a review in April 2014, the nursing establishment on Ward 23 was increased to a nurse to patient ratio of 1:6 with medical patients and 1:8 with less dependent patients. In February 2015, the agency or bank use of registered nurses and healthcare support workers was 13% and 43% respectively.
- Birthrate Plus assessment was undertaken in April 2014 and confirmed that the obstetric wards were compliant. Birthrate Plus® is the only national tool available for calculating midwifery staffing levels. The maternity service had an escalation policy for times of unexplained workload or sickness.
- The trust had invested in a plan for the main theatre department to run the obstetric theatres, providing dedicated scrub teams and freeing up midwives for labour ward-related duties. This was introduced following the 2014 Never Event, to be implemented from April 2015 and completed by April 2016.
- Planned and actual staffing levels were displayed at the entrance to all wards. There were 21 active supervisors of midwives who were available 24 hours a day, 7 days a week, to support midwives and women in an advisory role. Shift patterns on the gynaecology and maternity wards were mostly 12-hour shifts with some staff choosing a shorter working day.

- On the gynaecology ward, staff covered vacant shifts whenever possible by booking bank or agency staff. Agency midwives had not been booked for some time because a bank of midwives had been developed.

## Medical staffing

- The medical staffing mix was similar to the England average, but there were no middle-grade doctors in maternity. Recruitment to current vacancies at consultant and senior registrar levels was underway; however, there had been difficulties in filling the posts. To mitigate risk, experienced locum doctors who knew the service and the teams had been booked for 6-month periods, and gaps were filled whenever possible by internal staff working extra shifts.
- There was appropriate consultant obstetric cover on the labour ward weekly. This was consistently reported as 96 direct cover hours. The maternity service staffing levels for obstetric anaesthetists and their assistants were in line with Safer Childbirth (RCOG, 2007) recommendations. Anaesthetic cover was available 24 hours a day, seven days a week.
- Handovers took place in the morning and evening. We observed several ward rounds and handovers that were informative and well-paced.
- On two occasions we observed that the caesarean section list in theatre was disorganised with the start time delayed by staffing issues and late (day of surgery) pre-assessment care of the mother. The list order was not decided until the day of the operation.

## Mandatory training

All staff groups under obstetrics and gynaecology had a rate of 83% against a target rate of 100% for all modules of mandatory training. Maternity training levels were at 90% and gynaecology at 78%. Staff on the gynaecology wards had not been released for training because of the impact of the medical outliers and the need to keep the wards appropriately staffed.

## Major incident awareness and training

- Staff were aware of the major incident policy released in July 2014, and senior staff were aware of the business continuity plans. The gynaecology service followed the trust-wide major incident policy. An annual practical obstetrics multi-professional training (PROMPT) programme was established for the maternity services.

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## Are maternity and gynaecology services effective?

Good



Policies were based on guidelines from the National Institute for Health and Care Excellence (NICE) and the Royal Colleges. Local audit activity was discussed within the quality improvement and patient safety meeting (QIPS) and displayed on the ward.

The trust promoted breastfeeding and the important health benefits now known to exist for both mothers and babies. Breastfeeding initiation in November 2014 was 79%.

The Lucina Birth Centre and the enhanced recovery programme in obstetrics were proving popular options. Women we spoke with on the gynaecology and obstetrics wards told us that their pain had been well managed with appropriate analgesia or alternative methods such as water births and aromatherapy. We observed staff asking women about their pain and the effectiveness of their analgesia.

We heard examples of effective multidisciplinary team working in the community and the hospital. Staff told us they worked closely with health visitors, GPs and social services.

There was no evidence of risk for maternal or neonatal readmissions between April and November 2014. This showed that appropriate discharges were arranged and women well supported in the community. Access to medical support was available 24 hours a day, 7 days a week.

### Evidence-based care and treatment.

- Obstetrics and gynaecology were supported by a dedicated clinical audit facilitator based within the clinical audit department. This facilitator, with clinical leads, was responsible for ensuring a high standard of clinical audit within the specialties. The clinical leads developed and approved the obstetrics and gynaecology audit programmes, and monitored clinical audit performance in line with the trust's clinical audit strategy. Their aim was to promote a culture for improvement in performance at all levels.
- Presentations of clinical audit findings were discussed at the obstetrics and gynaecology audit meetings. This allowed the audit results to be debated within the clinical teams, lessons learned to be shared, improvements to practice identified and action agreed. Progress against audit action plans were reported at the specialties' quality improvement and patient safety meetings via the quality and patient safety reports for each specialty, and also at specialty quarterly performance reviews.
- Obstetrics and gynaecology participated in an annual local trust-wide audit of documentation and consent to ensure that information relating to the care of women was provided in line with both national and local recommendations.
- From September 2014 to March 2015, a number of actions had been implemented as a result of various local audits. These included the audit of neonatal resuscitation, the re-audit of the use of oxytocin in labour and the re-audit of the management of obesity in pregnancy. Actions taken included circulating in a newsletter the audit findings of areas for improvement, introducing oxytocin stickers and discussing obesity with GPs during their Protected Learning Time (PLT). PLT is an opportunity for practice staff to address their own learning and professional development needs.
- The maternity department had a dedicated clinical audit midwife who undertook audits and spot checks in high-risk areas and disseminated the findings to maternity and neonatal staff in a newsletter.
- The trust's guideline on antenatal care had been in place since 2012. It was based on the NICE clinical guideline 62 'Antenatal Care' (2008, modified 2014) and was updated in 2014 by the modern matron for outpatient services.
- The gynaecology team participated in national audits (for example, on heavy menstrual bleeds), which showed the average waiting time between referral from GP to first outpatient clinic visit was 4 weeks. Eighty-one cases were referred, and 37% of the 86.7% of women who received treatment were satisfied with the care they had been given in hospital.
- The trust was meeting the 2-week wait standard for immediate and moderate colposcopy referrals, despite the tripling of the workload associated with HPV testing. It was not meeting the 4 weeks to definitive treatment standard, in that 75% was being achieved against a



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target of 90%. Difficulties were reported in relation to turnaround time for histology, and locum consultant pathologists had been appointed to address this. The trust was planning on introducing digital pathology.

## Pain relief

- We observed staff asking women about their pain and the effectiveness of their analgesia. Women we spoke with felt that their pain and analgesia had been well managed.
- On the labour ward, we saw a variety of pain relief methods available including a birthing pool, aromatherapy, epidurals, Tens machines and Entonox®. In 2013/14, 63% of women chose to deliver in the birthing pool.

## Nutrition and hydration

- In November 2014, breastfeeding initiation was recorded as 79%. This was better than the trust's goal of 77%.
- On admission, patients had a nutrition risk screening undertaken using the Malnutrition Universal Screening Tool (MUST). This was documented in the nursing notes and, when necessary, high-risk patients were referred to the dietetic team.
- The trust had a rotational menu offering a wide variety of hot and cold choices. The menu was coded in terms of suitability for various diets, such as healthy choices and food to meet cultural needs. We heard varying reports about the meals, ranging from good to poor.
- We saw that any requirements for special diets were documented on admission, for example, gluten-free meals had been provided.

## Patient outcomes

- Responses to four of the five National Neonatal Audit Programme (NNAP) questions for UHCW were worse than the standard. Data from the 2013 NNAP listed the trust as below its standards in relation to mothers receiving antenatal steroids, retinopathy of prematurity screening, the proportion of babies receiving mother's milk and a documented consultation with the parents or carers by a senior member of the neonatal team within 24 hours of admission. The trust responded to this by implementing an action plan and the NNAP report published in October 2014 showed a marked improvement. The trust was now performing above the national average against all these standards, except for

the proportion of babies receiving mother's milk. Action was being taken to improve this: a neonatal breastfeeding lead had been appointed and the trust was working towards UNICEF Baby Friendly accreditation in 2016.

- There were 5,887 births in 2013; 732 of these were elective caesarean sections and 733 were emergency caesarean sections. Between April and November 2014, 4,176 births were recorded. There were 226 maternal admissions to the high-dependency unit in the same period.
- Admissions or transfers to the neonatal unit when gestation was 37 weeks and above was an average of 3% from April 2014 to January 2015. The neonatal readmission rate for November was 0.8%, which was below the trust's goal of 7%. There was no risk identified for maternity outliers. Perinatal audit recorded 26 deaths between April and November 2014.
- Waiting times were within national standards. The women and children's group achieved 18 weeks' referral to treatment time with a score of 91%.
- Information on the 31-day and 62-day cancer pathway targets was up to date for November 2014. The 31-day diagnosis to treatment cancer target was 100%. The 62-day urgent referral to treatment cancer target was 93%. Ninety-nine per cent of emergency attenders to the emergency gynaecological unit were seen and treated within the 4-hour target during the calendar year to December 2014.
- A caesarean section rate above the national average prompted an extensive action plan to reduce it. This plan was put in place and the rate decreased from 29.4% in July 2012 to 22% in January 2015, thereby reducing morbidity and promoting normality for women.
- Early smoking cessation support had proved to be effective in decreasing the number of women still smoking at the time of birth. The percentage reduced from 94% screened at booking to 30% at delivery.
- The trust was able to show continuous patient data contributions to the maternal, newborn and infant clinical outcome review programme (MBRRACE-UK). Actions taken included the implementation of diabetes and cardiology multidisciplinary clinics and high-risk clinics.

## Competent staff



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- All the staff we spoke with told us they attended mandatory training and their individual needs were identified at their annual personal development review.
- There were a number of clinical nurse specialists in gynaecology; their role included scanning, which was supported by the lead consultant.
- The maternity service had a practice facilitator who coordinated the induction of staff, an annual update of midwives and a competency programme for staff. Newly qualified midwives were given a preceptorship package, whereby they worked in all areas of the specialty. Student midwives told us they felt integrated into the staff team and were well supported.
- The maternity service had 21 trained supervisors of midwives, appointed by the local supervising authority, and two supervisors of midwives in training.
- Annual reviews were embedded in the service and separate to the personal development review process. The trust was used as an exemplar site for the **local supervising authority** review undertaken by the Nursing and Midwifery Council. Nursing and midwifery appraisal completion levels were currently recorded as 67.5% against the trust target of 75%. The Lucina Birth Centre's appraisal was currently recorded as 95%.
- Specialist midwives were trained in mental health support, drug- and alcohol-related issues, diabetes, ultrasound scanning and counselling. The ward staff learned from them, thereby enhancing their own skills and the experience of some mothers.

## Multidisciplinary working

- The maternity service promoted multidisciplinary team working, including antenatal services. Community midwives, health visitors, GPs and social services staff were all linked through joint working. The service held a weekly QIPS meeting in which cases of poor or unexpected outcomes were presented and discussed to identify lessons learned.
- In April 2014, a restructure of the community midwifery service was undertaken to co-locate midwives and health visitors within children's centres, and to promote integrated working. The aim, which was to provide a seamless service and improve communication within the multidisciplinary team (MDT), had resulted in positive feedback from women and their families.

- The gynaecology MDT and the urogynaecology MDT both held weekly meetings and worked closely with other specialty surgical teams, including those at other providers such as Worcester Acute Hospital NHS Trust.
- Physiotherapists supported mothers with mobility post-caesarean section when necessary. They supported the gynaecology ward and received antenatal and postnatal referrals, including those from the outpatient service.

## Seven-day services

- The maternity service offered a 24-hour, 7-day a week service. This included the ward presence of a consultant obstetrician 96 hours a week, with on-call cover 24 hours, 7 days a week.
- The antenatal clinic and foetal wellbeing unit with foetal medicine were generally available Monday to Friday only. The lead anaesthetic consultant for obstetrics was available during the day with on-call cover overnight.
- The emergency gynaecology unit offered 24-hour, 7-day access for all women with gynaecological or early pregnancy problems. The specialty was working towards offering a 7-day early pregnancy scan service, and strong collaborative working was observed with the obstetric team who supported the service. A weekend service was provided in line with service demand.

## Access to information

- We saw a wealth of information available throughout the maternity and gynaecology wards which gave advice and contact numbers for local services.
- Access to an interpreter service could be arranged in person or via the telephone depending on the individual need. We observed a midwife meeting with an interpreter prior to the admission of a woman on the ward; we saw full introductions carried out and observed the woman be put at ease.
- We observed medical notes to be placed back in to the trolleys after use and to be stored by the nurses station away from site of the public.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told that verbal consent was received from mothers before midwives carried out any tests on their baby.

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- We saw that the capacity of women was tested when necessary. An example of this was seen in the hospital passport of a woman with a learning disability, and also in her medical notes.
- We were told by midwives that they used multidisciplinary meetings to discuss risk and potential safeguarding situations.

## Are maternity and gynaecology services caring?

Good



The women we spoke with told us they had been well cared for by staff who were professional and compassionate.

The maternity service scored 95% against a trust target of 89% when patients were asked whether they would recommend their friends and family should receive treatment there.

Women told us they felt their antenatal care was good and they had good advice from the hospital obstetrician, the community midwife and the GP. Bereavement support was offered by a specialist bereavement midwife who offered counselling and support to families after late foetal loss, stillbirth or neonatal death. The Lucina Birth Centre offered a safe place to give birth for women assessed as 'low risk', and the enhanced recovery programme in obstetrics was proving to be a popular option for some women.

Women in the gynaecology clinics and gynaecology assessment centre told us they had received excellent care and support.

### Compassionate care

- The Maternity Service Survey 2013 covered the maternity services of 137 acute NHS trusts in England. Women were eligible to take part if they had had a live birth in February 2013, were aged 16 years or older, and had given birth in a hospital, birth centre, maternity unit or at home. At University Hospitals Coventry and Warwickshire NHS Trust (UHCW), 169 completed questionnaires were returned from the sample of 413, which was a response rate of 41%. The trust results were better than those of most other trusts on the question of the perceived length of stay after the birth being appropriate. The results were challenging compared with those of most other trusts with regard to skin-to-skin contact shortly after birth and staff introducing themselves. The action plan, drawn up by the specialty, had since been signed off as completed
- In February 2015 the trust maternity services scored 95% in the Friends and Family Test (a test which asks patients if they would recommend the hospital as a place of care for their friends and family) with a local target of 89%. Women told us they felt informed, able to make choices and emotionally supported.
- One question in the Maternity Service Survey 2013, CQC, ('looking back, do you feel that the length of your stay in hospital after the birth was appropriate?') scored better than in other trusts.
- In the national Maternity Service Survey 2013, CQC, UHCW was rated 'worse' when compared with other trusts in respect of patient experience regarding labour and birth, as well as staff. The maternity services team had developed an action plan to improve in these low-scoring areas. This included promoting birthing aids in the Lucina Birth Centre and on the labour ward, recruiting extra staff and redesigning the information pack given to women at antenatal appointments. The action plan was included in the trust's board papers for March 2014.
- We spoke with the bereavement midwife who ran the hospital-based bereavement support. They had a diploma in bereavement counselling and membership of the British Association for Counselling and Psychotherapy. Their role was to provide immediate and long-term support to families after late foetal loss, stillbirth or neonatal death. They saw families in their home to help them with the necessary arrangements, as well as meet their emotional needs. When required, they also provided advice and support in subsequent pregnancies. A large part of the role involved training and educating staff in bereavement care best practice, and effective and sensitive communication. While the help given was generally excellent, we observed one situation in which labour ward staff had not given early support, so that much needed to be done by the bereavement midwife when they came on duty.
- The bereavement midwife had won a national award for a 'Forever Photos' project that provided sensitive photographs for parents who had lost their baby in late pregnancy or soon after birth. They received the

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National Maternity Support Foundation (NMSF) Award for Bereavement Care at the Royal College of Midwives Annual Midwifery Awards in March 2015. The initiative aimed to make photographs of the baby as sensitive and meaningful as possible for the parents. The project also trained midwives to provide this service to grieving parents, no matter what time of day or night.

- Gynaecology had a monthly support group for patients who had suffered miscarriages. It also held a yearly memorial service and staff worked closely with the spiritual team. Women with gynaecological cancer were given a named clinical nurse specialist and contact number for support and advice during the normal week, plus emergency numbers out of hours. Women we spoke with in the gynaecology assessment unit and clinic told us they had found the staff kind, understanding and compassionate. We heard examples of staff taking time to listen to women and support them through difficult and emotional times.

## Antenatal care

- Antenatal care was shared between the hospital obstetrician, community midwife and GP. It was provided in the maternity unit, in the community or at Hospital of St Cross, Rugby, with scanning taking place in the antenatal clinic.
- Pregnant mothers were referred to the trust's foetal wellbeing unit when problems were identified by the midwife or consultant. Referrals were usually made after 26 weeks of pregnancy. The unit provided more frequent monitoring and observations when necessary. Pregnant women self-referred if they had concerns about their baby's movements.

## Labour and birth, staff and care in hospital after birth.

- Birthing partners were encouraged to stay with the mother during labour if she wished. Only the birthing partner and one other person were permitted to the labour ward during this time. At night, the entrance to the women's hospital was locked for security reasons with an intercom system in operation.
- The birth centre offered a safe place to give birth if a woman was assessed as 'low risk.' This meant there had been no complications or medical problems during pregnancy. An exclusion list was considered to ensure that all women's safety was considered over choice. These criteria were individually risk assessed with each woman.

- Introduced in autumn 2014, the enhanced recovery programme, led by anaesthetists and staff in the postnatal ward, had proved popular for some women. The programme reduced the length of stay following a caesarean section and, without complications, women were returning home on the first or second day after delivery.

## Postnatal care

- Eighty-five per cent of staff in the maternity unit had been trained in UNICEF breastfeeding. There were two dedicated infant feeding coordinators in post, which equated to one whole-time equivalent midwife. The ward managers had included a UNICEF-trained support worker on each shift, including evenings and night duty, to ensure that consistent breastfeeding support was available.
- Women who were breastfeeding were referred to the community support breastfeeding service. The number of referrals had increased: in May 2012, 142 women were referred and in December 2014 the number was 328. The infant feeding coordinators continued to monitor referrals and encourage staff to refer more women.

## Understanding and involvement of patients and those close to them

- Women in all maternity areas told us that they felt well informed and were able to ask staff if they were not sure about something. They felt they had been given time to talk to the medical staff.
- On the postnatal ward, the midwives had introduced a group discharge session. All mothers who were being discharged met in the breastfeeding lounge and watched a DVD for new parents that explained about taking a baby home and aftercare. Parents we spoke with told us they found the session reassuring and helpful.

## Emotional support

- Parents who had lost a baby or small child were invited to the trust's annual baby memorial service in the faith centre at the hospital. Although the service was broadly Christian, it was open to families of all faiths. Refreshments were served after the service, and the bereavement midwives and other nursing staff who families had had contact with were present. Those families who had an entry in the baby memorial book were also able to look at their entry.

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- We were told that midwives observed women for anxiety and depression throughout their pregnancy. Mental health screening forms were completed when necessary, and at times midwives referred women to the mental health team. Local independent counselling services were also available. Support and guidance information was displayed on ward noticeboards in the maternity wards.

## Are maternity and gynaecology services responsive?

Good



We found that 88% of eligible women at 12 week + 6 days' gestation were booked into the service. The maternity booking system had been reviewed and presented to the clinical commissioning group to show that the reasons for not achieving the 90% target were due to genuine late bookers, and also reflected the increased diversity of ethnic groups.

The birth centre promoted a 'home-from-home' experience for low-risk women who wished to have the comforts of a home birth with the reassurance of being in a hospital. In November 2014, 6.1% of babies were delivered in the birth centre. We heard that the women were fully informed about the process of emergency transfer should the need arise.

Colposcopy clinic initiative lists (to reduce waiting times) had been introduced one Saturday a month to maintain and improve waiting times. Translation services were available as well as information about the hospital in a variety of languages.

The trust's learning disability nurse lead arranged and monitored inpatients needing a higher level of support. We saw examples of mothers requiring mental health support being risk assessed, referred and monitored as necessary.

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

- Antenatal and postnatal clinics had been introduced in children's centres and at Hospital of St Cross, Rugby, to ensure that the service could review all pregnant women close to their home.

- We were told that the colposcopy clinic had an initiative list one Saturday a month to maintain and improve waiting times.
- There was a new breastfeeding lounge on Ward 25, which had been designed and funded by the trust's charitable funds raised by the trust's membership. Women and their partners used the lounge and it was there that they received discharge advice when leaving the ward.

### Access and flow

- The maternity service had been under the 90% target of maternity bookings before 12 completed weeks' gestation each month between April and November 2014, with the average being 88%.
- The maternity unit had not been closed in the past year. There was a maternity escalation policy that included closure or suspension of the service. This policy had been used but it had not led to the closure of the unit. An established maternity triage assessment unit was available 24 hours, 7 days a week. This assessment process offered assurance and advice, and avoided admitting some women who instead returned for a scanning review at a later date.
- We identified high bed use on the gynaecological ward by medical outliers. During the inspection, up to 22 outliers were present on the 28-bed unit including 2 surgical outliers. Because of the shortage of gynaecology inpatient beds, there were waiting list initiatives to maintain waiting times within national targets. Patients were called in at short notice when there were beds available and lists were arranged at the local private hospital.
- The gynaecology assessment unit provided a rapid assessment and diagnostic service for all emergency patients, as well as an early pregnancy assessment service. The unit was open daily, 7 days a week, and referrals were made by GPs, midwives, the emergency department (ED), and other community services.
- The gynaecology 4-hour emergency target and 18-week referral to treatment time were achieved by new approaches (for example, the gynaecology emergency unit offered direct admission and 'hot' clinics (where patients were seen before scheduled clinic appointments) to reduce avoidable ED attendances; laparoscopic hysterectomies reduced length of stay; and the ambulatory gynaecology outpatient service reduced admissions.

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- Discharge planning was arranged on admission. Women we spoke with on all the wards were aware of when they were potentially due to go home. Discharge information was issued to women with advice and guidance notes.

## Discharge and transfer

- One issue was raised relating to the inconsistent timing of some ward rounds on the obstetric wards, which had led to confusion on the wards and delayed discharge for some women.
- Community midwives told us that on occasions they felt the communication between them and the labour ward could be improved. For example, they heard from a mother that she had delivered her baby and was back home, rather than being told by the ward staff.

## Meeting people's individual needs

- Staff in the birth centre explained how they promoted a 'home-from-home' experience for women who wished to have the comforts of a home birth with the reassurance of being in a hospital. They offered a birthing pool, home furnishings, specialist equipment, bean bags, mattresses, birthing balls and aromatherapy to add to the comfort of women in labour. Individual rooms had mood lighting and music was available. The community midwives offered a 24-hour 'on call' home birth service to help mothers who had planned a home birth or needed advice.
- The urogynaecology department offered specialised care to women of all ages. Urogynaecological consultants were highly trained to offer an individualised, patient-focused service from referral to discharge.
- We saw a woman using the interpreter service on the labour ward. Translation services were arranged when necessary and information was available.
- We saw the trust's learning disability nurse lead supporting a woman who needed extra support that had been arranged by the midwife responsible for her care. We saw that the woman had a hospital passport noting her personal history, likes, dislikes and preferences.
- Women who needed mental health support were risk assessed, referred and monitored as necessary. Many of the midwives worked with specialists to provide a link with community maternity services. They gave extra advice and support to midwives and parents in areas

such as diabetes, drugs and alcohol, antenatal and newborn screening, twins and multiple birth, bereavement support, infant feeding and child protection.

## Learning from complaints and concerns

- There was a complaints policy and complaints were managed in line with the NHS complaints regulations 2009 and the Parliamentary and Health Service Ombudsman's principles for good complaints handling.
- The maternity service had a dedicated risk management team. Because the service experienced higher numbers of complaints than other specialties, the service took a proactive approach in meeting complaints face to face when appropriate, and complaints were discussed at quality improvement and patient safety meetings. The maternity service and gynaecology had no complaints investigated by the Parliamentary and Health Service Ombudsman in 2014/15.
- Twenty-eight complaints had been received in obstetrics and gynaecology between April and November 2014. The CRM received a number of complaints about patients not being able to contact staff and, as a result, a new telephone system was installed along with extra reception staff.
- Learning from complaints took place at both corporate level and within the clinical groups. We were told that there was 'lessons learned' time in team meetings when discussing complaints. Staff talked about how things could have been handled differently and what the outcome might have been.
- The Patient Advice and Liaison Service (PALS) offered help, support and advice to women, relatives or carers, about any issues relating to the trust.

## Are maternity and gynaecology services well-led?

Good



The staff we spoke with were familiar and engaged with the trust vision, 'Together towards World Class'. The service had strong leadership with an open culture and robust management of quality. Key issues and lessons learned from investigation of incidents were discussed at QIPS meetings and circulated across the units via email.



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Hospital staff we spoke with were aware of who their senior management were, including the chief executive; however, community staff told us senior management were less visible. We heard about the open 'no blame' culture and the work carried out on reflective practice.

The service was innovative and forward thinking. Staff had received awards for contributions to their area of work, including the publication of 'good practice guidance' for maternity staff on using interpreting tools and ensuring women understood the information given to them.

All the staff we spoke with told us they knew who they could talk to should the need arise. They mentioned unit managers, matrons and ongoing support from the pastoral team.

## Vision and strategy for this service

- We heard from staff about the trust's aim for all specialties to adopt the 'Together towards World Class' programme. This programme had a commitment to engage employees to achieve the vision and change the culture of the organisation. At its launch, staff were assured that their feedback would be listened to, and would support the completion of the programme. Staff told us that they did feel listened to.
- The head of midwifery and the midwifery team had a collective, passionate vision as to how to develop their service and increase the use of the birth centre.
- The strategy for maternity and gynaecology specialties supported the corporate strategy to develop UHCW as a hub for specialist, non-elective, elective and less complex services (for example, more use of the birth centre would provide more local access for routine births). Likewise, the ambulatory gynaecology services aimed to provide services locally and to develop these through partnerships, such as those with Worcester Acute Hospital NHS Trust and more local trusts.

## Governance, risk management and quality measurement

- The maternity service held a weekly meeting to review all clinical adverse events submitted that week. The key issues and lessons learned from reviews and investigation of incidents were circulated across the units via email. Also, over the past 6 years, the maternity risk management team had produced a monthly risk newsletter that disseminated all lessons learned from minor to serious incidents.

- The gynaecology service nursing and medical leads met weekly with the governance team lead to review all incidents. Key issues were discussed at weekly QIPS meetings and fed back through staff meetings.
- A trigger list had been developed for reporting incidents and this was seen in several formats, including a card on an identification lanyard, mouse mats and posters; this ensured that staff knew what to report.
- In November 2012, the maternity service achieved compliance with level 1 Clinical Negligence Scheme for Trusts (CNST) Maternity Clinical Risk Management Standards 2012/13, scoring 49 out of 50. The service was assessed against five standards each containing 10 criteria, giving a total of 50. One area was non-compliant relating to community midwives new born life support guidance.

## Leadership of service

- We saw exemplary leadership from the head of midwifery who attended daily all the areas she was responsible for. She familiarised herself with the names of all the staff including the student midwives to ensure they felt valued and part of the team. They practised 'test and challenge' whereby staffs knowledge was tested and decisions were challenged. They also held a listening clinic that staff could attend to discuss their progress or any worries or concerns.
- We spoke with the clinical director for maternity and gynaecology, and discussed his role. We also observed him on a ward round.
- Staff we spoke with were aware of who the senior management were, including the chief executive. Some members of the executive team had visited the directorate's wards.
- Community maternity services staff told us that directorate and senior management staff were less visible within community services compared with inpatient hospital services.

## Culture within the service

- Staff said they felt that the service had a 'no blame' culture and the emphasis was very much on reflective practice.
- A good working relationship was evidenced between the obstetricians and midwives; they supported each other's role with clear communication and regular review of the women.



# Maternity and gynaecology

- We were told by staff that, because of the increase in workload, they were routinely working on the maternity wards for long periods without taking breaks. We discussed this with the head of midwifery. She assured us that the staff were able to take breaks and that she would observe and review the current process.
- We heard examples of staff being encouraged to send 'good news' articles to the trust newsletter to celebrate successful outcomes and 'happy' events.
- All the staff we spoke with told us they knew who they could talk to should the need arise. We were told of an 'open door' policy by managers and matrons, and ongoing support from the pastoral team.
- We spoke with healthcare support workers within the maternity service who told us they sometimes felt their duties revolved around cleaning; however, more recently they were being involved in the care of the women and babies, and their job satisfaction had improved.

## Public and staff engagement







- Members of the maternity services liaison committee told us they had no current concerns about the service. They had attended meetings in the maternity unit.

- Each ward provided information about how it was performing against local and national targets, as well as how many staff were on duty on each shift, the number of complaints and specific safety data.
- Local support was advertised on the trust's website, including the contact details (for example, for NAPPY – newborn advice pregnancy and parenting information, a teenage pregnancy group and a breastfeeding network).
- We heard that volunteers were a valued part of the team at UHCW, and members of the trust had received an invitation to tour the recently opened Lucina Birthing Centre, which had proved very popular.

## Innovation, improvement and sustainability

- The head of midwifery had won the Healthcare Hero and Lifetime Achievement Award 2013/14 at the Coventry Telegraph's Pride of Coventry and Warwickshire Community Awards ceremony.
- The Lucina Birth Centre team had been shortlisted for a national MaMa award for promoting normal birth (to be announced in April 2015).
- The trust had published 'good practice guidance' for maternity staff on using interpreting tools and ensuring women understood the information given to them.

# Services for children and young people

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Requires improvement	
Overall	Requires improvement	

## Information about the service

The children's inpatient facilities are located at University Hospital, Coventry. The paediatric and neonatal departments are within the Women and Children's Clinical Group. The neonatal unit is part of the Central New born Network, with a designated network neonatal intensive care unit (NICU) with 11 critical care cots with 11 critical care cots and 16 cots in the transitional care nursery (14 Special care and Transitional care), the special care baby unit (SCBU) with 16 cots, and a transitional care nursery (TCN), where babies who are well enough to be looked after at their mother's side are cared for. There were 616 neonatal admissions from January to December 2014.

The children's unit is comprised of separate wards for infants, children and adolescents, along with a paediatric high dependency unit (HDU), a neonatal unit and a children's emergency department (CDU).with a paediatric high dependency unit (HDU) and a children's emergency department.

There is a hospital school, with a full-time play leader and a full range of specialist support staff, including dieticians, physiotherapists, speech and language therapists, and social workers; in addition, there are also clinical nurse specialists in diabetes, allergy, respiratory and oncology, and paediatric emergency nurse practitioners (PENPs) in the children's emergency department. The unit is staffed to all current recommendations, with more than 90% of the trained staff being registered sick children's nurses.

## Summary of findings

Children and young people's services at University Hospitals Coventry and Warwickshire NHS Trust required improvement:

- There was an incident reporting system in place. A trend of medication errors had been identified, and actions had been taken to raise awareness and facilitate learning. However we found learning was not demonstrated from a previous medication error relating to the administration of out-of-date intravenous fluids. During our inspection we found intravenous fluids available for use that were past their expiry date.
- The records for the resuscitation trolley in the transitional care unit did not demonstrate that they had been checked on a daily basis. If not checked, there was a risk that, if it was needed in an emergency, the equipment may be incomplete or out of date.
- Children and young people's needs were assessed appropriately, and care and treatment was planned and delivered in line with current standards and evidenced-based guidance.
- There was an effective system in place for young people to be supported in their transition from children's to adult services.
- Staff were kind, and had a caring, compassionate attitude, and built positive relationships with children, young people and their families.

# Services for children and young people

- Children were seen in purpose-built environments, which included their own designated children's emergency department.
- The trust was identified as an outlier for access to a paediatrician with an interest in epilepsy in the Epilepsy12 National Audit. It had, however had been proactive in identifying a consultant paediatrician to fulfil this role who completed the national training course in epilepsy in February 2015.

## Are services for children and young people safe?

Requires improvement 

Children and young people's services required improvement for safety:

There were processes and systems in place for staff to report incidents. We found an open and transparent approach that encouraged staff to report and learn from incidents. A weekly clinical adverse event (CAE) meeting was held, to review incidents all learning points were circulated to staff via email.

A trend in medication errors had been identified, actions were taken to raise awareness and learning for staff. However, during the inspection we found intravenous fluids available for use that were past their expiry date. A previous medication error had occurred where expired intravenous fluids had been administered, therefore in this instance we found that learning had not been demonstrated from the previous occurrence.

On the transitional care unit we found that the trust's own policy for checking resuscitation equipment had not been followed with gaps in the recorded checklist.

We saw that staff on the paediatric wards and HDU had completed their level 3 safeguarding training for children. However, we found there was no consistency in the provision of regular safeguarding supervision as recommended by the Royal College of Nursing.

The neonatal unit did not use agency nurses; bank staff were used to backfill shifts. There was a daily staffing tool used to identify any shortages of staff, a bleep holder for the service assessed and alleviated risk.

Children's and adult safeguarding information were not reported separately in the quality report, which was not best practice.

### Incidents

- A total of 176 incidents had been reported on the trust's electronic incident reporting system, from August 2014

# Services for children and young people

to November 2104. The incidents reported were then reviewed by senior members of staff, and investigated according to the grading and harm to the patient involved.

- A weekly clinical adverse event (CAE) meeting was held, where all CAEs which had occurred in the previous week were reviewed and discussed by all the ward managers, and locally approved. All key issues and learning points were circulated to staff via email.
- A speciality multidisciplinary quality improvement and patient safety (QIPS) meeting was held monthly, which reviewed a summary analysis of incidents and trends. A theme of medication errors had been identified and actions developed to address.
- Any member of staff involved in a medication error was asked to complete a reflective practice review. Staff that we spoke with confirmed the process, and felt that there was good learning from this process.
- A recent procedure that had been implemented and was observed during the inspection, was the use of red tabards by nurses whilst the medicines round was being performed. The purpose of the tabards was to ensure that nurses were not disturbed during the drugs round, in order to help lower the risk of drugs being dispensed in error.
- Serious incidents were managed by the trust's significant incident group, which met on a weekly basis to review new incidents, monitor ongoing investigations, and approve the investigation report.
- The strategic executive information system (STEIS) records serious incidents (SI) and 'never events'. ('Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.)
- We noted that there were two serious incidents reported for CYP services in the year preceding our inspection (STEIS data January 2014 to December 2014).
- The two serious incidents consisted of one trip and an MRSA bacteraemia. Both incidents underwent root cause analysis investigations and reports, including lessons learnt and action plans. The cases were reviewed at the paediatric and neonates clinical adverse event (CAE) group.

## Safety Thermometer

- The trust reported that there were no falls, pressure ulcers or catheter-acquired urinary tract infections in the children's department from July 2013 to July 2014.

## Cleanliness, infection control and hygiene

- During our observations of the environment in which children and babies received treatment and care, we found all areas to be visibly clean.
- We observed that trust staff complied with the trust's policies for infection prevention and control. This included wearing the correct personal protective equipment (PPE), such as gloves and aprons. We observed that staff adhered to the trust uniform policy and were 'bare below the elbows'.
- We reviewed two environmental audits that had been completed for paediatric wards 14, 15, and 16, and for CED, during November and December 2014. The audits showed a comparison of rating against compliance. Any area that had not achieved compliance, had a rate recorded which was achieved after the issues identified had been rectified. All of the audits reviewed showed a compliance rate of between 98% and 100%.
- Cleaning staff said that they felt unsupported by their supervisors. Their perception was that their workload was very high, as they were expected to keep several wards clean. However, in order to complete all the work expected of them, they were only able to complete the dusting and clean the floors. Other tasks had to be left, which affected cleanliness standards. We noticed how clean the wards were; however, we were told that if an audit was approaching, a team of cleaners would be drafted in to clean the area thoroughly, to ensure audit results were favourable.
- We spoke with one ward manager about their expectations for ward cleaning; they expected to have two cleaners per day, although occasionally, there would only be one cleaner on duty; they did not always have the same cleaners on a daily basis.
- Infection control nursing audits were undertaken on a monthly basis, with an infection control nurse, lead nurse for the area, and an estates and private finance initiative (PFI) representative. We reviewed five audits, which included the transitional care unit (TCU), wards 14 and 15, the neonatal unit (NNU), and CED; results from the audits showed compliance rates of 85 - 96%, between June 2014 and January 2015.
- Hand hygiene audits were undertaken on wards 14 and 15; in January and February 2015, results of the audits were 100%. Results were displayed on the patient Safety Thermometers. Posters promoting hand hygiene were visible to staff.

# Services for children and young people

- All babies admitted to the NICU were screened on admission and weekly thereafter, for MRSA, in line with national and trust policy.

## Environment and equipment

- The children's wards and NICU were purpose built, and had 'state of the art' facilities. The PFI equipment replacement policy ensured that equipment was up to date, and serviced with a regular replacement programme.
- All the equipment on the neonatal unit had been portable appliance tested (PAT). We saw stickers on the equipment, which confirmed that this had been completed in a timely way.
- During the inspection, we found the entry into the ward was protected by keypads and buzzers to ensure the safety of the children.
- On the transitional care unit (TCU) the resuscitation trolley had not been checked in line with the trusts own policy; on the day that we inspected the unit, the last date that the equipment was recorded as being checked was 8 March 2015, which was three days prior to our visit. From the 8 -15 February 2015, no equipment check had been recorded.
- The kitchen in ward 15 had no lock or keypad entry system; access from the ward for non-members of staff was possible without being observed. Expressed breast milk was stored in a fridge, as well as jars of baby food and formula, which would have been accessible to anyone entering the area. This posed a potential risk, as the area was not constantly observed.

## Medicines

- There was a paediatric pharmacist, who visited the paediatric wards and neonatal unit each weekday. The pharmacist reviewed all medication prescription charts. Allergies were clearly documented in the drug prescribing document.
- A trend of medication errors had been identified, and actions had been taken to raise awareness and facilitate learning. However we found learning was not demonstrated from a previous medication error relating to the administration of out-of-date intravenous fluids. During our inspection we found intravenous fluids available for uses that were past their expiry date.
- There were specific recording documents in place for the prescribing of Gentamicin. This is an antibiotic used for severe infections and, if not monitored carefully, can

cause lifelong side effects for small babies. We reviewed one document on the neonatal unit, which showed that the prescribed dose of Gentamicin had not been given at the correct time. We spoke with staff, who told us that a clinical adverse event (CAE) had been completed, and that learning from the incident would take place through discussion and reflection.

- Nursing staff that we spoke with were aware of the policies on the administration of controlled drugs, as per the Nursing and Midwifery Council (NMC) Standards for Medicines Management.
- On one ward, we checked the controlled drugs (CD) cupboard. Balance totals for CDs were displayed; the process of checking the balance occurred twice daily. All checks had been signed and dated.
- Fridge temperatures had been recorded and signed for daily. There was a separate fridge for TTOs (medication to take home) for patients.

## Records

- All babies children and young people had an individual medical records folder; individualised nursing care plans were used on the paediatric wards and neonatal unit.
- On the neonatal unit, we case-tracked one set of notes in which personal details for the baby and parents had been completed and recorded correctly. There was chronological recording of all contacts and events, including physical and social history, and there was evidence of multi-agency working recorded. There was a clear record of communication with the parents, and of conversations regarding care and decision-making processes. There was a record of verbal consent to treatment, agreed by one parent recorded clearly in the notes. There were no omissions; the record was complete.
- During our inspection, we noted that records were kept securely. We reviewed three sets of records, and observed that patients' details were recorded; there was evidence of discussions with parents, and assessments were completed, including pain tools. In one set of notes, there was clear evidence of multidisciplinary team input from therapy specialists, which included liaison with the community nursing team.

## Safeguarding

# Services for children and young people

- Nursing staff in CED, the neonatal unit and the paediatric wards were aware of what to do if they had a safeguarding concern. Staff were aware of the policies and procedures in place.
- Staff on the paediatric wards and the HDU were all 100% compliant in level 3 training for safeguarding children.
- There was no regular safeguarding supervision as recommended by the Royal College of Nurses: Safeguarding Children and Young People, every Nurses Responsibility, April, 2014, however, staff said that this happens on an ad hoc basis.
- Children's and adult safeguarding information were not reported separately in the quality reports, which was not best practice.
- The safeguarding team consisted of two lead paediatricians and a senior safeguarding lead for children.
- We reviewed minutes of the safeguarding meeting from February 2015; a new child sexual exploitation audit screening tool was being piloted, with the purpose of identifying at an early stage those at risk of sexual exploitation. If a young person was identified as being at risk and not known to services, they would be referred to social care.
- On admission to a ward, children received assessment of their social history, to ascertain if they were known to social care.
- Entry into the ward was protected by keypads and buzzers to ensure the safety of the children. However often it took some time for the buzzer to be answered in order to gain entry. Relatives told us that they had experienced delays when waiting for staff to allow them onto the ward areas

## Mandatory training

- Total compliance with mandatory training for staff in paediatrics for all modules, was 87%, against a target rate of 90%.
- All staff on ward 14 underwent clinical supervision, due to the high number of young people who had been diagnosed with mental health problems that were cared for on the ward. This was facilitated by the CAMHS service, and could be accessed by groups, or individually.
- Total compliance with mandatory training for staff in paediatrics for all modules, was 87%, against a target rate of 90%.

## Assessing and responding to patient risk

- We followed two children who had been admitted for day surgery; we observed that pre-operative checks were completed, including any known allergies; patient identifications were checked, consent signed, and the surgical safety checklist had been completed.
- Age-appropriate paediatric early warning scores (PEWS) were used within all the paediatric wards; these are charts where comprehensive escalation actions were described by staff if a child was unwell.
- There was a clinical operating procedure in place for the transfer of a seriously unwell child or young person internally between hospital departments, or externally to other hospitals.

## Nursing staffing

- Across the children's department there were 137.1 Whole Time Equivalent (WTE) clinical staff in post across the service. We were told that in April 2015, there was a 14.5% vacancy rate, the sickness rate for Paediatrics and Neonates was 4.8% overall for the whole department including non-clinical staff 2.64% for medical staff and 5.67% for nursing staff and 6% on maternity leave.
- From 01/12/2014 to 31/03/2015 bank requests accounted for 17.8% of rostered shifts with a fill rate of 92%. Where shifts were unfilled, staff were allocated according to clinical areas according to the dependency and occupancy within the children and young people's service.
- There was an escalation policy in place for paediatrics, where there was a paediatric nurse band 7 bleep holder on duty to support the flexing of staff across the service as required. There was a similar escalation policy in place for neonates, where staff were flexed between the transitional care and neonatal units.
- Nurses from ward 15 would support staff on the High Dependency Unit as required. There would always be a band 6 paediatric nurse on the HDU for each shift.
- On ward 16 on the day we inspected all band 6 and 7 nurses were either trained in Advanced or European paediatric life support.
- Agency nurses were not used on the neonatal unit; bank staff were used to backfill shifts. A daily staffing tool was used to identify any shortages of staff; the bleep holder for the service assessed and alleviated risk. Staff would



# Services for children and young people

be moved to cover shortages on the wards, or flex staff between the neonatal unit and the transitional care unit. A text message system was used to establish the availability of staff to cover shifts.

- There were currently 15 nurses undertaking a post-graduate qualification in neonatal intensive care; they were due to qualify in April 2015. This will increase the number of registered nurses having the neonatal nurse qualification in specialism (QIS).
- Occupancy rates on the neonatal unit, from April 2014 to October 2014, were between 68% and 98%. The neonatal service had recorded on the Childrens and young people's risk register the potential impact of sub-optimal staffing levels and HDU cots being closed. To address this, a business plan had been submitted to reconfigure the service to provide five additional HDU cots to be opened in May 2015 and a new model of care including both transitional care and special care.

## Medical staffing

- University Hospital, Coventry has 17.3 whole time equivalent (WTE) paediatric consultants. There was a designated lead consultant for both paediatric and neonatal services.
- On the paediatric HDU, children and young people on the unit were reviewed by a registrar every four hours.
- There was a consultant of the week providing cover from Monday to Friday, 9am to 6pm. A registrar was resident from 5pm to 10pm, during the week. There was a paediatric consultant of the week providing on-site service from 9am to 10pm Monday to Friday. On Saturday and Sunday there were two paediatric consultants, one working from 9am to 1pm and one working from 9am to 5pm. There was on call non-resident cover from 5pm to 9am the following day. There was a resident registrar service 24 hours, seven days per week.
- Neonatology consultants covered Friday to Friday from 9am to 6pm; one for NICU and the labour ward, and one for the postnatal ward. Weekend cover was split, covering for three days or nights. Handovers between medical staff occurred three times, morning and evening, as well as at 5pm.
- There was a neonatologist of the week providing on-site service from 9am to 5pm Monday to Friday. Two

consultants provided support to the neonatal unit (intensive care and high dependency) and the Transitional Care Nursery (special care and transitional care, plus the post natal ward).

- There was a neonatologist on call resident from 5pm to 10pm, and an on call non-resident neonatologist from 10pm to 9am the following day.
- There was a resident medical senior house officer or advanced neonatal nurse practitioner and a Registrar available 24 hours per day, seven days per week. On Saturday and Sunday there was one neonatologist working resident from 9am to 2pm and an on call non-resident from 2pm to 9am the following day.

## Major incident awareness and training

- Staff from the paediatric and CED department took part in a mock incident training day in October 2014.
- Winter management plans were in place to support children with respiratory conditions being admitted. There was a nurse led bronchiolitis care pathway, the HDU increased from four beds to six beds from October to March.

## Are services for children and young people effective?

Good



Children and young people's services were found to be good for effectiveness. This was because:

Children and young people's needs were assessed appropriately, and care and treatment was planned and delivered in line with current standards and evidenced-based guidance.

There was a multidisciplinary approach to care and treatment. There was engagement with other health and social care providers, and joint working in place, with effective communication, information sharing and decision making about children and young people's care and their changing needs.

On a ward where there was a high number of adolescents who had been diagnosed with mental health problems, all staff received regular clinical supervision

# Services for children and young people

There was a robust system in place for young people to be supported in their transition from children's to adult services.

Although 91% of nursing staff had participated in a personal development review (PDR), only 67% of medical staff had completed them, measured against a target of 90%. The PDRs of four consultants were out of date by one year, one by more than 2 years.

The National Neonatal Audit Programme (NNAP) Annual Report 2013 (published in 2014) showed that 88% (against a national average of 87%) of eligible babies were being screened on time for Retinopathy of Prematurity (ROP).

The trust was identified as an outlier for access to a paediatrician with an interest in epilepsy in the Epilepsy12 National Audit. It had, however been proactive in identifying a consultant paediatrician to fulfil this role who completed the national training course in epilepsy in February 2015.

## Evidence-based care and treatment

- Children's services used a range of guidelines that had been produced by the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH), to inform the treatment provided.
- Staff told us that there were care plans on the intranet which they could access for information. There were a total of 66 care plans for paediatrics; we looked at two of them for asthma and bronchiolitis, and found them to be comprehensive and in line with the British Thoracic Society Guidelines. There was a red, amber, green (RAG) rating system in place, to alert staff when the care plans needed to be updated.
- Paediatrics and neonatology had a wide selection of patient information leaflets available. A total of 127 leaflets could be obtained from the trust's health information centre, or via staff on the unit, who could print them off from the intranet.
- The trust participated in the Baby Friendly (UNICEF) initiative and had achieved stage 1 accreditation.
- We reviewed the audit of the Management of Babies with Prolonged Jaundice that had been completed, and which was developed in accordance with NICE

guidance. As a result of the audit, documentation was changed, as was the way in which jaundice was managed. The action plan indicated that re-auditing of this practice was due in June 2015.

## Nutrition and Hydration

- On the neonatal unit staff maintained a record of intravenous infusions and parenteral nutrition which allowed staff to monitor the baby's nutrition and hydration status.
- Young people told us that there was a choice of food available for them to choose from. There were drinks available throughout the day. However, some children and young people told us that they did not like the food that was offered.
- Within the CYP service there were facilities for mothers to store expressed breast milk, allowing them to meet their baby's nutritional needs.

## Pain relief

- The children's service used evidenced-based pain-scoring tools to assess the impact of pain when this was needed. We saw a pain score brochure with detailed descriptions of 0-3 scores for rating pain. Face scales were used for younger children.

## Patient outcomes

- The trust had been identified as an outlier for access to a paediatrician with an interest in epilepsy. The site specific report for the results of the Epilepsy12 National Audit were received in November 2014; the trust had been proactive in identifying a consultant paediatrician with an interest in epilepsy who had completed the National training course in Epilepsy in February 2015.
- Action has been taken to improve screening rates, for timely screening of babies for retinopathy of prematurity and an improved arrangement had been introduced, with ophthalmologists having set days when they would see babies. If any babies were discharged without being seen by them, parents would be contacted and an appointment made for them to be followed up. The National Neonatal Audit Programme (NNAP) Annual Report 2013 (published in 2014) showed that 88% of eligible babies were being screened on time for Retinopathy of Prematurity (ROP), against a national reported average of 87%.

# Services for children and young people

- The rate of multiple (two or more) emergency admissions within 12 months, from July 2013 to June 2014, among children and young people aged one to 17 years, with asthma, was 19%, compared to the national average of 17%. For diabetes, it was 18% against the national average of 14%, and for epilepsy, 30% against a national rate of 28%.

## Competent staff

- The group performance summary for paediatrics in January 2015 showed that 91% of nursing staff had participated in a personal development review (PDR). Medical staff also participated in PDRs, however only 67% having completed them; this was measured against a target of 90%. We were told that the PDRs of four consultants were out of date by one year, despite the national on-line appraisal and revalidation system producing reminders from the trust and the General Medical Council
- One consultant's appraisal was found to be more than 2 years out of date, and this was escalated to the executive team during our inspection.
- In January 2015 95% of Consultants in the paediatric service had a job plan (which sets out the duties, responsibilities, accountabilities and objectives of the consultant and the support and resources provided by the employer for the coming year) this was above the trust compliance target of 90%.
- The CYP service had a dedicated team of six play specialists. A play specialist from the team carried a bleep, to ensure that there was a rapid response to all paediatric areas.
- We were told that all the staff on ward 14, the adolescent ward, and all band 6 and 7 nurses across the paediatric service, had completed the managing actual and potential aggression (MAPA) training. There were two MAPA trainers within the children's and young people's service, and they delivered this training.
- There were a team of eight advanced neonatal nurse practitioners (ANNPs), who worked with the medical trainees and neonatal consultants. There were also nurse leads, who supported the service for education, breast-feeding and developmental care.
- Both paediatrics and the neonatal unit had practice facilitators in place, and provided departmental bespoke training for staff. Each core area undertook courses relevant to their specialities.

- On the neonatal unit, there was a programme for the development of new staff to the speciality. Recently, 17 staff had completed the neonatal programme; this was equal to approximately 20% of the workforce.

## Multidisciplinary working

- We spoke with staff who were part of the educational authority hospital outreach team; they worked with children who were inpatients within the paediatric unit. They also worked with play specialists, providing classroom-based teaching on ward 15 for those children who were able to attend. On the adolescent ward, ward 14, there was no classroom; teaching was provided by the bedside.
- There were transition clinics held jointly with adult consultant colleagues, for young people who were preparing to move into adult services. The purpose of these clinics was to facilitate a smooth discharge from paediatrics, and to retain continuity of care into adult services.
- There were joint cystic fibrosis clinics held, and young people were transferred over to adult services at 16 years of age.
- Young people with long-term conditions, or severe complex needs, engaged with community consultants. Each young person had their own care plan and folder, which they brought to the hospital or school. The care plan was written in by all staff who had an interaction with the child during their admission.
- We spoke with the ward manager on the high dependency unit (HDU), who told us that when children were being transferred from the unit, a specialist local transfer team would collect them and complete the transfer.
- A steering group for the local transfer service, Kids Intensive Care and Decision Support (KIDS), met every three months to discuss operational and clinical governance topics; a staff member from the HDU attended.
- We spoke with the liaison nurse specialist for Child and Adolescent Mental Health Services (CAMHS), who worked closely with the CAMHS team and other external providers. We were told that there was a good integrated working relationship with the CAMHS service, which is provided by an external agency. It was

# Services for children and young people

responsive, informative and timely, not only to young people experiencing self-harm, but also to those with other concerns, such as substance misuse and eating disorders.

- Play specialists carried out two year developmental checks, as part of the core offer of the Healthy Child Programme. The play specialists completed the Personal Child Health Record (PCHR) and documented the outcome of the developmental checks.
- General Practitioners (GP) had an e-discharge letter sent from the ward; patients not registered with a GP would have a follow-up letter sent.
- We observed that there were delays in the transfer of young people to tier-four beds (provided by CAMHS) which provide specialist inpatient care to children suffering from complex mental health conditions. The delays were due to tier 4 bed availability both regionally and nationally.

## Seven-day services

- There was access to radiological imaging 24 hours per day.
- There was access to physiotherapists outside of working hours, via an on-call system.

## Consent

- To assess whether a young person was Gillick competent (under 16 years of age, but able to understand treatment options and give informed consent), medical staff would assess and consult with nursing staff. There were two different consent forms used; for a young person aged 16 years or over, an adult consent form would be completed. Consent forms for children could be signed by the child, but their parent also had to sign.

## Access to Information

- The trust used electronic patient records, which meant that information was accessible.
- Trust intranet and email systems were available to staff which enabled them to access guidelines and policies.
- Access to an interpreter service could be arranged in person or via the telephone depending on the individual need.
- When children were discharged, health visitors were notified by telephone, and a paper copy of the notification was sent out daily.

## Are services for children and young people caring?

Good



Services for children and young people were rated as 'good' for caring:

During the inspection we observed that staff provided care that was compassionate and sensitive to meet the needs of the children and young people being cared for. Parents we spoke with praised the level of support and care they received from staff which alleviated their anxieties.

Staff were observed to be kind and built positive relationships with children, young people and their families and involved them in their care and decision making.

The neonatal unit supported baby's wellbeing, by ensuring that the environment was quiet and calm.

One young person told us that they felt safe on the ward, and that the nurses cared for and listened to them.

Feedback about care was sought using 'smiley faces' and children's characters, and was displayed in a way that children could understand.

Continuity of care was provided for children visiting the operating theatre.

## Compassionate care

- During our inspection, we observed that staff provided compassionate and sensitive care, which met the needs of the child, young person, parents and carers.
- We observed members of staff engage with children and young people in a way that we considered to be friendly and approachable. We observed staff feeding babies, talking and caring for them, with dexterity and gentleness.
- One parent told us that they had had to ask a doctor to explain what they were doing, when the doctor was going to insert a cannula into their child. However, the doctor had failed to explain this to them before starting the procedure.
- One parent told us that they had felt reassured by the way in which the nurses had cared for their child, and by speaking to them and offering reassurance, this had made the parent feel calmer.

# Services for children and young people

- Parents felt that they were well supported with breast feeding and skin-to-skin contact, and encouraged to do hands-on care for their baby.
- On the neonatal unit, there was quiet time, when lights on the unit were dimmed and cots covered, to offer babies a quieter environment. The neonatal unit had three electronic 'ears', which detected the ambient sound in the unit, showing green when the noise level was acceptable, and flashing red when the background noise limit was excessive.
- One parent that we spoke with told us that they did not know how to make a complaint. They also felt that they had not been treated with respect.

## Understanding and involvement of patients and those close to them

- On the neonatal unit, parents were encouraged to be involved in caring for their babies. For babies who required feeding through a feeding tube, there was a learning package for parents who wished to be involved in feeding their baby. Parents observed staff feeding their baby, and were observed by staff when they did the tube feeds. There was an assessment document for parent/carer competency, which had to be completed before they could tube feed their baby on the neonatal unit.
- We spoke with parents throughout different areas of the CYP services; the responses we had were positive regarding involvement and knowledge of their children's care plans.
- On ward 16, parents who did not have English as a first language had a translator arranged for them, and were supported whilst speaking with the consultant in charge of their child's care. This meant that they were able to understand what was happening to their child and could ask any questions they felt necessary.
- In October 2014 a Friends and Family Test (FFT) questionnaire was introduced into paediatrics, however there were not results available as the Trust was adapting the test to become 'paediatric specific' which they were intending to implement in April 2015.
- A local postcard feedback scheme gain opinions on their care from children and their families was used. This featured characters designed by trust staff and chosen by the children. The questionnaire was also available via

a tablet (computer). There was also a 'smiley faces' tick box card available in the wards, CED, outpatients and day surgery. Completed cards could be placed in a box provided in each area.

- The results were based on approximately 50 completed cards, per ward, per month. The results on ward 14 were that 60% of children, 25% of parents and 5% of carers thought that the ward was 'doing a good job'. The total number of responses for ward 14 was 66. For ward 15, the results showed that 32% of children and 61% of parents responded positively. The total number of responses for ward 15 was 68.
- As a result of the feedback from this scheme, some changes have been made, for example, to improve catering on the ward, where children and parents have the opportunity to sample food. Feedback from parents about being unable to get a drink if clinics were running late, resulted in a water cooler being fitted.

## Emotional support

- The process for escorting a child to theatre pre-operatively was designed to minimise anxiety. Children and families were provided with the assurance that they would receive support from the same healthcare professional before and after the child went into the operating theatre. We saw that staff worked well together to distract children during the pre-operative preparation stage, and interactions and language used were age appropriate.
- Children were made to feel comfortable. We spoke with a play specialist, who described the journey of a child with a learning disability, and how they and their family would be supported from a pre-operative assessment, through the process of familiarising the child to the area. When the child was asleep, the parents would be accompanied back to the ward area to wait, and be supported and offered a drink.
- We heard one child who had been prepared for theatre asking a member of staff, "Will you definitely be here when I wake up?" The presence of a children's nurse or other staff member, with whom the parent/carer and child were familiar, helped to ensure that the child had an advocate, who was able to support the child during the induction of anaesthesia, as well as being able to offer distraction therapies in order to reassure both the child and family.



# Services for children and young people

- One young person told us that they felt safe on the ward, and that the nurses cared for and listened to them.
- Parents were able to visit their children, and told us that visiting times were flexible, especially for parents who had some distance to travel to the hospital.
- Parents told us that the facilities for family members staying at the hospital were, in general, good. One parent we spoke with had stayed overnight in the family room, and said that they had access to refreshments.

## Are services for children and young people responsive?

Good



Children and young people's services were rated good for effectiveness.

The National Neonatal Audit Programme (NNAP) Annual Report 2013 (published in 2014) showed that 88% (against a national average of 87%) of eligible babies were being screened on time for Retinopathy of Prematurity (ROP).

The trust was identified as an outlier for access to a paediatrician with an interest in epilepsy in the Epilepsy12 National Audit. It had, however had been proactive in identifying a consultant paediatrician to fulfil this role who completed the national training course in epilepsy in February 2015.

Children and young people's needs were assessed appropriately, and care and treatment was planned and delivered in line with current standards and evidenced-based guidance.

There was a multidisciplinary approach to care and treatment. There was engagement with other health and social care providers, and joint working in place, with effective communication, information sharing and decision making about children and young people's care and their changing needs.

On a ward where there was a high number of adolescents who had been diagnosed with mental health problems, all staff received regular clinical supervision

There was a robust system in place for young people to be supported in their transition from children's to adult services.

Although 91% of nursing staff had participated in a personal development review (PDR), only 67% of medical staff had completed them, measured against a target of 90%. The PDRs of four consultants were out of date by one year, one by more than 2 years.

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

- There were both consultant- and nurse-led clinics that took place in the children's outpatients department. The respiratory clinic was held three times a month, seeing six new patients and six follow-up patients.
- Under the Best Practice Tariff for paediatric diabetes, there was a dietician who supported children on the diabetic pathway.
- On the transitional care unit (TCU) a health visitor visited once per week; however, this service only covers patients from the Coventry area. The TCU staff liaised with health visitors that cover other parts of the locality.
- Design of the new CED waiting area was funded by UHCW charitable funds, through money raised by staff, family and friends. Designs for the new waiting area were produced by children and young people locally.
- The paediatric wards and outpatients department had dedicated play areas, with age-specific games and toys. There were also purpose-built indoor and outdoor play areas, which children were able to access and use.
- There was a bespoke sensory room on ward 15 that was used by children with complex and special needs.
- Children were seen in purpose-built environments, which included their own designated CED. Young people aged 16 were able to choose whether they wanted to be seen either in CYP or in adult departments.
- On the neonatal intensive care unit, there was the facility to deliver laser therapy treatment for babies with retinopathy (an eye problem) caused by their prematurity.

## Access and flow

- There was provision for a four-bedded paediatric high dependency unit (HDU) from April to September. During the winter months, from October to March, the number of beds was increased according to seasonal demands, for children being admitted with respiratory conditions.
- There was a designated Paediatric Surgical Day Unit where children waiting for routine or minor surgery could be admitted. Pre assessment of children for day surgery was undertaken on the unit, familiarising children with



# Services for children and young people

the environment. We were told that the paediatric bay could have medical and surgical outliers. The ward manager sent daily reports of the numbers of inappropriate admissions to the Chief Executive Officer.

- The length of stay was the same as the England average for non-elective surgery, for all under 17 years of age.

## Meeting people's individual needs

- Children's services accept children and young people up to the age of 18 years. Young people aged 16 to 18 had a choice as to where their services were delivered, either within paediatrics or as part of adult services.
- We spoke with the liaison nurse specialist for Child and Adolescent Mental Health Services (CAHMS), who worked closely with the CAMHS team, and with other external providers. We were told that with the exception of the issues with commissioning and funding, there was a good integrated working relationship with CAHMS; it was responsive, informative and timely, not only to young people experiencing self-harm, but also to those with other concerns, such as substance misuse and eating disorders.
- End of life care and bereavement provision was well organised, with good support for families on the neonatal unit. Decisions were made with the parents and the healthcare staff in a separate room. There was support from the bereavement team, and from the spiritual team and the faith centre. There was a dedicated room where families could spend time with children who had either died or were on an end of life care pathway. This allowed them privacy to be cared for away from the unit, but with nursing input and support
- In February 2015, diaries were introduced on the neonatal unit, for parents and staff to record a personal record of a baby's journey whilst on the unit.

## Learning from complaints and concerns

- We were told that if a young person were to complain, staff would firstly discuss the complaint with them. The initial response would be to deal with it on the ward and resolve the issue if possible. Staff would follow the complaints process, and refer the young person to the Patient Advice Liaison Service (PALS) and record the complaint in the patient's notes.

## Are services for children and young people well-led?

Requires improvement



Services for Children and young people required improvement in the well-led domain:

Although some staff knew about the trust vision, staff did not consistently demonstrate knowledge of the goals and values of the service.

Governance arrangements were not always consistent in oversight of quality and performance. The data used in reporting performance management and high quality care was not always reliable therefore providing little assurance of the leadership team's scrutiny of their information and process to manage and investigate risk.

There was strong local leadership within children and young people's services, staff felt that they were supported, we saw examples of team working and collaboration throughout the service. There was a leadership development programme for senior managers. Band 5 nurses' leadership development was identified within their individual performance reviews.

Appraisal rates for medical staff in January 2015 were 67% against a target of 90%, rising to 78.6% in March 2015 when the inspection took place. Four consultant's appraisals were out of date by a year, one by more than 2 years.

## Vision and strategy for this service

- We were told by the executive team that the vision and strategy for the service was to be first class, and focus on children, parents and families.
- Both staff and senior leaders told us that there was a desire to raise the research and academic profile of the service.
- Although some staff knew about the trust vision, staff did not consistently demonstrate knowledge of the goals and values of the service.

## Governance, risk management and quality measurement

- The Central Newborn Network Clinical Governance Group met every three months to share network-wide governance issues; however recently, the senior nurse had been unable to attend these meetings due to time constraints.

# Services for children and young people

- Paediatric and neonatal risks were recorded on the local risk register, which were reviewed at the monthly management team meetings initially. Serious risks were escalated to be discussed at the quality improvement and patient safety (QIPS) meetings, and serious risks with poor controls were escalated to corporate level.
- Performance of the Women and Children's Clinical group, in which the paediatric and neonatal departments sit, was reviewed by the chief operating officer at quarterly face-to-face performance reviews, using an integrated performance report.
- Senior team members were unable to outline the detail of the data that had been flagged as not achieving its target with a red (RAG) rating, or the subsequent investigations and actions being taken.
- An example of this was that the data included a high hospital standardised mortality ratio (HSMR), which could have indicated that the trust had a higher than expected death rate in children's services. This calculation was found to be incorrect; however, the senior leaders had not noted or investigated this result, therefore providing little assurance of the leadership team's scrutiny of their information and process to manage and investigate risk.
- There was no explanation or discussion regarding the neonatal service's under-performance. There did not appear to be an awareness or concern about the under-performance issues that were evident from the audits in paediatrics.

## Leadership of service

- Paediatrics and neonates specialities had a dedicated consultant clinical lead, a paediatric lead consultant, a lead nurse and a group manager.
- There was a leadership development programme; clinical directors, matrons and group managers had leadership development opportunities every two months. There were two day residential courses that were run by the trust.
- Band 5 nurses' leadership development needs were identified in their individual performance reviews.
- Staff we spoke with reported good team working, support and flexibility. Staff reported that other members of the paediatric team were approachable and engaging.
- The group performance summary for paediatrics in January 2015 showed that 91% of nursing staff had participated in a personal development review (PDR).

Medical staff also participated in PDRs, however only 67% having completed them; this was measured against a target of 90%. Subsequent information at the time of the inspection showed that in March 2015 the completed appraisal rate for medical staff had increased to 78.6%; this was measured against a target rate of 90%.

- The PDRs of four consultants were out of date by one year, despite the national on-line appraisal and revalidation system producing reminders from the trust and the general medical council
- One consultant's appraisal was found to be more than 2 years out of date, and this was raised with the executive team during our inspection. Although the trust provided evidence to show the consultant had been actively seeking an appraisal

## Culture within the service

- Staff we spoke with felt valued, respected and supported. There was a collaborative approach of staff working together to ensure that good quality care was delivered to CYP and their families. Senior nursing and medical staff were known to the children's and young people's team and were visible on the wards and paediatric departments.
- On the Neonatal unit staff described a good team spirit, and looking after each other.
- There was a specific debrief policy that enabled staff, who had been involved in a critical incident, to receive support, as a group, or individually.
- Staff we spoke with were open about how they reported incidents; they felt positive about the learning that took place and the support given.

## Public and staff engagement

- The ward manager of ward 15 told us about a 'Paediatric Seminar Day' that had been organised for students from local colleges to attend. There were presentations, and the students, who were accompanied, visited the paediatric area. There was positive written feedback and evaluation from the 26 students who attended the day.
- Senior staff we spoke with on ward 14 told us that any new ideas from staff, to meet the needs of the children, would be discussed with line managers. Team meetings were a forum to discuss ideas, and the ward manager would email staff with updates.







# Services for children and young people

- Staff told us that they received messages and updates via the intranet, including opportunities for new training. The chief executive officer (CEO) had monthly talks with staff face-to-face, which were described as informative; the CEO had visited the ward in January 2015.
- As a result of feedback from the responses from the 'smiley face questionnaire one change that had occurred was regular meetings with the catering department with menu's being reviewed and updated. Feedback from parents about being unable to get a drink if clinics were running late, resulted in a water cooler being fitted.

## **Innovation, improvement and sustainability**

- The ward manager on the HDU told us about a recent innovation that had been introduced: non-invasive HiFlo oxygen therapy, which had resulted in children not having to be transferred to paediatric intensive care units for invasive ventilation. This meant that children were able to be treated locally, closer to home.
- Commissioners had agreed that from April 2015, an acute liaison team (ALT), responding to young people at risk of self-harming, would see and assess the child in the CED. The aim of this would be to avoid and reduce hospital admissions. There would be designated nursing staff and a psychiatrist as part of the team.

# End of life care

Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

## Information about the service

End of life care was delivered, when required, by ward staff throughout the hospital. The supportive and specialist palliative care service gave support and advice to patients who had complex care needs, and they facilitated rapid discharge for patients in their last days of life. The teams also provided support in conjunction with the chaplaincy service for patients at the end of life and their relatives. The specialist palliative care team saw 572 patients (85% with cancer and 15% with non-cancer diagnoses) in 2013/14. The supportive care team, who reviewed patients in the last days and hours of life, saw 877 patients (25% with cancer and 75% with non-cancer diagnoses).

The University Hospital specialist palliative care team worked from 8.30am to 4.30pm, Monday to Friday, with two consultants (both part-time) in palliative medicine, and four full-time and one part-time specialist palliative care nurses. The Hospital of St Cross, Rugby, specialist palliative care team operated from 9am to 5pm with one part-time consultant in palliative medicine and two part-time specialist palliative care nurses provided by the community palliative care team. University Hospital had a service level agreement with the community trust to provide this service.

We visited 11 wards at University Hospital, Coventry, and 3 wards at Hospital of St Cross, Rugby. However, there were no end of life patients at Rugby during our visit. We talked with 8 patients and 7 relatives and reviewed 37 records. We spoke with 48 staff including the supportive and specialist palliative care teams, the consultant in palliative medicine, the board member for end of life care, ward nurses and

doctors, the chaplaincy team, and bereavement services and mortuary staff. Before and during our inspection, we reviewed the trust's performance information in relation to end of life care. We also held two listening events for the public in Coventry and Rugby.

# End of life care

## Summary of findings

End of life patients were not always able to be in their preferred place of care because the discharge planning process was not fully effective. We reviewed 29 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms in patient records and found 13 had errors or missing information. We found 12 DNA CPR forms on which doctors had identified patients as lacking capacity although a Mental Capacity Act assessment (MCA) form had not been completed. Doctors were reluctant to discuss end of life care and DNA CPR decisions with patients. Leadership roles within both medicine and nursing in the supportive and specialist palliative care service were not clearly defined. Staff told us the multidisciplinary team meetings were not working effectively.

The supportive and specialist palliative care service had developed and implemented tools, processes and training for ward staff to deliver, monitor and evaluate care in line with current best practice. They regularly reviewed the complex care needs of patients to promote coordinated, safe and effective end of life care. Patients and relatives told us they had been involved in decisions about their care, and that care was delivered with compassion, dignity and respect.

## Are end of life care services safe?

Requires improvement



End of life care services required improvement. The end of life care committee had recognised that 'Do not attempt resuscitation' (DNA CPR) forms were not being completed accurately and an action plan to improve this had been devised and discussed. However, when we reviewed 29 (DNA CPR) forms in patient records we found 13 had errors or missing information. Therefore patients may not have been effectively assessed prior to DNA CPR decisions being made. Individual plans of care and support for the dying person did not always contain personalised information, such as patients' and relatives' preferences and wishes.

The supportive and specialist palliative care teams provided safe care and advice for patients, relatives and staff throughout the trust. Risk assessments were regularly reviewed, and used to assess and manage patients' pain and other symptoms safely. Anticipatory medicines were prescribed. Staff were up to date with their mandatory training including safeguarding of vulnerable adults and children. Staff were knowledgeable about safeguarding procedures.

### Incidents

- Staff were aware of how to report incidents using the electronic reporting system.
- Incidents relating to end of life care were reviewed at the bimonthly end of life care committee meetings. Themes and lessons learned were then shared at weekly multidisciplinary meetings.
- We reviewed the minutes of these meetings and saw that learning and action plans related to specific incidents were reported. For example, there was an issue with DNA CPR forms not being completed accurately and not accompanying patients into the community. Methods for improving the system were discussed and actions highlighted. However, we found errors in the completion of DNA CPR forms.
- There were 68 incidents reported between 1 August and 30 November 2014. Thirty-five of these incidents related to incomplete DNA CPR forms.

# End of life care

- There had been no 'Never Events' (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) in the specialist palliative care service during the preceding 12 months.

## Environment and equipment

- During 2011, The National Patient Safety Agency recommended that all Graseby syringe drivers (a device for delivering medicines by continuous infusion) should be withdrawn by 2015. These had been withdrawn from the hospital, and staff throughout the trust had been retrained to use the McKinley T34 syringe driver.
- We saw records showing that the medical equipment bio-engineering services department had maintained the new syringe drivers.

## Medicines

- Written guidance was available for doctors to prescribe appropriate end of life medicines to manage patients' pain and other symptoms in line with national guidance and best practice. Patient's records demonstrated that anticipatory medicines had been prescribed.
- We saw that copies of the West Midlands Palliative Care Physicians' Quick reference guide to opioid conversions on every ward either next to the medication trolley or on the controlled drugs cupboard to help staff in using opioids (medication to treat pain).
- Staff on the wards we visited told us they routinely kept stocks of palliative care medicines both to treat symptoms and for pain relief.
- The supportive palliative care team reviewed daily the medicines of patients who had been referred to them.

## Records

- The supportive palliative care team had developed and introduced individual plans of care for patients who were in their last days of life.
- We reviewed eight sets of these individual plans. They were more initial assessments of care needs than comprehensive plans for end of life needs. They did not contain enough information to identify the personal wishes and preferences of patients and their families.
- The plans included risk assessments of patients' nutrition, mobility and skin integrity. The records we looked at showed that these assessments had been regularly reviewed.

- Records demonstrated a systematic approach to reviewing symptoms four hourly to assess patients for any deterioration at the end of life.
- We looked at 29 DNA CPR forms. We found 13 were incorrectly completed or had information missing. For example, the sections on 'Discussions with patients' relatives' and 'Reviewed by a senior clinician' had been left blank. One form stated 'Not applicable' to the section, 'Discussion with patient'. One form had been signed by a doctor but the rest of the form was incomplete. Incomplete or incorrect DNACPR forms can lead to patients being subjected to attempts to resuscitate them when this is not appropriate or in line with their wishes. We highlighted these issues to the nursing managers on the wards who said they would raise them with the relevant consultants.

## Safeguarding

- Staff were knowledgeable about their role and responsibilities to safeguard vulnerable adults and children from abuse, and they understood what processes to follow.
- Staff were aware of how to access the safeguarding policy on the trust intranet and were given support by the safeguarding lead.
- Records seen showed that all members of the supportive and specialist palliative care teams were up to date with the trust's mandatory safeguarding training.

## Mandatory training

- The trust provided records of mandatory training completed by the palliative care (supportive and specialist palliative care) and end of life (supportive care) nursing teams. This training included health and safety, infection control, and safeguarding children and vulnerable adults. The records showed that all eight nurses were up to date with more than 76% of the mandatory training.

## Assessing and responding to patient risk

- The trust's individual plan of care for the dying person incorporated regular assessments of patients' needs to minimise risks and maximise symptom control. We saw risk documents had been reviewed.



# End of life care

- Management plans of how to care for deteriorating patients were documented in care records. Patients and their relatives told us they were involved in decisions about care. Discussions with relatives were not always documented in care records.

## Nursing and medical staffing

- The supportive and specialist palliative care service provided support, advice, training and care to patients and staff trust wide.
- The team consisted of four full-time and one part-time specialist palliative care nurses and three part-time supportive care nurses. The latter were primarily involved in supporting staff with the care of dying patients, and they were also instrumental in supporting the rapid discharge of patients whose preferred place to die was at home.
- Two part-time specialist palliative care nurses from the Rugby community specialist palliative care team provided an integrated specialist palliative care service in Rugby St Cross Hospital.
- There were three part-time consultants in palliative medicine covering both University Hospital and Hospital of St. Cross.
- The trust had recognised that it had insufficient consultant and nursing staff to provide a 7-day palliative care service. A business plan had been submitted to increase staffing to the required level.

## Major incident awareness and training

- The trust had a major incident plan that included specific sections for actions to be taken by the mortuary staff and the chaplaincy services.
- The supportive and specialist palliative care teams were able to access the major incident plan on the intranet.

## Are end of life care services effective?

Requires improvement



We found the junior consultants and doctors outside of the palliative care team were reluctant to discuss end of life and 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) decisions with patients. This resulted in delays in putting patients on the AMBER care bundle (which supports those whose recovery is uncertain and who are at risk of dying during their current inpatient stay). The end of

life care committee had recognised that this was an area where more training was required; they had secured funding and had plans to deliver communication skills training to cover 'difficult conversations'.

We reviewed 12 DNA CPR forms on which a doctor had indicated that the patient lacked capacity; Mental Capacity Act (MCA) assessment forms had not been completed for any of them.

Staff told us that the weekly multidisciplinary team (MDT) meetings were not functioning effectively.

End of life care was delivered in line with national guidance. Patients identified with end of life care needs were assessed, and, if appropriate, given an end of life plan to enable their symptoms and pain to be managed effectively. The individual plan of care for the dying person was in use based on the Priorities of care for the dying person set out by the Leadership Alliance for the Care of Dying People.

The trust had contributed to the National Care of the Dying Audit. This scored participating trusts against seven organisational and ten clinical key performance indicators (KPIs). The trust had not achieved six of the seven organisational KPIs. Five of the ten clinical KPIs were better than the England average with the other five being worse. The supportive and specialist palliative care service had developed an action plan that was being monitored by the end of life care committee.

Training in palliative and end of life care was given to ward staff by the supportive and specialist palliative care teams and the chaplaincy service.

## Evidence-based care and treatment

- The individual plan of care for the dying person had been developed based on the Priorities of care for the dying person set out by the Leadership Alliance for the Care of Dying People. This provided a framework across the trust for non-specialist end of life care practitioners to structure care for patients during their last days of life. This included guidance on end of life medicines and symptom management.
- The supportive and specialist palliative care service encouraged consultants and senior nurses to identify their own patients as requiring palliative care using the Coventry and Warwickshire Supportive and Palliative

# End of life care

Care Indicators Tool (SPICT). This was developed by one of the palliative medicine consultants working with the University of Edinburgh as a collaborator in the SPICT programme.

- An electronic clinical database alert, known as the “CRRS” supportive and palliative care alert, was used to help staff identify patients who would benefit from a supportive and palliative approach to their care. An online learning module accompanying this alert explained palliative end of life care and the role of specialist palliative care. The alert highlighted to staff working across care settings, including the hospitals, community and hospices, that a patient was being managed palliatively and promoted staff to use best practice and proactive care in the last stages of their life.
- The trust was participating in phase two of the National ‘TRANSFORM’ Programme (NHS IQ – Transforming End of Life Care in Acute Hospitals – Route to Success Programme). The TRANSFORM programme aims to improve the quality of end of life care within acute hospitals across England, enabling more people to be helped to live and die well in their preferred place.
- There were nine TRANSFORM wards across the two hospital sites. Extra training and resources had been made available on these wards. This was to identify patients in the last year of life, and to support patients, relatives and staff with advance care planning and implementing the AMBER care bundle.
- The trust was currently rolling out the TRANSFORM programme in the remaining wards, using a phased implementation approach.
- The supportive and specialist palliative care service had started auditing the TRANSFORM wards and use of the AMBER care bundles. We were told by the consultant in palliative medicine/end of life care that preliminary findings showed improvement in record keeping and discussions with patients.
- The trust was working in collaboration with the Myton Hospices to deliver national Quality End of Life Care for All (QELCA) training to support the implementation of the TRANSFORM programme.
- We were told by two nursing managers on different wards that junior (non-palliative care) consultants were reluctant to discuss end of life care with patients or initiate conversations about resuscitation decisions. We

found four patients who had been seen by the specialist palliative care team but had not had a DNA CPR form completed; one of these patients had been seen three times by the team.

- Staff felt that this caused delays in patients being put on the AMBER care bundle. We found one patient who had been put on the AMBER care bundle the day before being referred to the supportive care team for care in the last days of life. The AMBER care bundle could have been initiated earlier so that discussions could have taken place between staff, patients and their relatives about care preferences.
- We found 13/29 DNACPR forms had omissions or were completed inaccurately. For example, the sections on ‘Discussions with patients’ relatives’ had been left blank. One form stated ‘Not applicable’ to the section, ‘Discussion with patient.’
- DNA CPR had been identified by the end of life care committee as an area where further training and support were required, particularly for consultants and clinical nurse specialists about having conversations with patients and relatives about disease progression, prognosis and DNA CPR decisions. The end of life care committee had secured funding and had plans to deliver communication skills training to cover ‘difficult conversations’.

## Pain relief

- Thirteen of the 14 patients and relatives we spoke with told us that pain relief had been well controlled by the specialist palliative and supportive care teams. However, some relatives said pain had not been well controlled by ward staff before the patient was referred to the specialist team.
- Records showed that analgesia had been prescribed at a strength that was appropriate to patients’ pain scores.
- Patients identified as needing end of life care were prescribed anticipatory medicines. These ‘as required’ medicines were prescribed in advance to properly manage any changes in patients’ pain or symptoms.
- Staff told us they always kept stocks of commonly prescribed end of life medicines and did not experience significant delays in getting alternative or extra stocks from the pharmacy.

## Nutrition and hydration

- Patients’ records showed that those identified as being in the last hours or days of life had had their nutrition

# End of life care

and hydration needs evaluated and appropriate actions followed. Relatives of patients we spoke with confirmed that ward staff had clearly explained all changes in care relating to nutrition and hydration.

## Patient outcomes

- The trust had contributed to the National Care of the Dying Audit. This scored participating trusts against seven organisational and ten clinical key performance indicators (KPIs).
- The trust had not achieved six of the seven organisational KPIs. Five of the ten clinical KPIs were better than the England average with the other five being worse. The supportive and specialist palliative care service had developed an action plan that was being monitored by the end of life care committee. We saw that progress had been made to address the deficits (for example, in the implementation of the TRANSFORM programme on wards).
- The supportive and specialist palliative care team had not audited all patients to ascertain whether the team was enabling dying patients to die in their identified preferred place of death. However, 97% of patients referred to the supportive care team in the last days of life had received rapid discharges to die in their preferred places.
- Between 31 July 2014 and 1 February 2015, 86.2% of patients were seen by the supportive and specialist palliative care team within 24 hours of referral.

## Competent staff

- Training was provided by the supportive care and specialist palliative care teams to medical staff, healthcare assistants, ward nurses and allied health professionals. It included recognising palliative patients, palliative care, specialist palliative care, end of life care, managing dying patients in the last hours and days of life, rapid discharge of dying patients and symptom control. Extra training was provided on the TRANSFORM wards, including advance care planning and the AMBER care bundle.
- The chaplaincy also provided training on bereavement, loss and grief.
- Palliative care link nurses on each ward acted as a point of contact for the supportive and specialist palliative care service. They were also responsible for disseminating to colleagues on their ward the training they had received.

- Ward staff were aware of who their palliative care link nurses were, and confirmed that they disseminated updates and training on end of life care.
- Specialist palliative care staff said they would value more time and support from consultants to provide supervision. Within the trust's business plan to recruit extra staff for the service, a need was identified to appoint a consultant who would take on a lead within education.
- We saw evidence that the specialist palliative and supportive care team nurses had advanced continued professional development in end of life care. All palliative care clinical nurse specialists were educated to first degree level with some members having studied for second degrees within their specialty (for example, a Master's level degree in medical ethics and palliative care). All band 7 supportive and specialist palliative care nurses had completed an advanced communication skills course.

## Multidisciplinary working

- The specialist and supportive palliative care teams and consultants had weekly MDT meetings to discuss end of life patients in more detail and depth, and to review care and treatment plans. The chaplain also attended these meetings.
- Several staff told us that, these meetings were not functioning as effectively as they could. This resulted in inhibiting open discussion between team members.
- The specialist palliative care consultants attended three different condition-specific MDT meetings to advise on end of life care during patient reviews. For example, the cancer of unknown primary MDT, the Coventry integrated breathlessness MDT and the Coventry integrated motor neurone disease MDT meetings. We saw evidence of these meetings in the end of life care committee meeting minutes.
- There was close MDT working with the cancer and non-cancer site-specific clinical nurse specialists and with specialists across the two hospital sites from the oncology, haematology, elderly care, respiratory, renal, critical care and pain teams.
- The specialist palliative care nurses and supportive care nurses attended the 'board rounds' on the TRANSFORM wards to help doctors and nurses identify patients who were approaching the end of their life.

## Seven-day services

# End of life care

- The specialist palliative care team operated a 5-day service, working Monday to Friday 8.30am–4.30pm. After participating in the National Care of the Dying Audit, the trust had identified that a 7-day service was needed. A business case to increase staffing to the required level had been submitted.
- Out of hours, the Myton Hospices, led by Coventry and Warwickshire consultants in palliative medicine, provided clinical advice by telephone to professionals.

## Access to information

- We saw that care and risk assessments, care plans, case notes and test results were available to staff to enable them to deliver effective care.
- We saw on the TRANSFORM wards that resources were displayed and available to identify patients in the last year of life, and to support patients, relatives and staff with advance care planning and implementation of the AMBER care bundle.
- The CRRS supportive and palliative care alert highlighted to staff working across care settings, including the hospitals, community and hospices, that a patient was being managed palliatively and promoted to staff to use best practice and proactive care in the last stages of their life.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing staff were knowledgeable about processes to follow if a patient's ability to give informed consent to care and treatment was in doubt.
- However, we found 12 DNA CPR forms on which a doctor had indicated that the patient had no capacity; Mental Capacity Act (MCA) assessment forms had not been completed. We were shown the trust's MCA assessment form but this had not been used in any of the files we examined.
- We discussed this with two doctors who were unaware of the need to complete this documentation. They were able to describe the process for assessing a person's capacity, but they were not documenting who was involved in the process or why it was required at that particular time for that particular patient.

## Are end of life care services caring?

Good



Patients received caring and compassionate care. Relatives described the nurses as “compassionate and providing excellent care”. The mortuary staff were aware of procedures and able to facilitate rapid release of a deceased patient. This enabled the cultural wishes of families to be respected.

Those at the end of life and their relatives told us they felt involved with their care and were treated with dignity and respect. Emotional support was given to patients and relatives by ward staff, the supportive and specialist palliative care teams and the chaplaincy service. Patients and relatives told us they felt well supported by staff.

Training in communication and end of life care was available to ward staff from the specialist palliative and supportive care teams, and the chaplaincy.

## Compassionate care

- Patients and relatives we spoke with praised the service and said they were receiving good care.
- They told us that staff were respectful and that their dignity and privacy had been respected.
- Ward staff told us that, whenever possible, end of life patients were nursed in side rooms to increase dignity and privacy for them and those visiting them.
- Relatives described the nurses as “compassionate and providing excellent care”.
- While we were unable to witness care being given to end of life patients, we observed many interactions between staff and other patients on the wards. We saw that staff were friendly, polite and respectful.
- The chaplaincy service responded to the spiritual and psychological needs of patients at the end of life and their families. This included providing last rites services.
- The mortuary staff were aware of procedures and able to facilitate rapid release of a deceased patient. This enabled the cultural wishes of families to be respected.

## Understanding and involvement of patients and those close to them

- Patients and relatives told us they felt involved and consulted about the care being provided. They said that all risks regarding treatments and medication were explained to them.

# End of life care

- The supportive care team gave written resources to patients and relatives. A leaflet called 'Best care for dying people in the last hours or days of life' was attached to the individual plan of care for the dying person to be given to relatives at the appropriate time. This contained information about what relatives could expect regarding their loved ones' changing needs. An information booklet called 'Advice for bereaved families and friends' was also available to tell people about the procedures following the death of a loved one.
- Translation services were available for patients at the end of life and their relatives.

## Emotional support

- Emotional support for patients and relatives was available from the specialist palliative and supportive care teams, ward-based nurses and the chaplaincy team.
- Training in communication and end of life care was available to ward staff from the specialist palliative and supportive care teams, and the chaplaincy.
- The trust had a dedicated bereavement service whose staff provided support and guidance to families.
- Patients and relatives told us they felt well supported by the specialist palliative and supportive care teams.

## Are end of life care services responsive?

Requires improvement



We rated this domain as requires improvement. Staff told us the process for rapid discharge of patients to Warwickshire was not as efficient as that for patients being discharged to Coventry. Delays of up to 48 hours could occur, sometimes resulting in people dying before returning home. Patients in the last year of life and receiving palliative care went through the routine hospital discharge process. This could cause delays of a few weeks because of the need to organise packages of care in the community.

The supportive and specialist palliative care teams were responsive in seeing patients on the same day of referral or within 48 hours. The chaplain was often able to respond within minutes of being called to support patients and

relatives. Monthly drop-in support sessions were held for families who might need further emotional or spiritual support, or who had questions relating to their experience of being with a person who was dying in hospital.

Bereavement services were able to register deaths of people who lived outside Coventry but had died in the hospital.

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

- The supportive and specialist palliative care service had developed integrated collaborative working with other local palliative end of life care providers. These included two acute hospital trusts and the Myton Hospices, within the Coventry and Warwickshire Care and Support Towards Life's End (CASTLE) clinical implementation group.
- This collaboration had led to unified streamlined processes for advance care planning, individual plans of care for the dying person, and education and training in palliative and end of life care available to health and social care professionals in Coventry and Warwickshire.
- The service had recognised that they were not providing a 7-day service for patients. A business plan had been developed to recruit more staff to address this.
- The mortuary had two temporary body storage units available on site at University Hospital. These could be used if the mortuary's main body storage facility became full. These temporary storage facilities were being used at the time of our inspection because the main storage facility had a high occupancy level. Extra body storage capacity was also available at Hospital of St. Cross. Mortuary staff had criteria to identify bodies that could be moved from the University Hospital site to the Rugby site, should the extra storage capacity be needed.

## Meeting people's individual needs

- The supportive and specialist palliative care service was available between 8.30am and 4.30pm, Monday to Friday. Out of hours, the Myton Hospices led by Coventry and Warwickshire consultants in palliative medicine, provided clinical advice by telephone to professionals.
- The specialist palliative care team provided support for symptom control, psychological support for patients and relatives, and advance care planning.



# End of life care

- The supportive care team received referrals for support in the last days of life for patients and relatives, rapid discharge for patients in the last days of life and identification of patients with a prognosis of less than a year or so.
- The chaplaincy service responded to the spiritual and psychological needs of end of life patients and their families. This included providing last rites services. This service was available 24 hours a day.
- The chaplaincy service had a Faith Centre and offered individual spiritual support and guidance for people of all faiths and of none. Chaplains represented the Church of England; volunteers represented Sikh, Hindu and Muslim faiths and individual prayer rooms were available for people of these faiths.
- Annual memorial services were held in the multifaith centre and families who had lost a loved one in the previous year were invited.
- Monthly drop-in support sessions were held for families who might need further emotional or spiritual support, or who had questions relating to their experience of being with a person who was dying in hospital.
- Monthly drop-in sessions were also held to support staff who might be affected by working with bereaved people, or who had experienced a personal loss themselves.
- Bereavement services were able to register a death on site, and to help families who might live outside Coventry but whose family member had died in the hospital.
- Translation services were available for patients at the end of life and their relatives.
- Ward staff were able to access support and advice in caring for people with learning disabilities or dementia from clinical nurse specialists in these fields.
- Staff highlighted an issue of access to the ward 'out of visiting hours' to visit a relative who was receiving end of life care; this was because the ward had no intercom or door bell system.
- The mortuary staff were aware of procedures and able to facilitate rapid release of a deceased patient. This enabled the cultural wishes of families to be respected.
- Referrals to the specialist palliative and supportive care teams were made by ward staff electronically or by telephone. The teams met every day to review their current workload and allocate new referrals, which were prioritised and allocated based on urgency and need.
- Ward staff understood how to make a referral to the specialist palliative team. They consistently reported that the team responded promptly, usually seeing patients the same day or the day after.
- The ward staff told us that the chaplaincy service was also responsive, usually responding within minutes of referral.
- Patients receiving end of life care and who wished to transfer their care back to a care home or to an alternative service, and patients identified for rapid discharge, had their individual needs assessed by the supportive care team. This team aimed to discharge patients the same day if possible, but could sometimes do this within 4 hours.
- The team had not audited time taken for discharge. However, staff told us that, whereas rapid discharge often happened within 4 hours for patients living in Coventry, it was often delayed for patients living in Warwickshire. Difficulties arranging community packages in Warwickshire could cause delays of up to 48 hours, resulting in some people dying before they got home.
- Staff told us that patients receiving palliative care in the last year of life went through the normal hospital discharge process. This could cause delays of a few weeks for patients to get home due to difficulties organising packages of care in the community. Staff said it would be useful to have a discharge facilitator within the supportive and specialist palliative care service.
- The mortuary staff were aware of the procedures and able to facilitate rapid release of a deceased patient. This enabled the cultural wishes of families to be respected.

## Learning from complaints and concerns

- Complaints about end of life care and lessons learned were discussed at the end of life care committee meetings and also at the weekly multidisciplinary team meetings. Staff gave an example of learning from a complaint by a Mormon family member who felt the spiritual care their relative had received had been

## Access and flow



# End of life care

inadequate. The supportive and specialist palliative care service asked the relatives to speak at a meeting of all hospital matrons to share how care could have been improved.

- We saw from minutes that complaints were discussed at each end of life care committee meeting.
- Information was available throughout the hospital to tell patients and relatives how to make a complaint.

## Are end of life care services well-led?

Requires improvement



Leadership roles in medicine and nursing within the specialist palliative care service were not clearly defined. Staff identified that clear role definitions would help improve the service. It was recognised that the multidisciplinary team meetings were not effective but this had not yet been resolved.

Despite the inaccurate completion of 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms being entered on the risk register and an action plan formed, we found this was still an ongoing problem. The issue of delayed rapid discharge of patients to Warwickshire was not on the risk register.

The supportive and specialist palliative care teams were passionate about providing quality care to end of life patients and developing the skills of other staff. There were governance processes to monitor the quality of the end of life care strategy. The supportive and specialist palliative care service had shown learning and implemented innovative changes to practice as a result of audits and complaints.

### Vision and strategy for this service

- The supportive and specialist palliative care service had a strategy and vision with clear plans for improvement. These included a business plan to increase both nursing and consultant staff to provide a 7-day service for patients. Staff we spoke with were aware of the strategy.
- The end of life care committee supported and drove the development of end of life care at the trust. Subgroups of the committee were responsible for improvements in education and training, patient and user groups, bereavement and discharge.

### Governance, risk management and quality measurement

- The chief nursing officer and a consultant in palliative medicine/end of life care co-chaired the end of life care committee with wide representation from across the trust including the chaplain and a non-executive director lead for end of life care.
- Minutes showed that clinical standards, risks and quality improvements were reviewed and included as regular agenda items at the bimonthly end of life care committee meetings. All incidents, complaints and compliments were discussed. Themes were reviewed and further actions, including targeted education and training, were identified and actioned. An example was a complaint that had been received about poor pain management; this resulted in agreement for the specialist palliative and supportive care teams to provide more training for ward staff.
- However, despite the inaccurate completion of DNA CPR forms being entered on the risk register and an action plan formed, we found this was still an ongoing problem.
- The issue of delayed rapid discharge of patients to Warwickshire was not on the risk register.
- The end of life care committee was responsible for monitoring the action plan in relation to the National Care of the Dying Audit. The consultant in palliative medicine/end of life care told us that, once the audit results had been published, the results and action plan would be presented to the board and the learning shared with individual wards.
- The consultant in palliative medicine/end of life care also sat on the mortality review committee, which was the reporting committee for mortality reviews and data.

### Leadership of service

- We found the leadership roles within medicine and nursing were not clearly defined. Both senior medical and nursing staff we spoke with acknowledged that leadership roles needed to be clarified in order to improve the service. We saw excellent leadership potential.
- The supportive and specialist palliative care teams told us they felt well supported by the trust board.

### Culture within the service

# End of life care

- Staff in the supportive and specialist palliative care service were passionate about the quality of end of life care for patients and relatives.
- Staff told us that the weekly multidisciplinary team meetings were not effective as they could be. This resulted in inhibiting open discussions. This had been recognised but not yet resolved.




## Public and staff engagement

- During their stay and on discharge, patients were asked for feedback on the quality of service they had received. Any feedback relating to end of life care was collated and sent electronically, on a daily basis, to the board member for end of life care. They then fed this information back to the supportive and specialist palliative care teams and staff in the clinical areas.
- The end of life care committee was planning to roll out the National Bereavement Survey (VOICES) 2011 for bereaved relatives. The survey had been compiled and was awaiting dissemination for completion.
- The supportive and specialist palliative care service worked collaboratively with other services to improve end of life care for patients. This included community end of life and primary care services and hospices via the Care and Support Towards Life's End (CASTLE) clinical implementation group.
- Staff we spoke to within the specialist palliative care teams told us they felt listened to and were able to contribute to the vision and strategy for the service.

## Innovation, improvement and sustainability

- The supportive and specialist palliative care service used national guidance to plan, improve and sustain the end of life services provided in the hospital.
- The service had collaborated with the University of Edinburgh to develop the Coventry and Warwickshire Supportive and Palliative Care Indicators Tool (SPICT) to help doctors and nurses identify patients who would benefit from palliative care.
- CRRS supportive and palliative care alerts (based on the SPICT) highlighted to staff within the hospital, community and hospice settings that a patient was being managed with a supportive and palliative care approach.
- Quality End of Life Care for All (QELCA) training had been established between the trust and the Myton Hospices. The aim was a phased roll-out of education and training of ward managers and sisters/charge nurses across the trust to provide quality end of life care on wards by implementing the TRANSFORM programme.
- The supportive and specialist palliative care service tried to avoid unnecessary admissions for end of life care patients by liaising with community staff and the GP liaison nurse based in the emergency department. For example, the service received a call from the community palliative care team about a patient with motor neurone disease who was going to the emergency department. The patient was seen by a respiratory consultant in the department, thereby avoiding the need for admission.

# Outpatients and diagnostic imaging

Safe	Inadequate	
Effective	Not sufficient evidence to rate	
Caring	Requires improvement	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

## Information about the service

Outpatient services at the University Hospital in Coventry are mainly located in one area on the ground floor and were served by several reception desks. On average the trust runs approximately 2420 Clinics per week, covering a very wide range of specialities and conditions including, medicine such as cardiology, neurology, rheumatology, diabetes, respiratory and elderly medicine. There were surgical clinics such as ear, nose and throat, colorectal, vascular, orthopaedics and trauma.

There were a number of rapid access services within the outpatients department including Transient Ischemic Attack, (TIA) Rapid Access Chest Pain, Age Related Macular Degeneration Clinics, TB Clinic, Heart Failure and 'Hot Clinics' which were for patients whose pathway commenced in the Emergency Department and who were clinically safe to be discharged.

Blood test services were provided within the outpatient department.

The fracture clinic and dermatology clinics were nearby with separate receptions and facilities. The Arden Centre, which had a separate entrance, provides outpatients, radiotherapy and chemotherapy services. The oncology team was based there.

The radiology department, again, on the ground floor, supported outpatient clinics as well as inpatients, emergency and GP referrals and provided imaging for the diagnosis and interventional treatment of a number of conditions.

The Endoscopy Suite is a member of the Joint Accreditation Group in gastro intestinal endoscopy (JAG) and carried out 13,800 procedures, both routine and urgent, per year, through its five rooms.

During our inspection we spoke with 21 patients as well as some of their relatives. We also spoke with 41 members of staff including reception and booking staff, secretaries, managers, cleaning staff, nurses of all grades, radiographers, health care assistants, medical students, doctors and consultants.

We observed care. We received comments from our listening events and from patients and the public directly. We also reviewed performance information about the department and the trust.

# Outpatients and diagnostic imaging

## Summary of findings

In radiology, all the waiting areas we saw were inadequate. They were too small for the volume of patients.

Staff in the radiology department were not always aware of important information with regards to patients, for example if they had an infection or were subject to a Do Not Attempt Resuscitation order.

There was no process in place to ensure the nurses in the interventional radiology department had adequate scrub skills in order to protect patients from a hospital acquired infection when undergoing an interventional procedure.

There was no handover of ward patients when they arrived and waited for their investigation or procedure. We saw patients in one bed wait area left unattended. During one observation period, we noted that two had dementia; another had no pillow or blanket on their trolley. We saw one patient denied toileting facilities until we intervened.

The outpatient, radiology and endoscopy departments were clean. There was no robust system for screening patients for Methicillin Resistant Staphylococcus Aureus (MRSA). The hospital reported seven cases of MRSA bacteraemia from March 2014 - January 2015. We saw some poor compliance with hand washing in the radiology department.

There was only one nurse on call for interventional radiology out of hours. This had been identified by the trust and was on the risk register. However, this situation had not been resolved since entered onto the risk register in April 2014.

The departments held their own training records, which were mostly up to date with regards to mandatory training. However, 26 out of 34 staff in outpatients had not received safeguarding of vulnerable adults training in the past three years.

Most of the patients we spoke with told us they had been treated with dignity and their privacy protected. However, this was not evident in the fracture clinic or the radiology 'bed' waiting areas. Patients spoke highly of the staff in outpatients, radiology and endoscopy.

They found staff polite and caring. However, many patients complained to us about the lack of and cost of parking, the waiting times in the outpatient clinics and cancellations and changes to clinics.

Although a management restructure was underway, there was an unmethodical and confused reporting structure across both radiology and outpatients.

Staff reported incidents, via the trust's electronic reporting system. These were discussed at the clinical governance meetings within the directorates. There was some learning evident from incidents and complaints via staff meetings.

Medicines were stored and administered safely.

Staff demonstrated a commitment to patient-centred care. We found many examples of such care and of attention to patients' conditions and preferences

The trust had met its national targets and consistently performed higher than the national average in regard of radiology waiting times. Reporting of images were all done within 28 days, a national standard. There had been a backlog in reporting all images. In November 2014 there were 3,500 images unreported for more than 28 days. Considerable progress had been made, as none were outstanding when we visited.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Inadequate



We found the outpatients and diagnostic service to be inadequate for safety.

There were some systems in place to reduce the risk and spread of infection. However, these were not rigorous, enforced, or known by the staff to ensure that patients were protected from the risk of infection, particularly in radiology. There was no process of assuring the nurses in the interventional radiology department had adequate scrub skills to ensure patients were protected against the risk of infection when undergoing interventional procedures.

There was no process of identifying and protecting other patients, staff and visitors from the risk of infection when transporting patients with an infection around the hospital, or when they arrived in the radiology department. We saw some non-compliance with hand washing and poor infection control and prevention practice in the radiology department.

There was no robust system in outpatients or the preadmission clinics to undertake MRSA screening for those patients who were to undergo planned surgery.

There was only one interventional radiology nurse on call during the evening and weekends who was responsible for assisting during the emergency/urgent procedure. There was no system in place to ensure a second nurse was available to monitor and care for the patient during the procedure. This had been on the trust risk register since April 2014 and had not been resolved.

When patients arrived in the department from the wards, there was no handover, for example the patient's resuscitation status was not known by the imaging staff prior to an examination commencing. Therefore a patient who may have had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place may have had resuscitation performed when it was inappropriate.

Staff reported incidents in line with the trust's policies and demonstrated knowledge and understanding of the

system. Incidents were investigated, with feedback and learning shared at the monthly clinical governance meetings. Some staff considered that they did not always receive feedback from incidents they reported.

The endoscopy department had an excellent system, in line with national best practice, to clean and decontaminate endoscopes.

Medicines were stored and administered safely.

Mandatory training was managed and monitored within the outpatient, radiology and endoscopy departments. However, in outpatients 26 out of 36 staff had not received any safeguarding of vulnerable adults training.

### Incidents

- The trust used an electronic incident reporting system to record accidents, incidents and near misses. Training was in place on the use of the system. Staff we spoke with demonstrated knowledge and understanding of the trust incident reporting system. They knew what to report, and had reported incidents.
- We were given examples of incident reporting in phlebotomy, radiology and outpatient nursing and by clerical staff such as of lack of patients' records and delayed transport
- Staff told us that learning from incidents was discussed at team and departmental meetings. We saw various examples of minutes that demonstrated learning being discussed at meetings. However, not all individual staff who reported incidents felt that they received feedback from investigations.
- The radiology department had specific patient information and event report forms for identified risks in some procedures such as extravasation of x-ray contrast media and contrast reaction incidents. Staff demonstrated awareness of the importance of reporting any occurrences. We saw evidence of these incidents being reported on the trust's electronic reporting system and actions, in some cases, to minimise repeat incidences.
- The Clinical Directors told us that they held a monthly clinical adverse event meeting, which was attended by the radiologists (x-ray doctors) only. They gave us some examples of adverse incidents and the learning that had arisen from them. For example, when a patient collapsed when undergoing a procedure on their spine. There was only one nurse present at the time. Following

# Outpatients and diagnostic imaging

this, two nurses were required to be in the room when a patient underwent a procedure. This meant that one nurse could assist the doctor with the procedure, whilst the other was specifically allocated to care for and monitor the patient. However, the nurses reported to us although this happened in the daytime, out of normal working hours there was only one nurse on call. This meant that the nurse assisted the doctor with the procedure and there was no one specifically allocated to monitor and care for the patient. The staff told us that in theory, a nurse from the ward that the patient came from would accompany the patient to fulfil this task. However, in practice this rarely happened due to staffing pressures on the wards. The staff told us they often spent more than forty minutes on the phone trying to arrange assistance from the individual wards and the on-site manager or bleep holder, but assistance rarely materialised. It was difficult to quantify numbers as the nurses did not routinely report this as an adverse incident. This has been on the departmental and trust risk register since April 2014, where it states that the action to mitigate this is for the nurses to call for assistance by calling the emergency 2222 number. The review date on the risk register has passed, January 2015, but this situation has not been resolved. This meant that the trust had recognised the risk and had put in place actions that would mitigate the risk, however, the practice had not been embedded, leaving patients who were undergoing, often major procedures, at risk of harm due to lack of close monitoring.

## Cleanliness, infection control and hygiene

- Patients we spoke with felt that the areas were always clean. The outpatient survey carried out in January 2015 scored 99% for cleanliness.
- We observed that all staff complied with the trust policy of being bare below the elbow and wearing minimal jewellery.
- Hand gel was available in all clinical areas. Notices were displayed regarding hand washing and infection control.
- Mandatory training records showed that all staff had received infection prevention and control training within the last two years. Staff we spoke with demonstrated knowledge and understanding of cleanliness and control of infection.
- The trust performance team worked closely with Infection Prevention and Control (IPC) team to monitor trends and scores across outpatient and diagnostic areas, which were discussed and managed by a monthly operational cleaning meeting, which was chaired by the Director of Estates and was attended by all Matrons, ISS and hard service partners, Clinical Nursing Officers and Assistant Directors of Nursing.
- The Outpatients Department undertook regular infection control audits. We saw that each clinic scored highly, over 95% for cleanliness. However, there were none made available for us for radiology. Regular physical audits were also undertaken. Daily clean down of clinical areas and trolleys was undertaken and all staff undertook the department 'hand hygiene' training and review. A quality and safety matrix was performed monthly and the department had received 100% in all domains in pre-operative assessment at February 2015.
- We saw that where single use equipment was available, this was used, for example vaginal speculums.
- We saw evidence of good infection control measures in phlebotomy. Staff used gloves when they took blood from patients. We observed them washing their hands in-between patients, in addition to just changing their gloves.
- There was a preadmission service within the department, which was managed by the outpatient matron. No preoperative MRSA screens were undertaken in the preadmission department, this was done by the pre-operative nurse. However, the pre-operative nurse only saw those patients who were a higher anaesthetic or operative risk, for example, patients with co-existing morbidities. This meant that not all patients undergoing elective surgery were screened preoperatively, which has been a Department of Health recommendation since 2007. We saw some examples of poor hand hygiene in the radiology department. In the bed waiting area in ultrasound, we observed multiple interactions with patients and no hand washing/hand sanitation in between touching/handling individual patients. We observed a bedpan being given to a patient and although gloves and aprons were worn by the staff, one member of staff did not wash their hands after handling the patient and the bedpan. Their gloves and apron were taken off and the next task undertaken. The member of staff confirmed to us that they had undergone infection control, training. Another member of staff, after handling a patient and their bedpan, opened a cupboard and searched through clean linen with their contaminated gloves on.



# Outpatients and diagnostic imaging

- Although two members of staff told us that hand hygiene audits were carried out in the department, we were not shown these and they did not appear, from the evidence that the trust supplied us with, to form part of the trust wide hand wash audit data.
- The radiology department carried out a number of advanced interventional procedures, for example coiling of aneurysms and embolization of uterine fibroids. These advanced procedures are carried out under strict aseptic conditions, that is the instruments and field around the patient are sterile. The nurse and doctor carrying out the procedure would be 'scrubbed,' wearing sterile gloves and gowns. This ensures that the risk of infection, when a procedure where devices are introduced into a patient's body via the skin, is minimised. The nurses had undergone some 'on the job' training with regards to competencies with different procedures. We saw an example of completed competencies; however, there were no specific scrub competencies. The nurses we spoke with confirmed that one of the band 6 nurses carried out their scrub competencies, however, it was unclear what qualifications they had to undertake this training and whether the trainer or training complied with recommendations from The Association for Perioperative Practice. The nurses in the department did confirm that they were not aware of any advanced scrub practitioners from the operating department auditing or supervising the radiology staff scrub skills. This meant that there was no assurance that best practice with regards to infection control was being complied with and could have increased the risk of patients being exposed to an infection.
- If there was awareness that an in-patient, who required imaging, had an infection, they were scanned or x-rayed at the end of the list to allow all unnecessary equipment to be moved out of the room. The room was then thoroughly washed and cleaned at the end of the procedure. We saw that the domestic staff had separate mops and buckets for this, which were cleaned afterwards.
- We saw a trust wide transport policy dated October 2014, which stated, "Patients with an infection should not be moved around the hospital unless absolutely necessary." There appeared to be no robust process for identifying in patients, with an infection that could contaminate other patients, for example MRSA, who needed to attend other departments in the hospital.

Several staff told us that these patients were often not identified, "Until we are halfway through the scan." One porter told us, "The wards are so busy and so are we. We just take the call slip upstairs and get the patient. Sometimes they just forget to tell us they have an infection." However, the staff in radiology were clear that when one such a patient was identified all equipment in the room was thoroughly cleaned and decontaminated.

- The World Health Organisation (WHO) checklist was used prior to any invasive procedure. This is an internationally recognised set of preoperative checks, to minimise surgical errors. An audit of compliance was carried out in September 2013, which showed 93% compliance overall. However, there had been no further audits so that improvements could be measured.
- The bed wait area in CT and MRI was just large enough for a three beds, separated by curtains. Again this was an infection control risk for patients who were in such close contact with another patient. This was also a risk for immuno-compromised patients, (those that have a low resistance to infection). This had been on the trust risk register, since April 2014. The controls in place stated that the wards could request these patients were x-rayed or scanned on an in/out basis. However, in reality, patients who were immune-compromised and more commonly, those with an infection, were rarely identified prior to leaving the ward. This meant that the trust had a process in place to protect patients who used the radiology department from infection from other patients, but the processes were not embedded in practice, which put vulnerable patients at risk of infection.

## Environment and equipment

- The outpatient waiting area was very large and well lit, mostly by natural light. All areas of outpatients that we visited were tidy, including corridors. The atmosphere was generally calm, even where the clinics were very busy.
- There were 4 numbered receptions and the patients reported to the one that was indicated on their appointment letter.
- The phlebotomy department had a ticket system, where patients could take a ticket from a machine, and then the display and an audible message would indicate when a phlebotomist was free to carry out their blood test.

# Outpatients and diagnostic imaging

- We saw evidence of daily performance checks of equipment.
- Single-use equipment was available in the clinical areas.
- All equipment we looked at was visibly clean and stored appropriately.
- We saw several hospital owned wheelchairs with no, or only one, footplate. This meant patients had to put both feet on one footplate, or hold their feet in the air when being pushed.
- Emergency resuscitation equipment had been checked appropriately in all areas we visited.
- The trust's electrical maintenance engineering department was responsible for annual portable appliance tests.
- Ophthalmology had three laser rooms, which complied with national standards for the provision of laser treatment facilities to patients. The Radiology Department provided a full range of diagnostic and interventional imaging services utilising state of the art equipment. The equipment was updated as part of the PFI equipment replacement programme. Therefore, equipment was replaced regularly; this ensured patients had access to the latest technology. For example, up to date imaging equipment that minimised the dose of radiation.
- The Radiology Department was one of the equipment providers' 'reference sites' to showcase a wide range of imaging equipment to visiting staff from other Trusts in the UK. The department had also built good working relationships with the equipment manufacturer which had led to the company facilitating an onsite engineer to be located within the Radiology Department. This ensured that unplanned equipment downtime and delays to scans was kept to a minimum.
- The department had redesigned the current interventional area into a patient focussed interventional suite housing the latest technology. However, the plans for this had been available for two years and work has not yet started. One member of staff told us, "It's really frustrating, we have been promised this and nothing happens. It would be a really good retention tool. Also the way the department is at the moment, we can't see the patients properly." The fact that the nurses could not see the patients is also an item on the trust risk register since April 2014. The date for resolution is December 2015. There was no update with regards to this on the risk register.

- Work is also due to start on replacing 3 of the 5 MRI scanners this year to further develop research capabilities in the Trust.

## Medicines

- In outpatients, radiology and endoscopy, medicines were stored in locked cupboards in the department. Nursing staff ordered all medicines through the hospital pharmacy. Two nurses checked medicines taken from the locked cupboards. Lockable medicines fridges were in place, with daily temperature checks. Furthermore, the fridges all had a diligence system, which was managed by pharmacy. This is a system whereby the pharmacy can see if the temperature of the fridge has gone out of an acceptable range, out of the times the fridge was manually checked.
- In all three departments, most medicines were administered by doctors. Where nurses administered medicines such as analgesics, these were prescribed by the doctor and recorded in the patient's record. Once medicines were administered, nurses signed and dated the medicine record.
- FP10 prescription pads were stored securely.
- Outpatient prescriptions were dispensed from a high street pharmacy, which had a commercial arrangement with the hospital, within the main reception.
- Emergency trolleys were checked every day.
- Outpatients had no Controlled Drugs (CDs). These are medicines that are subject to strict controls in order to minimise their abuse. We checked a sample of CDs in both Radiology and Endoscopy and found that they had been ordered, reconciled and recorded in line with national guidelines and the law. However, we did find some condoms, used for sheathing probes, in the CD cupboard in Radiology. The nurse was advised by us they should be removed from the CD cupboard and stored somewhere more appropriate.

## Records

- The trust had raised awareness of the benefits, requirements and implications of robust documentation practice, the in-house non-medical education programme included an annual record keeping summit aimed at registered nurses. All of the staff who attended were issued with a copy of a credit-card sized reminder of the importance of records which was developed by the trust's practice facilitators.

# Outpatients and diagnostic imaging

- Written and electronic records are available for patients in outpatient department. A recent review of all records in the plaster room had resulted in improved documentation for recording patient care and as a result identified previously unrecorded income which was now being generated.
- Radiology was fully equipped with digital equipment in all areas. Reports for examinations were recorded on Radiology Information System (RIS) and images were recorded on the electronic PACS system.
- The fracture clinic used an electronic records system.
- We were told that sometimes patients' records were not available for patients' outpatient appointments, particularly if those with complex conditions were visiting both hospital sites within a short time. Clerical staff created a temporary set of notes, and the electronic patient records system meant that the referral letter and any previous clinic letters and blood test and x-ray results were available. However, on rare occasions, a patient could not be seen if the full set of notes was not available.
- The trust's outpatient incident log in respect of patients' records showed 14 recent incidents, which included misfiled records, inaccuracies and missing records. These were investigated and the actions demonstrated that the incidents had been discussed with the patients concerned and rectified.

## Safeguarding

- The safeguarding team consisted of a trust lead for safeguarding, which incorporated the role of the named nurse for safeguarding children. There was also a named nurse for safeguarding vulnerable adults, and a named doctor for safeguarding children as well as the lead clinician for safeguarding adults. There was full time administrative support.
- The trust safeguarding lead sat on the national scrutiny panel for multi risk agency risk assessment conference (MARAC). This enabled feedback regarding national policy development and advice from across the country.
- Staff told us that they received training in safeguarding for both children and vulnerable adults. We saw evidence of training undertaken.
- Staff demonstrated knowledge and understanding of safeguarding and of the trust's process for reporting concerns. They understood their role in protecting children and vulnerable adults. However, none of the staff in outpatients had attended safeguarding training.

## Mandatory training

- Mandatory training was done on both a face-to-face basis and via e-learning packages. All staff told us that as they were short staffed, it was often difficult to get their training completed.
- Trust records showed that compliance in mandatory training for outpatient's staff was 71%, against a trust target of 100%. We found that 26 out of 36 outpatient staff were not up to date with one or more aspect of their mandatory training.
- No department was reaching the trust target of 100% compliance with mandatory training. However, both the radiology and endoscopy departments' compliance was close to the trust target at 95%. The staff in the fracture clinic had completed 71% of their training and the pre-assessment department 72%. We did not see an action plan or training calendar to be able to ascertain whether the staff in these departments were on track to complete their mandatory training by the end of the year.

## Assessing and responding to patient risk

- Staff we spoke with demonstrated knowledge and understanding of patient risk, particularly for elderly or frail patients with more than one medical condition.
- Adult resuscitation equipment was stored within the department. We saw evidence that this was checked regularly and that staff signed to show that the equipment was checked and within the expiry dates.
- Processes were in place within the outpatients department to manage patients who present at risk within the department. For patients in attendance who show signs of rapid deterioration a call was placed to the emergency response team who will attend the department and assessed the risk to the patient and actions to be taken.
- In all bed wait areas, that is waiting areas where in patients waited prior to their procedure, there was a healthcare assistant allocated to the area, but they were often taken away to assist in the scanning or x-ray rooms. We observed patients arriving from the wards on their beds or trolleys and just being left by the porters. We observed the porters ensuring the patient had a call bell within reach; however, there was no hand over of the patient's status, for example, if they had an infection or were subject to a Do Not Attempt Cardio Pulmonary Resuscitation. (DNACPR). Over our two days in the

# Outpatients and diagnostic imaging

department we did not see any patient being accompanied by a nurse or healthcare assistant into the department. We saw no handovers being done. We observed several patients, who were obviously unwell, or had dementia and were disorientated, being left, unobserved. This meant there was a risk that a patient who was disorientated could attempt to move off the trolley and fall. We asked one of the lead radiographers how they knew, if for example, the patient was subject to a DNACPR. They told us, "The notes are left behind the reception. We don't usually take the notes into the scanner or x-ray room. If a patient did collapse, we would start resuscitation, then check in the notes." This meant that those patients, who were subject to a DNACPR order, could have had resuscitation attempted against their and their family's wishes.

## Nursing and Allied Health Professional staffing

- There was one matron who was responsible for the outpatients department and the nurses in the radiology department.
- Outpatients nursing staff told us that although they were busy, they felt they provided good and safe patient care. The outpatient nurses felt that staffing was generally sufficient; use of bank staff was rare.
- We were told that turnover of nursing staff was low. There were a few vacancies.
- The trust told us they were currently undertaking significant investment in attracting the right nursing staff to its hospitals and becoming an employer of choice. A rolling recruitment programme was ongoing with advertising websites, local media and university pitches. Plans were also in place to widen the recruitment drive internationally. However, the staff who were involved in recruitment had a perception was that it took a long time to get even direct replacements into post. One told us, "It all falls into a black hole somewhere. Someone told me it was to save money, but we use agency to replace them. That's much more expensive."
- The Registered Nurse in charge of each shift was clearly identified by yellow epaulettes.
- The trust's radiation protection adviser was based at Coventry together with four radiation protection supervisors.
- Radiology staff told us that the radiology department had several radiographer vacancies in all modalities and that recruitment took some time. The department did

have a number of newly qualified radiographers who rotated through several different modalities during two years. After this most of them left as there were usually no vacancies at this level. The manager saw this as positive. However, some of the staff we spoke with had different views. One told us, "We train them up so they just start to be useful, then no-one seems bothered, in fact its seen as positive, that they have to leave and go somewhere else. I don't understand it."

- There was a small team of radiology nurses in Interventional Radiology. They told us they felt they were permanently short staffed. However they were expected to look after patients in other areas when required (CT biopsy, MRI Sedation) and were called to all medical emergencies in the department.
- Agency radiology staff were used in the radiology department. Up to 20% of staff were temporary. When extra staff were required, this was covered by staff working overtime or by using bank staff. We saw the induction procedures and the completed paperwork for agency staff.
- There was some long-term sickness and vacancies; staff felt generally unsupported, although aware that recruitment was underway.

## Medical staffing

- The individual specialties arranged medical cover for their clinics. Medical cover was managed within the clinical directorates, who agreed the structure of the clinics and patient numbers. Some clinics, such as dermatology and ear, nose and throat, were managed by the clinical specialty and run by its doctors and nurses. Other clinics, such as the cardiology and respiratory clinics were managed by the outpatient nursing staff.
- Doctors we spoke with felt they had a good relationship with outpatient nursing and clerical staff. They said they could discuss issues with and were well supported by these staff.
- We spoke with two medical students, who told us, "It's a really positive experience working here. We get high quality training and are integrated into the team."
- Within Outpatients, consultant/registrar work plans are reviewed on a weekly basis and staff resource and skill mix are aligned to ensure the right staffing levels are in place to meet the clinic requirements.

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- There were 26 doctors of varying grades; there were 4 locums and 3 agency locums. These had been employed to ensure that waiting lists were managed in a timely manner. There was always junior staff and a consultant on call.
- The Radiology Department actively trains radiology specialist registrars and also hosted a twice yearly FRCR course in the clinical science building. UHCW is the only Radiology department in the region to have a Professor of Radiology in the department.
- Some of the junior doctors we spoke with reported some lack of support from some of the more senior colleagues when they were on call and felt they had to make decisions without always having the necessary experience.

## Major incident awareness and training

- The trust had an emergency planning department that was responsible for the delivery of major incident planning, training and exercising. The trust emergency planning steering committee was responsible for governing the direction of work delivered by the emergency planning department and also provides assurance to the trust board that plans are established, exercised and have been developed
- Most senior staff we spoke with had completed major incident training and were able to describe the department's role in the event of a major incident. Furthermore, the outpatient department staff recently took part in a mock major incident.
- As part of the Trust's responsibilities to provide training and exercising the emergency planning department facilitate and engage with table top and live exercises internally and as part of a multiagency response.
- The trust has in place a strategic business continuity plan to ensure that there is a clear process in managing the response to an event that causes disruptions severe enough to impede on the delivery of essential services.
- The major incident plan for radiology is available to all staff to view on the department's website and is an integral part of the local induction into the department. Staff are informed of any updates as and when they happen. Staff also participate in 'mock' major incidents events.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

University Hospitals Coventry and Warwickshire NHS Trust is a teaching hospital and therefore the consultants and doctors using the department were actively engaged in research and implementing national guidance in treatments.

There was evidence that staff competency was checked and that some staff received appraisals and opportunities for further training. We found examples of good multidisciplinary working both within and across teams.

The number of patients seen as a follow up against the number of new patient's rate was worse than the England average from July 2013 to June 2014.

Additional clinics, imaging sessions and endoscopy lists were run at weekends when required to ensure that waiting lists were kept within national targets.

## Evidence-based care and treatment

- Protocols were in place for radiology examinations such as cervical spine and orthopaedic x-rays.
- We saw protocols in place to ensure fast tracking where there were significant imaging findings for known or unknown cancer diagnoses, as well as severe abnormalities relating to benign or malignant growths. These findings were reported to the referrer and passed immediately to the multidisciplinary team for review and action. Clerical and electronic system procedures were included in the protocol.
- Dissemination of clinical audit findings was done via presentations at each of the Specialties Quality Improvement & Patient Safety (QIPS) Meetings. This allowed the audit results to be debated within the clinical teams, any lessons learnt to be shared and any improvements to practice identified and action agreed. Progress against audit action plans was reported at QIPS.
- Over the past few years the Professor of Radiology has influenced the culture of the department to promote research projects right across the radiology department. There were a number of radiographers, registrars and consultants working towards doctorates and MSc qualification. Advanced Practitioners also work within Patient Group Directions (PGD) and scope of practices.



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For example, we saw that reporting radiographers were in post. These are radiographers that are trained to recognise anomalies on certain images and formally report on them.

- In radiology interventions and the patient outcomes are entered into information databases held nationally, so that outcomes can be compared and measured with those in trusts undertaking similar procedures.

## Patient outcomes

- The number of patients seen as a follow up against the number of new patients rate was worse than the England average from July 2013 to June 2014. This meant that patients may have been followed up more regularly or for longer than the average. This is measured against all other trusts in England.
- In endoscopy, all examinations were audited, using specific software for these examinations. The rate for caecal intubation, for colonoscopy was over 90%. This is in line with national standards.

## Competent staff

- A Trust education and learning programme for non-medical healthcare staff, radiographers and nurses, has been developed and delivered in-house by the practice development team. The non-medical health care programme included:
- Leadership Development for Band 5 staff to provide staff with the opportunity to explore the concept of leadership and to demonstrate how the principles of leadership could be applied in the practice setting.
- Preceptorship - preparing the newly registered nurse in the transition from nursing student to professional practitioner.
- In outpatients one staff member told us they had just finished their preceptorship. As part of this they had identified areas for further professional development which had been actioned.
- Medicines Management workshops - to raise awareness of drug safety and security and the registered nurses role and responsibilities.
- The trust employed many specialist nurses within the Outpatients Department who provide nurse-led clinics alongside medical colleagues providing care for patients.
- New employees in Radiology were supported through a robust induction plan to achieve appropriate competencies for their job roles. Continual professional

development is promoted in the department and further training needs identified during annual appraisals. Staff were encouraged to take further responsibilities to widen their understanding of different aspects of the service.

Trust data showed that completed appraisal rates differed in each department:

- outpatients 80%
- radiology 88%
- endoscopy 100%
- Most staff told us that they had received an annual appraisal and that it was a useful process for identifying any training and development needs. However, many staff told us that the appraisal was done as a tick box exercise and not reviewed again until the next appraisal was due.
- An induction process was in place for new staff. We spoke with three new staff members who told us that they found both the trust wide induction and their local induction useful. One told us, "I've been here for two months and I've been really looked after. I have a mentor, but when she's not here, everyone else made sure I was ok."
- In addition to mandatory training, nursing staff undertook training, for example, wound care.
- Nurse practitioners provided face-to-face training. E-learning courses were also available.
- The trust is a teaching hospital, allied to Warwick University. Medical students were attached to different clinical specialities and rotated around these as part of their training.
- Junior doctors told us they had protected study time as part of their ongoing training

## Multidisciplinary working

- Ophthalmology (eye speciality) has various multi-disciplinary clinics. It has led nationally in training Optometrists in enhanced roles such as eye emergencies and in corneal, vitreo-retinal and medical retina clinics.
- The Radiology Department actively supports multidisciplinary team (MDT) meetings for all specialities and provides training for medical staff throughout the year. The department has two Consultant Practitioners and a significant number of Advanced Practitioners that are responsible for:



# Outpatients and diagnostic imaging

- Reporting plain film x-rays
- Reporting CT scans of heads
- Performing pneumocolon examinations
- Gastric band observation
- Performing contrast upper and lower gastro-intestinal studies
- Performing ultrasound scans
- Performing breast biopsies/aspirations
- The department had a number of Assistant Practitioners who provide a wide scope of imaging and also radiology assistants who are working towards a degree in radiography. The radiology nurses work closely with the radiographers and consultants to provide a dedicated and experienced team. All the above help the department to provide better access and increased patient flow in all specialities.

## Seven-day services

- Where the demand for appointments was greater than clinic availability, we were told that further clinics would be created. For example, Saturday clinics were being arranged to accommodate a backlog of hearing-aid patients. Endoscopy had developed a range of ways of utilising space made by cancelled procedures to minimise waiting times.
- The radiology department provided emergency 7 day services via an on call system at the University Hospital and a routine service 7 days per week for elective diagnostic work.
- The endoscopy unit offered a daily service for patients requiring an examination urgently, for example of they had an upper or lower gastrointestinal (GI) bleed. A range of treatments were available which could be done endoscopically to stop bleeding. This service also continued out of hours via an on call service. There was an on call GI doctor and nursing support, so any urgent endoscopies could be done swiftly.

## Access to information

- Information was readily available and easily visible. This included a map of the hospital, general outpatient information, and information about personal data confidentiality and coming into hospital. There was also information on the Patient Advice and Liaison Service (PALS) and how to make a complaint. In addition there was information on infection prevention and control.

- Condition-specific information such as hormone-replacement therapy, cataract surgery and barium swallow and meal investigation was available in the relevant clinical areas.
- Patients told us their relatives were included in discussions once their permission was given. One patient told us, "I always bring my wife as I like her to hear what the doctor says as well." Additionally, we saw information regarding cataract surgery, laparoscopic cholecystectomy and preventing a thrombosis (DVT). Patients undergoing hip and knee surgery receive information about their surgery, post-operative exercises and wound dressings.
- Trust data demonstrated that less than 1% of patients were seen on outpatients without full set of medical records. However, clinic letters were available electronically, so that the doctor knew why the patient was attending. This system also enabled the viewing of over 10 years of pathology and radiology results, within the outpatient consulting room. The system also provided endoscopy and theatre reports, cancer information, cardiac investigations/reports and a diagnostic request system
- Patients we spoke with told us they felt well informed. The patient survey we saw confirmed these findings.
- Waiting time for individual clinics was also written on boards in outpatients and phlebotomy.
- There was no health promotion information within outpatients.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence that staff had undertaken training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff demonstrated knowledge and understanding of obtaining consent, MCA and DoLS. One member of staff was able to describe a recent incident in the department.
- Staff told us that doctors discussed treatment options during the consultation. Where written consent was required, this would often be obtained in the outpatient clinic.
- We saw examples of completed consent forms in some of the records we looked at.
- Staff were aware of Fraser Guidelines with regards to gaining consent from children and young people.

# Outpatients and diagnostic imaging

- The clinical directors told us that they held outpatient clinics in conjunction with referring physicians or surgeons, when an invasive procedure was required. Consent was obtained in advance of the procedure to ensure the patient was fully informed of the risks and benefits of the procedure. This meant that surgeons and radiologists were working together to ensure the patient had the best and least invasive treatment for their condition.
- In endoscopy, consent was obtained prior to the procedure during the patient's admission. This was often done by the nursing staff who had received specific training in consenting patients.
- Staff had received training to provide information to patients to ensure they were informed of waiting times and the reasons for any delays. We observed this happened in all areas of outpatients during our inspection.
- In the fracture clinic, the consulting areas were separated by curtains only. This meant that confidential conversations could be overheard, including the doctor walking away from the consultation area and dictating into a recording device and discussions with regards to various patients within anyone nearby in earshot. We observed there was no attempt to lower voices, or try not to be overheard as it had just become accepted as a satisfactory situation.
- In radiology, the CT/MRI bed waiting area was inadequate. There were three small bays, separated by curtains. We observed a patient being moved into the corridor on their bed, so that two areas could be made into one, to allow for another patient to be transferred from their bed onto the MRI non-ferrous trolley. The curtains were too small to surround the bed spaces completely. This meant patients were partially exposed, whilst they were being moved. Conversations whilst an unwell patient was being moved could be clearly heard throughout the department. Although a slide sheet was used to assist with the transfer, the space was too small to allow for effective moving and handling of the patient. We observed that once a bed was in the corridor, to allow for patients to be transferred, there was no space for other beds or trolleys to get past to access or leave the MRI or CT scanner rooms. A member of staff from the CT area confirmed that all patients were transferred in the bed bay as the scanner room was too small to transfer them there.
- Conversations from reception could be heard in the bed wait area as could conversations from the CT control room be heard in the ambulant waiting area.
- The waiting and changing area for ambulant patients was inadequate, a corridor shared with the staff changing area. This meant that patients were waiting opposite and very near to, staff lockers. We saw boxes and shoes on top of the lockers. Furthermore, the chairs where patients waited were immediately adjacent to the staff toilet. One member of staff told us, "My wish would be that I could go to the toilet in privacy without patients sitting outside the door. It can't be very nice for them either." The changing areas for patients, although small, were clean. Patients with a disability would have

## Are outpatient and diagnostic imaging services caring?

Requires improvement



We found there were variations in how patients were cared for throughout the outpatients and diagnostic imaging services. All the patients we spoke with in outpatients and endoscopy were complimentary about the way staff had treated them. We observed staff constantly checking on patients and updating them on waiting times. Despite the area being very large, it felt calm, and patients felt well informed about their care and treatment.

However, In radiology, staff were rushed and we observed that a calm approach was sometimes forgotten. During one observation period, we noted one patient had no pillow or blanket to cover them whilst they were on their trolley. We saw one patient denied toileting facilities until we intervened.

### Compassionate care

- Patients we spoke with in the main waiting areas in both outpatients and endoscopy praised the staff and told us they were very helpful. One told us, "They're great; they treat us like you're part of the family." Another said, "I can't fault the way I've been treated so far." Other comments from patients we spoke with included, "Staff are really lovely," and "Staff are really patient."
- Patients were asked whether they wanted their family or friends to be present during consultation and treatment.
- We saw that clerical staff in clinics assisted patients promptly and were friendly and efficient in busy clinics.

# Outpatients and diagnostic imaging

been required to use the disabled bathroom as the MRI/CT changing area was too small to accommodate a wheelchair. In the endoscopy department patients were admitted into individual rooms so that they could discuss their procedure in privacy. There were separate male and female recovery rooms. Relatives were asked to wait in the reception area to ensure the dignity and privacy of patients was maintained. All patients undergoing a lower gastro intestinal endoscopy were given disposable privacy pants. These enabled patients to remain covered during their procedure. One patient told us, "I was so frightened. The staff were wonderful. They spoke to me so kindly and made sure I was comfortable. I am so grateful."

- Over two days, we observed the radiology department was extremely busy and all staff were under very high work pressures and, at times, it seemed the department lacked effective co-ordination and oversight. There were patients arriving and leaving constantly, on foot, in wheelchairs and on beds or trolleys. Although the staff were mostly kind and considerate, it was clear they were rushed. In the bed waiting areas there was constant movement of patients being brought into the department and then leaving the department to be returned to their ward after their examination.
- We were shown a tick sheet, the healthcare assistant told us it was an audit sheet, in order that "They're comfortable." It was unclear what happened to these sheets. There was nowhere to document basic care such as toileting, pain relief, or pressure area care.
- We observed the care assistant with their back to a patient who was obviously unwell. Another had an oxygen cylinder lying on their bed, not secured in a carrier. This restricted their movement and must have been uncomfortable.
- We saw another patient on a trolley with no blanket and no pillow. They were wearing pyjamas. We checked that they were comfortable and they confirmed they were.

## Understanding and involvement of patients and those close to them

- Radiology has introduced the 'Always Event' into the department. Resulting in the staff ensuring that the patients are aware of the following 3 things
- Introduction: 'My name is...
- Explanation: Your doctor has requested for you to have....
- Waiting times: ....mins

Although we saw patients being updated on waiting times, we did not observe any 'Always Events' taking place.

- We were unable to evaluate the Friends and Family Test (FFT) for outpatients or radiology as it is not yet available for these departments via NHS England.

## Emotional support

- Ophthalmology outpatients had an Eye Care Liaison Officer (ECLO) to provide emotional support and advocacy at the point of diagnosis.
- Patients told us that staff asked whether they wanted to have relatives present for consultations. The outpatient department, although busy, appeared calm and well ordered.
- In radiology, we saw patients being treated mostly kindly, despite the pressures on the staff. We observed a receptionist explaining to a patient's relative the likely waiting time whilst their loved one had an investigation and directing them to the nearby café for a drink.

## Are outpatient and diagnostic imaging services responsive?

Requires improvement

The provider did not always plan and deliver services to ensure that people's needs were met.

Patients told us their appointments were often moved several times. We saw that when people tried to book into follow up clinics, they were often not available due to being overbooked.

Some patients arriving for their appointments waited a considerable time to be seen. Results of the trust's patient survey and regular monitoring showed waiting times were an ongoing issue. We also received many comments regarding difficulty in parking. However, the trust was taking steps to improve this.

We observed that the fracture clinic was small and each cubicle separated by curtains, so confidential discussions could easily be heard. We saw though that despite this staff in all the clinics were responsive to patients' individual needs.

# Outpatients and diagnostic imaging

In radiology, the environment was too small for the volume of patients. We saw ambulant patients standing in the waiting area as there was not enough seating. The MRI/CT bed waiting areas and the ambulant patient waiting areas were inadequate and not fit for purpose.

A backlog in computerised tomography (CT) and magnetic resonance imaging (MRI) reporting had also built up. However, the radiologists had worked hard to reduce this backlog. Data from the trust showed that this backlog was almost resolved at the time of the inspection.

The wait for examinations and investigations in the endoscopy department and radiology was better than the England average. Patients who were suspected of having cancer, once referred from their GP, were also seen, more quickly than the England average.

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

- Data supplied to us by the trust demonstrated that for July, August and September 2014, 5048 appointments were cancelled by the trust. This equated to more than 2.5% of all patient appointments for that period. Patients reported to us that clinic times were often changed or cancelled. We were told this happened to ensure that patients who had been waiting longer for appointments, did not miss the government 18 week wait target. Breaching this target for individual patients meant that the trust incurred a fine.
- According to trust data, less than 1% of patients waited for longer than a few minutes for their appointment. However, the patients' perception was different. One told us, "Although they do tell me there is a delay, it seems to happen every time I come. I wonder why it can't be organised a bit better?"
- The hospital was very well signposted. We found access to relevant patient information in all areas of the outpatient services that we visited.
- The reception desks in outpatients were easy to find and very visible and the sub-wait areas were suitable to each clinic, for example, in ophthalmology signs to the department have been altered to black writing on a yellow background so that the many people who were partially sighted could use the department more easily.
- The outpatient departments were well signposted and colour coded; for example, there were clear signs to the radiology department.

- The dermatology clinic had created an additional evening clinic to meet the needs of patients accessing services outside of normal working hours
- Ophthalmology had also begun an intra-vitreous injection service at Coventry to provide services closer to home for Coventry patients. Previously these were only available by travelling to the hospital in Rugby.
- There was a desk in the main entrance of the hospital, manned by volunteers to assist patients and visitors find their destination.

## Access and flow

- In 2014 there were 496,670 outpatient appointments available.
- There were 391,681 appointments booked, of which there were 359,964 total attendances. This meant there were 31,717 patients who did not attend (DNA) for their appointment.
- The outpatients department had introduced initiatives to reduce DNA rates, such as text messaging to remind patients of their appointments and a team to call patients in the evening, to check intended attendance.
- The 'did not attend' rates were worse than the England average for the trust as a whole.
- The percentage of people waiting less than 31 days from diagnosis to first definitive treatment (all cancers) is better than the England average.
- The diagnostic waiting times were better than the England average.
- Nursing staff in outpatients were contracted for seven day working including longer working days. This was to build flexibility into the nursing service, to allow for clinics to be booked outside of traditional working hours.
- Ophthalmology had redesigned their acute pathway in order to create capacity in the outpatient department to treat patients normally seen in acute services. GPs and opticians are now able to book directly in to acute clinics rather than sending the patient to the eye emergency department. This has meant reduced waiting time for patients. Patients with non-emergency conditions are also able to book into this clinic so they do not have to wait in the eye emergency department to be seen.
- The percentage of people seen by specialists within 2 weeks, via urgent GP referral, the percentage of people waiting less than 31 days from diagnosis to first

# Outpatients and diagnostic imaging

definitive treatment and the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment were all slightly better than the England average. This was the case for all cancers

- In radiology, the number of patients waiting more than 6 weeks for their examination was nil. This is better than the England average.
- The average wait for endoscopy was around four weeks, again, better than the England average. The service did provide a direct access service for GPs who suspected that someone may have cancer. This meant the patient had their endoscopy within two weeks. However, a senior member of staff told us, this service was sometimes abused by some GPs for patients who were not suspected of having cancer. We were told that this was dealt with, by one of the service managers. One senior member of staff said, "It's a shame it's abused. I don't think GPs realise we only have a four week wait for any other patients as our admin department manages them all so well and squeezes in extra lists to minimise the wait."
- The trust monitored the demand for outpatient appointments and the utilisation of the clinics available, in order that waiting targets were not breached. However, patients reported to us that there was an ongoing issue with cancelled or altered clinics. One told us, "I was discharged as an in-patient and given an appointment for the 6th March to see the doctor, so he could see how I was getting on. I got another letter to say my appointment had 'slipped' to 20th March. Then I got another letter to say my appointment was 20th May. What a happened to April?" Another told us, "I was told I couldn't make an appointment in the orthopaedic clinic as there were no appointments available, so I would have to go on a waiting list. Then I got a letter asking me why I hadn't made an appointment. When I rang the hospital, they told me I couldn't make an appointment as the waiting list was full. Then, I got a second letter asking me why I hadn't made an appointment. In the meantime, my problem is getting worse. I have pain on both sides now."
- The clinical directors for the radiology department told us that over 90% of all in-patients visit the department. Some 460,000 examinations were carried out in 2014 and there is an overall growth of 5-6% per year. In CT and MRI growth was 10% per year. They told us that their CT scanner was the second busiest in Europe. We observed that every modality within the department

was frantic almost all the time over the two days we were present. We observed that all waiting areas for both patients arriving on beds or trolleys and those areas for ambulant patients were mostly full. We saw on several occasions in the ambulant waiting area, there was room for patients to stand only.

- An initial 5 week outpatient review 'room by room' was undertaken in 2014. This involved discussing with consultants their job planning regarding extending their working day. A repeat 5 week capacity review had been undertaken to look at environmental peaks and troughs, for example, bank holidays. Patients could either contact the Radiology Department by phone or by emailing into an inbox to cancel appointments. However, one patient told us that often no-one answered the telephone and here was no facility to leave a message. A receptionist confirmed that messages could not be left.
- Challenges include an increase in demand for imaging in CT, MRI and Ultrasound referrals. Over the years the service for MRI scans had been extended to include weekends and evenings. Inpatient access to routine ultrasound had been extended to include weekends.
- We were told that, in November 2014, there had been a backlog of 3,500 images which had been unreported for more than 28 days. We did not check this, however, the Clinical Leads told us it was because of staff vacancies, which reduced the amount of time that specialist doctors and radiographers were available to examine and report on the images. However, the Clinical Directors had ensured that this backlog was reduced to almost zero by March 2015. This had been done without any additional resources or outsourcing. This was a significant improvement with regards to safety as it meant that images were reported on in a reasonable time frame, so that any clinical problems could be identified quickly. However, one junior doctor we spoke with in the department said, "The workload is heavy and the reporting organisation could be better."

## Meeting people's individual needs

- There were signs in each sub waiting area asking patients to tell the receptionist if they had been waiting for longer than 20 minutes. However, these were not helpful for people who did not speak or read English. There were no vocal announcements informing patients of delays.



# Outpatients and diagnostic imaging

- Patients were often unable to make appointments for follow up when they left the clinic as clinics were already booked. Therefore they relied on a letter being sent giving an appointment date and time. This meant that for some, the appointment may not be convenient, and cause further delays arranging a suitable date and time for their appointment.
- Translation services were available on request and were generally planned in advance of the clinic appointment.
- We observed an interaction between an ambulance driver and a receptionist regarding a patient who required transport home after their appointment. The journey had been booked, but the ambulance driver just arrived in the department to pick the patient up, as they were in between other jobs and it was convenient for them. However, the patient had not been seen, so was not ready. The ambulance driver told the receptionist they would have to make a new booking, as they would not have time to return to the hospital. This meant that the patient's journey home, following their consultation would most likely be delayed. We checked the agreement the hospital had with the ambulance company and this breached the agreement. The receptionist told us this was a common happening and that patient often had delayed departures.
- Outpatient prescriptions were dispensed from a high street pharmacy, which had a commercial arrangement with the hospital, within the main reception. This meant that patients could collect their prescriptions from a branch of the high street pharmacy nearer their home and not have to wait at the hospital for medicines to be dispensed.
- In radiology we saw the receptionist ensure an elderly patient knew he would be collected from the waiting area for their examination. The receptionist also ensured that the patient knew where the toilet was, checked that they could walk there and find their way back to the waiting area.
- In the ultrasound waiting area, there were six bays, all full, although there was constant movement of patients in and out of them. We observed one elderly patient who had a blue pillow case that indicated they had dementia. Neither this patient, nor another in the area at the same time with a blue pillow case were accompanied. There was no member of staff visible, so one beckoned to us and asked for the toilet. The healthcare assistant told us it wasn't a good idea for the patient to go to the toilet. "If they're having bladder

scan, they need a full bladder." We ascertained the patient was not having a bladder scan, so could go to the toilet. We were concerned that if we had not been there, the patient's request would have been ignored.

- The waiting areas in MRI/CT for both ambulant and patients on trolleys were inadequate. The waiting area for ambulant patients, a small corridor, was shared with staff changing facilities and the staff toilet. There was a small bay with curtained off areas for three trolleys. If a patient needed transferring from a bed to a trolley and the bays were full, a waiting patient needed to be moved into the corridor to allow for the transfer of the patient. This meant the corridor to the scanners was blocked whilst this manoeuvre took place. We observed this happening several times whilst we were in the department. We saw one patient being moved whilst we were in the department and their distress, due to being in pain, was clear to everyone in the area.

## Learning from complaints and concerns

- The overwhelming complaint from staff and patients was about parking. Everyone we spoke with mentioned it. However, the trust were, at the time of our inspection, reconfiguring the car parking arrangements to make more space.
- In the outpatients department, most complaints related to delays in clinics. The staff said they did all they could to minimise them, but often the doctors were on the wards trying to discharge patients to make room for in patients awaiting admission. This often delayed them and meant the clinics started late.
- As a result of patient feedback the ophthalmology department had added curtains to its outpatient suites to provide privacy to patients during treatment.
- The redesign of the Plaster Room arose from learning taken from a clinical issue raised by a patient.
- In the Radiology department, complaints and incidents were discussed at the monthly clinical governance meetings. Furthermore, there was a radiology focus group to ensure that patients receive high quality care. Suggestions are followed up to continually improve the patient experience.
- In endoscopy, we saw information in the reception area regarding patient satisfaction rates, which were very high and included their plans to improve services further.



# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services well-led?

Requires improvement



Staff in outpatients and endoscopy generally felt listened to and well supported by their managers. However, in radiology some staff felt unsupported and told us their concerns were not listened to.

There was no clarity with regards to responsibility for specific decisions about the provision, safety and adequacy of care or clear oversight from senior staff with regards to risk..

In radiology, there was no oversight of basic infection control and prevention to ensure the risk to patients was minimised.

There had been a recent management reorganisation. However, the reporting structure over both outpatients and radiology appeared to be confused and unmethodical. This led to one senior manager not knowing what their title was and another telling us they reported to two people.

The staff in outpatients and radiology said they never saw senior managers, for example, the Chief Nurse. However, they did report that they had a recent visit from the Chief Executive.

### Vision and strategy for this service

- The trust was currently undertaking a programme to increase outpatient clinics in Coventry city centre to provide patients with access to services closer to where they live.
- The outpatients department was currently engaged in a project with medical staff and allied services, for example, occupational therapists to pilot a 'One Stop Hand Clinic'. This would provide comprehensive care for patients with hand injuries, who fit a strict criteria, enabling them to receive full treatment without unnecessary inpatient care. This will also improve inpatient bed availability.
- The ophthalmology department are having regular meetings with the local Clinical Commissioning Groups to discuss aspects of ophthalmology that can be

delivered in the community, including Coventry city centre. The first of these, related to those with minor eye conditions are planned to be seen by the community opticians in April 2015.

- The outpatients department was currently undergoing redesign to improve patient experience. A pre-operative assessment away day held in December resulted in a service vision drawn up by staff.
- The outpatients departmental vision was displayed within department.
- The Radiology Department has a long term strategy to provide access to patients for imaging in the city centre and further utilise the department at Hospital of St. Cross (Rugby) to improve response to the demand for imaging.

### Governance, risk management and quality measurement

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- On the trust's risk register commenced April 2014 we saw that all risks were rated according the likelihood of them happening and their risk to the patients, business continuity, or staff. There was a completion date for all risks, however, very few of them appeared to have regular updates of progress which meant the trust's board may not have had current oversight of risk or assurance the risk was being managed/minimised.
- The local risk register for radiology and outpatients, commenced April 2014 describes an infection control risk in the bed waiting area with a completion date for June 2016. Even though the risk was rated as high, the controls in place, for example daily curtain changes were not completed, there were no updates and no apparent urgency to ensure patients were protected from a hospital acquired infection.
- Patient Advice and Liaison Service (PALS) leaflets were available in waiting areas. These informed patients of the PALS service and invited patients to provide feedback and comments.
- Incidents which occur in outpatients, radiology and endoscopy are recorded on the trust's electronic incident recording system and investigated in line with the trust's investigations policies.
- Specialties have a consultant clinical lead who reports operationally to the specialty group management team and professionally to the clinical director. The groups are supported by specialist corporate functions such as finance and performance, human resources and quality.

# Outpatients and diagnostic imaging

- Performance of the specialty group is reviewed by the chief officers at quarterly face to face performance reviews, using an integrated performance report, which includes quality, safety, finance, training and staffing metrics.
- Radiology reviews their risks at their monthly multi-disciplinary risk management group and at their QIPS meetings.. However, out of 41 risks that had been identified and recorded on the departmental risk register, only 15 had updates since April 2014 when the register had been devised. Local risks that cannot be managed within the specialty groups are escalated to corporate level.

## Leadership of service

- Nursing staff told us that they felt well supported by their managers and that the managers were always available. There was particular praise for the newly appointed radiology and outpatient matron and the endoscopy matron.
- We observed that the managers were visible throughout the areas covered by their role and that staff were able to seek advice during clinics.
- There had been a recent management reorganisation. This was due to be completed, in that staff were going into their new roles at the end of March. However, the reporting structure over both outpatients and radiology appeared to be confused and unmethodical. This led to one senior manager not knowing what their title was and another telling us they reported to two people. There was matron for outpatients and radiology nurses. However, the radiology CT and MRI leads had responsibility for both the Coventry and Rugby site (St Cross Hospital). This was not the case for ultrasound or general imaging.

- The clinical directors in radiology reported that the executive team were supportive and engaged.

## Culture within the service

- Throughout the inspection, staff were welcoming and willing to speak with us. Staff described their role and most showed obvious pride in their department. They were very warm and complimentary about their peers and the hospital environment.
- The radiology staff were concerned that their department was not fit for purpose. One told us, "It just isn't big enough for the volume of work we do and no one seem to understand that."

## Public and staff engagement

- Pre-Operative staff were actively involved in the redesign of pre-operative assessment services including assessment documentation for patients undergoing both local and general anaesthetic. Staff attend monthly pre-op assessment project meetings. Regular departmental meetings and Band 6 meetings are held.
- The ophthalmology department had a patient advisor who had an open invitation to the QIPS meetings. The patient advisor also conducts department 'walk arounds' and speaks to patients about their experiences. We saw posters advising who the patient advisor is with contact details.
- Some staff felt that trust executives did not visit their specific areas of work. Most staff we spoke with in the nursing departments told us they had never seen the Chief Nurse. Others told us they had only seen the chief executive the week before because of the inspection.

# Outstanding practice and areas for improvement

## Outstanding practice

### We saw several areas of outstanding practice including:

- Outstanding practice in respect of trauma care: for example, the fracture patient pathway that encompassed effective pain management, and integrated daily and weekend physiotherapy sessions to develop improved outcomes for patients.
- The trust was working to improve the experience of older patients. Various initiatives included blue pillowcases, the screening of all patients aged 75 and over for risk of dementia, and the development of a 'care bundle'.
- The trust was adopting the 'VERA' technique as a means of communicating with a person with later-stage dementia.
- The trust was using the 'M' technique as a means of holistic communication by touching the hands and feet of older people. It included the repetition of stroking and conventional massage through slow, constant and rhythmical pressure.
- The electronic monitoring system used in the hospital for monitoring patients' vital signs enabled staff to review patient information in real time.
- The neuroendocrine tumour service was accredited as a European Centre of Excellence in March 2015 and is one of only eight centres in the United Kingdom to achieve this accreditation.
- Critical care had appropriate and innovated equipment to meet changing patient needs which was replaced and upgraded on a regular basis.
- GCCU had an excellent comprehensive multidisciplinary daily handover daily and effective multidisciplinary working which enhanced the patient care provided within critical care.
- The head of midwifery had won the Healthcare Hero and Lifetime Achievement Award 2013/14 at the Coventry Telegraph's Pride of Coventry and Warwickshire Community Awards ceremony.
- The specialist bereavement midwife had received the National Maternity Support Foundation Award for Bereavement Care at the Royal College of Midwives Annual Midwifery Awards 2015. They had provided sensitive photographs for parents who had lost their baby in late pregnancy or soon after birth.

## Areas for improvement

### Action the hospital MUST take to improve

#### Action the trust MUST take to improve

- Improve the ability of the emergency department to consistently respond safely to the demands placed on it and to respond to patient needs in a timely way once they have arrived at the hospital and in a way that promotes patients' privacy and dignity.
- Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance, including Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training.
- Ensure all staff have a clear understanding of Mental Capacity Act 2005 and deprivation of liberties as they apply in practice to the service provided.
- Review and reinforce staff knowledge of the 'Assessing mental health in ED' policy in order to better support staff to protect the rights of patients when any restraint power is used.
- Review medicines management within the medical division to ensure that controlled medicines are stored securely.
- Ensure the practice of multi-use administration of intravenous infusions is stopped until assurance can be made that it is safe and appropriate practice.
- Ensure that people who use services and others are protected against the risks associated with the unsafe management and storage of medicines. The trust should ensure that there is a system in place to prevent medicines of different patients being confused and/or ensure that patients receive or have access to all their medication when it was required.

# Outstanding practice and areas for improvement

- Implement robust processes in place to ensure that intravenous fluid expiry dates were checked to ensure that they were within date prior to be administered.
- Ensure that all patients attending for elective operations, including caesarean section, are routinely screened for MRSA before surgery.
- Ensure that its systems to review equipment and audit compliance are effective so far as they relate to checking resuscitation equipment and medical gases.
- Ensure there is a robust policy for transporting patients with an infection or who may be at risk of acquiring an infection in the hospital, so that staff are aware that special precautions need to be put in place to protect the patient and the public.
- Ensure that 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms are completed accurately.
- Ensure that planning of care reflects all the needs of the patient, including any comorbidities or pre-existing issues. This is something that is required as part of regulation 9(1)(b)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
- (ii) Planning the delivery of care and where appropriate treatment in such a way as to ensure the welfare and safety of the service user. However it was considered that it would not be proportionate for the finding to result in a judgement of a breach of the Regulation overall at the location.
- Review the admission process for the GP Assessment Unit to ensure that patients are appropriately referred to the service.
- Ensure that the access and flow of medical patients are improved, and delayed patient discharges managed appropriately.
- Ensure that CCCU contributes data to the Intensive Care National Audit & Research Centre (ICNARC), to ensure that comparisons and assurances could be made that the unit performed favourably with other critical care units.
- Improve arrangements for the handover between the critical care outreach team and the hospital at night team to ensure that deteriorating patients receive safe care.
- Increase the number of practice development nurses to reflect core standards for intensive care units.
- Medical staffing in the cardiac critical care unit should meet the requirements of the intensive care core standards.
- Ensure all outpatient staff complete their mandatory training.
- Review discharge procedures for both rapid discharge, (in particular to Warwickshire) and routine discharge procedures for palliative care patients in the last year of life.
- Consider clearly defining medical and nursing management roles in the supportive and specialist palliative care service.
- Support staff and develop their skills in promoting and creating personalised care plans for end of life care based on the individual preferences of patients and their families.
- Ensure that doctors (outside of the palliative care team) feel confident in discussing end of life care and DNA CPR decisions with patients.

## Action the hospital SHOULD take to improve

### Action the trust SHOULD take to Improve

- Manage the expectations of the ambulance services in respect of corridor nurse assessment and care while they are queuing for clinical handover with patients.
- Adopt a more effective approach to keeping patients informed while they are waiting in the emergency department.
- Make suitable arrangements to respond appropriately to any allegation of abuse in order to safeguard service users against the risk of abuse and that safeguarding concerns are reported to the local safeguarding authority in line with best practice requirements.
- Ensure consistency in the use of the World Health Organization (WHO) surgical safety checklist, including standardising practice in posting identification of patients and procedures within theatres. This is something that is required as part of regulation 9(1)(b)(ii) and (iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
- (ii) Planning the delivery of care and where appropriate treatment in such a way as to ensure the welfare and safety of the service user and (iii) to reflect published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice. However it was considered that it would not be proportionate for the finding to result in a judgement of a breach of the Regulation overall at the location.

# Outstanding practice and areas for improvement

- Consider how the waiting areas, particularly for radiology 'bed' areas could be used more appropriately.
- Consider the need for a more suitable waiting area for ambulatory patients whilst awaiting a CT/MRI.
- Plan caesarean section lists before the day of operation whenever possible.
- Ensure that staff carry out and document assessments of patients' needs so that the planning and delivery of care meet those needs..
- Ensure that there is handover of 'bed' patients to staff when they arrive from the ward into the radiology department.
- Ensure that there is a process in place so that vulnerable patients waiting for imaging are cared for as their needs dictate and this is recorded.
- Ensure that the nurses in imaging receive adequate scrub training from someone qualified to do so and that it is maintained.
- Ensure all staff complete their mandatory training, particularly child safeguarding training, level 3 in the ED.
- Ensure that community midwives receive regular and formal safeguarding supervision.
- Ensure that fluid scores are completed and recorded appropriately so that patients who are at risk of dehydration are correctly escalated.
- Provide information leaflets and signs in other languages and easy-read formats.
- Develop robust processes to meet the estimated discharge dates.
- Ensure they have robust arrangements in place to meet referral-to-treatment times.
- Ensure that learning from incidents is shared across all staff groups.

## Compliance actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision</p> <p>[Now Regulation 17 including Regulation 17(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]</p> <p>The provider did not operate effective systems to identify, assess or monitor risks relating to the health, safety and welfare of people who use services and staff. This included incident-reporting systems within the trust where we found actions plans, open, overdue and uncompleted; and risk management processes for the maintenance of equipment in surgery.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control</p> <p>[Now Regulation 12 including Regulation 12(2)(b)(g)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]</p> <p>The provider did not operate effective systems designed to prevent, detect and control the spread of infection and did not maintain appropriate standards of cleanliness and hygiene in relation to equipment. Staff did not always follow infection prevention and control guidance in medicine or outpatients.</p>



## Compliance actions

There was no robust process for identifying inpatients, with an infection, which could contaminate other patients, during transfers around the hospital.

People who use services and others were not protected against the risks associated with the unsafe management and storage of medicines in the division of medicine. The trust did not have a system in place to prevent medicines of different patients being confused and or to ensure that patients received or had access to all their medication when it was required on surgical wards.

### Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

[Now Regulation 17 including Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

(1) The provider had not ensured that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of:

(a) an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.

Documentation relating to patients' 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) records across the trust were not always accurately completed. Incomplete or incorrect DNA CPR forms can lead to patients being subjected to resuscitation attempts when this is not appropriate or in line with their wishes.

This section is primarily information for the provider

## Compliance actions

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

[Now Regulation 18 including Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and other staff working services to meet the needs of service users, including Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training, across the trust particularly in the emergency and outpatients department