

# University Hospitals of Leicester NHS Trust

## Leicester Royal Infirmary

### Quality Report

Leicester Royal Infirmary  
Leicester  
LE1 5WW

Tel: 0116 258 8940

Website: [www.uhl-tr.nhs.uk](http://www.uhl-tr.nhs.uk)

Date of publication: 27/03/2014

Date of inspection visit: 13-16 and 31 January 2014

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



Accident and emergency

**Requires improvement**



Medical care

**Requires improvement**



Surgery

**Requires improvement**



Intensive/critical care

**Good**



Maternity and family planning

**Requires improvement**



Services for children & young people

**Good**



End of life care

**Good**



Outpatients

**Good**



# Summary of findings

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# Summary of findings

## Overall summary

University Hospitals of Leicester NHS Trust is a teaching trust that was formed in April 2000 through the merger of Leicester General Hospital, Glenfield Hospital and Leicester Royal Infirmary. St Mary's Birth Centre provides care for pregnant women and their families for the trust. The trust provides care to the people of Leicester, Leicestershire and Rutland as well as the surrounding counties. Some of its specialised services provide care and treatment to people from all over the UK.

Leicester Royal Infirmary, which has approximately 963 beds, provides Leicestershire's only accident and emergency service. This site also provides a Children's Hospital offering a range of conditions from surgery and cancer to emergencies and broken bones. In addition to the on-site services within the Children's Hospital, it provides a range of outreach services within Leicestershire and other counties within the Midlands area. We spoke to 135 patients and their relatives while visiting the wards and departments in the hospital. We also held a listening event on 13 January where we spoke with around 80 people who came to provide their views on this and the other hospitals managed by this trust. We undertook two unannounced visits to the Leicester Royal Infirmary on Friday 31 January 2013 where we reviewed the gynaecological wards and the discharge lounge.

Prior to and during our inspection we heard from patients, relatives, senior managers, and all staff about some key issues which impacted on the service provided at this hospital. Across the trust there were three issues that the trust's management team had alerted us to, which impacted at all locations. These included staff shortages, pressures on all areas from the A&E department and the impact of the contracted out services. These three issues are discussed in detail in the trust overview report. The issues of most concern in this location include:

### Staffing

At this location the shortages of staff impacted on the safety of patients with in the A&E department, medicine, surgery, maternity and within the Children's Hospital. This often led to delays in patients receiving the care that they required. Due to the shortages of staff there was a lack of reporting of issues in some areas.

### Pressures in the A&E department

Demand for A&E services has been one of the key challenges at Leicester Royal Infirmary for some time. New arrangements for people coming into the department and the processes in place for discharging patients within the hospital are beginning to have an impact on the A&E department. However, the challenges of working in a department that was built for 100,000 people now seeing over 140,000 are ever present. This includes where patients wait while tests are completed and beds on wards are found. However, staff within the department ensure the comfort of patients through intentional rounding and ensuring that they are kept informed of what is happening. This is reflected in that patients report that they experience good care within the department.

### Capacity

This is the main location of the trust and provides a number of services which have increased beyond the physical capacity of the building. The increasing numbers of patients attending the A&E department requiring admission to hospital and the delays in discharges put significant pressure on the whole system at this location. The bed management meetings and the buy-in to the problem from other specialities are two of the innovative ways in which the trust is beginning to tackle these issues.

Unfortunately this issue relates not only to the acute areas of the hospital but to outpatients, where the number of outpatients clinics held at this site and extensive delays in some specialities, such as ophthalmology, impact on the patient's experience. This leads to cancellation of appointments and delays with waiting times from overbooked clinics. In maternity the increased number of midwife and consultant posts that remain outstanding impact on the experiences of mothers giving birth to the extent that delivery suites are not always available for birthing. Despite these capacity issues, the staff provide a service that is caring and most of the time safe.

# Summary of findings

## The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

### Are services safe?

The Leicester Royal Infirmary provided safe care for many of the patients it treats. The hospital has had one never event (a mistake so serious that it should never happen) at this site and action has been taken to address the issues that the investigation raised. The trust acknowledges the shortages in staffing and is actively seeking to recruit to the vacancies. However, gaps in staffing did have an impact on patients, despite the immediate actions taken by the trust.

The building is old and this was seen to have an impact on the management of patients, particularly in Nightingale wards (wards where there are no subdivisions or bays). At times this was potentially unsafe due to infection control issues. However, once highlighted, the trust took immediate action to remedy this issue. A side effect of the old building is the lack of storage space and this led to inappropriate storage of equipment which could lead to trip hazards.

**Requires improvement**



### Are services effective?

The Leicester Royal Infirmary provides many specialised services and we found they were provided effectively. The hospital participates in a number of clinical audits with national bodies and we saw some positive actions taken as a result. However these were sometimes slow to materialise. Nursing metrics were available on most wards and highlighted to staff and patients where the ward was performing well.

We saw that documentation in respect of the patients care was not always documented appropriately with some risk assessments not having been undertaken. However the documentation in the children's hospital was exemplary. Mandatory training was at times difficult for staff to attend due to staffing pressures; however, staff we spoke to had received training and support to undertake their role. We saw some good practices and instances of multi-disciplinary working, which enhanced patient outcomes.

**Requires improvement**



### Are services caring?

We found that all staff were caring, despite being busy due to staff shortages. The NHS Friends and Family test shows that patients would recommend most of the wards to their family, which implies that they received caring treatment. We saw a number of staff 'going the extra mile' to ensure that patients' needs were met.

Prior to our inspection we reviewed evidence that suggested that patients were not involved in their discharge planning. However, during our inspection, we found that patients did feel involved in all aspects of their care.

**Good**



# Summary of findings

The trust has put a number of systems in place to manage the number of patient it treats in a safe manner and, while we deemed these systems to be safe, they did compromise patients' privacy and dignity in some instances.

## Are services responsive to people's needs?

The trust had a number of systems and processes in place to ensure it received feedback from patients and their families. We were told of, and saw, a number of changes to practices and care as a direct result of patients' feedback.

The trust acknowledged the challenges it had achieving the maximum four-hour target waiting time in its A&E department and had taken steps to address this and make care responsive to the needs of patients. The single point of access had reduced the number of patients attending A&E, but had yet to have a significant impact on four-hour waits in this department.

Patients also experienced delays in care in other areas, including children's services, outpatients and planned surgery. Some of these delays resulted in cancellation of surgery or appointments, sometimes at short notice. This did not enhance the patients' experience of the hospital.

**Requires improvement**



## Are services well-led?

The trust recruited to a number of senior posts during the previous year. These included a new chief executive at the beginning of 2013 and a new chief nurse in September 2013. Staff told us that they were very clear on the direction for the trust and felt that the new chief executive and chief nurse were very visible in the hospital and supportive of issues raised with them.

Staff told us that there was a new, positive culture within the trust and that they were not afraid to raise concerns at this hospital. Staff felt that local managers were supportive and we saw some excellent team working. Staff received information from senior management and had appraisals to review their performance.

**Good**



# Summary of findings

## What we found about each of the main services in the hospital

### Accident and emergency

Patients felt that they received safe care within the A&E department. Despite the need to put patients in the middle area of the department when busy, which impacted on privacy and dignity, patients rated the care as good or excellent and were likely to recommend the unit to their friends and family. Patients in the department were at risk from developing a pressure sore as risk assessment were not consistently used and beds were not always available for those at risk and waiting over four hours in the department.

Receptionists in the Urgent Care Centre (run by George Elliott Hospitals NHS Trust) were aware of triaging guidance but those in the A&E department were not. This led to inconsistencies in which areas patients were sent to.

Staffing levels fell below the expected numbers for more than 50% of the time during the four weeks prior to this inspection. However, a recruitment programme was in place and gaps in staffing were covered by bank, overtime and agency nursing staff.

The team in A&E felt that they were well-led and that senior managers appreciated the pressures they were under.

Requires improvement



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

Services for medical care were generally safe and effective because there were systems in place to identify, investigate and learn from incidents. Sometimes care was not delivered in line with the trust's policy, which placed people at risk of receiving inadequate care. For example an infectious patient nursed in the main ward area, and patients discharged late at night.

Ward staff assessed patients' risk for falls and pressure ulcers and put plans of care in place to reduce these risks. There were processes to identify if patients' conditions were deteriorating. We found that staff were busy and at times areas were short of staff and this impacted on their ability to meet people's needs.

We saw that care was planned on evidence-based guidelines, but not always delivered in line with it. We noted the good practice being delivered on the elderly care wards at Leicester Royal Infirmary, with the introduction of the meaningful activities coordinators to provide support and activities for patients with dementia.

The wards/departments were generally well-led. Staff were clear about the vision of the trust and knew its values. They felt supported by both the local and senior management. Staff were positive about the future of the trust.

Requires improvement



# Summary of findings

## Surgery

Services in the surgical department were safe for most patients. Shortages of critical care beds resulted in some patients requiring this level of care remaining in the main recovery area of the theatre department or having their surgery delayed. The amount of space around some beds hampered care and could present a safety issue.

One of the measures for identifying the trust as a high risk trust was the fact that they are outliers in respect of groin surgery. The trust are currently investigating the reasons why they are shown to be an outlier in this respect.

We saw staff who were caring and patients spoken with complimented staff on their caring approach and professionalism. The service is fast outgrowing the hospital space within which it is contained. We found that the care, welfare and dignity of patients could be improved further by an increase in bed spaces in wards and theatres and improvements to the hospital environment.

Patients' operations were cancelled or delayed due to list over-runs or bed capacity. Gaps in staffing were met using bank, overtime and agency staff but these were not always available. The trust has an active recruitment programme however this is not yet impacting on this area.

Requires improvement



## Intensive/critical care

Patients received safe, effective and responsive critical care services. There were enough specialist staff to meet people's needs and ensure that they had appropriate 24-hour support. People received care and treatment according to national guidelines and admissions were prompt and appropriate.

There was always sufficient equipment available to meet patients' needs. Patients' medications were stored securely and within their expiry date. The intensive care unit was visibly clean and well-maintained, though there was a general lack of space, particularly between patients' beds. Patients had either one-to-one nursing, or were supported by one nurse to two patients. Where possible, patients were supported to make decisions about their care, and relatives were involved in their family member's care.

Good



## Maternity and family planning

Services for women in maternity were generally safe. However, we noted that the number of hours for consultants on the delivery unit was not in line with the recommended guidance, and equipment was not always either available or tested regularly to ensure safe usage. While the number of midwives had increased the midwife to birth ratio remained above that recommended given the complexity of the births undertaken at this site.

There was an effective mechanism to capture incidents, near misses and Never Events (mistakes so serious they should never happen). Staff told us they knew how to report these incidents to their manager. We saw a robust governance framework which positively encouraged staff to report incidents

Requires improvement



# Summary of findings

and information on how to make complaints was visible to the people using the service. There was also an extensive audit programme. However, we spoke with a number of staff who told us they did not always report incidents because they were too busy.

We noted two patient incidents which involved babies. However, once alerted, the staff responded and requested appropriate medical attention or took appropriate action. The unit closed to patients at times due to the number of women being treated on site. This meant that while patients in ambulances were diverted automatically, those who brought themselves to hospital were unaware of the divert in place (unless they had telephoned the unit in advance).

The wards/departments were generally well-led. However despite a report in 2012 recommending action to be taken on the number of midwives in post and ratio of supervisors to midwives these actions were yet to be implemented. The number of midwives in post has increased by 37.84wte from July 2012 to January 2014. These numbers include senior midwives and specialist midwives. There was also concern regarding the skill mix on maternity.

## Services for children & young people

We inspected the department during the day and at night to review the care given after hours and to give night staff the opportunity to speak to us. The children's hospital is in the older part of the hospital and requires some improvements and redecoration. The best use has been made of the environment and each ward has a dedicated playroom and a play specialist who was seen working to keep the children entertained. There is also a hospital school and a rooftop garden area.

While most care is safe on the children's unit we found some issues with infection prevention procedures. Shortages of staff impacted on patient care with care being delayed as a result of the numbers of nursing staff.

Almost without exception, parents and children (where able) could not speak highly enough of the staff and the excellent care they were receiving. They reported the excellent team spirit and working relationships at all levels on the wards and spoke of the friendliness and caring nature of all staff. Parents were generally happy with the outcome of their child's treatment and almost all remarked on the fact that they were fully informed and fully involved in the decisions around their child's care.

Over the previous two months, pressures on beds and shortages of staff had impacted on the numbers of elective procedures undertaken. In the previous two months, 150 procedures had to be cancelled. The use of the moon base as a waiting room for children and their families was not safe nor was it responsive to the needs of patients as waiting times could be excessive.

Good





# Summary of findings

## End of life care

Patients received safe end of life care. Patients who were nearing end of life were identified early so that they could be supported to make decisions about their care. Staff were knowledgeable and experienced in providing care that met patients' needs.

The hospital had actively listened to feedback from patients and relatives about end of life care and had made changes in response. The chaplaincy reflected the cultural diversity of the patients and responded to their individual needs.

There was board-level support for the role of the palliative care team and end of life care within the hospital.

Good



## Outpatients

Some of the clinics did not have equipment in place to allow all people to use the facilities safely. Staff were well trained and some had taken on extra responsibilities to develop their practice and offer flexibility in the services provided.

The hospital did not meet its targets for the 18 weeks referral-to-treatment time and some patients had clinics cancelled at short notice or had to wait some time for a follow-up appointment. People we spoke to at the listening event confirmed that this was a frustration.

We saw staff caring for people in a compassionate way and maintaining their dignity and privacy. The service was well-led by senior clinical staff who had a clear vision for their department and supported their staff.

Good



# Summary of findings

## What people who use the hospital say

The NHS Friends and Family Tests have been introduced to give patients the opportunity to give feedback on the quality of care they receive. The trust can be seen to be under the England average for the inpatient average component of the test, while the A&E score is significantly higher than the national average. This is positive as more

people than average would recommend the department to their friends and families. At the Leicester Royal Infirmary site three wards were described by the public as the least likely to be recommended to their friends and family – Wards 24, 8 and 36.

## Areas for improvement

### Action the hospital **MUST** take to improve

- All staff must adhere to Infection prevention and control practices.
- Patients must receive appropriate care delivered in a timely way that meets their needs.

### Action the hospital **SHOULD** take to improve

- Ensure that action is taken to minimise the impact on patient care from nursing vacancies.
- Patients in the theatre recovery room have access to toilet facilities overnight.
- Intentional rounding is documented in patients care records.
- Patients cared for in the middle area of A&E have their privacy and dignity respected as far as practicable.
- All receptionists are aware of the guidelines regarding triage of patients.
- Cancellations of elective surgery are reviewed appropriately and where possible not cancelled on the day of surgery.
- Ensure that the learning from incidents and feedback is given to staff.
- Confidential records are kept securely.

- Improve facilities for teenagers within the hospital.
- The trust should review the requirements for beds in the children's hospital and ensure that action taken does not impact on elective care.
- Take action to ensure that the recommendations from reports are put into practice in an appropriate time frame e.g. recommendations from the NMC supervisors report.
- All staff should report incidents.
- Translation services are appropriate to the needs of patients.
- Equipment is regularly checked and available.
- Staff adhere to the trusts own protocols especially in relation to discharge.
- Doctors are aware of patients on other wards and that they attend to their needs.
- Review the policy on the use of security guards for confused patients.
- Improve the Datix patient safety software system so that it captures variances in order that staff are able to report appropriately.
- Ensure that all staff report delays in the A&E department.

## Good practice

Our inspection team highlighted the following areas of good practice:

- Dementia and older person's champions were designated on all wards, providing advice and support to staff.

- Pictures of falling leaves were used to denote patients who were at risk of falling. These patients were grouped, ensuring that all staff were aware that there was a greater need for observing these patients.
- Meaningful activities coordinators were available for those patients with dementia, providing support and organising a variety of activities for patients in order to orientate them and make their day more meaningful.

**Requires improvement**

# Leicester Royal Infirmary

## Detailed findings

Services we looked at: Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; End of life care; Outpatients

## Our inspection team

### Our inspection team was led by:

Chair: Mike Anderson, Medical Director, Chelsea and Westminster Hospital NHS Foundation Trust

Team Leader: Fiona Allinson, Head of Hospital Inspection, Care Quality Commission

The team of 37 included CQC inspectors and analysts, doctors, nurses, patients and public representatives, Experts by Experience and senior NHS managers. We also had observers from the Dr Foster Intelligence healthcare information programme.

## Background to Leicester Royal Infirmary

University Hospitals of Leicester NHS Trust is a teaching trust that was formed in April 2000 through the merger of Leicester General Hospital, Glenfield Hospital and Leicester Royal Infirmary. The Leicester Royal Infirmary has 969 beds and provides Leicestershire's only accident and emergency (A&E) service. The hospital provides a Children's Hospital offering medical services for a range of conditions, from surgery and cancer to emergencies and broken bones. In addition to the on-site services, the Children's Hospital provides a range of outreach services within Leicestershire and other counties within the Midlands area.

The trust was chosen for inspection as they were rated as high risk in CQC's new Intelligent Monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. The issues raised as part of this risk identification model were: pressures in the A&E department, outliers in maternity, paediatric and general surgery services.

We also identified that the trust was consistently above the national average for development of pressure sores grade 3 and above and in catheter and urinary tract infections (using Safety Thermometer methodology). We reviewed both these measures while at the trust.

Leicester Royal Infirmary has been inspected by CQC six times. The most recent inspection was in November 2012, and the location was found to be compliant with all outcomes that were inspected. Leicester Royal Infirmary has also had two CQC warning notices served in May and July 2012. These related to the nursing of patients on trolleys in the medical assessment unit and the governance structures in quality of care provided by the trust. Subsequent inspections found that the trust had taken the necessary actions to comply with these warning notices.

## Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. We chose this trust because it was considered to be a high-risk service.

# Detailed findings

## 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?





The inspection team always inspects the following core services at each inspection:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning

- Children's care
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew about the trust. We carried out an announced visit between 13 and 16 January 2014. During the visit we held focus groups with a range of staff: nurses, doctors, physiotherapists, occupational therapists, administrative and clerical staff. We talked with patients and staff from all areas of the hospitals, including the wards, theatre, outpatients departments and the A&E departments. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event on 13 January where patients and members of the public shared their views and experiences of the trust. An unannounced visit was carried out on 31 January 2014 at Leicester Royal infirmary.

# Accident and emergency

Safe	<b>Requires improvement</b> 
Effective	Not sufficient evidence to rate
Caring	<b>Good</b> 
Responsive	<b>Requires improvement</b> 
Well-led	<b>Good</b> 

## Information about the service

The emergency department last year saw 143,097 patients and nearly 15,075 patients attending the eye casualty. The emergency department (A&E) was originally built for 100,000 attendances but is currently seeing in excess of 140,000 attenders. The trust anticipates that this figure will rise by 3% per annum. The trust has introduced a single point of access reception which triages (prioritises) patients into the urgent care centre operated by a neighbouring trust, which has reduced the pressure on A&E. During our inspection, we spoke to about 50 people and reviewed information from comment cards that were completed in the waiting area.

The A&E services consisted of minor injuries, major injuries (Majors), resuscitation, an assessment area and a paediatric area. An emergency decision unit, acute frail elderly unit and medical assessment unit were also part of the emergency care directorate. An urgent care centre (UCC) which was operated by a different provider was also on site adjacent to A&E. The UCC provided a triage and urgent care service for walk in patients. The service will triage patients to determine the most appropriate service to meet the patients' needs. Patients can be referred to their own GP, treated at the UCC or sent to A&E.

## Summary of findings

Patients felt that they received safe care within the A&E department. Despite the need to put patients in the middle area of the department when busy, which impacted on privacy and dignity, patients rated the care as good or excellent and were likely to recommend the unit to their friends and family. Patients in the department were at risk from developing a pressure sore as risk assessment were not consistently used and beds were not always available for those at risk and waiting over four hours in the department.

There had been a number of improvements made within the hospital to ease the pressure on the A&E department and these were beginning to have an impact on some of the performance data and on patients' experiences. However the trust was still not consistently meeting the national four hour wait target. Receptionists in the urgent Care Centre were aware of triaging guidance but those in the A&E department were not. This led to inconsistencies in which areas patients were sent to.

Staffing levels fell below the expected numbers for more than 50% of the time during the four weeks prior to this inspection. However, a recruitment programme was in place and gaps in staffing were covered by bank (overtime) and agency nursing staff.

The team in A&E felt that they were well-led and that senior managers appreciated the pressures they were under.

# Accident and emergency

## Are accident and emergency services safe?

Requires improvement 

### Safety and performance

The A&E department reported nine serious incidents between November 2012 and September 2013. This was less than 5% of the total number of incidents reported at the trust. Most incidents reported within the A&E department were rated as 'moderate harm' and related to implementation of care and ongoing monitoring/review. The department did not have a problem with abuse on staff or from patients to patients. When the bays in Majors became full, patients were nursed on trolleys in the middle of the major injuries' area. A nurse was assigned to this area to take responsibility for these patients. We were told that a maximum of 10 patients would be accommodated in this area. Before this number was reached, the trust's escalation policy would be used.

During the previous year, November 2012 to November 2013, the percentage of people acquiring a pressure sore while in hospital was above the national average at the hospital. Pressure sores begin at the moment that patient is confined to a bed or trolley for excessive period of time. Therefore, we spoke to staff about management and prevention and looked at patients' records. We were told that the Anderson risk assessment tool was used to identify patients at risk. When risk was identified a further risk assessment known as the Waterlow risk assessment was used to calculate the level of risk. We saw some evidence of these risk assessment tools being used. However, we also saw that many patients did not have any risk assessments for pressure sores, despite having been in the department in excess of four hours. We were told that patients who were at risk and delayed in the department for more than four hours would be given a hospital bed rather than a trolley. Staff told us that sometimes there were problems accessing a hospital bed.

### Learning and improvement

We spoke with staff about incident reporting. Staff used an online reporting system to report incidents such as falls and pressure sores. We asked staff if they would use this system to report when they felt the department was

unsafe. We received a mixed response; some staff told us they were too busy to do this. Staff also told us that they did not always receive any feedback about the incidents they reported. We asked staff about how they were informed about and how they learned from incidents that occurred within the department and in the wider trust. They told us that they received information via email and during team meetings and at patient handovers. Some staff were not aware of incidents that had recently occurred within A&E. One staff member was able to describe the action that had been taken to reduce further risk following an incident.

### Systems, processes and practices

#### Equipment/environment

We saw that the necessary equipment was in place and checked by staff each day.

#### Infection control

During our visit we saw that the department was clean. In accordance with guidelines, all staff were bare below the elbow and used appropriate protective equipment designed to reduce the risk of cross-infection. There was a good supply of hand-washing materials and educational posters about good hand washing.

#### Staffing

We spoke with teams about staffing levels and looked at staff rosters. The department included medical staff, nursing staff, emergency nurse practitioners, advanced nurse practitioners, healthcare assistants and non-clinical administrative staff. We saw that staffing numbers fell below the expected numbers for more than 50% of the time during the four weeks prior to this inspection.

Some staff told us that, when the department was busy, they did not feel it was safe. They said that when this was the case, they would report to the coordinator who would take appropriate action and escalate their concern. Staff also told us that, although there were shortages of staff, both medical and nursing, this situation had improved recently. We were also told that the trust had recently recruited 18 registered nurses.

We spoke with staff about security. They told us that security staff were based on the department and responded quickly when called. Some staff had not received any training about the management of violence and aggression.

# Accident and emergency

## Monitoring safety and responding to risk

The trust introduced a single entry system in July 2013. This meant that patients who walked in to the A&E department were triaged by the staff at the UCC run by George Elliot Hospital NHS Trust. Patients who entered via this route were triaged by the receptionists into the UCC, A&E or back to their own GP. This system was designed to relieve some of the pressures on the A&E department and to provide appropriate safe treatment to patients. The prioritising of patients by receptionist staff is an acceptable practice, called streaming, and guidelines are in place for receptionists to move patients into the correct area. While the receptionists in the UCC were aware of these guidelines, staff in the A&E department were not, and we saw one patient who had been inappropriately streamed by the A&E reception team. This person was diverted to the Majors department when their condition worsened.

Patients brought in by ambulance arrived in the assessment area and were generally assessed by the A&E staff within the national guideline time of 15 minutes. We spoke with three paramedics who regularly attended the department. They told us that there were times when there were longer delays in handing over the patient. Some A&E staff told us that, when the department was busy, patients could be queuing down the corridor waiting to be admitted to the assessment area. Once admitted to the assessment area, a system called the Manchester triage system was used to manage patients in a methodical way. Patients had their physiological observations recorded within 15 minutes and were seen by a doctor within an hour. During our visit we saw that patients were seen by nurses and doctors in a timely manner in the assessment area.

The senior doctor in the children's A&E told us that there were good working relationships between medical and nursing staff and that the team worked well. He stated, however, that nursing staff were often stretched when the department was busy. While nursing staff commented on the shortages of staff in the department, their bigger concern was on skill mix. They stated that there were often a large number of less experienced A&E staff, many newly qualified, and that when the more experienced nurses were in triage for prioritising care or Majors (major injury department); junior staff were "left alone" and this

was a huge source of anxiety. Staff were aware that new nursing staff had been recruited into adult A&E, with specific paediatric training which they felt was a positive step forward.

We spoke with staff about safeguarding policies and procedures. Staff knew the correct procedures to follow in the event of suspected abuse. Staff knew about the Mental Capacity Act and associated deprivation of liberty safeguards. This meant that people who lacked capacity would only have their liberty deprived following a best interest assessment.

The staff in the children's ED were asked to describe what they would do when a child is admitted about whom there were possible child protection concerns. Staff were able to describe the process they had to follow, and showed us a clear 'traffic light' system of criteria to determine safeguarding referrals. They showed inspectors that there is clear identification of children known to be at risk, those who have a social worker and those that are looked after. Previous attendance at A&E is clearly identified on the documentation and all patients' records include the name of the person with parental responsibility.

One example was shown of a teenager presenting with an overdose (the third in eight months) who was appropriately referred to the safeguarding team and Child and Adolescent Mental Health Services (CAMHS). We reviewed this child the following day with the safeguarding team and it was clear that all relevant partner agencies had been informed of this admission and that appropriate interventions and services were in place. Three further, randomly selected cases were reviewed with the safeguarding team who were able to demonstrate that all the children had been appropriately identified and referred to them by ED staff, and that relevant agencies had been alerted.

## Anticipation and planning

The A&E department was short of space when the department was busy. The trust had plans to redevelop and increase the size of A&E by 2015.

## Are accident and emergency services effective?

(for example, treatment is effective)



# Accident and emergency

## Not sufficient evidence to rate

### Using evidence-based guidance

Audits about emergency department metrics and nursing metrics were carried out. Where these showed areas of concern action had been taken to address the deficits. We were told that a recent audit of neurological observations had highlighted shortfalls. An action plan had been developed to address this shortfall and this had been communicated to staff. The trust participated in the College of Emergency Medicine regarding paediatric fever and renal colic. Action had been taken to address issues raised with the hospital in respect of these audits.

### Performance, monitoring and improvement of outcomes

We saw that nursing assessment documents were used to assess patients' needs. A number of these assessments were only partially completed. When we looked at records in the emergency decisions unit, acute frailty unit and acute medical unit, we saw that, in the majority of cases, all nursing assessments were completed appropriately.

We observed patients being treated in the resuscitation area. There were clear lines of responsibility for each member of staff involved and staff communicated effectively with each other. In the minor and major injuries area we saw that most patients were seen and assessed in a timely manner. Staff knew which patients they were responsible for and about the patient's needs.

### Staff, equipment and facilities

We spoke with staff about the training they received. They told us that access to training was good. All mandatory training was up to date and staff were able to access further training for their professional development. Two education practice development nurses were employed in emergency care. We were told that all staff had completed mandatory A&E training. There was a known shortfall in staff receiving training about managing violence and aggression, and the trust had recently taken action to address this. A number of advanced clinical practitioners were employed to work in the department. Doctors we spoke with reported that opportunities for

training and clinical development had recently improved and there was a dedicated consultant in the department for education and training. We observed medical staff delivering 'shop floor' training to junior doctors.

## Are accident and emergency services caring?

Good 

### Compassion, dignity and empathy

In August 2013, 793 people completed the NHS Friends and Family Test. This allows patients to recommend the hospital to their family and friends. Of those asked, 94.0% of patients were either 'likely' or 'extremely likely' to recommend the trust's A&E department to friends or family. This is above the national average and is a positive measure of caring within the A&E department. We spoke with a number of patients and relatives in all the emergency care departments we visited. The majority reported that staff were caring and kind. A relative commented, "the staff are wonderful, they have saved my son's life". Staff also communicated with patients' relatives effectively and in a kind and compassionate way.

### Involvement in care and decision making

Staff carried out 'intentional rounding' (also known as comfort rounds or round-the-clock care) to ensure that patients were comfortable and safe. Staff on the acute frailty unit carried out intentional rounds every two hours on each bay. However, the care provided to each patient was not documented.

### Trust and communication

Some patients told us they were aware of the treatment plan and what was going to happen next. Other patients knew they had to wait but were not sure of what they were waiting for.

### Emotional support

Patients reported and we saw that the staff discussed patients' condition and treatment with them and ensured that they and their families were supported and knew the outcomes of the treatments and any care that was



# Accident and emergency

required on discharge. In A&E we observed that staff were supportive to a relative of a recently deceased patient. Written information about bereavement was also provided.

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

Requires improvement 

## Meeting people's needs

The hospital is failing to meet the target of 95% of patients in A&E being seen, treated and admitted or discharged within four hours. However, they perform better than average with the percentage of people waiting between four and 12 hours to be admitted.

Some patients decide to leave the A&E without being seen and, at this hospital, the rate of this is above the national average. This is possibly due to the length of time they had to wait to be seen. However the new single access through the UCC has reduced A&E attendances by 30%. It is anticipated that this may have an impact on the number of patients leaving the A&E in the future.

The trust took action to address the number of patients who had to be readmitted to the A&E and this can be seen in the significant reduction in readmissions in 2013 compared to 2012, and the trust is now outperforming the England average. However, some staff reported that they felt pressure to discharge patients from the department to prevent breaches to the four-hour rule and that this was seen as more important than the overall quality of care.

The trust had implemented a number of strategies to manage and reduce the pressure on the A&E department. There was an escalation policy which outlined reporting mechanisms to senior managers. There were three bed management meetings held each day, designed to improve the management of patient flow and identify available beds in the trust. There were also operational meetings held by senior medical staff from all specialities three times a day.

Staff in the A&E department were aware of the four-hour target and there was a display screen detailing the

number of breaches, waiting times and beds available within the emergency care directorate. A non-clinical person was employed to track patient waiting times for escalating breaches, staff shortages and for chasing up available beds within the trust. This post was covered 24 hours a day. We observed this person communicating with the A&E coordinator about potential breaches and action they were taking to avoid this.

One patient was delayed in A&E for 13 hours and, during this time staff did not effectively manage the patient's pain or distress. A hospital bed was provided after four hours. We were told that the delay was caused by speciality referral, waiting for tests and then waiting for a bed on a ward. We spoke with the site manager about a patient who had been in A&E for 13 hours. We attended a bed meeting and noted that this patient was not discussed until a CQC inspector raised this issue.

When the department was busy and patients were on trolleys in the 'middle area' this arrangement compromised their privacy and dignity. Because of limited space, patients were directly next to, and in touching distance of, other patients. One female patient who was directly opposite a male patient in a bay said, "I do feel exposed and I don't like it here". We asked staff how they managed to provide personal care to patients in this area of the department. They told us they had to take one patient out of a bay, use that area to deliver the personal care to the other patient, and then move both patients back. We saw that staff were carrying out observations and speaking to patients in the 'middle area'; this did not respect patients' confidentiality or privacy.

While in A&E, patients could be given sandwiches and drinks but there was limited access to hot meals. Staff told us that when patients were delayed for a long time, they did try to access a hot meal for them. A staff member also told us that when vulnerable patients who lived alone were discharged home, they were often supplied with sandwiches to take with them so they could have something to eat when they arrived at home. Staff in the emergency decisions unit reported that hot meals could arrive on the ward any time within a two-hour window. We observed a lunchtime meal being served on the acute frailty unit. We saw that staff assisted people with their meal when this was required. We saw that staff offered nutritional snacks and drinks to patients.

# Accident and emergency

We reviewed data spanning four weeks about the usage of the A&E and found that, as with many A&E services, the department had the most number of patients on a Monday evening. We noted that the department was quietest between midnight and 9am, steadily increasing to a fairly consistent level between 2pm and 9pm. Staffing levels reflected this pattern of activity.

## Vulnerable patients and capacity

We spoke with staff about patients with mental health needs. There was one registered mental health nurse employed in the department. Patients with mental health needs were moved to the emergency decisions unit. Once medically fit, a referral was made to the mental health crisis team. Staff reported that this process could be frustrating because the single contact telephone number often resulted in waiting on hold for lengthy periods. Once seen by the crisis team and a decision to admit to a psychiatric ward was made, there was no further input from the crisis team. This meant that patients with a mental health need could be waiting in the unit for a long time for a psychiatric bed to become available. During our visit we saw that a patient waiting for a psychiatric bed had been waiting in the seated area of the unit for longer than seven hours. Staff reported that this was a frequent occurrence. There was only one trained mental health nurse employed in the emergency department. This meant that people who may be experiencing a mental health crisis were being cared for, for long periods of time, by general nurses. This was exacerbated by ongoing staff shortages and unsuitable accommodation.

During our visit, there was no appropriate or safe accommodation for patients with mental health needs in the emergency decisions unit. The seated area was near the exit of the unit and did not conform to expected standards. The trust was in the process of building appropriate accommodation for patients with mental health needs. At the time of our visit it remained unclear as to how this would be staffed.

## Access to services

The trust provided a service to a diverse population. We saw that some signage in the waiting area was available in different languages, as were discharge information leaflets. We spoke with staff about how they communicated with people whose first language was not

English. They told us they had access to a telephone interpreter service (Language Line) and that many staff were bilingual or multilingual and could interpret for patients.

Staff had received training about caring for people with dementia. There were also a number of champions for older patients and those with dementia.

## Learning from experiences, concerns and complaints

We saw that Message to Matron boxes were situated on each of the emergency units. Patients were also asked to fill in patient experience questionnaires, and we saw information about this survey in all the emergency wards and departments. We were told that each nurse was allocated a number of patient experience surveys to complete each month. The trust employed non-clinical patient advisers. We spoke to one adviser and they explained that their role was to provide information to patients about the trust.

We spoke with staff about complaints. We were told that a higher proportion of complaints had been made by younger people. The trust had responded to this by organising a listening event for younger people aged 11 to 25.

We were told about an initiative known as Listening into Action. Staff attended meetings and were able to put forward their concerns and ideas. A staff member told us how attending the meetings had resulted in additional equipment being purchased for the emergency directorate.

## Are accident and emergency services well-led?

Good 

## Leadership and culture

We spoke with staff about leadership in the department. They told us they felt supported by their line managers. Matrons were highly visible and approachable. Staff felt that they all worked as a team and supported each other. There were opportunities to learn lessons at debriefing sessions. This would improve the service for patients. Staff also had access to a counselling service if they needed further support.








# Accident and emergency

## Patient experiences, staff involvement and engagement

Staff told us that, although they felt stressed when the department was busy, staffing levels had recently improved. They felt that the trust was aware of their concerns about staffing levels and the volume of patients

in the department. They were aware of action that had been taken to address this and about future plans for the emergency directorate. Staff were aware of audits taking place in the departments. Results of audits were fed back to staff by email and during staff meetings and departmental handovers.

# Medical care (including older people's care)

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

## Information about the service

The acute medical services at the trust are provided across three hospital sites and consist of about 19 wards/ departments at Leicester Royal Infirmary.

At Leicester Royal Infirmary, we visited:

- Wards 19, 24, 25, 29, 34, 36, 37, 40, the Fielding Johnson Ward, infectious diseases unit
- The discharge lounge.

This includes acute medical units, general medical wards and care of the elderly.

## Summary of findings

Services for medical care were generally safe and effective but some areas were understaffed and care in the discharge lounge was suboptimal. Sometimes care was not delivered in line with the trust's policy, which placed people at risk of receiving inadequate care. For example, an infectious patient nursed in the main ward area, and patients discharged late at night.

Ward staff assessed patients' risk for falls and pressure ulcers and put plans of care in place to reduce these risks. There were processes to identify if patients' conditions were deteriorating. We found that staff were busy and at times areas were short of staff and this impacted on their ability to meet people's needs.

We saw that care was planned on evidence-based guidelines, but not always delivered in line with it. We noted the good practice being delivered on the elderly care wards at Leicester Royal Infirmary, with the introduction of the meaningful activities coordinators to provide support and activities for patients with dementia.

The wards/departments were generally well-led. Staff were clear about the vision of the trust and knew its values. They felt supported by both the local and senior management. Staff were positive about the future of the trust.

# Medical care (including older people's care)

## Are medical care services safe?

Requires improvement 

### Safety and performance

It is mandatory for NHS trusts to report all patient safety incidents. An analysis of the trust's reports revealed that it was reporting patient safety incidents appropriately and in line with other trusts in England.

The hospital used the Datix patient safety software system to record incidents. Between July 2012 and June 2013, the trust reported 341 safety alerts in medical specialities which accounted for 46% of all incidents at the trust. Staff knew how to report incidents and the wards collected data on how many incidents of harm had happened on their ward.

All the wards we visited had safety information prominently displayed for patients and staff to see. The trust rate for new pressure sores was above the national average for between April and August 2013. We spoke with the tissue viability team and were assured that they had put systems in place to address this issue. The trust's performance improved between September and November 2013 and the trend was going down. Each ward we visited collected data on pressure sores and recorded how many days it had been since a patient had developed a new pressure sore. Most wards we visited also had up-to-date information on the number of falls that had happened.

### Learning and improvement

We saw evidence that incidents were reviewed and lessons learned from them. For example, on Ward 29 there had been four falls and the matron had conducted a root cause analysis to see if there were any trends. This had been fed back to staff. This is good practice. Staff we spoke with were aware of learning from incidents in their area. Information was shared with staff through emails, bulletins, and staff meetings. Staff all received emails about safety data and received bulletins from Medicines and Healthcare Products Regulatory Agency and could describe what actions they took to ensure the recommendations from the bulletins were implemented. Awareness of the Never Events (serious mistakes that should never occur) which had happened in the trust was low. Learning from incidents across the trust needs developing further, as staff could not always describe what had happened in the other trust hospitals.

### Systems, processes and practices

The trust took steps to protect patients who were vulnerable. An example of this is the network of dementia champions and older people's champions. These staff had received enhanced training for this role and were visible across the wards and represented in all staff disciplines. This helped to raise awareness of care for older people and those with dementia in all areas of the hospital. Champions we spoke with were passionate and proud about the role.

### Infection control

Infection rates for August 2012 to July 2013 were similar to other trusts for MRSA and Clostridium difficile (C. difficile). The trust had an infection prevention and control team and an infection control policy detailing the precautions needed to minimise the risk of infection. Generally these procedures were being followed. The wards we visited were clean. We saw staff washing their hands and using hand gel appropriately and wearing personal protection equipment such as aprons and gloves. Hand gel was available in all the wards we visited, except Ward 36 where there was none available at the entrance to the ward. Hand gel was available, with prominent signage to remind visitors to the ward to use it on arrival and departure. Patients who had infections were identified and usually nursed in side rooms. However, we inspected one Nightingale ward (which accommodates many patients) where a patient who had been identified as having an infection was not nursed in a side room. Failing to isolate patients appropriately put other patients at risk of infection. We raised the issue immediately with ward and senior staff. Staff took appropriate steps to address this, including moving the patient to a side room and reporting the breach of policy as an incident.

### Risk assessment

Risk assessments were generally undertaken and deterioration of a patient's condition escalated. Patients received appropriate treatment because of this. However, we found one patient who did not receive a timely blood transfusion as the doctor had not completed the appropriate documentation and nursing staff had not escalated the deterioration of the patient's condition. This was possibly due to the ward being isolated from the rest of the unit.

Staff were aware of the safeguarding policy and how to access it on the trust intranet.

# Medical care (including older people's care)

On the discharge lounge there was criteria for patients who were suitable for admission. For example, patients with pressure sores higher than grade 2 were not to be admitted. Staff working in this area had a list of questions to ask to ensure that patients were suitable to be looked after on the unit. We found a patient who had been on the unit for more than two hours who had a grade 3 pressure sore at the base of the spine. We found no completed skin care plan and no pressure-relieving cushion for the patient to sit on to prevent further damage.

National Institute for Health and Care Excellence (NICE) guidance recommends that patients like this should not be sitting for more than two hours at a time. The records showed that the patient had been sitting in various units all day. We brought this to the attention of unit staff and senior nursing staff. The following day, we saw a patient on the discharge lounge who had, according to their records, red pressure areas and needed a pressure-relieving cushion. This information had not been provided to the staff on the discharge lounge and there were no cushions available for use. The patient was on the discharge lounge for over two hours. This correlates with data we reviewed prior to our inspection reporting that the proportion of patients with new pressure ulcers on the day of survey has been above the England average for the majority of the year (November 2012 to November 2013) with the exception of January and February 2013.

The trust had a low rate of falls with harm and the number of falls with harm has been below the national average for November 2012 to November 2013. We saw that patients at risk of falling were identified and had risk assessments in place. On Ward 31, which cared for older people, people identified at high risk of falls were identified by a 'falling leaves' indicator – a picture of falling leaves above beds. There were posters describing how visitors could help to reduce falls. Patients at risk of a fall were cared for in a 'falls bay' which always had allocated staff. There were weekly staff meetings where initiatives were discussed and the ward had seen a reduction in falls from five a month to two to three a month.

## Medicines management

We found that, generally, medicines were kept securely. However, on Ward 19 we found that the intravenous fluids cupboard was not locked. Medicines fridges were locked and daily temperatures were checked and within the recommended range. Controlled drugs were stored

securely and records were completed appropriately. Generally, medicines were made available in a timely manner. There was one patient on the discharge lounge who was waiting for medicine for diabetes: staff were monitoring their blood sugar to ensure safe levels were being maintained while they waited for the medicine to arrive. Medicines reconciliation was done on the admission units before patients arrived on the wards.

## Resuscitation equipment

As part of our inspection we inspected the emergency resuscitation equipment available on the wards and units. Despite a recommendation from the resuscitation officer, there was no standardisation of trolleys and equipment available. This could lead to a delay in being able to find equipment quickly. For example, one ward had an over-full trolley, which meant it could be difficult to access equipment in an emergency. Records showed that resuscitation trolleys were checked regularly but the issues we found had not been identified.

## Treatment of patients on trolleys

Our data showed that the trust had been treating stroke patients in a timely manner, as the rate was below the national average. However, in recent months, this rate had been increasing and in November 2013 was above the national average. Before our visit we had been told that patients who had suffered a stroke were sometimes given thrombolysis treatment on trolleys as there was a shortage of beds on the ward, and it was essential that patients received this treatment within a defined time. At our inspection, staff confirmed that there had been at least five occasions when patients had been thrombolysed on trolleys. This means that patients do not have piped oxygen, suction or monitored bed space available, which had to be either borrowed from the nearest bed space or portable supplies used. There were also potential problems for maintaining a patient's dignity as curtains were not available. In June 2013 a formal contract query notice had been issued to the trust by the clinical commissioning group regarding stroke performance indicators. The trust had put a plan in place to address the concerns and the notice was now closed.

## Monitoring safety and responding to risk

### Staffing

Patients received safe care, but the staffing levels on some wards were of concern. Most of the medical wards we visited had vacancies, some as many as nine nursing and



# Medical care (including older people's care)

four healthcare assistant vacancies. The trust was actively recruiting staff, but current levels were having an impact on patient care. Staff were moved from one ward to another to cover unexpected staffing gaps, bank, overtime and agency staff were used to cover known gaps. However, staff reported that these were not always filled. The trust had an electronic reporting system which allowed staff to report whether shortages were manageable or not. This was on display in the management suite and senior staff could see where potential issues could occur. Patients reported that it sometimes took staff a long time to answer call bells, but in general their feedback was positive about the ward staff.

We met with staff from allied health professionals such as physiotherapy, occupational therapy and pharmacy staff who reported that there were also vacancies in these staff groups. They commented positively on the improved recruitment processes which resulted in faster appointments.

The CQC staff survey 2013 shows that the trust performed better than the national average in the categories staff overtime, and teams' willingness to report potentially harmful errors, near misses or incidents in the last month. This means that staff were rested and aware of their responsibilities to report incidents and errors. The trust scored worse than the national average for staff satisfaction with work and the quality of patient care they are able to deliver, the availability of hand-washing materials, and the proportion of staff who would recommend the trust as a place to work or receive treatment. This may be reflective of the shortages in nursing staff. The medical staff were more positive about working at the trust and this was reflected in the General Medical Council survey.

## Anticipation and planning

The trust had systems in place to monitor how it performed against a number of key safety performance indicators. These systems were embedded on the ward. Staff told us that any changes were communicated by email. Important messages were printed off and displayed for staff to see and shared in staff meetings and at handover.

On all wards we visited, safety metrics (information about performance against targets) were displayed to monitor the safety of care.

**Are medical care services effective?**  
(for example, treatment is effective)

Requires improvement 

## Using evidence-based guidance

### Falls audit and care

The Royal College of Physicians' National Audit of Falls and Bone Health in Older People examined the organisation and commissioning of services provided to older people for falls prevention and bone health, the clinical care delivered to people who have fallen and fractured a bone, and patients' experiences of fall services. The trust was performing within expectations for most of the areas assessed; however, four areas were tending to worse than average and these included: written documentation, patients attending an exercise programme, and the prescribing of medication for osteoporosis.

### Stroke audit and care

The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. The data for the trust showed that, between October and December 2013, 52% of patients were taken to the stroke unit within four hours of admission. The target was 90%. The data from 3 January 2013 to the date of our inspection showed that this had improved to 63%. There was a stroke escalation policy in place which described actions to take if there was shortage of beds on the stroke unit. The senior on-call manager could approve for up to two patients to be cared for on trolleys for up to four hours if there was a shortage of beds. The policy did not describe what extra nursing staff would be provided to care for the extra patients. Over the nine months prior to our inspection, there were nine incidents reported where patients had been cared for on trolleys. The most recent incident of a patient receiving thrombolysis on a trolley was in December 2013, when the record showed the patient had waited just over five hours on a trolley. On the day following this incident, records showed that the overnight bed management team had suggested that the acute stroke unit had taken extra patients on trolleys as no beds were available. Staff on the acute stroke unit had refused as they felt it was unsafe.

# Medical care (including older people's care)

## Performance, monitoring and improvement of outcomes

### Inter-hospital transfer

We inspected a number of areas where inter-hospital transfer occurred. This included areas such as the discharge lounge and the assessment units. We found that staff did not always adhere to the operational policy in place for these areas and that this impacted on the safety of these patients. For instance, there was an operational policy in place on the discharge lounge which described how the lounge would be run and what types of patients it would accept. The policy was due for review on September 2013. Parts of the document had been highlighted as needing to change. The policy detailed how to escalate issues when patients had to wait a long time and when incidents were to be reported via the Datix patient safety software system. There were several omissions in the operational policy: it did not explain what staff should do if patients were:

- Admitted who should have been excluded according to the criteria
- Discharged after the unit's closing time
- Discharged in breach of the trust's guidelines for discharging to care homes.

The operational policy stated that one of the ways it would measure effectiveness would be by number of Datix incidents reported. There was a danger that incidents may not be recognised or reported as they had been omitted from the policy. We saw records that showed the unit had discharged a patient after the agreed time to a care home. The patient had been discharged from the hospital at 8.20pm (the latest time for discharge to a care home was 7pm). This had not been identified and reported as an incident. The policy did not describe how risks to patients would be identified.

### Staff, equipment and facilities

#### Clinical audit programmes

Ward metrics were available on all the wards we visited. These were used to improve performance. For example, on Ward 29, the matron explained what actions she had taken to improve hand hygiene following an audit where the result was 75% compliance. There had been extra training

for staff, infection control link nurses and spot checks which had improved compliance. This was good practice, especially with the high number of staff vacancies in the service.

An audit of resuscitation trolleys had been carried out in December 2013. The results were not available at the time of the inspection but we found concerns with trolleys being overfull, and some having equipment missing, during our visit. Every cardiac arrest call in the trust had to be reported via the Datix patient safety software. The resuscitation officer correlated the Datix reports with the switchboard's records of emergency calls. If an incident report had not been completed at the time of the emergency, a report for 'failure to complete' was done. The resuscitation officer reviewed the incident records weekly and raised any areas of concern with the patient safety team and the matron for the area to cascade to ward teams. Rates for life support training were low and between June and December 2013, 700 spaces were made available in the evening, as staff said it was difficult to be released from the ward during the day. Only 50 spaces had been taken up.

### Multidisciplinary working and support

We saw evidence that multidisciplinary teams worked effectively together to provide care for patients.

## Are medical care services caring?

Good 

### Compassion, dignity and empathy

The trust has consistently scored below the England average for the Inpatient NHS Friends and Family test from July 2013 onwards. When we spoke with patients and family on our inspection they were all very positive about their stay in the hospital and the care they had received. They told us they felt involved and that doctors had explained to them about their care and treatment.

We observed the care being provided on the wards we visited. We saw that staff introduced themselves and were kind and caring when looking after patients. Although staff were very busy, they did not rush patients and people looked very well cared for. Patients told us that they sometimes they had to wait for a nurse to respond to a call when there were staff shortages but felt that "staff went the extra mile" to care for them.



# Medical care (including older people's care)

Patients were treated with respect and notes were respectfully written. Patients care plans were up to date and risk assessments were updated and reflected current need. Care was being delivered which met the identified needs. Curtain clips were used throughout the wards to ensure that patients' dignity was maintained and we saw that staff always checked before entering.

## Involvement in care and decision making

Analysis of data from the CQC's Adult Inpatient Survey 2012 shows the trust performed about the same as other trusts in all 10 areas of questioning. The trust performed worse than other trust's on two questions; these included noise at night and being involved in their discharge from hospital. However, we found that patients and relatives we spoke with told us that they felt involved in discussions about their care.

Where patients lacked capacity to make decisions, the appropriate assessments had been made. On the wards we visited we saw that risk assessments were generally well completed and updated and care was delivered in line with the assessments. Where pressure-relieving aids and turning of patients in bed were required, these were in place and being recorded. Where a patient was at risk of falls, they had the bell to call the nurse and were nursed closed to the nurses' station. There was a system for identifying patients who required support with meals. Intentional rounding (comfort rounds) took place on the wards every hour, which means that staff checked patients every hour to see that their needs were being met.

Staff we spoke with had a good awareness of capacity assessments under the Mental Capacity Act 2005, and an understanding of when deprivation of liberty safeguards were required. On the stroke unit, there were information leaflets for patients discussing decisions to not resuscitate, which is good practice. There was also an innovative and effective proforma for patient notes and treatment history which was well completed.

Patients knew which team members were looking after them for the day. At our listening event, people had raised concerns that communication with doctors and nurses was poor. When we visited the hospital, patients told us that staff talked to them about their care. Patients were able to tell us what was happening with their treatment and when they were likely to be going home. Staff they were able to

tell us about patients' needs and how they were being cared for. Risk assessments for patients were generally well completed. The standard of medical clerking – keeping accurate patient notes and treatment history – was good.

## Trust and communication

We saw examples where patients' and families' wishes had been respected, for example, when a relative requested that the patient be kept on the ward rather than wait in the discharge lounge, this had been arranged. Patients were generally looked after on the appropriate ward for their needs.

Before and during the inspection, we received reports from patients about the lack of pain control. While we were in the hospital, however, patients told us that their pain was well controlled and they felt they could say if they were in pain and action would be taken. Patients said they were kept informed about any new medicines prescribed or any changes to their treatment.

## Emotional support

Where there were not enough nurses to provide care for patients who needed one-to-one care because they were confused, the trust employed security guards to sit with patients. We spoke to a security guard on one ward who was looking after a patient and he had a good understanding of the patient's rights and described distraction techniques he used when looking after the patient. The guard knew the limits of what he was allowed to do and said he would escalate the situation to the nurse in charge if restraint was required. Trust staff told us that they were hoping to reduce the use of security guards in providing this care to patients.

There were policies for respecting patients' decisions about their care. Staff we spoke with knew the resuscitation status of patients. Records were generally scored securely. During the inspection we did see that records were occasionally left on the notes trolley during ward rounds.

The meaningful activities coordinators on three elderly wards worked with patients and were seen as having a very positive impact on the care of patients. They worked individually with patients during their stay. This was an example of best practice.

**Are medical care services responsive to people's needs?**

# Medical care (including older people's care)

(for example, to feedback?)

Good



## Meeting people's needs

In Leicester, 36% of the population belong to minority ethnic groups. Three main languages other than English were identified as being spoken by patients. However, there were no signs in the hospital in other languages.

The trust was planning the introduction of electronic surveys which would be available in a range of languages. There was a 24-hour translation service on all wards which staff knew how to access. Information leaflets were available on all wards. Not all wards stocked leaflets in other languages, although staff knew how to access them.

Trust staff told us that there was a low level of outliers, which is where patients are not cared for on their specialised base ward. On the day of our inspection, we were told there were 10 outliers at the hospital. Staff on the wards said that they sometimes experienced difficulties getting doctors to visit outlier patients which can lead to delays in treatment and discharge.

## Vulnerable patients and capacity

We met with trust staff to discuss how they had planned care for patients with dementia. They had met with community groups to find out their experiences and needs.

The trust had a dementia strategy in place and there was an active network of staff identified as champions for older people and those with dementia. These staff wore badges to identify them and received extra training to support patients and colleagues throughout the hospital. Champions were from all staff groups: administration, nurses, doctors, porters and allied health professionals, and those we spoke with were very passionate about their role and helped improve care for these patient groups throughout the hospital.

## Leaving hospital

To improve patient flow through the hospital and reduce waiting lists in A&E, the trust had reviewed the way they managed bed occupancy, and during the week of our visit, a new meeting commenced for staff including clinicians. There were a range of meetings throughout the day which monitored the bed availability and identified any problems

which might affect discharge, such as a delay in obtaining take-home medicines. In the discharge lounge, there was a dedicated pharmacist, which was reducing delays in patients getting their medicines.

In addition, the trust had set up a number of initiatives, including a discharge lounge, an elderly frail unit and a short stay older person's ward. The patients and families we spoke with were informed and included in their discharge. There were policies in place for the safe discharge of patients, which detailed times after which patients would not be discharged to care homes and community hospitals. Trust staff told us that patients would not be discharged to care homes after 7pm.

## From experiences, concerns and complaints

The trust had effective systems in place to gather information from service users, and had records about people's experience from more than 4,000 patient surveys. This was being used to improve care, for example, addressing delays in answering call bells.

There were Message to Matron postcards on all the wards we visited for patients to give feedback on areas for praise and concern. These were monitored by the matrons and fed back to ward staff to drive improvement.

Patients' complaints were monitored as part of the ward metrics and staff were aware of them and actions taken to address them. Patients knew how to raise concerns and complaints with staff and were confident that they would be dealt with.

Two years earlier, the trust had been told that patients from non-English speaking communities were not filling out surveys as they felt no action would be taken. Trust staff had gone out in to the community to meet with patient groups. The most common theme was about food as the Asian community did not trust that it had been sourced or prepared appropriately. In response, the trust had outsourced common Asian dishes from a local provider from the Asian community.

The trust had held workshops in the autumn of 2013 on 'Improving Experience for Patients and Staff' and had looked at the different ways people communicate and receive information.

Are medical care services well-led?

# Medical care (including older people's care)

Good 

## Vision, strategy and risks

The trust had a published vision and most wards we visited had their own vision aligned to this. Staff we spoke with knew the trusts values and were proud to work at the trust. Staff were passionate about their work and said that they had seen improvements since the changes in executive leadership. The chief executive was very visible. Staff said he sent regular emails and held Breakfast with the Boss which staff of all levels told us they had attended. Staff also spoke positively of the Listening into Action programme. Nursing staff told us that the recently appointed chief nurse was very visible and commented positively on the fact that she was often seen on the wards in uniform.






At ward level, staff told us they felt very well supported by matrons. On the day of our inspection, the matron for Ward 29 was helping cover staff shortage by working on the ward delivering care. Staff were very committed to providing good care.

## Leadership and culture

Staff told us that the culture of the trust had changed and that they now felt able to raise concerns and were more confident that they would be listened to. This corroborates what the 2012 CQC staff survey showed – that there has been significant positive improvement on the survey undertaken in 2011. Staff were aware of the risks in the department and how the trust were monitoring them and actions taken to mitigate them.

The trust performed better than expected in the General Medical Council (GMC) National Training Scheme Survey in two or more areas in palliative medicine and stroke medicine.

# Surgery

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

## Information about the service

Leicester Royal Infirmary is the largest hospital site of the trust and provides both elective and emergency surgery. Surgery admissions include trauma and orthopaedics, paediatrics and gastroenterology. The trust last year saw 22,000 inpatients and 81,000 day case patients. The trust has 10,000 whole-time-equivalent staff over three sites.

We visited six wards out of the nine wards at this hospital, the discharge lounge, main theatres, day theatre, anaesthetics and recovery areas to observe care provided both pre-operatively and post-operatively. We also held focus groups and individual discussions with junior doctors, the pain team, consultants regarding Never Events (events so serious they should never happen) and heads of services.

## Summary of findings

Services in the surgical department were safe for most patients. Shortages of critical care beds resulted in some patients requiring this level of care remaining in the main recovery area of the theatre department or having their surgery delayed. The amount of space around some beds hampered care and could present a safety issue.

One of the measures for identifying the trust as a high risk trust was the fact that they are outliers in respect of groin surgery. The trust are currently investigating the reasons why they are shown to be an outlier in this respect.

We saw staff who were caring and patients spoken with complimented staff on their caring approach and professionalism. The service is fast outgrowing the hospital space within which it is contained. We found that the care, welfare and dignity of patients could be improved further by an increase in bed spaces in wards and theatres and improvements to the hospital environment.

Patients' operations were cancelled or delayed due to list over-runs or bed capacity. Gaps in staffing were met using bank, overtime and agency staff but these were not always available. The trust has an active recruitment programme however this is not yet impacting on this area.

# Surgery

## Are surgery services safe?

Good



### Safety and performance

Surgical specialties accounted for 24% of the total incidents reported by the trust to the National Reporting and Learning Service (NRLS) between July 2012 and June 2013, with trauma and orthopaedics accounting for 60 of the 134 incidents. The majority of the remaining incidents occurred in general surgery. Half of the 40 severe incidents in the surgical speciality were subcategorised as trauma and orthopaedics. The trust reported three never events between 1 December 2012 and 31 November 2013. One never event occurred at this location this involved surgery. We discussed these events with relevant medical staff and reviewed the follow-up investigation reports and findings, action plans and lessons learned. We were informed that never events were discussed at cross-site meetings and were attended by all band 6 and 7 staff to share findings. New protocols and procedures were put in place to minimise risks as part of lessons learned from the events.

We were also informed that incident reporting was promoted within wards and theatres however; one person told us that no feedback was given to the reporter. The data we received prior to our inspection suggested that there may be a lack of reporting by staff, but the staff we spoke with demonstrated that they knew what and how to report incidents. Some medical staff felt that the importance of reporting incidents could be highlighted at their induction.

### Learning and improvement

The trusts data in relation to falls shows that they are below the national average which is positive. We reviewed documentation and spoke with ward staff about management of falls. We were informed that all staff routinely assessed patients pre- and post-operatively for falls risks, we saw this in the pre-op assessment document Green for Go and we were informed that a large number of falls occurred due to the patients' perception of their ability to mobilise post-operatively despite being given this information before their operation.

We reviewed patients' notes and observed practice during the visit and noted that where elective surgery was being undertaken, this included discharge planning and the plans included mobilisation from day one following

surgery. We found that all documentation included falls risk assessments. The Best Shot Nurse ward initiative included the nurse highlighted on bed noticeboards if a patient was at high risk of falls by using a falling leaf picture. We were informed that observations were recorded regularly to reduce risks. The observation boards seen were mostly up to date. We noted on an orthopaedic ward that they were undertaking the Royal College of Psychiatrists 'Quality Mark for Elder-Friendly Hospital Wards' initiative, which included buying appropriate equipment such as adjustable beds, increasing staffing levels and employment of an activities coordinator to assist confused, older patients and those with dementia. Additionally the unit has been maintained as a 24-bed unit to ensure the patients who have higher dependency needs are appropriately managed and to reduce risks, including falls. We saw the international nurses' induction programme which included a training session on management of falls in week four of the programme.

Six reportable incidents were recorded in the operating theatre and 166 in ward areas. Ward areas account for 82% of incidents. These include pressure ulcers, slips, trips and falls and surgical errors. Grade 3 pressure ulcers accounted for the majority of the incidents in the 12-month period from 1 December to 31 November 2013 (59%). We reviewed documentation pre- and post-operative assessments and noted that all relevant measures were being taken to alleviate this. We reviewed the trust's pressure ulcers policy and most recent audit (April–December 2013) which indicates a downward trajectory for both grade 2 and grade 3 avoidable pressure ulcers. We noted that the chief nurse oversees a monthly remedial action plan for the reduction in avoidable pressure ulcers and we saw the action plan which is due for review in January 2014. We noted on wards and in theatres that appropriate pressure-relieving equipment is in place. One ward we visited told us they had been free from pressure ulcers for 298 days due to the 'Best Shot' initiative, which involved the nominated person undertaking visual inspection of all pressure areas and reviewing risk assessments at least twice daily. This is a ward-based initiative and staff said they felt this was the reason for a reduction in the number of pressure sores.

Since November 2013 the Venous thromboembolism (VTE or blood clot) rates have increased to above the England average rate. To ensure patient safety, the department introduced a VTE care pathway which meant that all patients were assessed for their risk of VTE at the



# Surgery

pre-admission clinic and again immediately after surgery. We noted that the World Health Organization (WHO) surgical safety checklists were completed as per clinical guidelines in all records we looked at.

## Systems, processes and practices

### Infection control

Our data told us that the trust's infection rates for *Clostridium difficile* (C. difficile) and MRSA lie within a statistically acceptable range. We saw evidence in patients' pre- and post-operative records of relevant blood testing and infection screening taking place. We observed hand hygiene procedures in ward and theatres areas and noted that, although appropriate equipment, including hand-washing material and anti-bacterial gels were provided, some staff did not wash their hands thoroughly. We noted that a storage area in theatres contained a large amount of dust.

### Environment

We found that, overall, ward areas were, safe clean and well maintained. We found on a particular ward attention had been given to the safety and security of children by providing a children's-only toilet and a nappy-changing facility. There were 17 recovery bays in main theatres, including four paediatric bays. We found that two recovery bays in main theatres were unusable due to faulty monitoring equipment. The issue has been escalated to senior managers and staff had been informed that it could be up to two years before new monitors were available and before these bays would be fully functional again. We were informed this has resulted in delays or cancellations in patients' surgery.

We noted on wards and in theatre areas that there was insufficient storage for equipment and supplies. The large amount of equipment stored in inappropriate areas presented an increased risk to patients and visitors, particularly those with limited mobility. We saw a range of chairs, hoists, emergency trolleys and equipment, medicines trolley immediately outside the patient bays, equipment being stored in many corridors, large amounts of lounge chairs at the side of patients' beds. We were informed of an injury sustained by one member of staff as a direct result of the storage of equipment in inappropriate spaces.

### Medication

Our pharmacist found that fridges were locked and daily temperature recordings were within the normal range. Controlled drugs were locked away appropriately, registers had required entries and staff checked stock balances at least daily. Medicines were available to meet the needs of patients and this was corroborated through staff comments and evidenced from charts. Staff said that they knew how to report errors and incidents and they received feedback from incidents in their own directorate but not trust-wide. Medicines reconciliation, to check what is supposed to be there and what is actually present is done by the pharmacist. Staff said that access to take-home medicines could be an issue in delaying discharge, but they were not sure if this was a prescribing or dispensing issue. Patients were told how to take their medicines at home before they leave hospital by nurses and or pharmacist. Our CQC pharmacist noted one unlocked intravenous fluids storage area on ward 17 which could be a safety issue.

### Monitoring safety and responding to risk

We reviewed the case notes of a large number of patients and found that, in general, these reflected the needs of patients. They had appropriate risk assessments and consent had been taken for the proposed surgery. We discussed with staff a recent incident involving pain relief and noted the actions taken to reduce the risk of this happening again.

The trust scored worse than the national average for staff satisfaction with the work and patient care they are able to deliver. We spoke to staff who told us that the shortages of staff meant that they could not give the care they wanted to. We saw evidence of good practice in staffing on a number of wards. For example, on the day case ward where children are admitted, the rotas showed evidence of paediatric nurses on duty each day throughout the day. In day case recovery, we were informed by a senior member of staff that all paediatric patients are helped in recovery only by specialist paediatric nurses where practicable. The trust had implemented a new electronic rostering system which is designed to ensure full coverage on shifts. However, this system had caused some problems with staff being rostered to work five straight 12-hour shifts. Staff were very flexible and showed goodwill when filling additional shifts. Staff were moved from ward to ward where the need arises. One ward said they were proud of the staff retention another told us they had a good established team.

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We found that, on wards accommodating older people who showed difficult behaviour or confusion, staff were assisted to manage this by using the Nursing in Secure Environments (NISE) system. They also used agency nurses, learning disability nurses and, on occasions, security staff were used to prevent escalation and to reduce risks to all patients. Some staff told us that this was very helpful as specialist nurses were trained to manage behaviours and they could nurse patients on a one-to-one basis, but this had caused difficulties on occasions when nurses had not turned up for shifts.

A theatre coordinator was responsible for the daily management of all theatres. We found that staffing levels were undetermined in recovery areas and that, on occasion, only one recovery nurse was looking after three to four patients simultaneously; some medication errors had occurred as a result of this. The trust uses the Association of PeriOperative Practitioners guidance regarding staffing levels and flexes these to meet the needs within theatres. However, theatre staff had concerns that this was insufficient.

## Anticipation and planning

An overseas recruitment programme has commenced and a number of qualified nurses have been employed by the trust to increase staffing numbers. Some wards we inspected were aware of this and staff in wards and theatres talked about the difference this would make, as currently many shifts are covered by bank (overtime) or agency staff. Staff spoke to us about the international nurses' induction programme which is to be implemented.

### Are surgery services effective?

(for example, treatment is effective)

Requires improvement 

## Using evidence-based guidance

Staff on wards and in theatres told us about their experiences of training and training availability. Most clinical nursing staff told us they had time to do mandatory training and had been given an e-learning account which they could either access from home or could do at work during less busy periods. Most staff told us they had completed mandatory training. A number of staff told us they had completed safeguarding and dementia training. However, it was apparent from discussion with staff that

they were responsible for completing the training in their own time. Ward managers told us they can access the e-learning account and analyse staff training records to ensure the required training was being completed. Concerns were raised about the training that agency nurses have. However, we were informed that new induction training was to be implemented. We heard evidence from senior staff that monthly teaching for band 6 and 7 staff was being provided to improve management skills.

## Performance, monitoring and improvement of outcomes

Groin surgery was identified as a tier 1 risk on the Patient Reported Outcome Measures (PROMs) EQ-5D-5L score, also supported by the National Institute for Health and Care Excellence (NICE). The EQ-5D-5L is a simple measure which patients complete at the start and end of treatment. It comprises five dimensions of health: mobility, ability to self-care, ability to undertake usual activities, pain and discomfort, and anxiety and depression. We discussed the clinical audit with a consultant surgeon who stated that the trust was in the lowest quarter and that case note reviews were continuing with the audit lead.

## Staff, equipment and facilities

We noted that, where specialisms were required for example, children's day surgery or patients with dementia, appropriate staff were rostered, thereby increasing the level of care for these patients.

## Multidisciplinary working and support

We saw good evidence of team and multidisciplinary team working in most areas we inspected. We were informed, and saw, that daily consultant's rounds were taking place. We saw records of patients admitted for surgery which demonstrated multidisciplinary team input. We spoke with all staff about the clinical governance framework and were assured that full multidisciplinary meetings were held each daily during the week with heads of departments.

### Are surgery services caring?

Good 

## Compassion, dignity and empathy

Prior to our visit and at the listening event we held, we were informed that the experience of patients in pain was variable. Some patients reported that they were left in pain

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for extended periods of time and that their pain was not managed by the doctors at the hospital. We checked this when we inspected the hospital. Our pharmacy inspector reported that patients we spoke with all reported good pain control and felt they could say if they were in pain and action would be taken. Patients said that they were kept informed about any new medicines prescribed or any changes to their treatment.

The NHS Friends and Family Test asks patients whether they would recommend the hospital wards to their friends or family if they required similar care. Response rates for the trust were below the national average. We visited two wards identified on the survey, and a number of other wards, and found through talking to patients and relatives that they were mainly all very positive about their own experiences of being on the ward.

Patients and staff on the fractured neck of femur ward told us about the activities coordinator and described her as “very passionate” This role was funded by the Lord Mayor’s Appeal and was active on three elderly care wards. Patients involved in this initiative are identified by way of a flower in their notes. Patients receiving the input of the activities coordinator are said to have increased wellbeing. Staff told us that some patients have been able to reduce their use of anti-psychotic drugs and re-admissions have decreased.

## Involvement in care and decision making

Patients we spoke with told us they had either been introduced to their named nurse and knew who to ask for if they needed any assistance. We saw in some wards that named nurses were written on boards above patients’ beds, along with their consultant’s name. We saw evidence of patients making decisions and being consulted with during assessment of records and confirmed by way of discussions with them.

Pre-op assessments include capacity assessment and take into account patients’ and relatives’ views. Where mental capacity is a risk, pre-assessment information includes the contact details for the multidisciplinary team.

The CQC Adult Inpatient Survey 2012 showed that noise at night was worse in this trust than in others. A patient told us that, on one occasion, they had been constantly disturbed by nursing staff during the night and woken up to have paperwork completed; this showed a lack of respect for the patient’s care and welfare. Another patient told us that buzzers were constantly going off over night and

therefore they got very little sleep so were very tired most of the time. We saw that one ward had implemented a system of intentional rounding where staff make regular checks of patients, using torches at night rather than turning lights on in the patient bays. The information was transferred to staff by way of a newsletter which the ward manager produced bi-monthly.

## Trust and communication

The trust has developed a Caring at its Best strategy. We found evidence of this initiative on all wards visited and staff were fully aware of it. Staff were working hard to achieve the targets set by the trust for completion of questionnaires, and we saw evidence of an action plan for the Message to Matron postcard for gathering patients’ comments. Patients we spoke with knew how to make a complaint and had been given information in pre-admission documentation.

## Are surgery services responsive to people’s needs? (for example, to feedback?)

Requires improvement 

## Meeting people’s needs

The Department of Health monitors the number of elective surgery cancellations and this is an indication of the management, efficiency and quality of care. The trust is performing in line with the statistical average for cancelled operations. We received an analysis of operations cancelled on day of admission/surgery from the trust which indicated that 484 cancelled in the last quarter (October to December 2013). This is a slight rise from the previous quarter. The breakdown of cancelled operations indicated that reasons for cancellations included: lack of theatre time; overrun of waiting lists; lack of high dependency unit bed availability; and ward bed spaces unavailable. The highest percentage of cancellations was due to bed availability on wards and theatre overrunning was next highest.

We discussed cancellations with clinical, medical and surgical staff and were informed that elective surgery was often cancelled on the day due to pressure of beds and staffing. We were told that this is a regular occurrence and that, on occasions, whole lists are cancelled and then have



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to be rescheduled. This caused some breaches in referral to treatment guidelines. We were also informed by a number of ward and theatre staff that cancellation of elective surgery was determined by the increases in emergency surgery, and bed space availability, particularly for the intensive care unit.

Nursing staff told us that a significant lack of critical care beds (or beds available for patients with level 2 care needs) resulted in patients requiring high-level critical care recovery being kept in the recover area overnight. During the inspection we noted that one patient had been in the recovery area for 24 hours while awaiting a high dependency unit bed. Two further patients were still in recovery in the morning having had overnight surgery.

We noted that on a number of wards there were no side wards or isolation rooms. We also noted that, on the day ward, the recovery of patients undergoing dental surgery was carried out on a bay on the day ward rather than in a specific recovery area. Recovering patients were visible to others going to theatre and to other ward visitors, hence privacy and dignity was minimised.

## Access to services

We were told that, on day surgery wards, there is an ongoing issue of removal of beds from the ward to other areas of the hospital; this has resulted in delays for the Monday lists, particularly where children are having surgery and because trust policy states that children must have a bed to transfer to or /from theatres. We were informed by staff that this had been escalated to senior managers but was an ongoing issue yet to be resolved. We were informed that a paediatric nurse had resigned due to the risks associated with this matter.

We saw evidence on certain wards of interpreting services for non-English speaking patients.

## Leaving hospital

The CQC Adult Inpatient Survey 2012 showed an upward trend in delayed discharge and patients not being involved in decisions about discharge. We attended the twice-daily bed meetings which are facilitated by the senior nursing team along with the head of operations and involve a number of stakeholders. At these meetings, the ward teams highlight any patients who are medically fit for discharge and discuss any issues preventing an appropriate discharge. These issues are then resolved using the combined influence of the team attending. Some staff felt

that these meeting added pressure on the ward staff to discharge patients; however, when we attended the team they were challenging but were supportive of an appropriate discharge.

We found that discharges were delayed due to long waits with the ambulance service. We visited the discharge lounge and spoke with two staff, two patients and one relative. Staff told us that an escalation plan had been implemented to deal with the delays with ambulances transferring patients from the hospital. Ambulance personnel told us that they were concerned that they had to wait long periods of time for patients to be discharged. This was due to a number of reasons, including patients not being dressed or ready to leave because of waiting for take-home medication. A relative told us that his mother and other family members had been involved in all decision making regarding discharge. The patient said she had been involved in these discussions.

Where patients were admitted as day cases and wards closed at 7pm, we found that there were appropriate arrangements in place to move patients to alternative wards should they require an overnight stay.

## Learning from experiences, concerns and complaints

The trust also introduced the Listening into Action strategy to improve the patient experience. This was evidenced while in discussions with senior staff on wards, theatres and in focus group discussions. We found that this area had multiple information leaflets available for patients in a wide variety of languages. We also saw a folder containing key phrases and photographs for staff to use to help patients understand pre- and post-operative issues.

We were informed by staff that the theatre arrival area had been refurbished and was due to open imminently. This area was completed as a response to patient feedback about the patient journey when transferring from ward to theatres. We were told that the developments were based on good practice used in another trust.

The CQC invited patients to share their opinions of services, and 25 responses were received, all of which were negative comments about poor care, staff attitude, safety and dignity. NHS Choices had 604 reviews for Leicester Royal Infirmary, of which 62 reviews rated the hospital 5 out of 5 stars for communication, cleanliness, good pain management, well organised, good communication and 1

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star for rudeness of staff, waiting times and poor care. We received many comments from patients and relatives regarding both clinical and medical staff over the time of the inspection. Patients told us they were aware of how to make a complaint and most had received feedback. We noted that comments cards did not include a space for the person to add their contact details should they wish to discuss their concerns and receive feedback.

## Are surgery services well-led?

Good



### Vision, strategy and risks

The trust's strategic objectives (in its Caring at its Best strategy) included having a professional, passionate and valued workforce who are creative in their work. Key objectives included staff training and development, better employment, and encouraging innovation. At this location we received very positive feedback from clinical and medical staff we interviewed about the vision of the new chief executive officer and chief nurse, describing them as "inspiring." We were told that staff morale appeared to be improving since they were appointed. Clinical staff told us that they considered that information was disseminated well from the chief executive and chief nurse and was well received. We were also informed that the chief executive was very visible, making himself available for staff discussion at the Breakfast with the Boss meetings, which are held regularly. We were informed by senior staff that the re-structuring of the clinical management teams had improved the way issues were escalated and managed.

### Governance arrangements

#### Medication

The hospital has an electronic prescribing system which allowed the pharmacy department to undertake a variety of audits on the prescribing and administration of medication. Where patients are transferred from this hospital, there is a system to ensure that their medication records are printed off and sent with the patient. There is training available for medical staff. There is an accountable officer who takes responsibility for the controlled drug usage at the trust. Quarterly occurrence reports are sent to the Controlled Drug Local Intelligence Network. Surveillance data has identified an issue that resulted in one member of staff being dismissed and referred to their

professional body. Medication errors are presented at the Medicines Optimisation Committee, which includes nurses and doctors, to share learning. Pharmacy technicians work full time in the discharge lounges at Leicester Royal Infirmary and Glenfield Hospital to provide access to 'to take out' drugs and patient counselling so patients know how to take medicines when they get home. The trust has produced patient information leaflets to support patients take their medicines safely and effectively after they leave hospital. Concerns were raised in a focus group about the skill mix in pharmacy. This was discussed with the acting chief pharmacist and we were reassured that action was being taken in this respect.

### Leadership and culture

We were informed that training was perceived to be poor in theatres due to lack of staff, and that opportunities for training were reduced because staff were busy on call, resulting in teaching being cancelled and poor support for exam preparation. Some staff in theatres/recovery informed us of their concerns regarding the management culture which they described as "bullying" and the lack of opportunities to undertake training or to take time off in lieu of hours worked. However, most staff on the surgical unit did not feel this way.

We found that leadership was variable. In one ward, we spoke with a ward sister about management of staffing – we saw good interaction and leadership during her discussions with the matron regarding ensuring the most skilled and experienced staff were available to cover the shifts identified. In another ward, we found dissatisfaction with a more senior member of staff who was not actively supporting on the ward.

We saw evidence of innovation in two wards where the ward sister had developed a newsletter for staff which included messages to the team, trust updates, management of stress, training and study days, bed disinfection, emergency equipment information, pressure ulcer and falls updates. We were told that, even when a person is off sick or on maternity leave, the newsletter was sent out ensure they were kept informed. In another ward, staff told us there was no clear leadership and that student nurses occasionally were working beyond their competences; others told us that the ward sister was due to leave soon and was not being replaced.

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## Patient experiences, staff involvement and engagement






Stakeholders reported that trainees were either left alone or forced to cope with problems beyond their competence or experience on a regular basis, that handovers were not adequate and that they had concerns about the experience they were getting. We noted that in certain wards junior doctors were supervised by consultants who used ward rounds as teaching opportunities. This is recognised as good practice. Also, junior doctors were encouraged to attend training and consultants would adjust their schedules to accommodate this. We found no evidence of junior staff being left without supervision or inappropriate out-of-hours cover on wards we visited. A junior member of

medical staff informed us that, in specialised areas, they would be briefed and wholly supervised by a senior doctor while undertaking a procedure and that they received clinical education and supervision, but that documentation was not always completed to confirm this.

## Learning, improvement, innovation and sustainability

We were informed that, over the preceding two weekends, the chief executive had put in place the 'Super Weekend' initiative to provide seven-day week working. We discussed this with clinical and medical staff who told us that generally it had been a good initiative but could not comment on the outcomes or future intentions.

## Intensive/critical care

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

### Information about the service

The critical care service at Leicester Royal Infirmary has 19 beds in the intensive care unit (ICU), delivering care to adult patients with life-threatening illness. In addition to this, there are four high dependency unit (HDU) beds, located on another ward within the hospital, for patients who are too ill to be cared for on a general ward. A critical care outreach team assists in the management of critically ill patients on wards across the hospital and is available 24 hours a day, seven days a week.

We talked to two patients, one relative and 20 staff, including nurses, doctors, consultants and senior managers. We observed care and treatment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

### Summary of findings

Patients received safe, effective and responsive critical care services. There were enough specialist staff to meet people's needs and ensure that they had appropriate 24-hour support. People received care and treatment according to national guidelines and admissions were prompt and appropriate.

There was always sufficient equipment available to meet to the needs of the patients. Patients' medications were stored securely and within their expiry dates. The ICU was visibly clean and well-maintained, though there was a general lack of space, particularly between each patient's bed. Patients had either one-to-one nursing, or were supported by one nurse to two patients. Patients were supported to make decisions about their care, where possible, and relatives were involved in their family member's care.

# Intensive/critical care

## Are intensive/critical services safe?

Good 

### Safety and performance

The service was focused on safety. Each member of staff we spoke with confirmed they knew how to report incidents using the trust's electronic incident reporting system. The matron confirmed that incidents were analysed by senior clinical staff and appropriate specialists recommended improvements. Staff told us that they received feedback from the incidents they reported, both individually and in ward meetings.

### Systems, processes and practices

#### Equipment/environment

Staff reported, and we saw, that there was always sufficient equipment available to meet the needs of the patients. We spoke with a member of staff responsible for managing the equipment and received an explanation about the stock management system. The system included monitoring the expiry date of disposable equipment. We were told that a new electronic stock management system was being introduced within the department. We saw the equipment was serviced at regular intervals and in line with the manufacturer's instructions. The emergency resuscitation trolley contained all the equipment necessary to deal with a medical emergency. The contents of the trolley matched the contents detailed on the checklist. The emergency resuscitation equipment was checked twice a day. We saw the recording of these checks which confirmed what we had been told.

During our visit we saw that there was a general lack of space in the ICU, particularly between each patient's bed. This meant that the department was not meeting the national standards for ICUs. In addition to this, some areas appeared cluttered with equipment and there was a lack of storage facilities for equipment and supplies that were not being currently used.

#### Medicines management

When we checked the medications in the ICU, we saw patients' medications were stored securely and within their expiry dates. We saw that some medication needed to be stored in a fridge. A thermometer was kept in the fridge, and we were told the temperature of the fridge was

checked on a daily basis. However, the daily recordings of the temperature could not be located. The locked controlled drugs cupboard was inside the locked medication room. Controlled drugs are classified by law based on their benefit when used in medical treatment and their harm if misused. The nurse in charge held the key to the controlled drugs cupboard. The use of controlled drugs was clearly recorded in the controlled drugs register. When we checked the register against the stock in the controlled drugs cupboard, we found these matched.

#### Infection control

We saw that the ICU was visibly clean and well-maintained. Although we saw there were not sinks between each bed, we found that infection rates were low. Patients were cared for in a clean environment with clean equipment. Hand hygiene gel was available at the entrance and exit of the units. Staff members were observed wearing uniforms and other appropriate personal protective equipment, including gloves and aprons. We saw staff washing their hands before leaving the units and between assisting patients. Patients were protected against the risk of infection. Pedal bins and sharps bins were available for waste disposal. We saw there were processes in place for the cleaning of environment, including schedules which included the frequency and detail of the tasks performed. We reviewed the comprehensive infection prevention and control policies. We observed and spoke with staff who were able to demonstrate their awareness and knowledge of these policies, and confirmed they had training in relation to infection control and prevention.

We saw appropriate risk assessments had been completed in relation to intravenous lines and urinary catheters. The latest Intensive Care National Audit & Research Centre (ICNARC) report for 2012/13 showed that the trust was performing below the national average for rates of MRSA. This is a positive indicator of infection control practices within the unit. The patients and relative we spoke with told us that, "The ward and the hospital is clean" and they had no concerns about the cleanliness or infection control within the ICU.

#### Monitoring safety and responding to risk

There were enough appropriately trained staff to meet patients' specialist needs. We were told that a number of vacancies currently existed, though many of the vacant positions had been recruited to following an international recruitment drive. This resulted in some staff being

## Intensive/critical care

recruited with less experience and training in ICU nursing. However, we saw a comprehensive and structured eight-week induction programme for new staff joining the ICU. In addition, we were told that each new member of staff had a mentor (a more experienced nurse) to assess the individual's performance, skills and provide ongoing training and development. The matron told us that the National Competency Framework for Adult Critical Care Nurses were used within the ICU. These competencies provide a framework for staff training and development within ICU nursing. One member of staff told us: "We never stop learning, we can't afford to". The staff we spoke with confirmed they had regular one-to-one meetings with a senior member of staff, and received an annual appraisal.

Patients had either one-to-one nursing, or were supported by one nurse to two patients. If these ratios could not be maintained then the unit had a policy to bring in staff from other ICUs provided by University Hospitals of Leicester NHS Trust to ensure that emergency patients could be admitted. The unit did not admit any more patients if a safe level of nursing care could not be assured. We were told, and found, that the ICU worked towards the national standards for staffing in ICUs.

### Anticipation and planning

We saw the ICU had a comprehensive business continuity plan which gave details about how patients' care would continue to be provided in an emergency situation – for example, an electricity power-cut, or disruption to the supply of medical gases. This told us that contingency arrangements were in place.

**Are intensive/critical services effective?**  
(for example, treatment is effective)

Good 

### Using evidence-based guidance

The latest ICNARC report showed that the trust were performing within expectations and below the average (in this situation, preferable results) for: unit-acquired MRSA, out-of-hours discharges to wards, out-of-hours discharges to wards (not delayed) and unplanned readmissions within 48 hours. However, the trust was performing within expectations but above the average for: hospital mortality and delayed discharges (four-hour delay). We were able to corroborate some of this information at our inspection.

We were told how patients were supported to make decisions about their care. Due to the nature of patients' conditions in the ICU, it was explained that, if the patient was unable to provide consent, treatment would be provided in their best interests. Staff were aware of the need to comply with the Mental Capacity Act 2005 and gave an example of a recent situation where such an assessment had been used.

### Performance, monitoring and improvement of outcomes

An effective critical care service ensured prompt, appropriate admissions. Patients were admitted and received care and treatment according to national guidelines and this was monitored. The ICU had clear criteria for patient selection and senior staff said the system was effective.

### Staff, equipment and facilities

The trust's mandatory training programme included training such as safeguarding the vulnerable and infection control. In addition there was a specialist training programme for all staff working in the ICU. This included courses in respiratory and cardiovascular care. We saw from the display in a corridor, that the majority of staff had attended, or were due to attend, the training offered. Staff had appropriate training to provide effective care and confirmed that training and skills development opportunities were available.

The performance of staff was monitored through one-to-one meetings with a more senior member of staff and an annual appraisal. We were told that there are regular sessions where staff are assessed when demonstrating a particular skill. Poor performance is managed through the relevant trust policy.

### Multidisciplinary working and support

Throughout our visit, we saw good communication from the staff working in the ICU with other healthcare professionals working within the Leicester Royal Infirmary. A range of professionals were involved in the patients' care, including speech and language therapists, physiotherapists, tissue viability nurses, microbiologists, radiologists and pharmacists. We were told that there was easy access to these professionals. We saw that effective handovers occurred, when a patient is discharged from the ICU to a medical or surgical ward within the hospital. We



# Intensive/critical care

were told there was effective communication with other hospitals and the ICU was part of the East Midlands Critical Care Network where developments, results and themes were regularly discussed.

## Are intensive/critical services caring?

Good 

### Compassion, dignity and empathy

Patients told us they were treated with care, consideration and compassion. We spent some time observing the activity on the ICU during the lunchtime. We saw staff having good, appropriate interactions with patients. Such interactions were unhurried and at a pace suitable for the patient's needs. We saw staff introducing themselves to patients. We heard one member of staff providing a patient with a clear explanation about the equipment being used to meet their needs. This explanation was at a pace and in a language which could be easily understood by the patient. We observed staff treating patients in a kind, calm and respectful manner. One consultant told us that "patients are proactively involved in preparation of withdrawal of care" from the ICU.

Patients were treated with dignity and respect. We observed that staff greeted patients every time they entered a room. They engaged with patients to make sure they were comfortable. Curtains were drawn around patients to ensure they had privacy.

### Involvement in care and decision making

Nursing staff explained procedures to patients and reassured them. Staff respected people's rights to make choices about their care. Patients told us that they were kept informed about their treatment and that doctors provided them with updates during ward rounds.

Relatives were involved in patients' care. The ICU had a quiet room, sitting room and bedroom for relatives. We were told that staff could access the chaplaincy services for patients and relatives, and all denominations were available.

### Trust and communication

Throughout our visit, we observed that patients' confidentiality was maintained at all times. Discussions which occurred at the patient's bedside were discreet and could not be overheard by other people on the ward. Other

discussions were held at the nurses' station or in offices, so that they could not be overheard. This told us that staff took steps to ensure patients' confidentiality was maintained.

We reviewed patients' records and saw that the notes were written in a respectful way about the patient. The notes, including assessments and care plans, were very detailed and provided a clear picture of the care the patient required and the care the patient had received. We saw the adult ICU recording chart at the end of each patient's bed. This chart was developed by the ICU service, and contained important information about patients' physical observations and any intervention given. This chart was designed in such a way that it could be folded over to preserve patient confidentiality. The charts we reviewed were comprehensively completed and gave a clear picture of the patient's condition and the interventions that had been given.

Patients received adequate nutrition and hydration in the ICU. Records were kept of the amount of fluids patients drank to ensure that they remained hydrated. Patients told us the food was good and choice was offered.

## Are intensive/critical services responsive to people's needs? (for example, to feedback?)

Good 

### Meeting people's needs

Patients' welfare was regularly monitored to ensure that changes were responded to in a timely manner. There were sufficient senior doctors at night to ensure that patients' health did not deteriorate out of hours. A critical care outreach team provide a 24-hour, seven-day-a-week service across the ICU at the Leicester Royal Infirmary. This team assisted in the management of critically ill patients on wards across the hospital. The trust used an early warning system, which helped identify when a patient's physical health was deteriorating to ensure that appropriate action was taken.

We were informed that consultant cover for the ICU was in line with the national ICU guidance. However, there were some gaps in the junior doctor rotas and there were some

# Intensive/critical care

difficulties in recruiting to the junior doctor training rota. At times when there were shortages, consultants would “act down” to cover the shortfall. We were told that there was a business plan to increase the medical workforce in the ICU.

We saw information about the University Hospitals of Leicester NHS Trust’s Patient Information and Liaison Service (PILS) team displayed in public areas. The PILS team deal with queries, concerns, and complaints. In addition to this, we saw that an adult intensive care patient survey was available for patients and their family to complete. We saw there was also an Ask Matron system for staff to leave comments and questions for the matron. The staff we spoke with were aware of the trust’s complaints procedure.

## Vulnerable patients and capacity

Where patients could not fully understand or be involved in decisions about their care, the unit ensured that treatment decisions were made in their best interest, and their relatives and support network were involved. Staff were aware of the need to comply with the Mental Capacity Act 2005 and gave an example of a recent situation where such an assessment had been used.

Patients were given comprehensive information on how to manage their condition or respond to concerns. General information leaflets on the wards were, however, only available in English, although information in other formats or languages could be requested or downloaded from the trust’s intranet.

We were told that bereavement sessions for families whose relative had died on ITU were held twice a year. This gave families the opportunity to discuss their experience and to also ask questions. The consultants told us they see relatives, if requested, to talk about the care that was given and the reason for the death.

## Leaving hospital

The unit responded to changes required to keep people safe. The majority of discharges from the ICU were to a medical or surgical ward. We were told that occasionally a patient will be discharged directly to their home, but this only occurs on average twice a year. We were informed that the ICU does not discharge patients after 6pm, due to the risk that a rapid deterioration in the patient’s physical health may coincide with the reduced resources available out of the usual working hours. We were told and saw from data which the trust provided to us, that the issue of

delayed discharges was problematic. A delayed discharge occurs when a patient’s condition improves and they no longer require an ICU bed. At the time of our visit, we were told that a number of patients experienced a delayed discharge on the ICU due to a lack of suitable beds within the rest of the hospital. The bed management team were actively attempting to find suitable beds, although this took time.

## Are intensive/critical services well-led?

Good 

### Governance arrangements

We saw, and were told about, the communication systems within the ICU. There were handovers and ward rounds which specifically discussed patient care. At a department level, there were various information-sharing meetings, including monthly morbidity and mortality meeting, audit meetings and clinical management group meetings. This told us that there were systems in place for the regular sharing of information.

### Leadership and culture

The ICU was well-led. We saw evidence of highly visible leadership within the ICU. The nurse in charge wore a name badge which meant they were easily identifiable for patients, staff and visitors. We were told that the matron regularly visited the ward. Senior managers and clinicians had a good understanding of the performance of their department and staff were a strong and cohesive team. All staff were involved in monitoring quality of the units and there was a willingness to respond to change. Monthly meetings demonstrated that staff openly discussed concerns about the service and clinical care, and discussed how the service could improve.

### Learning, improvement, innovation and sustainability

Good practice is shared across all ICUs provided by University Hospitals of Leicester NHS Trust. We saw that up-to-date, current information, research and developments in ICU were stored on the trust’s computer system, and could be accessed by staff working within the ICU. This meant that staff had access to current information relating to the specialist care they were providing to patients.








## Intensive/critical care

We saw that the ICU had a comprehensive business continuity plan which gave details about how patients' care would continue to be provided in an emergency situation,

for example, an electricity power-cut, or disruption to the supply of medical gases. This told us that the trust had risk-assessed vital services and had put in place contingency arrangements if such services failed.

# Maternity and family planning

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

## Information about the service

The trust provides a full range of maternity services. Maternity services are provided on three sites: St Mary's Birth Centre, which has approximately 250 births per year, Leicester General Hospital, with around 4,000 births per year, and the Leicester Royal Infirmary with about 6,000 births per year. The birth rate has fallen from 10,919 in 2011 to 10,300 births recorded in 2013. The Leicester Royal Infirmary provides care and treatment for women with low- and high-risk pregnancies and provides care during their antenatal, intrapartum and postnatal period. The Leicester Royal Infirmary provides neonatal intensive care and so will look after all women including those whose babies will need intensive care or neonatal surgery.

In addition to maternity services being delivered in these three locations, there are also 10 teams of community midwives and maternity care assistants who deliver antenatal and postnatal care in women's homes, clinics and children's centres across the city and county of Leicestershire, as well as supporting women to give birth at home. Last year just less than 2% of women experienced a home birth.

Across this speciality we spoke with 84 members of staff, including doctors, midwives, nursery nurses, student midwives and maternity support workers. We also spoke with 23 women who used the service and nine partners of women.

## Summary of findings

Services for women in maternity were generally safe. However, we noted that the number of hours for consultants on the delivery unit was not in line with the recommended guidance, such as 'Safer Childbirth', and equipment was not always either available or tested regularly to ensure safe usage. While the number of midwives had increased the midwife to birth ratio remained above that recommended given the complexity of the births undertaken at this site.

There was an effective mechanism to capture incidents, near misses and Never Events (mistakes so serious they should never happen). Staff told us they knew how to report these incidents to their manager. We saw a robust governance framework which positively encouraged staff to report incidents and information on how to make complaints was visible to the people using the service. There was also an extensive audit programme. However, we spoke with a number of staff who told us they did not always report incidents because they were too busy.

We noted two patient incidents which involved babies. However, once alerted, the staff responded and requested appropriate medical attention or took appropriate action. The unit closed to patients at times due to the number of women being treated on site. This meant that while patients in ambulances were diverted automatically those who brought themselves to hospital were unaware of the divert in place (unless they had telephoned the unit in advance).

The wards/departments were generally well-led. However, despite a report in 2012 recommending action

# Maternity and family planning

to be taken on the number of midwives in post and ratio of supervisors to midwives, these actions were yet to be implemented in full. The number of midwives in post has increased by 37.84wte from July 2012 to January 2014. These numbers include senior midwives and specialist midwives. There was also concern regarding the skill mix on maternity.

## Are maternity and family planning services safe?

Requires improvement 

### Safety and performance

It is mandatory for the trust to report serious incidents. Of the incidents reported, only a very small number (less than 3%) were reported in the maternity unit. However, we saw that there was an effective mechanism to capture incidents, near misses and never events. Staff told us they knew how to report these to their manager. We saw a robust governance framework which positively encouraged staff to report incidents and information on how to make a complaint was visible to the people using the service. There was also an extensive audit programme; we saw audits had been carried out on such topics as foetal heart rate monitoring, augmentation of labour, missed appointments, antenatal screening and mental health. However, we spoke with a number of staff who told us they did not always report incidents because they were too busy.

### Learning and improvement

We reviewed three recent serious untoward incidents and saw that a root cause analysis investigation had taken place. The incidents were well investigated with clear action plans. The action plans referenced national guidance and best practice. The changes were implemented in a timely manner.

We asked staff to explain how learning from incidents and complaints was cascaded to all staff. Their response was mixed. Some staff told us they did not receive feedback unless directly involved in the incident or complaint. Others were able to explain to us what changes to practice had been implemented because of learning from incidents. During our visit we saw newsletters, emails and memos with information on incidents, complaints and recent changes to practices. A number of staff said they could not always access a computer and their emails. However, we did see that other methods of communication were used. During our visit, we saw newsletters in a variety of staff areas, which demonstrated the provider disseminated learning.

# Maternity and family planning

## Systems, processes and practices

We saw a variety of policies and guidelines for clinical care. We asked a number of staff to demonstrate how they would access policies and guidance. All the staff showed us they could access documentation when required. We randomly selected three policies and saw they were current and all had been reviewed to and updated as necessary.

## Equipment

We checked to see if equipment was regularly checked and maintained. Unfortunately we found an unsupervised drugs trolley open on one ward, several pieces of equipment (in different departments) had gaps in their checking history. We also spoke with a number of staff who told us they sometimes had difficulty locating equipment, for example large blood pressure cuffs, thermometers and foetal scalp electrodes. When questioned, staff told us they very rarely thought to report lack of equipment using the incident reporting system.

## Infection control

During our visit we observed all areas appeared clean and well maintained. The department was in the process of a £2.6 million refurbishment plan. We noted that delivery suite was in the process of the refurbishment and not all rooms were accessible due to the work. None of the staff we spoke with expressed any concern regarding this temporary disruption to the environment.

## Monitoring safety and responding to risk

The acting head of midwifery confirmed that the birth ratio was within national recommendation of one midwife to 32 women and was presently one to 31. We saw that this ratio had improved from one to 37 and a working sub-group was continuing to work towards best practice of one to 28. We also spoke with a number of women and their partners. All told us they felt safe and were happy with the service provided. One partner told us: "We felt very safe. My wife had excellent care".

There was good consultant presence between the hours of 8am and 8pm, Monday to Friday. However, we spoke with a number of staff on the delivery suite, maternity assessment unit and the wards who told us doctors were over-stretched out of hours and consultants were much less visible. We spoke with the head of service who told us there was currently 60 hours of consultant presence on delivery suite.

The Royal College of Obstetricians and Gynaecologists' safer childbirth recommendations stated that, for the number of births, the Leicester Royal Infirmary should have 168 hours of consultant presence.

We saw evidence that the provider had recognised the deficiency in consultant cover and had a robust plan in place. Two consultants had recently been appointed with two more to commence employment by April 2014. The head of service explained to us that they were also reviewing existing consultants' job roles and plan to complete the process within three months. Once the appointments and changes are implemented, the provider will reassess and consider further appointments if required. This demonstrated to us that the provider had recognised the problem, had an interim solution in place and had initiated a longer-term solution. Monitoring of action implementation was through the clinical management board.

## Anticipation and planning

A number of midwifery and medical staff expressed concerns with the number of induction of labours booked for each day. We explored this further and found no guidance on how many inductions of labour should be safely carried out each day. In practice we saw that a multidisciplinary discussion took place at 8am each morning to clinically prioritise the work for the day. We also spoke with a woman who had had their labour induced. They told us: "I was booked for an induction because I was overdue. My induction was delayed because I did not have any problems and labour ward was very busy". We saw evidence that this had been discussed at a senior level and that the induction of labour guidance had been revised.

During our visit we saw two events of concern. We spoke to a mother who explained she had alerted the staff an hour earlier that she felt her baby was not well. We observed the baby and asked the staff to respond immediately. Once alerted the staff responded and requested appropriate medical attention. The baby was immediately transferred to the neonatal unit for closer observation and monitoring. We also saw a baby left unattended in the nursery while the mother was not on the ward. We again alerted the staff who explained this was normal practice and explained mothers were aware of the risks of leaving their babies unattended.

# Maternity and family planning

## Are maternity and family planning services effective? (for example, treatment is effective)

Good



### Using evidence-based guidance

The provider was able to demonstrate to us that policies, protocols and guidance were based on nationally recognised guidelines and standards. We saw the provider had a specialist midwife with responsibility to ensure all clinical effectiveness was embedded in practice and all policy and standards were evidence and research-based. The provider had robust systems in place for the ratification of new policies and guidance.

We saw regular review and updating of policies and guidance. We spoke with staff and asked them if they were engaged in the development of policies and how new guidance was communicated to them. All the staff we spoke with told us they did not see draft reports and were not able to comment prior to the ratification of policies. However, we were able to confirm that all new and updated policies were reviewed by the maternity guidelines group. Once approved, policies were circulated to senior midwives to disseminate to all staff. New guidance and policies were also included in newsletters, emails and memos to staff.

All relevant National Institute for Health and Care Excellence (NICE) guidance was reviewed in the maternity guidelines group. The midwife for public health and quality standards explained that, when new NICE or national guidance was published, a multidisciplinary working group was set up to discuss implementation or demonstrate the rationale for why the guidance was not implemented.

### Performance, monitoring and improvement of outcomes

The trust has previously been identified as part of the maternity outlier surveillance programme for significantly high rates of puerperal sepsis. The trust's outcome for this indicator remains high but is now within expected limits. During our visit we spoke with the clinical director who was the nominated lead for the progress and implementation of actions to improve the rate of puerperal sepsis. We saw an action plan, last updated in December 2013, and noted

that eight actions had been completed and the remaining eight actions were on track to be completed by March 2014. The clinical director explained to us that 90 health records were reviewed. The main issue identified was that of incorrect coding. However, further steps have been introduced, such as the introduction of sepsis prompt questions for staff to complete prior to discharge, inclusion of sepsis on the maternity quality dashboard and the introduction of the sepsis care package.

The provider undertook a variety of daily, weekly, monthly, quarterly and annual internal and national audits. We also saw evidence of progress against national maternity indicators and directorate quality dashboard. The results of the internal audits, such as infection control, safety thermometer and patients' comments were displayed in each ward and department. Staff were able to see on monthly basis how they were performing against each audit standard. We spoke with a number of staff and the majority were able to explain how to access the results from audits and quality monitoring. We also spoke with a number of doctors in training who were involved in carrying out audits.

### Staff, equipment and facilities

Women were cared for by suitable qualified and competent staff. We saw evidence that staff were able to access a variety of mandatory training and there were opportunities for further development. This training included formal courses and emergency skill drills. We spoke with maternity support workers who explained they were very supported within their role. We reviewed the women and children's division mandatory training dashboard. We noted that there was an overall poor uptake of some training, in particular, conflict resolution and safeguarding training. This had been recognised and managers had been alerted and staff encouraged to attend the training.

## Are maternity and family planning services caring?

Good



### Compassion, dignity and empathy

All the women we spoke with told us they were happy with their care. One woman told us: "I have had lots of hospital appointments and have always been seen in a timely

# Maternity and family planning

manner. I have always felt well cared for. Treatments and processes have been well explained to me.” During our visit we also saw good staff interaction which was polite and respectful.

We saw evidence that the NHS Friends and Family Test was carried out and the results displayed in the ward areas for staff and patients to view. We saw a variety of cards for women and their families to record their comments about their experiences. We also noted that women and their families could use the meridian website. Monthly comments were displayed for staff and people to view.

Both the staff and women we spoke with assured us there was a culture of caring. However, a number of staff explained they often felt over-stretched and found it difficult to find the time they needed to give good care. A number of staff felt that more personnel were required to enable appropriate and timely care to be given.

## Involvement in care and decision making

Women we spoke to said that they were involved in their care and we saw evidence of this in their care records. Women were able to choose the type of birth that they wanted. However when units were closed or busy this was not always available. Midwives discussed this with women and agreed a birth plan with them.

## Trust and communication

Analysis of data from the CQC’s Adult Inpatient Survey 2012 showed the trust performed about the same as other trusts in all 10 areas of questioning. This was reflected in the comments we received about maternity care.

**Are maternity and family planning services responsive to people’s needs?**  
(for example, to feedback?)

Requires improvement 

## Meeting people’s needs

The staff we spoke with had a good understanding of the population who used the service and were all able to explain with confidence the requirements of the people who were inpatients. Staff had access to interpreters, a number of staff members who spoke different languages and the Language Line telephone interpreter service. When asked how useful these services were, the majority of staff

told us it was very useful. However, staff explained it was not always appropriate for women in established labour and some women were not comfortable explaining intimate symptoms with a male interpreter. We also saw a variety of communication aids in departments. However, all the signage we saw was in English.

## Vulnerable patients and capacity

The provider had an extensive team of specialist midwives, who supported midwives to care for the more vulnerable people within the community. We saw specialists for bereavement, safeguarding and female genital mutilation (female circumcision). We spoke with a couple of specialist midwives who explained how they supported staff to care for women, both in hospital and in the community. We also saw that the number of clinics had been expanded to accommodate increased demand. For example, we noted that a clinic had been developed for women with obesity. We also saw examples of multidisciplinary antenatal clinics, which included obstetricians, physicians and specialist midwives.

## Access to services

We discussed staff comments about lack of capacity to care with the delivery suite lead midwife. They explained to us that the flow of women and their babies through the department was sometimes poor. During our visit we noted that five women and their babies were still on labour ward waiting for postnatal beds. Senior management explained to us that the flow of women through the service had been identified as an issue and an action plan had been developed and monitored through the operational group and discussed with the clinical commissioning group. We also saw that there was an extensive refurbishment programme in progress. We saw that the maternity assessment unit had been relocated away from labour ward and two high dependency beds were shortly to be available. We also heard that plans were underway to create 13 new antenatal beds and a bereavement suite.

We found that, at busy times, staff were redeployed to the delivery suite. Staff told us that the midwifery assessment unit and the birth centre were sometimes closed to allow the staff to move to the busier areas. We were also told by staff that there were occasions when women delivered in the maternity assessment centre or wards because the designated delivery rooms were all occupied. We discussed this with the acting head of midwifery. They explained that, when there was a peak in activity, clinical care was



# Maternity and family planning

prioritised and staff were moved to ensure the safest care possible was delivered. The provider may wish to note that, although staff told us they were unhappy when units were closed, they did not report it using the incident reporting system. This meant that it was difficult to assess the impact this had on service provision or on the women using the service.

## Learning from experiences, concerns and complaints

The provider had a robust complaints process. We saw evidence of services learning. We saw newsletters, team meetings and emails which contained changes to practice following learning from a complaint. We saw a newsletter which identified a trend in complaints' themes. The newsletter identified what actions had been taken and that further review of the issues would be undertaken to ensure the actions had improved the issues.

## Are maternity and family planning services well-led?

Good



## Governance arrangements

We saw a robust governance framework and reporting structure. Incidents, serious untoward incidents, complaints and audits were analysed and reported through the committee structure to the board. However, despite seeing various methods used to communicate the findings and learning to staff, we were repeatedly told that staff did not understand the trends, learning and changes to practice.

## Leadership and culture

We spoke with a number of staff who told us that senior managers and modern matrons were visible in the clinical areas and that communication was good. Doctors we spoke with felt there was good medical management and support.

## Learning, improvement, innovation and sustainability

Staff told us they felt supported by the modern matron and ward managers. Supervisors of midwives were available for

support and were on call throughout the day and night. The ratio of supervisors to midwife was one to 20, higher than the recommended national standard of one to 15. None of the staff we spoke with expressed any concerns with access to a supervisor of midwives. The majority said they had received their annual appraisal. The local supervisors audit in June 2012 made six recommendations; including reducing the number of midwives to supervisors in with Nursing and Midwifery Council guidance and that there should be enough midwives to provide safe care for women using the service. The trust continues to work to meet these recommendations.






One senior midwife expressed concerns with the skill mix of staff and felt there were too many junior midwives. They also felt management were disconnected and support could be a problem, especially out of hours. We spoke with a number of junior midwives who felt they were well supported by more experienced midwives and felt their perceptorship training year was structured and enabled them to gain vital experience.

We saw a variety of training was available for staff to attend and there were two dedicated education and development midwives employed. Staff were able to describe to us what midwifery and obstetric training was required.

We saw a risk register which was completed and reported through to the governance committees and on to the trust governance structure to the board. The top three risks were: capacity, due to the refurbishment programme; lifts not working in the maternity building; and failure to achieve NHS Litigation Authority maternity risk management standards.

We saw and heard that the consultant cover was being increased and a plan had been developed to appoint consultants and review the present job roles of consultants. A further review was planned to ensure the planned changes had improved the consultant presence within the maternity unit. We also saw plans to develop the role of the midwifery support worker to include such tasks as scrubbing in theatre for elective caesarean sections, phlebotomy and preparing discharge documentation.

# Services for children & young people

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

## Information about the service

The Children's Hospital at the Leicester Royal Infirmary comprises a children's emergency department (ED), a children's assessment unit (CAU) (ward 9) and the children's outpatients department (COPD), containing the children's development centre (CDC). There are six wards: Wards 10 and 11, which are surgical inpatient and day case wards; Ward 12, a respiratory inpatient ward which also incorporates the high dependency unit (HDU); Ward 27 (paediatric and teenage and young adult oncology) and Wards 14 and 28, medical inpatient wards. There is, in addition, a children's intensive care unit (CICU).

## Summary of findings

We inspected the department during the day and at night to review the care given after hours and to give night staff the opportunity to speak to us. The children's hospital is in the older part of the hospital and requires some improvements and redecoration. The best use has been made of the environment and each ward has a dedicated playroom and a play specialist who was seen working to keep the children entertained. There is also a hospital school and a rooftop garden area.

While most care is safe on the children's unit we found some issues with infection prevention procedures. Shortages of staff impacted on patient care with care being delayed as a result of the numbers of nursing staff.

Almost without exception, parents and children (where able) could not speak highly enough of the staff and the excellent care they were receiving. They reported the excellent team spirit and working relationships at all levels on the wards and spoke of the friendliness and caring nature of all staff. Parents were generally happy with the outcome of their child's treatment and almost all remarked on the fact that they were fully informed and fully involved in the decisions around their child's care.

Over the previous two months, pressures on beds and shortages of staff had impacted on the numbers of elective procedures undertaken. In the previous two months, 150 procedures had to be cancelled. The use of the Moonbase (a short stay treatment area) as a waiting room for children and their families was not safe nor was it responsive to the needs of patients as waiting times could be excessive.

# Services for children & young people

## Are services for children & young people safe?

Good 

### Learning and improvement

There are good reporting systems in place for incidents. Senior ward staff were all familiar with these systems and were able to give us examples of when they have used them, most around escalation of staffing issues. Not all staff nurses were aware of how to access these systems but could all describe incidents that would require reporting and most stated that they would, in the first instance, raise their concerns with their ward manager.

The trust provided a summary of two serious incidents that had occurred in the children's hospital in the last three years, involving the CAU staff. There was clear evidence of learning from these incidents, with a new standard operating procedure being put in place, changes to the triage and observation process, documentation and the appointment of additional medical staff. These changes were discussed with senior nursing and medical staff, who confirmed clear improvements in the management of patients in CAU.

Ward staff could also describe other methods they use to raise issues – mainly through ward meetings and Message to Matron comments postcards. There was considerable variability as to whether they received feedback from these. Staff interviewed were asked if they could provide examples of changes to practice following feedback from staff, patients and families, but no one could recall any.

### Systems, processes and practices

#### Infection control

We reviewed infection control in the children's emergency department. The unit was clutter-free, clean and with good visibility to most areas. There was a good supply of hand-washing materials and educational posters about good hand washing. All staff were observed to be bare below the elbows, in line with good hygiene practice. All toys were washable and were in good repair. Oxygen and suction was clean and covered and ready for use. The clean utility area was neat and tidy and the door was locked with a combination key pad. There was a fridge in the clean

utility area for storing food to give children who missed mealtimes when waiting. We acknowledge that there is nowhere else for this, and it is clear that no other medical products are stored here.

All food was fresh and within use-by dates and the fridge was scrupulously clean. However, staff were told that food fridges, however well managed, should not be present in clean utility areas. Staff were also advised to review their policy on the use of sterile water bottles that were opened, timed and dated. These are used for mixing oral medications such as antibiotics or feeds, this is renewed every 24 hours; wound irrigation is undertaken using saline solution.

### Monitoring safety and responding to risk

Staff raised concerns about the shortages of personnel and stated that this had impacted on the care of children. This reduced staffing capacity is recorded as an issue on the trust's Women and children's clinical management group risk register and the Area Children's Cancer Group, women and children's subgroup risk register. Staff nurses were aware of how to communicate and escalate staffing issues to their ward manager. Ward managers recorded incidents on the Datix patient safety software system. Trust figures confirm that, in the months of October to December 2013, there were 18 incidents where staff had reported staffing concerns, 13 of which took place in December 2013 (this compares to 16 last year, 6 of which were in December).

Matrons told us that staffing establishment figures were reviewed annually following a patient dependency review on each ward and unit. Figures provided by the trust, after adjustments to take into account staff waiting to start, suggest there is a shortfall of 2.16 unqualified staff and 23.1 qualified staff across the children's hospital. This vacancy shortfall has been compounded by staff sickness (although this is at a rate comparable with previous years) and maternity leave. Managers described actions being taken to recruit to vacancies, including attendance at national and international jobs fairs, a further recruitment open day and maximising use of agency staff on long-term bookings. However, like comparable units, they are struggling to recruit qualified children's nurses that are in short supply nationally.

### Anticipation and planning

In the weeks before the inspection, these staffing shortages coincided with a surge in the number of children requiring critical and high dependency care. Weeks 43 – 50 bed

# Services for children & young people

occupancy figures in these areas (in all weeks except one) showed increased occupancy of between 9.00% and 31.6%. Four of those weeks were in excess of 23% compared to the same weeks in 2012. The trust also reported a 'high number' of children attending the CAU with 10% more being admitted to wards than in the same period in 2012. In order to reduce the pressure on beds and improve patient flow through the hospital, managers have implemented a number of strategies to include:

- Reduction of 50% of elective surgery and a daily review of remaining 50%, prioritising only clinically urgent patients.
- Admission of only urgent planned medical admissions and diversion of clinically appropriate children from the CAU to the rapid access clinic.
- Increased senior review of acute cases, and close liaison with mental health and community health providers to facilitate safe, effective and prompt discharge from acute beds.
- Increased daily review meetings with all managers to escalate issues, liaise with bed managers and waiting list teams and plan strategy.
- Increased deployment of agency staff and matrons to work in clinical areas.

One significant outcome of these strategies is that approximately 150 elective surgical procedures had to be cancelled in the last two months – this compares to only 50 that were cancelled for the whole winter period in 2012.

## Are services for children & young people effective?

(for example, treatment is effective)

Good 

## Performance, monitoring and improvement of outcomes

We saw that monthly quality metrics were undertaken and displayed in the wards. Matrons carried out monthly audits on pressure area risk assessment, intravenous cannula care, infection control and documentation. Monthly results are displayed in each ward area. We found that almost every score throughout the unit was in the high 90% for all quality measures, and this is impressive. A new senior manager stated that, when she saw these results for the

first time, she thought that the measures must be set at a low benchmark, but admits being impressed when she realised how challenging the audit tools were. We agree. It is also clear from those we saw from earlier in the year, that these scores are consistent over the last year, a fact confirmed by matrons.

## Staff, equipment and facilities

We reviewed a selection of patient notes on each ward. Documentation was of a very high standard, in keeping with national guidelines and included entries from all of the multidisciplinary team. All were dated, timed and included the name and designation of staff. Histories were thorough, with a clearly recorded diagnosis, treatment plan and description of what needs to be done, and when. All notes included full risk assessments of pressure areas, falls, use of cot sides, moving and handling, and nutrition. All had been completed. There was also evidence in the notes that an appropriate age-related pain assessment tool was in use. Progress notes were recorded daily by those caring for the patient. We also reviewed notes of patients who had been in hospital during the recent busy period to see if the quality of note-keeping was affected by increased patient activity, but found these to be of an equally high standard.

## Are services for children & young people caring?

Good 

## Compassion, dignity and empathy

We spoke to 20 different parents in interviews across the ward areas and many more spoke to us as they passed, wanting to tell us about the care in the hospital. Over three-quarters of parents reported that they were extremely happy with the care they had received from medical and nursing staff. All of these identified excellent communication between the healthcare professionals and parents and children. Three parents had had concerns about the care their child had received. Most of these related to the amount of time they had been kept waiting for a bed in CAU, this ranged from five to seven hours, but some reported waiting for attention while on the ward when it was particularly busy.

## Involvement in care and decision making

Almost without exception, parents and children (where able) could not speak highly enough of the staff and the



# Services for children & young people

excellent care they were receiving. They reported the excellent team spirit and working relationships at all levels on the wards and spoke of the friendliness and caring of all staff. Parents were generally happy with the outcome of their child's treatment and almost all remarked on the fact that they were fully informed and fully involved in the decisions around their child's care.

## Trust and communication

We spoke to parents of children who were in hospital for a longer period of time. All parents felt that the care they received was good. One parent identified the costs of staying in hospital and the lack of facilities for parents, for example, poor restaurant opening hours and limited facilities to prepare your own food. All parents stated that car parking charges were high for those staying a long time around £50.00 per month. Support for such parents was discussed with the matrons. They provided further information to say that a local charity had financed the refurbishment of three parents' bedrooms for use of parents with children in CICU, and that there was a fund of £200 to help parents in specific need which three families had benefitted from this year.

## Are children's care services responsive to people's needs?

(for example, to feedback?)

Requires improvement



## Meeting people's needs

The CAU is a newly refurbished area designed to receive patients from children's ED and from GP referrals. The environment is very clean, bright, children-friendly and well designed for its purpose. Our only observation was that the 'moonbase' waiting area only had two doors, both of which were not in a direct line of sight to any position where staff routinely sit and that the room had solid walls instead of glass, which would ensure staff could see the children at all times. All children presenting to this area, irrespective of their origin, have to be triaged within 15 minutes of arrival. Children will then be transferred either to the waiting room, 'Moonbase', or a bed in the Launch Pad bay. Following an assessment by medical staff, children are treated, reviewed and discharged or admitted elsewhere for further management. There was a consultant working in CAU between 9am and 5pm daily. We visited this area on many

occasions during our inspection. On one visit we spoke with two parents who told us that overnight they had been waiting in this area four-and-a-half and six hours for a bed, despite one parent seeing that beds were available on the ward. One parent had had to go and find a nurse as their child was in pain. This child slept across two chairs as they were not given a bed.

CAU was discussed with matrons, ward managers and medical staff. The escalation policy in place, to be implemented if CAU admissions exceed a number that can be effectively cared for by the existing staff, does not appear to be embedded. At present, staff are pulled in from other areas to support CAU when it is busy. It was acknowledged that children are often waiting many hours for beds. 'Moonbase' effectively becomes a 'waiting room' for patients coming up from ED while they await a bed on the ward, but unlike ED where there is a four-hour target, there does not appear to be any standard applied to CAU, and patients can be waiting for hours in uncomfortable surroundings. Wards have identified beds for elective admissions, but on occasions where emergency patient flow exceeds expectations, some areas will be required to release these elective beds to accommodate emergencies. This results in a reduction in elective bed capacity. Patients are either cancelled or sent elsewhere as an 'outlier'. Patient flow around the hospital is acknowledged as a considerable challenge to managers.

Despite these challenges and long waits, parents still remain positive about the care they receive. One Dad said, "it is not the care, it's the organisation."

## Vulnerable patients and capacity

The staff in the children's hospital were asked to describe what they would do when a child is admitted about whom there were possible child protection concerns. Staff were able to describe the process they had to follow, and showed us a clear 'traffic light' system of criteria to determine safeguarding referrals.

## Access to services

We received comments from teenagers regarding the lack of facilities for them in the hospital. We saw that all the activities were aimed at younger children and the playroom was filled with young babies and toddlers and there was nowhere else for teenagers to go. Staff reinforced this, telling us there needs to be facilities for teenagers, like the room on Ward 27 which has an impressive 'chill out



# Services for children & young people

room' consisting of soft sofas, TV, games consoles, snack preparation area, books and games. One matron stated that it would be great to have the same facilities for all young people.

Staff and parents reported that one of the weaknesses in the children's hospital is the availability of translators. Ward staff do have access to translation services, but within the population it services, there are now approximately 84 different languages spoken and the trust cannot provide services for each one. We looked at the information displayed on wards, in units and handed out to patients within each area. All information displayed on walls was in English only. Staff reported that there were a number of medical and nursing staff who spoke other languages who were often called on to provide translation services when they were on duty. Translators were not always available after hours and staff provided examples of children being asked to translate for parents, younger brothers and sisters and other family members and also being relied on to communicate between parents/patients and staff. One example was of a patient and parent using a mobile telephone to call a family member who then translated a conversation regarding their diagnosis, admission and treatment.

## Leaving hospital

Discharge plans, in most cases, were also clearly recorded, although the implementation of discharge arrangements was slow. Delayed discharge was often referred to in discussions with matrons and the bed manager, as this is a contributory factor in the challenging patient flow within the hospital. The matrons reported that this was an area where they were looking to improve. They stated that medical staff make it a priority to see children awaiting discharge first thing so that they can be discharged promptly and a bed released. The bed manager stated that she believed the development of a discharge lounge would be beneficial, but that there was no space for one.

## Learning from experiences, concerns and complaints

We did see evidence of feedback forms on the wards, and even saw some being handed to patients. However, we did not see any that were particularly child-friendly. Two children clearly could not understand what was being asked and left the forms unfinished. We did not see any forms in languages other than English. It was reported that there were other tools in use, but we did not see these during the

inspection. On CAU, staff were able to tell us about how feedback from teenagers, receiving treatment in the clinical room who did not like to see needles, syringes and other medical equipment visible, resulted in new racking in the area where this could be hidden away. We were also told about how the young people on Ward 27 had helped design their chill-out area. We also saw posters around the hospital asking young people to take part in a listening event later this month, so there is some evidence that young people are involved in the services being provided to them.

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

Good 

## Leadership and culture

Staff appeared knowledgeable about the trust's agenda and plans, and all reported being positive about the way forward. Staff were asked how they learned about changes to policy or practice within the children's hospital. Some staff stated that they heard about changes through ward meetings, others through the 'communications book' and also through other trust meetings and bulletins. One ward manager sent emails to staff after each management meeting to communicate key issues, and staff felt this was an effective way of keeping them up to date. Ward meetings were happening regularly on some wards, but on others they are rare. In addition, matrons reported that the restructuring in management and administration has meant that some of the regular management forums and meetings had been temporarily suspended, and others had not re-convened after the busy period. This, they stated, was having an adverse effect on communication, but would soon be resolved when the new structures were in place.

Without exception, staff reported that their biggest source of pride in their work was the teamwork found within each ward. At all levels, this was the outstanding feature. Students, staff nurses, visiting therapists, pharmacists, doctors, play leaders, ward clerks and housekeepers described cohesive teams who were supportive, helpful and respectful of each other and their individual roles. This was confirmed by comments made by parents, who all identified this as a positive.





## Services for children & young people

Ward 14 was particularly complemented in this respect. Ward staff also spoke with great respect about the band 7 managers. They reported great leadership, communication and support. All staff reported that they had up-to-date appraisals and could ask for support at any time. Student nurses interviewed talked about excellent induction and competency packages that had helped them settle well into the wards. They told us that, during busy times, ward managers would work alongside them and that matrons would also come onto the wards to provide additional, hands-on care and support.

The only negative comment, which was repeated by around two-thirds of staff, was that matrons were not very visible on the wards, other than at extremely busy times. They reported that they raised issues via Ask Matron comments cards, in meetings or in person, but feedback was not always received and, if it was, it was often slow, and did not always address the issue. Matrons stated that they would always make themselves available to support ward staff by accompanying children and covering for breaks or for ward meetings, but that staff need to request this. The management tier above matrons was acknowledged to be open and approachable and it was felt

that they did their best to address issues facing the children's hospital. Staff reported that, after their busy period, they had received a 'thank you' from senior management and that this had been greatly appreciated.






### **Patient experiences, staff involvement and engagement**

Staff reported that policies and procedures were kept on the 'INSite' trust intranet system. Paper copies are no longer kept on wards to prevent any out-of-date policies being used, and all policies are kept updated on the system. Staff were asked if they had any input into changes in policy or practice, or if they could provide examples of any recent changes that had been communicated to them, but no one could provide any.

Medical staff interviewed during the course of the inspection reported that they felt much supported by senior medical staff, adding that they were very approachable and that the level of supervision they received was good.

Staff felt able to challenge decisions made about the service.

# End of life care

Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	

## Information about the service

University Hospitals of Leicester NHS Trust had a specialist palliative care team, led by consultants in palliative care medicine and specialist palliative care nurses and covered all three hospital sites. Palliative care was provided across all wards at the Leicester Royal Infirmary, seven days a week, with access to specialist advice out of hours. The palliative care team provided direct patient care where palliative needs could not be met by the hospital team. The team also provided training and support to medical and nursing staff and was involved in developing and implementing patient pathways.

The bereavement service included a trust-wide, multicultural chaplaincy service to support people during end of life care. They provided practical and emotional support to families after the death of a relative.

We talked to 10 patients and 33 staff, including a palliative care consultant, palliative care nurse specialists, doctors, chaplains, bereavement coordinators, mortuary technicians and porters. We observed care and treatment and looked at 10 records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we received performance information from the trust.

## Summary of findings

Patients received safe end of life care. Patients who were nearing end of life were identified early so that they could be supported to make decisions about their care. Staff were knowledgeable and experienced in providing care that met patients' needs.

The hospital had actively listened to feedback from patients and relatives about end of life care and had made changes in response. The chaplaincy reflected the cultural diversity of the patients and responded to patients' individual needs.

There was board-level support for the role of the palliative care team and end of life care within the hospital.

# End of life care

## Are end of life care services safe?

Good 

### Safety and performance

Patients received safe palliative and end of life care. Where patients chose to receive their care at home or at another care setting, suitable support services were implemented to ensure safe care. The records of 10 patients who were receiving palliative or end of life care at Leicester Royal Infirmary demonstrated that they had been assessed for their needs and they were being treated appropriately for their condition. Pain relief, symptom management, nutrition and hydration were being provided according to patients' needs.

The discussions between medical staff, patients and their relatives around care and treatment during end of life care was documented clearly. The information on the decisions around resuscitation was documented appropriately in the notes and the Do not attempt cardio-pulmonary resuscitation (DNA CPR) forms had been signed by the appropriate doctors.

### Learning and improvement

The service was focused on safety. Staff reported incidents and told us they did receive feedback and shared the lessons learned. There had been learning from previous safeguarding incidents within the bereavement service, where procedures were now in place to protect patients who had no next of kin or traceable family. The records of each death had an electronic record that could not be closed until all the procedures had been followed and signed off. When the team had established there was no next of kin, the hospital arranged contract funerals and a referral to the treasury solicitor was made. We spoke with a bereavement officer and their manager; they both demonstrated a good understanding of the procedures and their responsibilities. There had been monitoring of these procedures and staff had been tested during their appraisals to ensure that the procedures were robust.

## Are end of life care services effective? (for example, treatment is effective)

Good 

### Using evidence-based guidance

The end of life care followed government guidelines. In line with national guidance, the trust no longer used the Liverpool Care Pathway for the care of the dying patient and so this was not used at the Royal Infirmary. In its place the palliative care team had created guidance for staff to support individualised care for dying people. The guidance recommended a multidisciplinary assessment of a patient who is thought to be in their last days of life. The guidance covered recognition that the patient is dying, sensitive communication, patient preferences for care, review of treatments and investigations and ongoing assessments of their needs.

### Performance, monitoring and improvement of outcomes

The palliative care team are in the process of implementing an 'AMBER care bundle' on 15 wards (across the trust). The AMBER care bundle helps prompt staff to identify patients who have an uncertain recovery and are usually still undergoing active treatment. The identification of these patients is a multi-disciplinary process, with the patient's own consultant retaining overall responsibility for clinical decisions. The care bundle prompts the team to consider, in conjunction with the patient and their next of kin, decisions about ongoing care and treatments, including preferences around place of care now and in the event of deterioration or recovery. The AMBER care bundle promotes regular communication between professionals, patients and their families. The end of life facilitators regularly attend the ward where the care bundle is being used to help support staff identifying appropriate patients and providing education and training. This has involved around 300 patients (across UHL) since November 2012.

From October 2013, at least 50 patients (from this hospital and Glenfield Hospital) receiving palliative care from clinicians and the trust's specialist palliative care team hold their own 'Emergency Health Care Plan', which contains information about their key clinical problems and individualised management plans. These are created in conjunction with the patient and a clinician, frequently a

# End of life care

Palliative Care Specialist. Where necessary, a patient's preferred place of care and resuscitation information is also recorded. This initiative placed the patient at the centre of their care and provided a holistic view of their care as it records previous discussions and decisions and promoted continuity of care.

## Multidisciplinary working and support

Patients' end of life care was managed effectively. The palliative care team responded promptly to referrals from all members of the multidisciplinary team, patients and their relatives. The team across the trust included three consultants in palliative care medicine who also worked at the local hospice. The trust employs 9.27 WTE specialist palliative care nurses who work across all three sites. Included within this, is one clinical nurse specialist who works for 0.6 WTE on research and development activities. There is a 0.8 WTE end of life care facilitator and two WTE end of life care project facilitators seconded to the specialist palliative care team. These facilitators are responsible for implementing and sustaining the AMBER care bundle as well as delivering education and service development around end of life care. The service included spiritual support from the chaplaincy team.

## Are end of life care services caring?

Good 

## Compassion, dignity and empathy

The trust performed 'better than other trusts' nationally for one of the questions in the 2012/13 Cancer Patient Experience Survey. There were 27 questions where the trust performed 'worse than other trusts' nationally. These were around communication, confidence in staff, provision of information and the number of people who would rate the treatment as 'excellent or good'. However, at inspection we found that staff were sensitive to the privacy needs of relatives and patients at end of life, so patients were accommodated in quiet areas of the wards where possible. However, there had been occasions where managers had asked that patients be moved to another area of the hospital due to pressure of bed availability in acute areas.

Palliative care nurses and doctors were actively involved in the training of all staff in palliative and end of life care. End of life care training is incorporated into the healthcare assistants induction programme and in the preceptorship

programme for qualified nursing staff. Staff were trained in caring for people after they had died to preserve their dignity in line with national guidelines. A recent initiative to aid staff was the production of a 'care after death' checklist card for all staff.

## Involvement in care and decision making

The palliative care team had applied and been selected by the chief executive's Listening into Action initiative to improve care. The team had six months up to May 2014, where patients and their carers could feed back their experiences; the palliative care team could then provide solutions to improve care. This builds on work from the Quality End of Life Care for All (QUELCA) programme, where the team have already seen changes in practice. For example, ward staff have noted that relatives had reported that reliance on staff for refreshments was not effective. The team had made changes on the ward to enable relatives to make their own refreshments independently of staff and this therefore released more time for the staff to care. In response to other feedback, there had also been fundraising for the provision of comfort packs for palliative care patients who had no access to toiletries and sundries. We spoke with three patients who all told us that staff had gone the extra mile to provide good care. One patient told us "the staff have a very positive attitude" and another patient felt confident with the staff knowledge and skills, they told us "all the staff know their stuff".

## Emotional support

Patients' spiritual needs were met by the chaplaincy team who had 11 chaplains with Christian, Roman Catholic, Muslim, Hindu and Sikh faiths. There were a team of volunteers who worked closely with the chaplaincy team to provide pastoral support for patients. There was further access to all faiths and members of the community faith groups when the chaplains were not on duty. The hospital had a multi-faith room which had washing facilities and a chapel.

Following the death of a patient in the hospital, the team of bereavement officers liaised with medical staff to coordinate the provision of essential documents. They met with families in the bereavement suite that had private rooms and a garden in which people could take time to reflect. The bereavement officers supported families with practical guidance about the bereavement services and ensured they receive their relative's personal belongings and completed essential documents.

# End of life care

## Are end of life care services responsive to people's needs?

(for example, to feedback?)

Good 

### Meeting people's needs

Patients were involved in making decisions about their treatment and place of care. Patients were also fast-tracked to get immediate funding to facilitate the right home care package or nursing home, depending on their wishes. The palliative care team could make direct referrals to the hospice at home team. Patients were discharged with patient held records that informed the community teams of their medical condition, details of their palliative care and their preferences for care and treatment. These records were accessible electronically on the wards, in A&E and out-of-hours medical care.

### Access to services

The chaplaincy responded to people's cultural and religious beliefs. Where people had no specific religious or cultural needs, the team provided "a listening friend". The chaplaincy team had the skills to help facilitate family reconciliation and support in end of life care. There were alerts on the electronic records that triggered the chaplaincy to a person's needs, such as long in-patient stays, previous chaplaincy visits, or a referral from staff. The members of the chaplaincy team could speak languages such as English, Urdu, Gujarati, Arabic, Hindi, Kutchi, Punjabi, Marathi and Polish, which reflected the patient population at the hospital.

Where patients required a burial or repatriation within 24 hours of their death for cultural or religious reasons, the

hospital had systems in place to recognise that this would be required and could release people for burial in a timely way. The hospital had achieved 91% of requests for immediate release for burial in the last year.

## Are end of life care services well-led?

Good 

### Leadership and culture





The chief nurse of the hospital took an active role in supporting and providing help to the palliative care team to navigate through processes to improve services. The chief nurse represented the palliative care team on the trust board.

### Learning, improvement, innovation and sustainability

The palliative care team were active members of the Leicester, Leicestershire and Rutland working group for end of life care, which included community palliative care groups, the hospice and the clinical commissioning groups. The working group had worked strategically to plan and implement an alternative to the Liverpool Care Pathway, a guide to anticipatory prescribing and a unified DNA CPR policy and procedures.

Staff facilitating the 'AMBER care bundle' represent University Hospitals of Leicester as part of a national 'Route to Success: Transforming End of Life Care in Acute Hospitals' initiative to improve end of life care. All these records were audited and the outcomes are shared with other hospitals taking part in the same initiative. The end of life facilitators worked closely with other hospitals to share good practice and overcome barriers.

# Outpatients

Safe	Good 
Effective	Not sufficient evidence to rate
Caring	Good 
Responsive	Requires improvement 
Well-led	Good 

## Information about the service

The University Hospitals of Leicester NHS Trust provides outpatient services at Leicester Royal Infirmary, Leicester General Hospital and Glenfield Hospital. Appointments are for a variety of specialties. Last year at Leicester Royal Infirmary 436,196 people had outpatients appointments, 143,474 of these were new patients and 292,722 were follow-up appointments. The trust has had difficulty in meeting the 18 weeks referral-to-treatment target, particularly in ophthalmology.

## Summary of findings

Some of the clinics did not have equipment in place to allow all people to use the facilities safely. Staff were well trained and some had taken on extra responsibilities to develop their practice and offer flexibility in the services provided.

The trust did not meet their targets for 18 weeks referral-to-treatment time and some patients have had clinics cancelled at short notice or may have to wait some time for a follow-up appointment. People we spoke to at the listening event confirmed that this was a frustration.

We saw staff caring for people in a compassionate way and maintaining their dignity and privacy. The service was well-led by senior clinical staff with a clear vision for their department and who supported their staff.



# Outpatients

## Are outpatients services safe?

Good 

### Safety and performance

Staff were aware of incident reporting procedures and they told us that they received feedback about incidents either at team meetings or via email. Incidents were reported via the Datix patient safety software system. This is an electronic reporting system used by many healthcare providers. We saw an action plan formulated following an incident that identified the concerns and the actions taken to ensure they were corrected.

### Systems, processes and practices

#### Equipment/Environment

The main outpatients department was clean but staff told us that the age of the facility sometimes impacted on care. For example, there was not always enough seating and most of the seating available was unsuitable for some patients with limited mobility, as it was of the upholstered kind arranged in rows. Staff told us that they were concerned that cleaning of the department was not sufficiently frequent, particularly the toilets. Regular audits were completed by the matron and a domestic manager. We saw a recent audit that showed a score of 89% against a target of 95% in eye clinic.

Staff used personal protective equipment appropriately and there were hand-sanitising dispensers available for staff and public to use.

In ophthalmology we saw that patients were required to use a variety of seating equipment to use diagnostic machines such as slit lamps which allow for close examination of the front of the eye. The seating was a mixture of office type chairs that swivelled; some had casters although these were placed on non-slip mats. Senior staff we spoke with were concerned that patients with limited mobility would be unable to use this equipment and that it presented a hazard. We were told there were no hoists available in ophthalmology to aid patients to use the equipment. Other equipment that we examined such as phototherapy equipment had been appropriately serviced and maintained.

### Staffing

There were enough staff on duty at the time of our visit. During our inspection there were a number of nurse-led clinics. These were operated by staff with extended skills who had received the appropriate training to undertake that type of care. One member of staff was running a phototherapy clinic. They demonstrated a thorough knowledge of the skills required to fulfil their responsibilities as well as procedures and protocols intended to ensure patient safety. Staff in Outpatients had received training in the Mental Capacity Act 2005 and three members of staff we spoke with could accurately describe their responsibilities in relation to people who may have reduced capacity. Staff had attended safeguarding training and all staff we asked had a good knowledge of what action to take if they had concerns about safeguarding.

## Are outpatients services effective?

(for example, treatment is effective)

**Not sufficient evidence to rate**

### Using evidence-based guidance

Patients received care that was planned and delivered in accordance with best practice guidelines. For example, we saw that the care provided to people requiring phototherapy for skin condition such as psoriasis met with the National Institute for Health and Care Excellence (NICE) Excellence pathway 2012. We saw that the risks of the procedure had been discussed with patients and that appropriate risk assessments were in place.

### Performance, monitoring and improvement of outcomes

We saw that clinical audit was carried out in the department. The matron for main outpatients had adapted an audit tool so that it was suitable for the department and this was being rolled out to all outpatient departments. The audit ensured that standards within the department were monitored regularly.

### Staff, equipment and facilities

Staff in the department had access to training including mandatory training and also National Vocational Qualifications (NVQs). Some staff had received additional training which allowed the department to offer services such as phototherapy. A senior member of staff had

# Outpatients

developed a competency tool. Once completed this meant staff were suitably trained to work across different areas of the department. Staff could be effectively deployed to meet the needs of the department.

## Multidisciplinary working and support

The outpatients department worked with external professionals to ensure continuity of care for patients. There was information for referring people to community nursing services and referral forms contained the necessary information to communicate patient's needs effectively.

## Are outpatients services caring?

Good 

## Compassion, dignity and empathy

Patients we spoke with told us that they were happy with their care. We saw changing areas in the main outpatients department that ensured people's dignity and privacy. However, changing facilities in the radiology department would not be suitable for a patient in a wheelchair who also required the assistance of a carer. If there was a significant delay for patients, then refreshments and snack boxes were made available. If patients had mobility issues, there was a vehicle and staff available to take them to their clinic.

## Involvement in care and decision making

We saw one person being actively involved with their care and care planning. They were given time and information in order to make a decision and they weren't rushed. Another patient told us that they had been involved in decision making about their treatment and their views were listened to and acted on. The patient was given information to take away so that they could consider their options without being rushed.

## Trust and communication

Staff introduced themselves when talking to patients and took time to check patient's details and inform them if there was a delay in clinic and how long the delay was. Confidentiality was maintained as notes were kept out of sight and staff were discrete when talking on the telephone.

## Emotional support

We observed staff talking to patients in a respectful and polite way. There was positive engagement with patients

and we saw humour used to develop rapport. There were quiet areas for patients who may have received difficult news and staff told us how they supported people in those circumstances.

## Are outpatients services responsive to people's needs?

(for example, to feedback?)

Requires improvement 

## Meeting people's needs

Translation services were available for people who did not speak English and all the staff we asked about this were able to tell us how to access these services.

## Access to services

## Performance data

The trust had been failing to meet its 18-week target for referral-to-treatment for outpatients. This would involve the initial contact with the consultant through the outpatients department. Our information showed that the trust had failed to meet its target in 2012/ 13. According to NHS England, in November 2013, 92.3% people started treatment within 18 weeks, against a target of 95%. Before our inspection, we were aware of significant delays in ophthalmology appointments. For the same period in ophthalmology, 83.6% of people started treatment within 18 weeks compared to a target of 95%. Prior to our inspection, we were aware that the East Midlands Training Programme for doctors in ophthalmology had concerns about the department including high rates of cancellations, administration, over-booked clinics and poor induction for trainee medical staff in October 2013. Incident forms for November 2013 showed errors in administration continued. They had returned in December 2013 and found that administration in clinics had improved but that clinics were regularly overbooked.

Staff we spoke with told us that the department had been improving with fewer cancellations than previously, although overbooking was still common. We asked to see formal complaints in ophthalmology. From the period 1 November 2013 to 16 January 2014, there were 59 complaints. The NHS Choices website had several negative reviews based on cancelled appointments and poor communication. In many instances the trust had

# Outpatients

responded to these reviews. We saw incident forms from December 2013 that indicated that late cancellation of appointments still occurred and follow-up appointments were not booked according to clinical requirements. We are aware of a recovery plan in place to address the referral to treatment times across the trust and while improvements have been made, further work is required to effectively manage patients' access to appointments in the outpatients department.

## Waiting times

We spoke with staff about the volume of patients they saw in clinic. The daily average for people seen in clinics across the trust was 3,068. We were aware of a large number of cancellations and delays in rebooking patients for clinic. Matron for general outpatients collected information on the service via the Message to Matron postcard system. The two most frequent areas of concern for patients were waiting times in the department and issues with booking appointments. We spoke with staff who confirmed that late cancellations occurred and that it might not be possible to contact patients before they arrived in clinic. We saw that, up to December 2013, 18.5% of ophthalmology appointments were cancelled by the hospital. We spoke with a member of staff responsible for booking patient appointments who confirmed that for some specialities, patients may have to wait six months before being seen in clinic.

NHS Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. It is a way for patients to choose their own appointment that suits their needs. We were told that, in some specialties, after a patient had booked their appointment it was triaged and, if they are considered to be lower priority, a different appointment may be offered. This meant that some patients could be given an appointment not suited to their needs. In some clinics, evening sessions had been commenced to address access issues and offering people with commitments some flexibility in their appointments. The radiology department ran a system that identified patients who had not attended for X-ray and contacted them to see if the appointment was still required.

## Learning from experiences, concerns and complaints

There was information displayed around the department informing patients and carers to make a complaint. Staff

we spoke with knew the procedure in dealing with complaints. We saw that a thematic analysis of responses had been completed each month of the issues raised in the Message to Matron postcards. Most responses received were of a positive nature and the results were displayed prominently in public areas. Where there had been concerns that fell within the matron's responsibilities, we saw that action had been taken to address them. For example, where space permitted, more comfortable chairs had been purchased.

## Are outpatients services well-led?

Good 

## Vision, strategy and risks

In the outpatient department we saw the trust and department visions and values displayed. Staff we spoke with were aware of the vision for the department and future plans.

## Leadership and culture

The matron for the main outpatients department demonstrated a strong, coherent vision for the services for which they were responsible. They were passionate and enthusiastic about improving the service for patients and demonstrated this through service changes made in response to feedback. Staff said they saw the executive team around the department on occasion and regularly saw the matron responsible for their department.

## Patient experiences, staff involvement and engagement

All staff felt well supported in their roles and understood their responsibilities. They had regular supervisions and team meetings and said they felt confident to raise any concerns directly with their manager. All staff told us they had received training and many had undertaken further training such as NVQ to develop their skills.

There was clear consistency in leadership across the three hospitals at departmental level. The matron also had a contact phone number displayed in public areas so patients could call them direct with any issues.

## 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
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control.</p> <p>Patients on Fielding Johnson ward who have an infection which is contagious were not isolated. Therefore measures were not in place to ensure that patients were not at risk from the spread of infections.</p> <p>Regulation 12 (1) (a) 2 (a)</p> <p>In the Children's Hospital sterile water bottles that were used for many purposes such as wound irrigation and mixing antibiotics once opened.</p> <p>Regulation 12 (2) (c) (iii)</p>

Regulated activity	Regulation
Surgical procedures	<p>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control.</p> <p>Patients on Fielding Johnson ward who have an infection which is contagious were not isolated. Therefore measures were not in place to ensure that patients were not at risk from the spread of infections.</p> <p>Regulation 12 (1) (a) 2 (a)</p> <p>In the Children's Hospital sterile water bottles that were used for many purposes such as wound irrigation and mixing antibiotics once opened.</p> <p>Regulation 12 (2) (c) (iii)</p>

Regulated activity	Regulation
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## Compliance actions

Treatment of disease, disorder or injury

Regulation 9 HSCA 2008 (Regulated Activities)  
Regulations 2010 Care and welfare of people who use services.

Patients were not protected from the risk of receiving care that is inappropriate or unsafe because assessments of needs were not always completed.

In the discharge lounge we saw a patient who had grade three pressure sores and was sitting on a chair without any aids. Regulation 9 (1) (a) (b) (i)

In the children's hospital children were left in the Moonbase overnight despite beds being available on the ward. One child was in pain during this time. Regulation 9 (1) (a) (b) (i)

A bay on the day surgery ward was inappropriately used for dental extraction recovery. Regulation 9 (1) (b) (i)

In the palliative care service one patient did not receive a timely blood transfusion as the doctor had not completed the appropriate documentation and nursing staff had not escalated the deterioration of the patient's condition. Regulation 9 (1) (a) (b) (i)

### Regulated activity

### Regulation

Maternity and midwifery services

Regulation 9 HSCA 2008 (Regulated Activities)  
Regulations 2010 Care and welfare of people who use services.

Patients were not protected from the risk of receiving care that is inappropriate or unsafe because assessments of needs were not always completed.

In the discharge lounge we saw a patient who had grade three pressure sores and was sitting on a chair without any aids. Regulation 9 (1) (a) (b) (i)

In the children's hospital children were left in the Moonbase overnight despite beds being available on the ward. One child was in pain during this time. Regulation 9 (1) (a) (b) (i)

A bay on the day surgery ward was inappropriately used for dental extraction recovery. Regulation 9 (1) (b) (i)

## Compliance actions

In the palliative care service one patient did not receive a timely blood transfusion as the doctor had not completed the appropriate documentation and nursing staff had not escalated the deterioration of the patient's condition. Regulation 9 (1) (a) (b) (i)

### Regulated activity

### Regulation

Surgical procedures

Regulation 9 HSCA 2008 (Regulated Activities)  
Regulations 2010 Care and welfare of people who use services.

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### Regulated activity

### Regulation

Diagnostic and screening procedures

Regulation 9 HSCA 2008 (Regulated Activities)  
Regulations 2010 Care and welfare of people who use services.

Patients were not protected from the risk of receiving care that is inappropriate or unsafe because assessments of needs were not always completed.



## Compliance actions

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