

Inspection Report

We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

University Hospital

University Hospital, Clifford Bridge Road,

Walsgrave, Coventry, CV2 2DX

Date of Inspection: 07 January 2013 Date of Publication: March

2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use	
services	

Met this standard

Tel: 02476964000

Care and welfare of people who use services

Met this standard

Safeguarding people who use services from abuse

✓ Met this standard

Supporting workers

Met this standard

Assessing and monitoring the quality of service provision

Met this standard

Details about this location

Registered Provider	University Hospitals Coventry and Warwickshire NHS Trust
Nominated Individual	Mr Mark Radford, Chief Nursing Officer
Overview of the service	University Hospital provides a wide range of acute services for patients requiring planned and unplanned care including specialist services in cardiology, neurosurgery, stroke, IVF, diabetes, cancer care and kidney transplants. University Hospital is one of two hospital sites managed by University Hospitals Coventry and Warwickshire (UHCW) NHS Trust, serving a population of 1,000,000 people.
Type of services	Acute services with overnight beds Community healthcare services Urgent care services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Management of supply of blood and blood derived products Maternity and midwifery services Services in slimming clinics Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We reviewed all the information we have gathered about University Hospital, looked at the personal care or treatment records of people who use the service, carried out a visit on 7 January 2013 and observed how people were being cared for. We checked how people were cared for at each stage of their treatment and care, talked with people who use the service, talked with carers and / or family members and talked with staff.

An external specialist advisor was part of our inspection team.

What people told us and what we found

During this inspection we focused on inpatient areas where patients could expect to stay for a short period of time so their condition could be monitored and a decision made about their treatment and care needs.

We visited the Clinical Decisions Unit (CDU) and Ward 12, an observation ward. We also spent a short time on Wards 3, 10, 33 and 43, which we visited to speak with people who had been moved to these wards from the short stay areas in the hospital. We spoke with people in the hospitality lounge who were waiting to go home.

During the course of the day we spoke with 18 patients and two of their relatives. We pathway tracked four patients to look at their experience of the care and support they received. We spoke with 15 staff from various disciplines. We met with the bed management team, the safeguarding team and the trust's quality and governance team.

We found that staff worked hard to uphold the dignity and promote the privacy of patients.

Patients we spoke with were satisfied with the care they received. Their comments included.

"Couldn't wish for anything better here."

"Excellent. Can't fault the staff. They are so kind."

We found that staff at University Hospital were given the training and support they needed to meet patients' needs effectively.

We found evidence that staff took appropriate action when they suspected abuse or

neglect.

The trust had systems in place to review the quality of the service they provided to patients.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services



Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care. People's privacy, dignity and independence were respected.

Reasons for our judgement

Observations we made on the wards we visited showed the service supported patient's privacy and dignity. For example, we saw staff knocking and waiting to be invited into side rooms before entering. We also observed staff closing the curtains around a patient's bed prior to assisting them to get into bed. We noticed that frail or more vulnerable patients were not left uncovered or exposing parts of their body. We observed staff attending to patients to make sure they were covered appropriately to maintain their modesty.

Staff spoken with demonstrated a good understanding of how they would respect privacy and dignity.

All the patients we spoke with told us they felt their privacy and dignity was upheld. One patient said, "The doctor and paramedic were both excellent, but it would be nice to have a space to have a private conversation."

Care records we looked at showed that personal preferences and beliefs were recorded. For example, patients' care records recorded their spiritual beliefs. The provider might find it useful to note that one patient told us, "Due to my religion I won't have a blood transfusion. I was asked twice downstairs and once upstairs about this. Once I have signed (to state this) why am I asked the question three times?"

We observed the principles of delivering single sex accommodation were adhered to within all clinical areas. For example, a four bed area in the hospitality lounge was available for patients waiting for discharge who needed to remain in bed. There were no patients using this area at the time of our visit. A senior member of staff told us that this area was assigned to single gender when it was in use.

In one ward area we observed two male members of staff approaching an elderly female patient to deliver personal care. The patient had been admitted from a care home because she had become increasingly confused. It was not clear what efforts had been made to

establish whether the patient found it acceptable to receive personal care from male staff. We spoke with a senior member of staff about gender preferences in personal care. We were told that preferences would be respected where possible if the person asked. The provider might find it useful to note that some people using the service may not have had the ability to express their personal preferences.

We observed patients being offered choices and staff explaining the care they wanted to provide so that patients were informed and could provide consent.

A range of information leaflets were available to cover all procedures carried out by the hospital trust at University Hospital. The hospital trust had a number of services to support communication and the involvement of patients, such as access to interpreting services. The trust's website gave information about the services they provided at University Hospital. It also outlined the complaints process, and how to access the Patient Advice and Liaison Service (PALS), as well as providing an outline of the trust's core values.

The most recent results of the trust's own patient surveys ('Impressions') had been published on their website. This recorded that the majority of patients felt they were well informed and were involved in making decisions about their care and treatment.

Most of the patients we spoke with said they felt well informed about their plan of care. They told us medical and nursing staff explained things well. This was more of a challenge in the clinical decision unit and observation ward. Some of the patients we spoke with were uncertain about what was going to happen to them although nursing staff had told us about the care decisions. The provider might find it useful to note that information was not always given to patients in a timely manner in the short stay areas. One patient commented, "I don't know what's happening to me. I couldn't tell you anything. I'm just waiting here, waiting for things to happen."

Care and welfare of people who use services



Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

We spent time on the observation ward which was fully occupied. A senior nurse explained that patients were moved to the ward from the Emergency Department (ED) in order to "avoid the four hour breach" (an NHS target to discharge or transfer patients). The provider might find it useful to note that although the observation ward was designed to accommodate patients under the medical care of the ED, 10 out of the 17 patients on the ward at the time of our visit were under the care of the acute medical team (AMT). A senior nurse told us, "Medical patients can take a day or more to move which stops an ED patient coming onto the ward. It can be because they are awaiting blood results and scans." The nurse said, "We can get an ED doctor here within 30 minutes but if the patient needs to be seen by a specialist doctor, such as neurosurgery, you can wait all day before a doctor will come."

Patients were under the care of an ED consultant and received regular reviews, but two out of the four patients we spoke with had been on the observation ward for 24 hours and had not been seen by a specialist doctor. For example, one patient newly diagnosed with diabetes had not been seen by an endocrinologist.

We spoke with four of the 17 patients on the observation ward. Everyone we spoke with was satisfied with the care they received. Patients told us staff were "busy but always find time to do what is needed." Another patient said, "They (staff) have been in to regularly check on me. If I need to contact them I have this (pointed to call bell)."

Another patient told us they had seen the nurse manager from their specialist ward accompanied by the consultant doctor. This patient told us they had been admitted to hospital several times in recent years, they said "It's excellent. You couldn't wish for better."

The nursing staff on the observations ward were very well informed about the patients on the ward and the plans for their treatment. We saw evidence that staff communicated effectively with each other, both in writing and verbally.

Nursing staff told us that one of the patients accommodated in a four bed bay was expected to die. The provider might find it useful to note that this patient had been moved

from a side room on the observation ward because a room was needed to isolate a patient with an infection. We observed that staff provided sensitive and attentive care to the patient and his family, but acknowledged that the environment was inappropriate for a dying person.

We spent time on the Clincal Decisions Unit (CDU). We were told that the unit was designed for medical patients under the care of the acute medical team (AMT). In practice, like the observation ward, the CDU had a mix of medical and ED patients. A senior nurse told us there was "linked use with the observation ward with a movement of patients between the two as needed."

All the patients we spoke with were positive about the care they were receiving and the staff. We observed staff working extremely hard to meet patient's care and welfare needs. We could see that arrangements had been put in place to manage the huge variation in the needs of patients going through the CDU. Staff spoken with told us that staffing changes to support their ability to meet patient needs had taken place over the last 12 months but it was still a challenge at times. One example given was the night time staffing levels when staff numbers were reduced but there was a similar amount of work to do.

We visited the Hospitality Lounge where patients were transferred from ward areas to await discharge. Patients were transferred to this area to 'free' beds on ward areas for new admissions and improve patient 'flow'. In this area patients continued to be provided with personal and nursing care as required while they waited for 'take home' medicines or transport. The area had capacity to accommodate 30 patients in armchairs and four patients in bed. We spoke with three patients waiting for discharge. They told us they had been made comfortable and staff had made sure they had something to eat and drink. Patients told us they were kept fairly well informed although one patient told us, "I'm waiting for an ambulance to take me home. I don't know how long it will be, the nurses don't know how long it will be. You might as well ask how long is a piece of string?"

We pathway tracked the care of four patients from their admission through the Emergency Department, Clinical Decisions Unit or observation Ward 12 through to admission to a ward. We found evidence that patients were being individually assessed and had their care planned to meet their individual needs. We saw medical histories had been recorded, known allergies identified and any identified risks to the patient recorded and acted upon to ensure their safety.

We met with the bed management team in the 'control room' of the hospital. The team met several times a day to monitor the flow of patients through the hospital. The analysis at the time of our visit showed that 12% of the patients in the hospital were 'outliers'. This meant those patients were not being cared for in ward areas that matched their specialist need. This had the potential to adversely impact their care outcomes. Staff told us the percentage of outliers was usually 5%. We were told that the majority of outliers were medical patients. We saw evidence of systems in place to make sure patients got the treatment and care they needed in a timely way. For example, the trust had developed a medical 'buddy' system so that ward staff could easily access a doctor from the appropriate team to respond when required.

Three out of the four patients we pathway tracked were 'outliers'. We found no evidence of adverse outcomes for these patients.

We were told by members of the trust's management board that plans were in progress to

change the balance of bed numbers in the hospital to increase the number of medical beds.	

Safeguarding people who use services from abuse



Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

In all the clinical areas we visited during our inspection, we observed that patients felt confident in approaching the staff and asking for support. We saw patients were treated respectfully.

When we asked, "Do you feel safe here?" patients responded positively. No one expressed concerns about their safety.

On the wards we visited we saw there was a good supply of leaflets telling patients what to do if they wanted to make a complaint or wanted to share their views on the quality of the service. The leaflets gave information on how to contact the Patient Advice and Liaison Service (PALS).

Records given to us by the provider showed most staff had completed training in safeguarding vulnerable adults, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff spoken with were able to describe signs and symptoms of abuse. Staff told us they would report any observations of potential abuse to the person in charge and felt confident their concerns would be acted upon. Staff had an awareness of whistleblowing and the agencies they could report concerns to.

We looked at the care records of a patient on the observation ward who had attempted to harm themselves while in the Emergency Department (ED). We saw a hospital security guard present outside the four bedded ward where the patient was accommodated. Staff told us a security guard was necessary "to stop the patient leaving." The patient's records showed they were under the influence of drugs or alcohol which had impacted on their abilities to reason and make judgements when they were admitted to the ED. We saw a checklist in the patient's notes recording an assessment of their capacity to make a decision under the Mental Capacity Act (MCA). The outcome of the assessment was the patient lacked capacity. The provider might find it useful to note that the patient's capacity had not been reassessed at the 'one to two' hourly intervals advised on the checklist. When we spoke with the patient they told us they had "a lot of problems" and understood

the decision had been made in their best interests at the time they attended the ED.

We met with the trust's safeguarding team which included a representative for adults, children and midwifery safeguarding.

The safeguarding team told us they provided training and case management across the trust. They told us staff training had increased the volume of referrals. There was an average of 10 to15 safeguarding referrals to the team each week each for adults and a similar number for children. An investigation was not always necessary for each of these referrals; the circumstance of each referral was considered individually. Safeguarding referrals were forwarded to social services. We were told 30 - 40% of adult safeguarding concerns related to pressure ulcers. The other main areas identified were physical or financial abuse, or neglect.

The Trust is a member of the Coventry Harm Reduction Group which reviews safeguarding activity.

We were told that the trust was represented on Adult and Children's Safeguarding Boards for both Coventry and Warwickshire, working within their respective procedures.

Supporting workers



Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Patients we spoke with thought there were adequate numbers of staff on duty to meet their needs, although they felt that staff were kept very busy. Patients told us their requests were generally responded to quickly. Three patients told us that they would like the staff to know how appreciated they were. One person said, "Excellent staff...couldn't fault them."

The trust had arrangements in place for the induction of newly appointed staff. For example, newly appointed healthcare assistants undertook an 'Effective Care Practices' programme and newly qualified nurses attended the preceptorship programme.

A senior nurse on the observation ward described staff induction training reflecting 'Essence of care'. This was designed to promote privacy and dignity and basic care skills across a range of areas including nutrition, hygiene, mobility bed bathing and risks to health.

The 'rolling programme' of mandatory training provided for all staff included moving and handling, infection control, life support for adults and safeguarding. The trust gave us documentary evidence that showed most staff had completed mandatory training. We saw evidence of a system in place to monitor the percentage of staff who had completed the necessary training.

The trust sent us an overview of other specialist areas of training they delivered for nursing staff. Specialist training was delivered in response to training needs analysis and included wound management, tissue viability and venepuncture.

Effective supervision arrangements were in place. Staff told us an annual appraisal system was used to keep their performance and development under review. A staff nurse we spoke with described her appraisal as a "helpful, private conversation that identifies training and development needs and opportunities".

One senior nurse told us that performance issues were effectively monitored at ward level.

All of the staff we spoke with were positive about training and support. In all the areas we visited we had consistent feedback from staff about training, annual appraisals and

support from their managers. Even in the busiest areas staff told us they felt part of a supportive team. They told us they helped each other, felt valued, were committed to their patients and enjoyed their jobs.

One healthcare assistant said, "The job is enjoyable and rewarding."

Assessing and monitoring the quality of service provision



Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

We observed that patients were asked on a routine basis by staff if they were happy with the service they were receiving. There was also a formal system for requesting feedback from patients through a patient satisfaction real-time monitoring system called "Impressions" which took place at ward level and was also available on-line, in paper format or could be facilitated by volunteers using i-pads.

We met with representatives from the trust's quality and governance team.

Data collated by CQC and used to create a Quality and Risk Profile (QRP) for the trust did not indicate a high risk in this outcome. The trust had used the QRP as part of the quality monitoring process and had been proactive in responding to changes in risk by sending us action plans telling us what they were doing about it.

We saw the trust had arrangements in place and responsibilities defined for measuring the quality of services provided. We saw there were a number of mechanisms in place for measuring the quality of care. These included nurse sensitive indicators, the NHS patient safety thermometer and a range of infection control measures. For example, we saw that the trust monitored against local and national targets for health care associated infections (HCAI) and reported information to a national database which was published by the Health Protection Agency.

The trust demonstrated that they continuously learnt from incidents or investigations. We saw that the trust's board conducted a monthly review of a range of performance measures which assessed quality and patient safety. There were systems in place for reporting adverse incidents. Staff we spoke with were clear about the reporting system at the hospital. They confirmed that incidents were investigated and quality issues and learning was discussed at staff meetings, in addition to individual feedback.

The trust had routinely published information about the quality of their services on their website. The trust's board papers were available to read and also included performance outcomes. Regulatory reports were available on the trust's website such as OFSTED's inspection of safeguarding and looked after children services.

The trust published its 'Quality Account' and annual report to evidence their accountability to patients and the commissioners of service. The report included a review of progress against the objectives set for the previous year. The trust had identified elimination of avoidable pressure ulcers, increasing effective discharge of patients and using real time feedback to affect change as their local priorities for 2012/13.

The trust had a clear and accountable complaint handling process. Information was available around the hospital to advise people how to make a complaint or raise a concern. Complaints were monitored by the trust and learning taken from the outcomes of each investigation.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ Met this standard

This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

× Action needed

This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

Enforcement action taken

If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance:* Essential standards of quality and safety. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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