

# University Hospitals Birmingham NHS Foundation Trust

## Good Hope Hospital

### Inspection report

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### Ratings

#### Overall rating for this service

Inspected but not rated 

Are services safe?

**Requires Improvement** 

Are services effective?

**Inspected but not rated** 

Are services responsive to people's needs?

**Inspected but not rated** 

Are services well-led?

**Inspected but not rated** 

# Our findings

## Overall summary of services at Good Hope Hospital

### Inspected but not rated



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

- The Queen Elizabeth Hospital Birmingham
- Birmingham Heartlands Hospital
- Good Hope Hospital
- Solihull Hospital

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

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

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

Concerns had been raised through enquiries and serious incident reporting about medical care services at Good Hope Hospital in relation to:

- Venous thromboembolism (VTE) assessment and management
- Discharge processes and communication
- Staffing
- Incident reporting and sharing of learning including never events
- Support, care, and treatment for patients with learning difficulties
- Patient care and emotional support
- Concerns around 'do not attempt cardiopulmonary resuscitation' paperwork
- Concerns around staff culture
- Infection control procedures
- Nutrition and hydration

# Our findings

These concerns led to a decision being taken to complete an unannounced (staff did not know we were coming) focused inspection on two separate dates: 2 and 9 December 2020. We inspected elements of our safe, effective, responsive, and well led key lines of enquiry. The inspection team comprised two CQC inspectors and a specialist advisor who had expert knowledge in the medicine core service.

During our inspection we visited eight wards and spoke with 25 members of staff. This included medical staff, nursing staff between band four to seven, flow co-ordinators, ward clerks and ward managers. We also held two remote interviews with site and divisional directors.

We reviewed 202 sections of patient records. During the first day of our inspection, we reviewed ten records of current inpatients to explore venous thromboembolism (VTE) assessment and management, discharge processes and nutrition and hydration management. We reviewed 20 further patient records for the purpose of reviewing VTE management only. We also reviewed five records for patients already discharged. On the second day of inspection, we looked at 121 records specifically for the purpose of reviewing VTE management, 15 records for the purpose of reviewing nutrition and hydration and 16 ReSPECT forms. Please note that some of these records may have been for the same patients. In addition, we reviewed 10 records of discharged patients to review discharge management.

The medicine core service was last inspected in 2018 (the report was published in 2019). During the 2018 inspection, the service was found to be in breach of Regulation 18: Staffing due to not having the required numbers of nursing staff to keep patients safe.

During this inspection, we again found safety concerns in relation to nurse staffing. This was a breach of the Health and Social Care Act (2008) (Regulated Activities) Regulations: Regulation 18 Staffing. We also found evidence of a breach of Regulation 12: Safe Care and Treatment.

Following this inspection, we did not re-rate all key questions inspected. We have only re-rated key questions where we identified a breach of regulation.

During our inspection we found:

- The service did not have enough nursing staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels however this did not resolve the low numbers of registered nurses present on wards. Staff sickness rates and nurse vacancy rates were high. This resulted in some tasks being rushed, not enough staff to observe patients at high risks of falls, and some patients having to wait to be supported with eating meals. Ward staff did not have the capacity to meet the individual needs of all patients living with dementia.
- Staff completed VTE risk assessments for each patient but did not always review these in line with the trust policy. Staff did not follow the trust policy consistently when discharging patients.
- The service did not always control infection risk well. Staff did not always wear appropriate personal protective equipment as designed.
- Not all staff could access patient records. Some assessments such as ReSPECT forms were not fully completed or updated.
- Staff were not familiar with or aware of serious incidents or never events which had occurred across the trust.
- Not all staff had received or updated training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

# Our findings

- Staff did not all feel respected, supported, or valued by the wider trust.
- Processes were in place to manage identified risks, however some actions such as those in relation to managing staffing, were not enough to mitigate the risk to patient safety.
- Not all risk registers accurately captured risks to the service. Some actions such as those in relation to managing staffing, were not enough to mitigate the risk to patient safety.

However, we also found areas of good practice:

- Staff were passionate about helping patients and wanted to have the capacity to do more.
- Staff had training on how to recognise and report abuse.
- Staff kept the premises visibly clean.
- The design of the premises kept people safe.
- VTE medicines were mostly prescribed in line with national standards.
- Staff recognised and reported most incidents and near misses. Managers investigated local incidents and shared lessons learned with the local team.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for patients' religious, cultural, and other needs.
- Patients with a learning disability could access the site based team to get support. Staff supported patients to choose food based upon dietary preferences.
- Divisional leaders operated effective governance processes, throughout the service. Staff at senior levels had regular opportunities to meet, discuss and learn from the performance of the service.

# Medical care (including older people's care)

Inspected but not rated



## Is the service safe?

Requires Improvement



Our rating of safe stayed the same. We rated it as requires improvement because:

### Safeguarding

**Staff did not always take enough time when caring for patients to ensure patients remained free from harm. Staff had training on how to recognise and report abuse.**

Nursing staff received training specific for their role on how to recognise and report abuse. Data from the trust showed that the numbers of staff trained in safeguarding adults level two met the trust target for all wards we visited during the inspection. All but two wards had met the trust target for safeguarding adults level three training.

During our inspection, an example of a safeguarding concern was provided. This example was about a patient who had been discharged to a care home with suspicious bruising. We saw that this case was investigated within the trust. It was determined that although abuse was not evidenced, staff were potentially putting patients at risk of bruising by undertaking personal care too roughly. We saw this incident had been reported using the electronic reporting system.

Managers told us that they were aware staff were rushing, which may impact upon patient care, and encouraged staff to slow down and if necessary, work differently. For example, where staff were rushing patient bed baths to have done this by a certain time; instead, staff could consider a shorter wash of the essential areas for appropriate patients on a rotating basis. Or they could hand such tasks over to staff who would be on shift later that day.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we asked knew how to escalate a concern if they felt patients were at risk of neglect or abuse.

Staff had access to two separate safeguarding policies, one for children and one for adults, which outlined their responsibilities.

### Cleanliness, infection control and hygiene

**The service did not always control infection risk well. Staff did not always wear appropriate personal protective equipment as designed. They kept the premises visibly clean.**

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). At the start of our inspection, we saw 12 staff leaving the hospital not wearing face masks.

We also observed eight staff leaving hospital wearing scrubs and ten staff still in uniform at the end of their shift within a 25-minute period. The Royal College of Nursing (RCN) 'Uniform and Workwear Guidance' released in April 2020

# Medical care (including older people's care)

recommends that staff get changed into their work uniform at the hospital and transport their work clothes to and from the site in a plastic bag. This is to reduce the risk of cross contamination, and to improve public perception of infection prevention and control during the COVID-19 pandemic. We saw the trust guidance issued to staff which included advice around uniforms. This mirrored the above guidance. Therefore, not all staff chose to apply the guidance to themselves.

Staff on the wards were mostly observed to be following PPE (Personal Protection Equipment) guidance. There were four occasions where we witnessed staff with masks incorrectly placed below the nose, but they were corrected in our presence.

Ward areas were visibly clean in the main. We saw some debris on the floor on one ward such as a tissue.

Staff told us about patients who had contracted COVID-19 as an inpatient and felt this was linked to the site management and allocation of patients to wards. For example, patients who were screened as COVID-19 negative being located on COVID-19 positive wards. Staff reported infection break outs and the trust managed these accordingly.

On rare occasions visitors attended wards, such as when a patient was at the end of their life, staff took visitor details as part of the COVID-19 'track and trace' programme.

## Environment and equipment

### The design of the premises kept people safe.

The design of the environment followed national guidance. However, at times wards were cluttered. We observed the corridor areas on ward eight and nine and found them to be cluttered with equipment, however there was no adequate storage areas to keep this elsewhere. Staff were aware of this and showed us how they kept it as minimised as possible.

Wards which were identified as COVID-19 positive were locked and required a staff key card to enter or exit. This prevented unauthorised entry or exit.

The service had enough suitable equipment to help them to safely care for patients. However, the ward staff from some wards had to go and collect this from the stores due to short staffing within the facilities department. This included supplies such as PPE.

## Assessing and responding to patient risk

**Staff completed venous thromboembolism (VTE) risk assessments for each patient but did not always review these in line with the trust policy. When discharging patients, Staff did not follow the trust discharge and transfer of care policy consistently. Due to staffing levels, fall management plans were not always followed which resulted in patient harm.**

The trust reported and monitored hospital acquired thromboses (HAT). Hospital acquired thromboses (HAT) are any venous thromboembolic (VTE) event that occurs within 90 days of hospitalisation. VTE includes deep vein thrombosis (DVT) and pulmonary embolism (PE). Data showed for a six month period, almost a quarter of hospital acquired thromboses were avoidable or potentially avoidable. A training presentation showed data from January to July 2020 about HAT across the trust. Out of a total of 788 recorded thromboses, 224 (28.4%) were HAT. Of the 224 HAT, 51 were identified as either avoidable or potentially avoidable. This was 6.5% of the total recorded thromboses, but 22.7% of the HAT figure. No thromboprophylaxis being prescribed was the most significant identified reason for avoidable or

# Medical care (including older people's care)

potentially avoidable HAT (17 out of 51). The second identified reason was a delayed VTE risk assessment (14 out of 51). In 11 of the 51 cases, a delay in prescribing thromboprophylaxis was indicated as the reason, and in nine cases the incorrect enoxaparin dose was prescribed (enoxaparin is a blood thinning medicine used to prevent VTE). Four patients were found to have an incorrect VTE risk assessment, and in one case no risk assessment was completed.

The trust had reported several potentially avoidable VTEs across the trust through the national reporting system. Of the 13 that were potentially avoidable, one occurred at Good Hope Hospital and had been investigated by the trust.

Staff completed venous thromboembolism (VTE) risk assessments for each patient on admission, using a recognised tool, however, did not always review this in line with the trust policy. We reviewed VTE assessment and re-assessment across six wards. We reviewed the records of 161 patients, out of those records 37 patients had not had a 72 hour VTE review or re-assessment. One patient had not had their initial VTE assessment.

We asked the trust to review these records to identify if there were valid reasons for not undertaking a 72 assessment, in line with the trust training programme which stated 'risk assessments should be repeated every 72-96 hours or whenever the patient's clinical situation changes.

The trust's review showed that all but one assessment did not require a re-assessment. However, we found where VTE risk re-assessment was not indicated following the initial risk assessment, staff did not document this decision and the rationale for it in the patient record. This meant staff may not be able to see the most up to date clinical information when reviewing the electronic patient record. Also, staff reviewing the record would not immediately know if a patient was not re-assessed due to clinical decision making, or due to it being missed.

We found that prophylactic anticoagulant medicines were prescribed and administered appropriately across all wards we visited. The pharmacy team conducted audits into missed doses. However, learning from these incidents only tended to be shared if a dose was missed on that local ward. We found mechanical prescriptions were appropriately made in all but one case. On ward seven, we found a patient who had been prescribed compression stockings to reduce the risk of a blood clot forming. Upon review of this patient's record, it was clear that this was an inappropriate prescription due to co-morbidities. Therefore, nurses had chosen not to follow the prescription and did not use the stockings.

On one occasion, nursing staff had not followed the prescription for mechanical preventative treatment. Another patient had been prescribed stockings appropriately several days before our inspection, but these had not been put on by staff despite the stockings being available on the ward. These were placed on the patient at our request. On other wards we saw that stockings were used as prescribed. Staff told us that some patients, particularly those who were confused, would remove the stockings.

Staff told us they received training about VTE and how to reduce the risk of this for patients as part of their electronic training package. Nurses told us they could contribute to the assessments although these were primarily done by doctors. The trust sent confirmation that both nursing and medical staff received VTE training. We saw the presentation given to medical staff on induction which very clearly outlined both the importance of and the process for appropriately assessing and prescribing for VTE prevention. Medical staff were aware of why they would need to reassess a patient to ascertain if their VTE risk had changed. For example, if a patient's level of mobility changed.

The trust sent us audit documents regarding VTE assessments upon admission, whether this was within 24 hours and if any prophylaxis was prescribed. The audits were undertaken in January, May, and September 2020.

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Although we noted not all wards were sampled equally, we noted ward eight had the highest incidences of errors as identified by the audit which could indicate this ward would benefit from additional audit.

The January 2020 audit covered two patients from relevant wards we visited. Both were appropriately managed. For this audit, 29 patients in total were reviewed. Of these 82% had a timely VTE assessment and 97% had a correct and timely thromboprophylaxis.

In the May audit, six patients from wards we visited were audited. We saw that all except one were appropriately managed. Where prophylactic prescriptions were not made, this was due to clinical decision making in line with good practice. However, one patient from ward eight was assessed as requiring both mechanical and medical preventative prescriptions on 17 May 2020, none were given until 21 May 2020.

In the September 2020 audit, we saw that two patients from ward eight had a delay in receiving their prescription. One of two patients from ward nine were audited in September 2020; one patient did not receive an initial assessment and staff found a delay with medicine. One patient on ward 11 and one patient on ward 12 did not receive an initial assessment until a week after admission, although both patients were prescribed appropriate prophylaxis on admission. However, nine patients had been managed as per trust policy on the wards we visited.

Interventions had been put into place to reduce the risk of harm from inappropriate VTE assessment and/or prescribing. The trust had an anticoagulation department to support medical staff and, as above, were provided with clear training. Staff had access to patient information leaflets which provided information about VTE prevention.

Staff were aware of risk factors which could contribute to a fall. Staff had access to equipment to mitigate the risk of falls such as crash mats, beds that could be lowered and bed alarms which alerted staff if a patient tried to get out of bed unaided. For all patients but one that we reviewed, a falls risk assessment had been completed.

We found four examples where patients who required a dementia assessment were overdue with these. We raised this with ward staff who told us they would address this.

Staff checked patients' skin daily for tissue damage or changes to risk factors. Any deterioration or damage was noted on body maps. However, staff said they did have to do this quickly due to staffing pressures, so it was possible that some damage was not always noted.

Not all patients were discharged safely and in line with the trust discharge and transfer of care policy. The trust had two comprehensive discharge checklists that staff were to complete before and at the time of discharge. One was for patients who were being discharged to an external agency, and the other was a general checklist. Both included details such as discharge letter sent, to take home medicines checked and cannula in situ check and removal. The discharge form for patients going to a care home also had questions to complete such as whether the patient had had any falls in hospital on this admission, current level of mobility, any tissue damage and details of any referrals made.

We reviewed discharged patients records across five wards. We reviewed 15 records of recently discharged patients and found that 12 had no discharge checklist. One patient had a fully completed discharge checklist and three had partially completed discharge checklists. Flow co-ordinators who managed discharges told us during their working hours, they completed these forms in conjunction with the nursing staff. However, often patients were discharged outside of the flow coordinators working hours, or the discharge process was too rushed to complete the checklist fully. This meant that staff made errors at this time, such as discharging patients with cannulas still in.



# Medical care (including older people's care)

Shift changes and handovers included all necessary key information to keep patients safe. Shift handovers took place on all wards to share information from the previous shift to oncoming staff. During handovers, staff discussed discharge plans and incidents such as patient falls. We saw handover sheets that demonstrated this.

Staff shared key information to keep patients safe when handing over their care to others. Staff took part in safety huddles where they shared information about patients with specific areas of risk or need; for example, falls risk, special diet, or tissue damage. We saw evidence this was completed daily at shift handovers, and staff mostly signed to say they had attended. On occasions the forms were not fully filled out. Some of the forms for areas such as cardiology were different in layout and contained information relevant to that speciality. Other forms were not always standardised and did not have a specific area or instruction for staff to sign. Also, we noted a number of these forms were completed using only patient bed numbers as identifiers for the patients. Staff were asked to add initials as patients were being regularly moved around the ward during the pandemic. Ward 15 was an exception to this as they used clearer patient identifiers. We saw some handover sheets contained 'hot topics' with information to share with staff.

Staff reported there were unsafe transfers of patients between wards. Staff provided an example whereby shortly before the end of a shift they received eight new patients from another ward in the hospital without a handover. The handover could not be provided due to staffing issues on the other ward. Staff also told us that patients being admitted from accident and emergency or transferring from the acute medical unit rushed onto the wards without proper handover or diagnosis.

## Staffing

**The service did not have enough nursing staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels however this did not resolve the low numbers of registered nurses present on wards. Staff sickness rates and nurse vacancy rates were high.**

The service did not have enough nursing staff to keep patients safe. The number of nurses and healthcare assistants did not match the planned numbers. The Royal College of Nursing (RCN) provides guidelines on safer staffing ratios of registered nurses to patients, and nursing staff (such as health care assistants) to patients. Although the recommendations are not a legal requirement in the UK, consideration should be given to ensuring enough staff of the right skill mix are available on wards per shift.

During our inspection, we visited eight wards. All wards were working with a reduced number of staff across some shifts; some nurse-to-patient ratios were 1:17 at the time of our inspection. The wards that reported the most impact of low staffing upon patient safety were those looking after older adults.

There were not always enough staff to protect patients from harm in line with specific risks. Across all the wards we visited, staff told us that a major concern was avoidable falls. Due to low staffing numbers, patients at a high risk of falls were not monitored as per the trust policy. For example, where patients were assessed as requiring one to one support or observation, if no staff were available, these patients were placed into a high visibility bay where one member of staff could be responsible for observing up to eight patients (four per bay across two bays).

Staff told us they tried to get support to monitor patients safely, but often this was not possible due to the overall low staff numbers across the site. We were told of additional risk if a patient assessed as requiring one-to-one supervision was in a side room and there were no staff to provide this level of supervision.

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We were provided with examples of potentially avoidable falls due to low staffing numbers. On ward 11, a patient fell and passed away after sustaining an injury. At the time of the fall, the ward was short staffed, and all staff were busy with other patients. An investigation report was produced as a result which highlighted staffing as a concern.

We reviewed a root cause analysis (RCA) report from March 2020 for a patient who had an unwitnessed fall which showed the level of staff supervision at the time of the fall was not appropriate. The patient was assessed as needing enhanced supervision due to a previous history of falls and confusion which led to attempts to mobilise independently. At the time of the fall, the member of staff assigned to watch the bay was assisting another patient.

We saw a further RCA for a fall that happened in August 2020 where a patient sustained a fractured neck of femur following a fall. Staff shortages were cited as a contributory factor in this case. However, this occurred on ward 16 which was not a ward we visited during the inspection.

Staff told us of the impact of the reduced staffing numbers, including where staff had been allocated to a ward but directed elsewhere to cover for shortfalls. As above, one area of concern for staff was not being able to consistently provide one to one support / observation in line with the trust policy when it was required. For example, staff told us of occasions where they were monitoring eight patients who were at high risk of falls. The patients were in two separate bays of four and the staff member was stood in between both. We saw within the trust policy 'procedure for delivery of enhanced care' that bank and agency staff should not be requested for the sole purpose of delivering enhanced care. On inspection, staff told us shifts would be offered to bank staff for this purpose to keep patients safe.

Staff told us of an incident whereby a patient attended x-ray with a porter, but no clinical staff escorting. This patient had a fall with harm. Following this staff were told all patients attending for an x-ray must be escorted by a nurse or HCA. However, where multiple patients needed to attend scans on the ward this was not always possible due to staffing numbers. In these instances, the ward staff tried to adapt the scan or x-ray time to accommodate staff escort availability.

The trust monitored the number of falls across the wards we visited. Data showed that for the two months before our inspection, 145 falls were reported. Wards with the highest number were wards nine (28 falls recorded), ward eight (25 falls recorded) and ward 11 (20 falls recorded). The ward with the lowest number of patient falls recorded was ward 23 (nine falls). All other wards we visited had between ten and 20 falls within the set time.

Data from the trust showed that a risk assessment had been completed to determine where staffing could safely drop below the planned numbers and to what extent. This was completed for all areas across the hospital.

The staffing assessment showed the following for each ward we visited:

Ward seven, which could take up to 33 frail and elderly patients, was budgeted for three registered nurses (RN) and three health care assistants (HCA) for a day shift and the same overnight. The figure which had been assessed as safe to staff the wards were two RNs and three HCAs per both the day and night shifts.

Ward eight was budgeted for four RNs and five HCAs for a day shift and three RNs and four HCAs overnight. The figure which had been assessed as safe to staff the wards were three RNs and four HCAs for both the day and night shifts.

Ward eight was an elderly care ward and could take up to 33 patients. This was a COVID-19 positive ward at the time of our inspection. Staff told us that staffing had been very low during the pandemic; often dropping to two RNs and one

# Medical care (including older people's care)

HCA. Staff told us that where possible vacant shifts were filled by bank staff or staff pulled from other wards on the day. On the second day of our inspection, 9 December 2020, there were three RNs and two HCAs on shift. Staff described this as a 'luxury' despite being below the agreed safe level of required staff for HCAs. We were told at the time of the inspection; nine staff were absent due to being COVID-19 positive.

We noticed on a safety huddle record sheet for ward 8 that there was no nurse in charge role for a particular shift on 27 November 2020; and this was highlighted as unsafe. It was reported that there were two RNs and five HCAs on shift. On this shift, every patient was identified as a falls risk according to the handover sheet.

Ward nine was budgeted for four RNs and five HCAs for an early day shift and four RNs and four HCAs for a late shift. Overnight was budgeted for three RNs and four HCAs. The figure which had been assessed as safe to staff the wards were three RNs and four HCAs per early day shift, three RNs and four HCAs per late day shift and two RNs and four HCAs per night shift.

Ward nine had elderly patients and was a COVID-19 positive ward. Due to increased capacity, the ward could offer up to 33 beds for patients. Staff reported that often the staffing levels was usually two RNs and three to four HCAs per shift which was lower than the agreed safe figures.

Ward ten was budgeted for five RNs and four HCAs for a day shift and three RNs and four HCAs overnight. The figure which had been assessed as safe to staff the wards were four RNs and four HCAs for the day and two RNs and four HCAs per night shifts.

Ward 11 and 12 were budgeted for four RNs and five HCAs throughout the early day shift, four RNs and four HCAs over a late day shift and three RNs and four HCAs over a night shift. The safe figures were three RNs and five HCAs for an early shift, three RNs and four HCAs for a late shift and two RNs and four HCAs for a night shift.

Staff told us there were 11 vacancies on ward 11 at the time of inspection. There were also staff off with sickness or other concerns.

Ward 12 was an elderly care ward and due to the high number of patients with COVID-19 was not open to further admissions at the time of our inspection. On the first day of our visit, 2 December 2020, staffing was below the agreed safe figures for HCA cover for the early day shift and for the night shift. However, an additional RN had been placed on the shift.

Ward 15 was budgeted for five RNs and five HCAs through the day, and 4 RNs and three HCAs overnight. The safe level was assessed at three RNs and five HCAs during the day, and four RNs and three HCAs overnight.

Ward 15 took up to 29 medical patients and had one COVID-19 positive patient at the time of inspection. Staff told us they were generally staffed to the agreed safe levels. However, staff could be re-allocated to support other wards with lower staffing levels.

Ward 23 was a cardiology ward with six coronary care unit (CCU) beds. Therefore, this had a higher budgeted nurse staffing level of seven RNs during the day with two HCAs, and six RNs at night with two HCAs. The safe number was five RNs to one HCA across all shifts. Of these two RNs were allocated to the CCU (six beds) and three RNs for the rest of the cardiology ward (22 beds).

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Cardiology staff told us the agreed safe staffing numbers were generally allocated to the ward, however a staff member would often be re-allocated to cover other ward shortages. Therefore, staffing could be reduced to four RNs and two HCAs. Staff also told us those left on the ward could be more junior members of staff therefore may not have the full range of skills and competencies required to care for this patient group.

Staff across several wards told us they believed staffing levels were often unsafe. Wards reported they were often operating well below establishment levels. When wards were at establishment level or the agreed safe level, they often had staff members moved to fill gaps elsewhere in the hospital.

Staff from the wards we visited reported a total of 27 incidents relating to nurse staffing for the three months before our inspection. The ward with the highest number of staffing related incidents was ward eight, which had seven incidents. Ward 12 had six incidents, ward 11 had five, ward nine had three and wards seven and 15 had one apiece. Ward 23, the cardiology ward, had 4 staffing incidents reported against it. We noted that compared to the other two sites we visited (Queen Elizabeth Hospital Birmingham and Birmingham Heartlands Hospital) this was a high figure as Good Hope Hospital was the smallest of the three sites. In comparison, Birmingham Heartlands Hospital reported 27 nurse staffing incidents for 19 wards reviewed. Queen Elizabeth Hospital Birmingham reported 28 nurse staffing incidents reported for eight wards.

Several of the wards had trainee nursing associates (TNA) or registered nursing associates (RNA) who were trained to undertake most of the tasks nurses did. RNAs were employed at band four whereas RNs start at band five which is a higher level of seniority. TNAs were counted in HCA numbers. Nurses working on the wards were a mix of band five and band six. We saw that RNAs were counted in the nursing staffing figures; therefore, some wards may have had shifts with one registered nurse and one registered nursing associate. In addition, ward managers (band seven RNs) were also counted in the nursing numbers despite being scheduled to work between 8am to 4pm for both clinical and non-clinical duties. This meant that a ward may have appeared to have had three RNs; however, one may have been an RNA and one may have been the ward manager. This would then leave 7am to 8am and after 4pm with only two of the three nurse spaces filled. Some RNAs or newly qualified band five nurses had not yet completed all their competency training such as administering medicines; therefore, often one nurse was required to undertake such a job for the whole ward. In addition, although ward managers did undertake clinical duties; they were unable to complete as many of their managerial duties due to being required to cover the ward outside of their clinical hours.

At times TNAs would be required to undertake training specifically for their role, which meant they were not always available to act as a HCA despite being allocated to a HCA shift. Student nurses were not always getting the full support required from registered nurses due to the nursing staffing numbers being so low.

Staff across several wards told us they often had to stay hours beyond their 12 hour shift to ensure patients were safe. Reasons given included drugs rounds over running, catching up on paperwork and lack of staff on the next shift so staying until cover arrived.

Many of the staff we spoke with were undertaking additional bank shifts, at times in slightly different roles or on wards different to that agreed (for example a flow co-ordinator who was dual trained as a HCA would undertake HCA shifts outside of their normal working pattern). This contributed to staff exhaustion.

Despite all vacant shifts being offered out to internal bank staff, not all of these were filled. Internal staff discussed shift vacancies using secure social media chat groups to try and fill empty shifts. We heard varied responses about the use of

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agency staff. Some staff did not believe agency staff were able to be used at the time of the inspection whereas other staff thought they could be; but agencies could not fill the vacant shifts. We clarified this with senior leadership who reported that all vacant shifts could be put out to agency if unfilled by bank, and there should not be a financial or other block on this.

The trust risk register for the older adults speciality highlighted a lack of nursing and medical staff as a risk to patient care. These risks had last been reviewed in November 2020. We noted that although both risks (medical staff and nursing staff) were rated as moderate, the nurse staffing risk had a higher risk rating.

The trust submitted data for all wards we visited except ward 10 for the months of September, October, and November 2020. This data showed that for all wards except ward 7, nursing staffing figures were low across the wards we visited, although the trust did compensate by allocating higher numbers of unregistered staff (HCAs).

For September 2020, day shift registered staffing (nurses and trained nursing associates) varied between 56% (ward nine) to 105% (ward seven, which was the frail and elderly unit) of what was set as a safe level of staff. For night shifts, the ratio of rostered staffing rates versus safe staffing rates ranged from 78% (ward nine) to 101% (ward eight).

Unregistered staff including HCAs had a much higher compliance for September 2020. For day shifts this ranged from 84% (ward 15) to 131% (ward 23, cardiology). For night shifts compliance ranged from 106% (ward 11) to 162% (ward 23).

October 2020 data showed compliance for registered nurses on day shifts ranged from 56% (ward 9) to 104% (ward 7). For night shifts, compliance ranged from 78% (ward 9) to 92% (ward eight).

Day shift figures for unregistered staff in October 2020 showed compliance between 84% (ward 15) to 114% (ward 12). Night shift figures ranged from 106% (ward 11) to 152% (Ward 23).

Across November 2020, compliance for registered staff working day shifts ranged from 56% (ward nine) to 99% (ward seven). Overnight, staffing ranged from 73% (ward 7) to 91% (ward 12).

Unregistered staffing throughout November 2020 averaged between 73% on ward 15, to 114% on ward 12. At night figures ranged from 99% on ward eight, to 140% on ward seven.

We noted that support staff coverage was low at times. For example, on ward 12, the ward clerk role had been covered part time until recently where the additional hours had been recruited to. However, the ward clerk on this and other wards described undertaking duties additional to their role, such as those of the flow co-ordinators when they needed support and housekeeper duties. Or working face to face with patients to provide some emotional support or assisting with meals in the absence of activities co-ordinators, volunteers or relatives being able to support patients. Similarly flow coordinators told us of supporting the ward clerks, and the HCAs to undertake patient care where they were appropriately trained to do so.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with staff availability. However, there was not enough available staff to cover all shifts. The trust had processes to try and mitigate the low staffing. This comprised of a daily review by the matron in charge of each speciality or area. Staffing could be re-allocated depending on staff availability and daily acuity of each ward. Staffing concerns could be escalated to the senior responsible clinicians, who were responsible for overseeing the site in response to the pandemic. More locally, ward managers escalated projected staff shortages (for example if a future shift

# Medical care (including older people's care)

could not be covered) and immediate concerns such as a staff member being unavailable to work at short notice. Ongoing recruitment, and enhanced pay for bank staff were used to support shortages. However, staffing levels had remained stable across the three month period reviewed which indicated these initiatives had not made a significant difference during phase two of the pandemic.

A 'float' roster was in place as an additional measure to mitigate staffing shortages. Staff assigned to this rota could be assigned anywhere they were required.

The service had high vacancy rates for RNs on some wards. However, overstaffed the shift with additional HCAs to compensate for the reduced number of RNs. The trust sent vacancy rate data for September, October and November 2020 for RNs and HCAs.

Wards with the lowest vacancy rates were ward 15 (1% averaged across the three months reviewed), ward 12 (4.1% averaged across the three months reviewed), ward seven (4% averaged across the three months reviewed) and ward 23 (4.5% averaged across the three months reviewed).

Wards with higher vacancy rates were ward eight (13.1% averaged across the three months reviewed), ward nine (7% averaged across the three months reviewed) and ward 11 (9.7%) averaged across the three months reviewed). We did not receive data for ward ten.

Vacancy data for the same period for HCAs showed that five out of seven wards were over their establishment. Over the three month period reviewed, ward seven had an average of 4.1% staff surplus, ward nine had 5.8% over, ward 11 had 4.9% over, ward 12 had 2.7% over and ward 23 had an extra 0.9% HCAs.

Two wards had HCA vacancies: ward eight had 3.1% and ward 15 had 2.2% averaged across the three months reviewed.

Nurse and HCA vacancies were actively being recruited to at the time of the inspection. However, many staff told us this process was slow, and even when suitable applications were submitted; these were put on hold therefore delaying the recruitment process and potentially losing suitable candidates to roles at other trusts. Difficulties in securing staff and addressing concerns raised by specialities were reported in clinical governance meetings held from October to November 2020. We discussed this with the senior leadership team who reported that there was no trust wide block on recruitment, and they were eager to recruit applicants on a rolling basis rather than waiting for job advert dates.

The service had high and increasing sickness rates. Data from the trust showed high levels of staff sickness across most wards we visited from September to November 2020. On several of these wards, the nursing sickness rate rose sharply in November 2020. The trust target for sickness was 4%.

The wards with the lowest sickness rates included ward seven, which had zero sickness for nurses or additional clinical staff (such as HCAs). Ward 15 had zero sickness for HCAs across September, October, and November 2020. Sickness rates for RNs was also zero for September and October 2020 but rose to 17.12% for RNs in November 2020.

Ward eight had an average of 7.1% for HCAs and additional clinical staff and 3.9% for RNs across the three month period. Ward 23 had an average of 5.1% for HCAs and 2.83% across the three month period.

Wards with significantly higher average sickness rates included the remaining wards which were ward nine, ten, 11 and 12.



# Medical care (including older people's care)

Ward nine had an average rate of 25.1% sickness for HCAs, and 14.6% for RNs. The RN sickness rate rose sharply in November 2020 to 28.8%.

Ward ten had an average of 14.9% for HCAs sickness and 5.6% for RNs. Again, a sharp increase to 15.5% sickness for RNs was noted in November 2020.

Ward 11 had an average of 6.8% for HCAs and 9.2% for RNs across the same three month period. November 2020 RN figures were much higher than the average at 16.7%.

Ward 12 had an average of 14.12% sickness for HCAs across the three month period and 8.12% for RNs.

Medical staffing was also low. The trust used regular locum doctors to cover shortages. One incident was reported about low medical staff numbers for ward 15 for the three months before the inspection.

## Records

**Not all staff could access patient records. Some assessments such as ReSPECT forms were not fully completed or updated. Records were mostly kept securely.**

Records were mostly stored securely. Paper records were kept in lockable trolleys on the ward. In the main we saw records were kept in the trolleys when not in use, and these were locked. On one ward we saw a trolley was not locked and two sets of patient records were left on the top. No staff were visible at this point, so it was not clear if anyone was actively using these. However, this ward was locked to visitors and only trust staff had access.

Not all staff could access patient records easily. Some patient nursing records at Good Hope Hospital had recently been transferred to an online system. Ward clerks and HCAs had access to this and were able to input patient details and update the system for example when a patient was admitted, discharged, or moved from the ward. Nurses and medical staff did not have access to this system. Out of hours, HCAs did not have the time to update the systems due to being understaffed. Therefore, this was often left for staff working Monday to Friday. This meant that there could be a backlog of notes to update on the system, particularly following a weekend. In addition, where RNs and HCAs discharged, admitted, or moved patients out of hours, the exact times and locations were not always written down. As a result, ward clerks had to guess at what time patients had entered or left the ward and had to spend time tracking patients down who had moved on, such as to other wards around the hospital.

Staff told us that this meant there were times where relatives rang to speak with a patient, but ward staff did not know exactly where the patient was. This corroborated intelligence gathered by CQC before the inspection such as complaints from patients and relatives.

Staff told us there were problems whereby the previous system had been shut off very quickly, and staff had no or reduced access to this. Therefore, there was confusion over the transfer of patient records as both systems generated different ID numbers.

The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. Staff complete documentation to record the

# Medical care (including older people's care)

conversations held for each applicable patient, and discussions had with the patient and family/carers. We reviewed 26 ReSPECT forms and found 18 did not contain all the relevant information. For example, next of kin details were not included despite some forms showing evidence of staff discussing this form with family. In addition, the forms were not always signed by a consultant and a review date was not always set.

We requested the last two documentation/patient record audit results from the wards we visited at Good Hope Hospital. The trust sent a narrative about what they are currently auditing for example specific to discharge documentation. We did not receive any completed audits or results. The trust told us they were in the process of a documentation audit at the time of inspection and were reviewing ten sets of patient notes per ward. Therefore, we were unable to review previous audits to ascertain how the relevant wards monitored this and drove improvement.

## Medicines

**VTE medicines were mostly prescribed in line with national standards. However, staff did not always follow processes when administering medicines.**

VTE medicines were prescribed appropriately during our inspection. Where they were not prescribed on admission, this was based on clinical guidelines and best practice.

On two wards, we observed that nursing staff did not wear any apron or tabard whilst undertaking a medicine round. This meant it was not visually obvious that these staff were not to be disturbed during this important task.

Doctors told us they reviewed medicines daily and checked the medicines chart during ward rounds. However, staff told us the current electronic system could make reviewing medicines and prescriptions more difficult as it was not user friendly.

Staff were aware of the need to check patients medicine on discharge, including whether this was given in a blister pack or in standard boxes.

Enoxaparin (a medicine to prevent blood clots) supplies had been low on one ward, but staff had resolved this by going through pharmacy and to other wards.

## Incidents

**Staff recognised and reported most incidents and near misses. Managers investigated incidents and shared lessons learned with the local team. Managers shared actions from patient safety alerts however staff were not always aware of wider learning.**

All staff knew what incidents to report and how to report them. Staff we spoke with knew the procedure for reporting incidents and gave examples of what they would report. However, some staff told us they did not get time to report all incidents using the electronic reporting system. Instead, they alerted the manager such as tissue viability concerns or spoke to other staff on shift about it. Managers told us staff told them of incidents.

Staff raised concerns and reported most incidents and near misses in line with trust policy. Staff told us they felt confident to raise incidents with their managers and these would be reviewed.



# Medical care (including older people's care)

Staff were kept informed about learning from incidents from emails and received important updates during safety huddles in the mornings. However, this tended to be from a ward level perspective. Data from the trust demonstrated that learning from local incidents was shared with ward staff.

Evidence of local learning was found during the inspection, for example one patient had their equipment needs reviewed and changed after a fall. Updates and changes to practice were displayed on wards. For example, information about conducting cardiovascular assessments for patients who had fallen was displayed in a staff room we visited. Notice boards contained information relevant to the type of patients being cared for.

On ward nine, outside of the two COVID-19 waves, the ward manager did a 'hot topic of the week' to highlight learning from incidents and areas where good practice could be reinforced or to highlight areas for improvement.

Ward managers discussed learning from incidents in ward manager meetings. Managers told us they discussed incidents with other managers during meetings and could share this information with ward staff for example during safety huddles on the ward.

Managers investigated incidents thoroughly. We saw evidence of local investigations and action plans produced as a result.

Locum medical staff did not get as much insight into learning from specific serious incidents that had occurred. However, they received trust wide emails which did include some shared learning and updates about topics such as falls.

Incidents and learning from other wards were not consistently shared. We asked staff if they were aware of any incidents linked to VTEs as this was a trust wide focus, however staff were not aware of any such incidents.

## Is the service effective?

Inspected but not rated



### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. However, some patients had to wait to be supported with eating due to staffing constraints. The service adjusted for patients' religious, cultural, and other needs.**

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients dietary requirements were discussed at shift changes during handover. This clarified if patients required assistance with eating or drinking or were on a specialised diet or feeding regime.

Staff told us they mostly managed to provide support to patients who required help with eating, although sometimes it did take longer than it should due to low staffing levels. The wards had a red tray and red jug system which highlighted patients who required additional support.

# Medical care (including older people's care)

Staff did not consistently complete patients' fluid and nutrition charts where needed. We reviewed fluid balance and nutrition charts across five wards. We reviewed 25 records and found that 14 sets of monitoring paperwork were fully completed. One of the records had the date missing but had been signed and filled in correctly. However, the remainder of fluid and food charts were incomplete. For example, fluid charts were not updated each time a patient in took fluids, or output fluids. Therefore, it was more difficult for staff to quickly review and ensure patients were receiving enough fluids to keep them healthy.

Staff monitored intravenous fluid infusions whereby patients were provided with fluid and / or nutrients intravenously rather than orally.

When nutritional problems were identified, staff made referrals to dieticians to support patients.

Staff noted dietary needs and preferences such as vegetarian diets and handed this information over to other staff at shift changes.

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

**Not all staff had received or updated training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards, although there was a plan in place to achieve this.**

Not all staff received and kept up to date with training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Of the eight wards we visited during our inspection, one ward (ward seven) had met the trust target for mandatory training relating to the Mental Capacity Act 2005 (MCA). The remaining wards had compliance which ranged from 50% (20 out of 40 staff on ward 11) to 81% (30 out of 37 staff on ward 23, cardiology). Training targets had been impacted by the COVID-19 pandemic and staffing shortages as described within the safe domain of this report. We saw in clinical governance minutes from the medicine speciality, that mandatory training attendance was being prioritised to enable staff to attend training essential to keeping patients immediately safe from harm. This meant some training compliance was lower and this was agreed through the trust processes. The trust had a plan to develop consent training in line with the MCA training.

Staff on the wards had access to specialist teams for support with managing the consent process with patients who did not have the capacity to consent to care, treatment, or a loss of liberty. At the time of the inspection, no audits were conducted around the consent process, including monitoring the quality of MCA assessments. Therefore, we did not have data to form a judgement on staff adherence to trust policies around this.

Staff implemented Deprivation of Liberty Safeguards (DoLS) in line with approved documentation. Staff knew when they should apply for DoLS authorisation such as if they were placing a patient under one to one supervision and that patient was unable to consent to this due to a lack of capacity. We asked the trust about applying DoLS where patients who could not consent were not able to leave the ward (locked wards). The trust response was each patient without capacity to consent to this would be assessed to identify if a DoLS was needed. DoLS guidance under the Mental Capacity Act stipulates if a patient attempts to leave a ward but is prevented from doing so, even in their best interests, and is showing a lack of capacity to consent to ongoing care and treatment as an inpatient, then a DoLS should be applied for to lawfully restrict the patient's movements.

# Medical care (including older people's care)

## Is the service responsive?

Inspected but not rated



### Meeting people's individual needs

**Ward staff did not have the capacity to meet the individual needs of all patients living with dementia. Patients with a learning disability could access the site based team to get support. Staff supported patients to choose food based upon dietary preferences.**

Due to the pandemic, staff did not have the time available to support patients living with dementia and learning disabilities. Wards we visited had equipment to support patients with additional needs, such as learning disabilities or dementia. We saw distraction trolleys which included games, puzzles, and activities. Due to the pandemic, at the time of the inspection, staff had limited time to engage with patients in activities other than those essential to day to day care and treatment. Relatives were, in the main, unable to visit patients and volunteers were not working during the pandemic. Therefore, patients were receiving less mental stimulation and distraction than they would receive before the pandemic. Staff told us this was challenging as many patients were experiencing a sharper decline in mental health and cognitive function due to the lesser stimulation, which then impacted upon behaviour on the ward.

At the time of the inspection, due to the pandemic, wards were not designed to meet the needs of patients living with dementia. Within the Richard Salt unit, a room behind the reception desk on each ward had previously been used to support patients and as a therapy area for allied health professionals. One ward had used charitable funds to ensure the room met patients' needs. However, these rooms had been transformed into bed spaces for patients due to site capacity needs. Therefore, there was no space for patients to independently work on tasks such as jigsaw puzzles.

Some wards had been decorated for Christmas to boost patient and staff morale. Some wards we visited were not yet decorated but staff had plans to do so soon. Staff told us they had gained authorisation for having decorations and were following guidance to reduce the risk of infection, such as only using trees, and disposing of these after Christmas.

Some staff members on elderly care wards told us the most difficult part of the pandemic was relatives being unable to visit the hospital unless a patient was end of life. Most staff told us they were unable to contact relatives as much as they would like to and provide an update on their wellbeing. Relatives not being able to visit also meant staff did not have the same level of support with assisting patients to eat or assisting patients with their basic hygiene that they otherwise would have had.

The service had suitable facilities to meet the needs of patients' families. Wards had mobile phones to support patients to communicate with their families. At the time of our inspection the 'mobile' phone used by patients to speak with family on ward 12 was broken. This meant the ward clerk had to hold a landline for the patients to converse with family members and wait until these conversations were finished. As a result, the ward clerk was away from their desk and had a reduced capacity to complete their workload whilst doing this.

Staff told us relatives and carers had complained more so during the pandemic about not receiving timely updates about patients. Staff did try to answer the phones as much as possible, and support patients to speak directly to relatives. However, due to the clinical needs of the patients, staff were not always present to be able to do so.

# Medical care (including older people's care)

Ward eight had introduced a communications officer who took responsibility for contacting relatives. Staff told us this brought more regularity to contacting relatives and had reduced complaints and frustration from relatives. Most wards also had a mobile phone which patients could use to talk to relatives if they did not have access to one.

Some relatives turned up directly to the hospital to complain. This was managed by site security and by ward managers who worked to resolve any concerns.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. During our inspection we saw updates about accessing the learning disability team, and the process that should be followed, were displayed in staff areas. Staff told us that the specialist learning disabilities team attended the wards to support patients diagnosed with a learning disability.

Where patients were displaying symptoms of mental health conditions or were also diagnosed with a mental health condition as well as their physical health condition, staff liaised with the community mental health teams.

As part of the protective measures to reduce the spread of infection, all staff were required to wear masks covering their mouths and noses when on site; and an additional visor when providing patient care. This may have impacted on communicating with patients and staff who were deaf and relied on lip reading to understand speech.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients dietary preferences were reported during shift change handovers. For example, staff recorded if patients were vegetarian or had other dietary preferences.

## Access and flow

### **Patients experienced a high number of bed moves due to the pandemic.**

Staff moved patients between wards at night. The trust provided data relating to bed moves for October and November 2020. This data covered wards seven, eight, nine, ten, 11 and 12 and was for bed moves within and outside of the hours of 10pm to 8am.

Bed moves between 10pm and 8am across the above wards for October and November 2020 totalled 615. Between 8am and 10pm, bed moves totalled 2,123. Bed moves should usually be kept to a minimum to improve patient experience and to reduce distress and confusion. The trust clarified many of these moves were to manage infection control during the pandemic; and some were to facilitate a higher level of care where patients required this. To support this high number of moves, a trust transfer team was established to support patient safety.

Staff working on COVID-19 positive wards told us patients could be moved numerous times per week to accommodate new patients being admitted. Whilst staff understood this was to manage patient flow and safety; they also reported that this was having a detrimental effect on those patients being moved so regularly. Particularly elderly or vulnerable patients.

Deceased patients were not always transported from the wards in a timely manner. On ward eight, a patient had passed away at 6.45am, at 11.35am the patient still had not last offices completed or been transported from the ward due to low staffing levels. This was reported by several staff members and it caused them distress.

# Medical care (including older people's care)

On one ward, we saw male patients were placed in a bay within the female only area due to the number of patients needing beds. Whilst the male patients were in a separate bay, they were still visible to the women which staff told us some women were not happy about. Staff told us that a patient in a side room had decided to stop using the bathroom facilities which required her to leave her bedroom due to the presence of male patients.

Before our inspection, we received nine complaints from care homes regarding the discharge process of patients from wards at Good Hope Hospital. This was from January to October 2020. Themes included poor communication between the ward and the care home, patients being unwell when they were discharged; and medicines and equipment not being organised in a timely manner.

Staff told us they believed a lot of the complaints regarding patients discharged 'in a worse condition than when they were admitted' was due to relatives being unable to visit. Therefore, staff believed patients had noticeably deteriorated by the time they next saw their loved ones. However, this was not reflected in the complaints we received before our inspection.

During our inspection we reviewed the discharge process. Staff expressed they did not feel pressured to discharge patients before they were medically fit. Although staff felt there was a high incidence of patients returning quickly to hospital post discharge which at times indicated a patient may have been discharged before they were fit enough. Staff reported that discharges were more likely to be delayed due to awaiting test results including from COVID-19 swabs. However, staff told us that the discharge process itself could be rushed; and reported they were too busy delivering patient care to fully undertake all required checks and complete paperwork.

Managers and staff worked to make sure patients did not stay longer than they needed to. Each of the wards had a flow co-ordinator who was responsible for facilitating patient discharges. The flow coordinators took part in discussions with doctors and nurses daily to discuss which patients were ready for discharge, and what barriers were preventing patients from going home. Staff told us that this role helped ease some of the pressure on nurses with regards to discharge. Flow co-ordinators liaised with social services to find placements in care homes for patients that needed this. Placements could only be requested when a patient was medically fit and had completed any required therapy which meant there was sometimes a delay and patients could start to become deconditioned (deteriorate in their physical health). At the time of the inspection the trust social worker teams were not regularly attending on the wards, so some tasks which were usually covered by them were undertaken by the flow coordinator such as specific checks and capacity assessments.

Managers and staff did not always work to make sure they started discharge planning as early as possible. Staff from different wards told us discharges did not seem well managed overall. These could be rushed and last minute, or planned discharges would be cancelled at short notice.

Patients were discharged from medical wards when they had received a negative COVID-19 swab test result within the previous 48 hours. Due to delays associated with this, patients sometimes had to be re-swabbed and therefore be discharged on a later than scheduled date.

Staff told us that due to pressure from the site office they often had to rush discharges to try and balance out issues with patient flow and bed capacity. Staff believed this caused mistakes, such as patients being discharged with incorrect or missing medication.

Staff could access a trust wide discharge team for support with more complicated patients.

# Medical care (including older people's care)

The trust had set up several pathways to enable efficient and timely discharges during the pandemic. These were in conjunction with local organisations such as the local authority, and the clinical commissioning group.

The trust had a discharge policy which staff could refer to. This was due for review in March 2020, however, was being reviewed at the time of our inspection. The delay was due to the pandemic. Certain elements of the policy could not be complied with at the time of the inspection. For example, item 3.4.8 stated all suitable patients must be discharged through the discharge lounge. However, the discharge lounge was re-purposed at the time of inspection therefore this was not possible. Some elements were not always complied with due to lower staffing numbers. For example, item 3.4.3 stated preparation for discharge begins before or immediately on admission. Staff told us this was not always possible due to time constraints. Another point was 3.4.10 which stated correct trust discharge documentation is completed. However, as documented within the safe domain of this report, we found this was not always complied with during our inspection. In addition, we had received several complaints and concerns from a range of care homes, patients and family members regarding patients being discharged in an unsafe way and without effective communication. We saw the policy had a clear line of governance outlining who had responsibility to ensure the policy was complied with. At the time of inspection, discharge documentation or processes were not audited.

The trust sent data relating to delayed discharges. Since April 2020 up until the time of our inspection, delayed discharges across Good Hope Hospital did not go over the trust target of 1.4% of all discharges. This meant patients were not delayed from leaving hospital if they were deemed medically fit to do so.

Good Hope Hospital had a low rate of readmissions within 72 hours (three days). From August to October 2020, 1,666 patients were discharged from the wards we visited. Of these patients, 33 (2%) were readmitted within three days. The wards with the highest rate of readmissions were elderly care wards. These included wards seven (nine out of 239 patients; 3.77%), ward eight (six out of 215 discharges; 2.8%) and ward nine (four out of 153 patients, 2.6%).

## Is the service well-led?

Inspected but not rated



### Culture

**Staff did not all feel respected, supported, or valued by the wider trust. However, staff were focused on the needs of patients receiving care and were passionate about helping patients get better.**

During our inspection, despite significant pressures due to the pandemic and low staffing numbers, almost all staff we spoke to described being passionate about helping patients and undertaking the role they were in. Where staff did not express this, they reported that this was because of the work pressures and difficulties faced in every shift, rather than a lack of motivation to do the role.

Staff told us they were tired. Some staff told us they and colleagues were physically and emotionally exhausted to the extent of becoming upset or angry during or outside of shifts. Staff highlighted the importance of being aware of colleagues' emotional state; so that they could support others or cover for staff who needed to take a few minutes off the ward to recover composure. However, this was not always possible due to the lower staff numbers on several wards.

# Medical care (including older people's care)

Staff on most wards reported tension being present. We heard and were told about interpersonal differences between staff which had led to conflict, particularly between staff from different wards and grades. All staff we spoke with told us they were trying to work as a team where possible and support each other. However, despite some staff promoting a team based approach to work, we were told some of the tension on wards was due to a perceived lack of effort by some staff.

Staff reported a varied level of support by the medical team on the wards. Most staff reported that the medical staff worked well to support them, and they worked effectively as a team. However, some staff told us some doctors, particularly those on rotation, were not always 'hands on,' preferring instead to remain in their office. In addition, staff told us a small number of doctors did not always take enough time when dealing with patients which meant patients were spoke at and over.

Staff told us there had been gaps in management support in some areas at times due to vacancies and other absences. However, staff told us they felt supported by their ward managers to raise issues. We saw during our inspection a staff member was able to approach a ward manager to report a concern; and action was taken as a result. Ward managers told us they had an open door policy.

Some ward managers were proactively holding meetings where possible to improve morale and discuss concerns in an open and transparent way. These meetings were able to facilitate physical attendance by a limited number of staff due to social distancing and availability of staff on the ward. In addition, staff could dial into the meeting, and minutes were produced to share with those who could not attend.

We were told by some staff they felt happy to approach the matron of their area with concerns and felt the matron was supportive. However, other staff told us their matron was not visible on the ward and they rarely saw them. Some staff felt that managers above ward level were not as supportive as they could be during this time.

Staff spoke of the changes to their level of physical and emotional support available throughout the pandemic. During the first wave staff were inundated with support by both the trust and the public, which was appreciated. However, staff felt this support had significantly waned and many staff were not fully aware of the facilities available to them such as the wellbeing hub which was still open at the time of the inspection. Staff also reported they did not have the time within their shifts to access support.

During the pandemic, many changes had been made such as where specialities were located, changes to elective surgery pathways, ward refurbishments and ward capacity numbers. As a result, many staff had worked flexibly across the hospital, often on a new ward or a new area of work. For some staff this had been a short term change before returning to their usual place of work but for others this had become a permanent change. Staff who had been affected told us the changes were stressful, but they understood why these had happened.

Some local management of specialities within medicine considered staff morale and culture. This was evidenced within clinical governance meeting minutes. For example, within the stroke speciality meeting minutes from September 2020, a discussion was held around the impact the hospital environment and sickness levels were having upon therapy staff and their ability to carry out their role. However, it was noted that management above this level were not as supportive to address concerns raised. The trust wide speciality minutes also highlighted differences between sites as to how staffing and environments were being managed. Within the gastroenterology meeting minutes from September 2020, a member of the medical team promoted a mindfulness and wellbeing course as suitable for staff as well as patients to help manage the stress generated from working in a pandemic.



# Medical care (including older people's care)

## Governance

**Not all trust wide communication was received at local level. However, divisional leaders operated effective governance processes, throughout the service. Staff at senior levels had regular opportunities to meet, discuss and learn from the performance of the service.**

The trust wide medical division held speciality specific clinical governance meetings regularly. These were monthly or quarterly depending on the speciality. The agenda held standard items including clinical performance, financial performance, incident review, updates and policy changes, staffing and issues relating to COVID-19.

We saw that, in the main, the minutes from these meetings had a clear focus on patient safety from local speciality leadership. Emphasis on patient safety and quality, including audit completion was given. Reasons were provided where audits were not completed or were delayed. These were related to the pandemic and the impact that had upon completing tasks not immediately relating to hands on patient care. This supported what ward managers told us during our inspection.

The minutes from the cardiology speciality demonstrated engagement with the trust wide executive team to gain support, as necessary.

The trust monitored Venous Thrombosis Embolism (VTE) performance and reviewed this through formal governance channels, such as the clinical quality monitoring group (CQMG). We saw minutes from two CQMG meetings within 2020 to evidence this.

Divisional directors attended the above meeting and chaired monthly safety meetings whereby incidents across the division were reviewed and themed. Other agenda items included complaints, risks and feedback from the quality and safety meeting. We reviewed a range of meeting minutes from division three (medicine), division four (which included ward 15; gastroenterology), division two (which included ward 23, cardiology) and division five which included ward ten.

Meetings entitled nursing incident quality assurance meeting (NIQAM) were regularly held to discuss serious incidents including falls, infection control incidents and pressure ulcers. Meeting agendas from October and November 2020 showed they covered specific incidents which had occurred on a range of wards including some of those which we visited as part of this inspection.

We reviewed matron meeting minutes and saw these meetings occurred weekly. Staffing concerns were highlighted from some of the wards we visited during both our inspection days. We saw this was escalated up into other clinical governance meetings.

Some ward managers held team meetings when possible to share information and learning. Despite this staff told us they only regularly heard about local learning or updates. Most staff could not recall learning from incidents from other areas of work. However, staff were aware of some trust wide changes to practice that affected them locally, such as how to better support patients with learning disabilities.

## Management of risks, issues, and performance

**Not all risk registers accurately captured risks to the service. Some actions such as those in relation to managing staffing, were not enough to mitigate the risk to patient safety.**



# Medical care (including older people's care)

Each speciality had a separate risk register which covered all locations. We saw risks were reported alongside the site to which they applied. Whilst most risks were trust wide, we saw some specific to areas we visited within Good Hope Hospital. For example, the gastroenterology speciality identified a risk relating to too many general medical outliers on ward 15 which may impact upon patient safety. The risk register for care of the elderly speciality and the gastroenterology speciality highlighted medical and nurse staffing as a risk to the service including wards we visited. The trust did not provide action plans associated with the risk register therefore we were unable to assess the quality of these.

We reviewed the clinical governance meeting minutes from the three months before our inspection for each speciality as provided by the trust. We saw every speciality except cardiology and care of older patients discussed staffing at length and demonstrated concern about the impact of staffing upon patient safety and care. For example, within the stroke speciality, staff at the meeting discussed band five nurse shortfalls being covered by health care assistants (band two). However, we noted ward eight (which held stroke patients during the pandemic) at Good Hope Hospital was not highlighted in the speciality risk register with regards to staffing despite this ward having a high nurse vacancy rate (13.47 WTE vacancies in November 2020). The minutes from the healthcare of older people speciality clinical governance meeting held in November 2020 did have an agenda item linked to staffing. However, the minutes for this were brief and focused upon appraisals and staff training rather than staff shortages as per the risk register.

Most staff we spoke with were concerned that patient safety was compromised due to the low numbers of staffing and higher acuity of patients during the pandemic. Many staff told us they reported low staff numbers either through the electronic incident reporting system, or their local management team. As reported in the safe domain of this report, 27 incidents were reported about nurse staffing across the wards we visited for the three months before our inspection.

Staffing numbers presented a risk which was reviewed daily by matrons and site management. A 'float' rota was scheduled whereby staff covered where they were needed each day. Staff were also regularly reallocated from one ward to another to cover shortages. Where staff shifts on rotas were not filled, these were put out to the internal bank. Managers could request agency staff if shifts were unfilled by bank. There was varied feedback about this. For example, some staff felt requests for agency staff were being rejected or not permitted. Other staff felt agency staff were not able or willing to fulfil the shifts offered.

Managers had reviewed budgeted staffing figures to risk assess working with lower staff numbers. Managers had created a template which set out an agreed safe number of nurses and health care assistants per shift. The agreed safe figure of staff was below the budgeted number of staff for all wards we visited. However, we found actual nurse staffing numbers often fell below the agreed safety number. This meant the wards were not safely staffed in line with national guidance. In addition, we found evidence of harm as an impact of low staffing as detailed within the safe domain of this report.

Rolling recruitment was ongoing for nurse staffing however this did not help to recruit enough staff to safely cover all shifts. Data from the trust demonstrated some recruitment had been successful. For example, we saw that the vacancy rate on ward 11 went from 10.01 whole time equivalent (WTE) in September and October 2020 to 9.01 in November 2020 which indicated one whole time equivalent (WTE) nurse had been recruited. The same was noted on ward 23 whereby the vacancy rate went from 4.84 WTE in September and October to 3.84 in November 2020. Conversely, some wards showed an increasing vacancy rate. For example, ward eight went from 12.55 WTE vacancies in October 2020 to 13.47 WTE in November 2020. We noted vacancy rates on other wards we visited did not significantly change over the three month period. This data indicated that the recruitment programme was not effective to mitigate the ongoing nurse staffing problem.

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The trust had approved an enhanced rate of pay for some shifts to encourage bank staff to work more shifts. However, for some staff this financial increase was minimal and did not work as an incentive.

Ward managers reported that due to the staffing pressures they were not able to consistently complete the full suite of audits and performance monitoring tasks that should be undertaken. This impacted upon the full range of data availability to monitor performance during the pandemic.

Meeting minutes demonstrated quality performance and risk was monitored and reviewed by divisional senior management through a range of clinical governance meetings. Patient safety was an item on every agenda viewed; with incidents being themed and highlighted for learning.

The trust monitored VTE performance and regularly reviewed this within clinical quality group meetings. Data from the trust showed several audits were undertaken to support this. The trust worked to improve their performance, particularly in relation to reducing hospital acquired thromboses (HAT). A quality improvement (QI) project had been initiated on VTE risk assessment, and prevention, pausing and restarting anticoagulants. We saw training presentations and other projects were in place to improve performance. For example, a pilot project to optimise anticoagulation safety in elderly patients had been funded to run for one year.

The trust had introduced an electronic patient system which medical staff used to assess patients and prescribe any required medicines at the Queen Elizabeth Hospital Birmingham before our inspection. This had improved how patient information, including prescriptions and medicine records, was managed. It worked in tandem with a separate patient information system which had very recently been introduced at Good Hope Hospital to replace the previous electronic patient records used there. A new patient electronic record system was due to be rolled out at Good Hope Hospital in 2021, after being rolled out at Birmingham Heartlands Hospital. The trust explained how using this system improved patient safety. For example, when completing assessments including VTE assessments, staff were prompted to update or repeat these; or to input information. Therefore, the use of this at Good Hope Hospital was anticipated to drive improvement. However, as can be seen within the Queen Elizabeth Hospital Birmingham Report, medical staff could override certain features, or were not consistently prompted to undertake certain tasks which impacted on patient safety. As a result, the trust planned to build extra features into the electronic system such as automatic reminders to check paused anticoagulant prescriptions, which would be in place by the time the system was in use at Good Hope Hospital.

At the time of our inspection, we found that discharge paperwork was not used consistently by ward staff at Good Hope Hospital, and incidents and complaints had demonstrated poor discharge experiences for patients. Before our inspection, the quality of documentation, including adherence to discharge processes was not audited routinely; therefore, there was no data to support how well the staff adhered to trust policies. However, the trust told us they were in the process of a documentation audit at the time of inspection and were reviewing ten sets of patient notes per ward. This audit would also identify gaps in the discharge process with an aim to drive improvement.

The trust had initiated a quality improvement programme to improve communication about patient discharges in response to several concerns raised from community care homes. The aim was to improve patient's experience of being discharged, and to reduce the number of complaints. This project had been started before the pandemic; however, had been put on hold due to this.

# Medical care (including older people's care)

## Areas for improvement

The provider MUST:

- The provider must ensure that nurse staffing is adequate to keep patients safe. Regulation 18 Staffing (1).
- The provider must ensure that Venous Thrombosis Embolism (VTE) risk assessments are completed and recorded for all patients in line with guidance. Regulation 12 Safe care and treatment (1) (2).

The provider SHOULD:

- The provider should ensure staff are following best practice guidance with regards to wearing and laundering uniform. Regulation 12 Safe care and treatment (2)(h)
- The provider should ensure ReSPECT forms are fully completed. Regulation 12 Safe care and treatment.
- The provider should ensure staff are able to identify patients being referred to in ward handover paperwork. Regulation 12 Safe care and treatment.
- The provider should ensure staff provide a handover when transferring patients between wards or units. Regulation 12 Safe care and treatment.
- The provider should ensure records are always securely stored. Regulation 12 Safe care and treatment.
- The provider should ensure staff can undertake training for the Mental Capacity Act when possible. Regulation 12 Safe care and treatment.
- The provider should ensure staff morale is considered to promote a healthy and safe culture. Regulation 17: Good governance.
- The provider should ensure staff are documenting that discharge planning is taking place and discharge checklists are used to ensure a safe discharge. Regulation 12 Safe care and treatment (2) (a)(b).
- The provider should consider reviewing its process for sharing trust wide learning from incidents so that all staff receive this information in a consistent way.
- The provider should consider providing tabards / red aprons for nurses undertaking drugs rounds.

# Our inspection team

The inspection team comprised two CQC inspectors and a specialist advisor who had expert knowledge in the medicine core service.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing