Care Quality Commission

University Hospitals Coventry and Warwickshire NHS Trust

Quality Report

Clifford Bridge Road
Coventry CV2 2TX
Tel: 024 7696 4000
Website: www.uhcw.nhs.uk

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

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

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

University Hospitals Coventry and Warwickshire NHS Trust is one of UK's largest trusts and serves a population of about 1,000,000 across Coventry, Warwickshire and beyond.

Inpatient services are provided from two hospital sites, University Hospital Coventry (the larger site) and the Hospital of St Cross, Rugby. In total, the trust has 1,250 beds and provides both elective and emergency care. A major trauma centre, University Hospital Coventry specialises in cardiology, neurosurgery, stroke, joint replacements, in vitro fertilisation (IVF) and maternal health, diabetes, cancer care and kidney transplants.

The Hospital of St Cross, Rugby provides a smaller range of hospital services, including an urgent care centre, general medicine including elderly care, elective surgery including a surgical day unit, and a range of outpatient services.

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

We also undertook an unannounced inspection on 19 March at University Hospital Coventry and on 29 March at the Hospital of St Cross, Rugby.

Overall, we rated University Hospitals Coventry and Warwickshire NHS Trust as 'requires improvement'.

We have judged the service as 'good' for caring. We found that most of the time services were provided by dedicated, caring staff. Patients were treated with dignity and respect and were provided with appropriate emotional support.

However, improvements were needed to ensure that services were safe, responsive to people's needs and well-led.

Our key findings were as follows:

Cleanliness and infection control

In most areas patients received care in a clean, hygienic and suitably maintained environment. Staff were aware of and applied infection prevention and control guidelines. However, we saw poor infection control practices in the radiology department, poor maintenance of the environment in parts of outpatients and some poor cleaning practices.

We observed good practices in relation to hand hygiene and 'bare below the elbow' guidance and the appropriate use of personal protective equipment, such as gloves and aprons, while delivering care in children's services, the emergency department and maternity. These practices were not so well embedded in the critical care, medical and surgery departments, where examples of poor infection control practice were observed.

There was a pre-admission service within the outpatients department; however, no preoperative MRSA screening was undertaken during this consultation. This meant that not all patients undergoing elective surgery were screened preoperatively. Screening has been a Department of Health recommendation since 2007 and is in line with the trust's own policy.

There were 13 cases of MRSA bacteraemia affecting 11 patients reported between April 2014 and February 2015, with nine of these cases developing during the patient's period of care within the trust.

We found detailed investigations of infection control incidents were not always undertaken and so the opportunity for learning and prevention of harm to patients from these incidents was lost.

The standard of record completion varied across the services: in some areas we found gaps in the completion of records and care plans were not always individualised.

Records in most departments were stored securely in line with requirements. However, on some medical wards we found records were not always kept in a secure area.

We found that do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were not always correctly completed. Incomplete or incorrect DNA CPR forms can lead to patients being subjected to attempts to resuscitate them when this is not appropriate or in line with their wishes.

Staffing

Summary of findings

Staffing levels at the time of the inspection were adequate, although there was significant use of agency and locum staff. The trust had taken action to ensure that agency and locum staff had access to the trust's information systems; these staff were issued with smart cards if working more than 5 days and had to complete a 2-hour e-learning package.

The trust used the nationally recognised Safer Nursing Care Tool along with National Institute of Health and Care Excellence guidance to assess required nursing staff levels.

Vacancy rates, staff turnover and sickness were audited monthly. Daily checks were completed across all areas to check staffing requirements and availability against gaps in the rota.

Care and treatment within the Cardiac Critical Care Unit was led by consultant cardiac surgeons with support and advice, when required, from intensive care consultants. However, the arrangements for senior medical cover did not meet the requirements of core standards in intensive care.

Mortality

Our Intelligent Monitoring report of December 2014 showed that there was no evidence of risk for summary hospital mortality level indicators or for hospital standardised mortality ratio indicators.

Incidents

The trust used a centralised web-based reporting system for staff to report incidents and near-misses. Staff had a good knowledge of this system and were encouraged to use it.

However, some staff did not feel confident in completing incident reports and said they did not always get feedback.

Serious incidents were managed through trust's Significant Incident Group. Trust root cause analysis leads were appointed to manage the investigations and actions were assigned to address the issues. However, action plans following investigations were not always completed in a timely manner and learning was not always transferred to practice.

We found the trust risk register did not reflect the risks that were present within the services being delivered.

Nutrition and hydration

The trust had processes in place to meet patients' cultural and specialist needs in relation to eating and drinking. Patients were supported by dieticians and by the speech and language therapy team. Patient records included an assessment of patients' nutritional requirements based on the malnutrition universal screening tool.

The trust used national guidance for parenteral and enteral nutrition. Policies were in place to help patients who were unable to take oral nutrition or fluids to be given specialist feeds until they could be seen by a dietician. Patient records we looked at confirmed that these policies were in use. This meant that patients were protected against the risk of malnourishment.

As well as mandatory training, catering staff received annual training from the dieticians.

The systems in place for managing and storing drugs, including controlled drugs and oxygen, were inconsistent throughout the trust.

In some areas there was insufficient storage space for the quantity of medication, resulting in medication being stored insecurely. We also observed out-of-date intravenous fluids and oxygen cylinders available for use.

We found some patients who were in pain and had not been given their prescribed drugs when they needed them.

Anticipatory prescribing in end of life care was common, in line with best practice. This meant that pain relief and other medication could be started quickly if patients became unwell.

In the critical care unit we observed that intravenous fluid bags were used for preparing intravenous injection/infusions for more than one patient and were used for up to 24 hours. There was a risk that the bags could be contaminated by poor infection control practices, or maliciously while left unattended on trolleys on the units. This practice was escalated to the trust executive team during the inspection.

Flow and capacity

There were significant issues with flow and capacity within the trust and challenges in discharging patients to an appropriate place, resulting in patients staying longer

Summary of findings

within the emergency department than was appropriate. The trust's performance had consistently fallen below the requirement for patients being discharged from the emergency department within four hours.

There were a number of patients requiring medical specialities care who were being cared for in other areas. This meant they were being cared for in areas that may not have been appropriate to meet their needs or by staff who did not have the right level of skill to provide their care.

At the time of the inspection there were 133 patients within the trust who could have been discharged. This involved more than 10% of the trust's beds. This was affecting the trust's ability to treat patients in a timely manner, with referral-to-treatment time for many services in excess of the required 18-week wait.

We saw several areas of outstanding practice including:

Outstanding practice in respect of trauma care: for example, the fracture patient pathway that encompassed effective pain management and integrated daily and weekend physiotherapy sessions to develop improved outcomes for patients.

The trust was working to improve the experience of older patients. Initiatives included blue pillowcases for patients with dementia, the screening of all patients aged 75 and over for dementia and the development of a 'care bundle'.

The trust was using the 'M' technique as a means of holistic communication by touching the hands and feet of older people. It included the repetition of stroking and conventional massage through slow, constant and rhythmical pressure.

The head of midwifery had won the Healthcare Hero and Lifetime Achievement Award 2013/14 at the Coventry Telegraph's Pride of Coventry and Warwickshire Community Awards ceremony.

The specialist bereavement midwife had received the National Maternity Support Foundation Award for Bereavement Care at the Royal College of Midwives Annual Midwifery Awards 2015. They had provided sensitive photographs for parents who had lost their baby in late pregnancy or soon after birth.

The trust had developed a specialist teaching centre that was using technology to allow staff to have enhanced training in surgical techniques. This unit is the only one in the UK and is accessed by staff from many organisations across the country.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to University Hospitals Coventry and Warwickshire NHS Trust

University Hospitals Coventry and Warwickshire NHS Trust is one of the UK's largest trusts and serves a population of about 1,000,000 from across Coventry, Warwickshire and beyond.

The trust provides services from the University Hospital Coventry and the Hospital of St Cross in Rugby. The trust provides both emergency and elective care at University Hospital Coventry and elective care at the Hospital of St Cross. A major trauma centre, University Hospital Coventry specialises in cardiology, neurosurgery, stroke, joint replacements, in vitro fertilisation (IVF) and maternal health, diabetes, cancer care and kidney transplants.

The trust has been inspected twice in the last two years. Hospital of St Cross, Rugby was inspected in September 2013 and was found to be compliant. University Hospital Coventry was inspected in January 2014 and was also found to be compliant.

Our inspection team

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

Head of Hospital Inspections: Helen Richardson, Care Quality Commission

The team included 12 CQC inspectors and a variety of specialists including junior doctors, medical consultants, senior managers, child and adult safeguarding leads, trauma and orthopaedic nurses, paediatric nurses, an obstetrician, midwives, surgeons, an end of life care specialist and experts by experience who had experience of using services.

How we carried out this inspection

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

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

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

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

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

We also undertook an unannounced inspection on 19 March at University Hospital Coventry and on 29 March at Hospital of St Cross, Rugby.

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

Summary of findings

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

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

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

What people who use the trust's services say

Overall the trusts performance as assessed by the national Friends and Family Test was generally in line with the England average for inpatients, emergency department (ED) and maternity; 89% of patients were extremely likely or likely to recommend the trust to family and friends if they needed similar treatment or care.

Response rates for inpatients have consistently been below the England average. Response rates for ED were mixed with three of the six months above the England average and three below.

The CQC inpatient survey was conducted between September 2014 and January 2015. A questionnaire was sent to 850 recent inpatients. Responses were received from 354 patients. The trust was about the same for overall experience when compared against similar trusts.

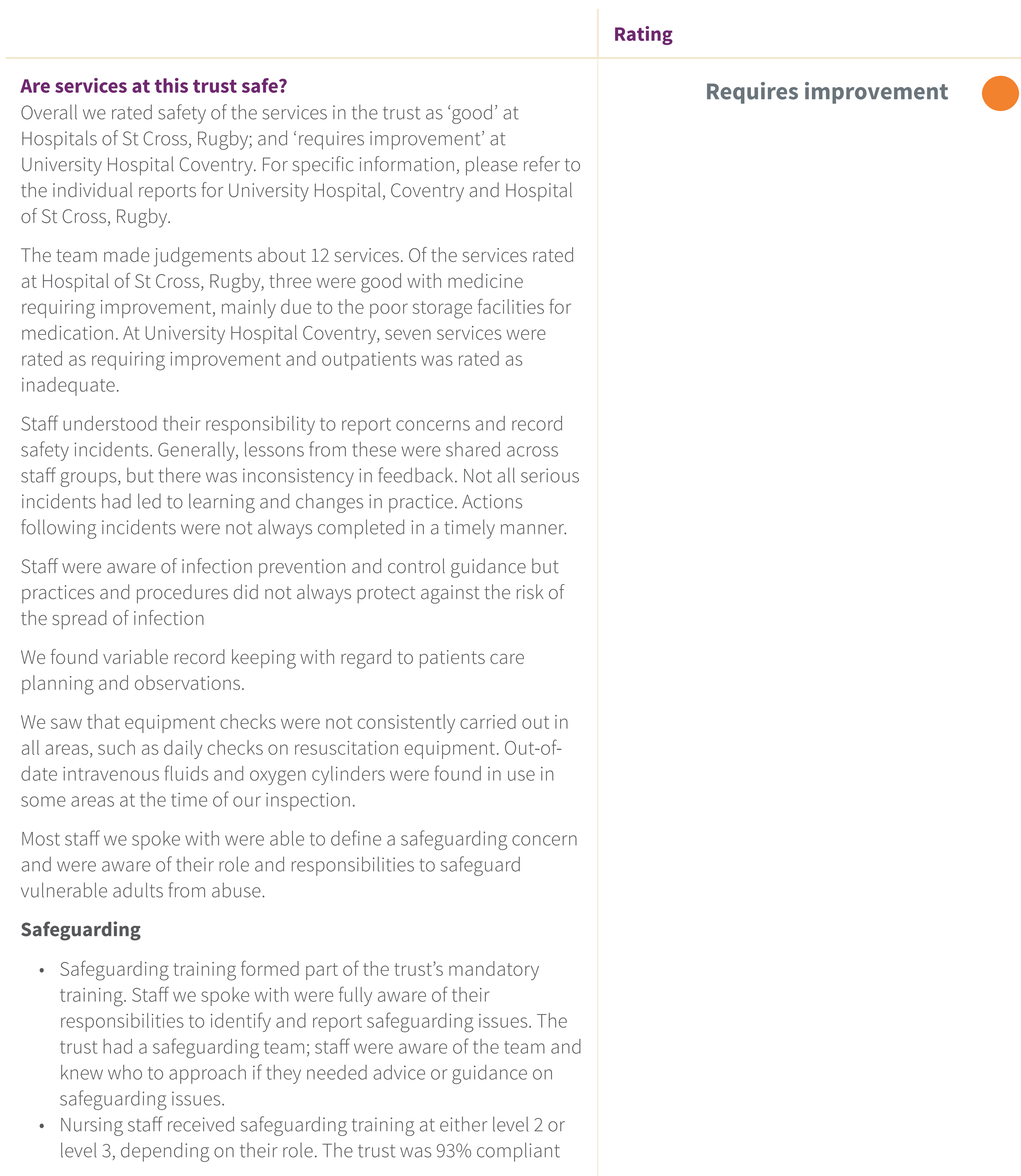
Facts and data about this trust

The trust provides services from the University Hospital Coventry (the larger site) and Hospital of St Cross, Rugby. In total, the trust has 1,250 beds and provides both elective and emergency care. A major trauma centre, University Hospital Coventry specialises in cardiology, neurosurgery, stroke, joint replacements, in vitro fertilisation (IVF) and maternal health, diabetes, cancer care and kidney transplants.

Coventry is ranked 50 out of 326 Local Authorities in the Indices of Multiple Deprivation, with deprivation levels worse than the England average. The districts of Warwickshire are ranked: North Warwickshire – 182, Nuneaton & Bedworth – 108, Rugby – 219, Warwick – 257 and Stratford Upon Avon – 278, where deprivation levels are much better than the England average.

Summary of findings

Our judgements about each of our five key questions



	Rating
Are services at this trust safe?	**Requires improvement**

Overall we rated safety of the services in the trust as 'good' at Hospitals of St Cross, Rugby; and 'requires improvement' at University Hospital Coventry. For specific information, please refer to the individual reports for University Hospital, Coventry and Hospital of St Cross, Rugby.

The team made judgements about 12 services. Of the services rated at Hospital of St Cross, Rugby, three were good with medicine requiring improvement, mainly due to the poor storage facilities for medication. At University Hospital Coventry, seven services were rated as requiring improvement and outpatients was rated as inadequate.

Staff understood their responsibility to report concerns and record safety incidents. Generally, lessons from these were shared across staff groups, but there was inconsistency in feedback. Not all serious incidents had led to learning and changes in practice. Actions following incidents were not always completed in a timely manner.

Staff were aware of infection prevention and control guidance but practices and procedures did not always protect against the risk of the spread of infection

We found variable record keeping with regard to patients care planning and observations.

We saw that equipment checks were not consistently carried out in all areas, such as daily checks on resuscitation equipment. Out-of-date intravenous fluids and oxygen cylinders were found in use in some areas at the time of our inspection.

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

Safeguarding

- Safeguarding training formed part of the trust's mandatory training. Staff we spoke with were fully aware of their responsibilities to identify and report safeguarding issues. The trust had a safeguarding team; staff were aware of the team and knew who to approach if they needed advice or guidance on safeguarding issues.
- Nursing staff received safeguarding training at either level 2 or level 3, depending on their role. The trust was 93% compliant

for level 3 training for safeguarding children and 87.7% compliant for level 2. Training was available as an online package or a face-to-face session. Joint adult and children training sessions had been co-delivered by the safeguarding team and the clinical commissioning group. The events included learning from recent serious case reviews.

- At the daily bed meeting when reviewing elective patients for the next day, there was a specific question as to whether the patient had had a best interest meeting or was vulnerable. Vulnerable patients were prioritised and protected from cancellations when there were bed availability pressures.

Incidents

- Staff understood their responsibility to report concerns and record safety incidents. However, some staff did not always feel confident in completing incident reports and said they did not always get feedback.
- We found that incidents were reported and investigated in most areas. Generally, lessons from these were shared across staff groups, but there was inconsistency in feedback. Not all serious incidents had led to learning and changes in practice. Actions following incidents were not always completed in a timely manner.
- There were 132 serious incidents reported between 1 July 2014 and 31 January 2015. The trust had a process in place whereby these were investigated and discussed at the Significant Incident Group that met weekly.
- We found at the time of the inspection that a number of action plans relating to serious incidents had not been completed; 15 action plans remained open and overdue from 2014 and 10 action plans remained open and overdue from 2015. There were also two action plans that had not been completed from 2013. This meant that effective action to prevent similar occurrences and potential harm to patients had not been taken.
- There had been four never events (largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) over the last 12 months, three relating to theatre procedures and one relating to a misplaced nasogastric tube. Action had been taken to improve and standardise the delivery of the WHO surgical safety checklist within theatres. However, during our inspection we found that this was not well embedded in all areas and that there was inconsistent practice within some theatres.

Staffing

- Staffing levels at the time of the inspection were adequate, although there was significant use of agency and locum staff. The trust had taken action to ensure that agency and locum staff had access to the trust's information systems; these staff were issued with smart cards if working more than five days and had to complete a 2-hour e-learning package.
- All staff we spoke with, from the management team to healthcare assistants, recognised nursing recruitment as a major safety risk to the service. Vacancy rates across the core services ranged from 13% in the surgical teams to 17% in the Cardiac Critical Care Unit.
- Vacancy rates, staff turnover and sickness were audited monthly. Daily checks were completed across all areas to check staffing requirements and availability against gaps in the rota. Vacant shifts were offered to bank or agency staff.
- A rolling recruitment programme was ongoing with advertising websites, local media and universities. Plans were also in place to widen the recruitment drive internationally. Staff were aware of these initiatives and supported them.
- Care and treatment within the Cardiac Critical Care Unit was led by consultant cardiac surgeons with support and advice, when required, from intensive care consultants. However, the arrangements for senior medical cover did not meet the requirements of core standards in intensive care.

Cleanliness and infection control

- The trust had arrangements in place for the prevention and control of infection, including a nominated director of infection prevention and control (DIPC) with a dedicated specialist team. However, there was some confusion about how the role of the DIPC was being delivered.
- Hand hygiene and practice relating to 'bare below the elbow' was variable. When patients were infectious or suspected of having an infection, practices and procedures did not always protect against the risk of the spread of infection.
- Clostridium difficile rates were better than the England average, except for a small rise between November 2013 and March 2014, with a peak during January 2014. Between April 2014 and February 2015, there had been 41 cases.
- There were 13 cases of MRSA bacteraemia affecting 11 patients reported between April 2014 and February 2015, with nine of these cases developing during the patient's care within the trust.
- We found detailed investigations of infection control incidents were not always undertaken and so the opportunity for learning and prevention of harm to patients from these incidents was

Summary of findings

lost. In some cases there was lack of involvement and ownership by the clinical teams caring for the patients and on occasion investigations were not completed in the absence of a member of the infection prevention and control team.

Environment and equipment

- We saw equipment checks were not consistently carried out in all areas, such as daily checks on resuscitation equipment. Out-of-date intravenous fluids and oxygen cylinders were found in use in some areas at the time of our inspection.
- In most areas the environment was found to be clean, hygienic and suitably maintained, although some poor cleaning practices were observed and maintenance of some areas within the outpatients department was poor.

Medicines

- The systems in place for managing and storing drugs, including controlled drugs and oxygen, were inconsistent throughout the trust. In children's and young people's services, outpatients, critical care, medical services and the emergency department, drugs were stored and maintained in line with regulations.
- In some areas there was insufficient storage space in the cabinets for the quantity of medication, resulting in medication being stored insecurely. We found storage temperatures at Hospital of St Cross, Rugby to be higher than recommended. We also observed out-of-date intravenous fluids and oxygen cylinders.
- We found some patients who were in pain and had not been given their prescribed drugs when they needed them.
- Anticipatory prescribing in end of life care was common, in line with best practice. This meant that pain relief and other medication could be started quickly if patients became unwell.
- In the critical care unit we observed that intravenous fluid bags were used for preparing intravenous injection/infusions for more than one patient and were used for up to 24 hours. This process had not been risk assessed and no protocol was available. There was a risk that the bags could be contaminated by poor infection control practices, or maliciously while left unattended on trolleys on the units. This practice was escalated to the trust executive team during the inspection.

Records

Summary of findings

- The standard of record completion varied across the services. In some areas we found gaps in the completion of records relating to sepsis recognition, venous thromboembolism assessments, fluid balance charts, comfort rounds and individualised care plans.
- Records in most departments were stored securely in line with requirements. However, on some medical wards we found records were not always kept in a secure area.
- We found that do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were not always correctly completed or had information missing. Incomplete or incorrect DNA CPR forms can lead to patients being subjected to attempts to resuscitate them when this is not appropriate or in line with their wishes.

Mandatory training

- Training was delivered in a number of ways including online learning, classroom-based sessions and individual face-to-face support.
- Monitoring was undertaken at both local level and corporately through quarterly performance meetings.
- Mandatory training rates were variable, and not all staff in all areas had received the required level of mandatory training in line with the trust's target.

Duty of candour

- The trust had a system in place to ensure that patients were informed when something went wrong, given an apology and informed of any actions taken as a result. This is known as the duty of candour. Most staff were familiar with the term 'duty of candour'.

Are services at this trust effective?

Good

Overall we rated effectiveness of the services in the trust as 'good' at Hospitals of St Cross, Rugby; and University Hospital, Coventry. For specific information, please refer to the individual reports for University Hospital, Coventry and Hospital of St Cross, Rugby.

The team made judgements about 10 services. Outpatient services are not currently rated for effectiveness. Of the services rated, nine were judged to be good and end of life care required improvement. This demonstrated that the majority of services provided care, treatment and support that achieved good outcomes, promoted a good quality of life and were based on the best available evidence.

The trust took part in a number of national audits; performance in these varied across the trust. Staff, teams and services mostly worked well together to deliver effective care and treatment.

Summary of findings

Some improvement was required for staff to have a clear understanding of mental capacity and deprivation of liberties and how to apply this in practice within the service provided.

Evidence based care and treatment

- Care and treatment were delivered in line with National Institute of Health and Care Excellence and Royal College guidance, supported by local guidelines.
- Policies and procedures were accessible to staff and they were able to guide us to the relevant information. In most areas care was monitored to show compliance with standards and there were good outcomes for patients.
- Staff support was variable throughout the trust, with some good access to supervision and additional training courses. However, not all staff had received an appraisal.

Patient outcomes

- Engagement with national audits was good and local audits were used to monitor outcomes and identify opportunities for improvement.
- In the national care of the dying audit, the trust had not achieved six of the seven organisational key indicators. It was unclear what action was being taken to address this.
- Our Intelligent Monitoring report of December 2014 showed that there was no evidence of risk for summary hospital mortality level indicators or for hospital standardised mortality ratio indicators.
- Mortality and morbidity reviews were undertaken and discussed at the quality improvement and patient safety meetings. However, during our inspection we found a mortality alert within the trust's data that on review was found to be incorrect; this had not been recognised or investigated by the trust or speciality concerned.
- Pain assessments were carried out. However, we found that pain scores in some areas were not consistently used to ensure that adequate pain relief was being given and that some patients did not receive timely pain relief.

Multidisciplinary working

- Multidisciplinary working was evident in the majority of services to coordinate patient care.
- Staff, teams and services mostly worked well together to deliver effective care and treatment. However, we did find some clinical services where there was challenges between staff within teams.

Summary of findings

Consent, Mental Capacity Act & Deprivation of Liberty Safeguards

- The safeguarding vulnerable adults policy contained information relating to mental capacity, consent and Deprivation of Liberty Safeguards. Information on how to contact independent mental capacity advocates was also in the policy.
- Staff mostly had a good awareness of both adult and child safeguarding. However, in some cases staff did not have a clear understanding of mental capacity and deprivation of liberties and how to apply this in practice within the service provided.

Are services at this trust caring?

Good

We judged the caring provided by staff as good within most services in each hospital.

For specific information, please refer to the individual reports for University Hospital, Coventry and Hospital of St Cross, Rugby.

Staff were providing kind and compassionate care which was delivered in a respectful way. There were some areas, albeit in the minority, where at times privacy could be compromised when private conversations could be overheard and procedures observed.

Compassionate care

- In most areas patients received compassionate care and we observed a number of positive interactions between patients and staff.
- We observed positive interactions between many staff and patients and their families and we saw how patients responded to this. The staff concerned included housekeepers, catering staff, porters, doctors and nurses.
- We found that caring required improvement in the radiology department. It was clear that staff were under pressure and we observed that a calm approach was sometimes forgotten. We observed there could be more focus on the task than the patient and there was lack of consistency in how well people's needs were recognised and responded to. Patients were observed on trolleys without blankets or a pillow. Patients living with dementia were unsupported while waiting in the department.
- The trust participated in the NHS Friends and Family Test. Overall, the trust's performance was generally in line with the England average for inpatients, ED and maternity, with over 78% of the respondents for December 2014 said they were likely to recommend the trust to friends or family.

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

Understanding and involvement of patients and those close to them

- Staff were professional and knowledgeable, which gave them confidence when dealing with people.
- In most areas patients said they were kept informed and felt involved in the treatment they received.
- Patient feedback was obtained through routine patient experience surveys. Data for July 2014 to September 2014 showed that the majority of patients responded positively about their involvement in care and treatment and about whether staff treated them with dignity and respect.

Emotional support

- Emotional support was available for patients, staff and visitors from the trusts chaplaincy service.
- Some disciplines had dedicated staff to assist patients and their families during difficult times. These included the trauma and orthopaedic service, which had a counsellor who visited one day a week. An increase in healthcare support workers was expected to enhance the support available. Ophthalmology had an eye care liaison officer and advocacy at the point of diagnosis. Neurosurgery had introduced a quiet room where bad news could be broken; this ensured that privacy and dignity were maintained at all times.
- Staff from a number of disciplines described how appointments were routinely extended when patients or family members needed more time to come to terms with upsetting news.
- The specialist bereavement midwife had received the National Maternity Support Foundation Award for Bereavement Care at the Royal College of Midwives Annual Midwifery Awards 2015. They had provided sensitive photographs for parents who had lost their baby in late pregnancy or soon after birth.

Are services at this trust responsive?

Requires improvement

Overall, we rated the responsiveness of the services in the trust as ‘requires improvement’. For specific information, please refer to the individual reports for University Hospital, Coventry and Hospital of St Cross, Rugby.

Summary of findings

The provider did not always plan and deliver services to ensure that people's needs were met. The team made judgements about 12 services across the two hospitals. Of those, seven were judged to be good, and five required improvement

Across the trust there were challenges with patient flow. Patients were not always able to leave hospital when they were medically fit, as some were waiting for ongoing care, however the trust had developed several initiatives to improve patient flow. We found that referral to treatment times exceeded national targets. Elective surgery had been cancelled in response to the pressures

Meeting people's individual needs

- There were a number of patients who required medical specialities care who were being cared for on gynaecology wards. This had been an issue for over 12 months and was on the trusts risk register. Actions were in place to ensure patients were seen by medical staff. However, nursing staff raised concerns about their ability to care for this group of patients adequately because their needs were very different from gynaecology patients. They were also concerned about being able to provide care for gynaecology patients with privacy and dignity under these circumstances.
- There was support for vulnerable people, such as people living with dementia or mental health problems. Flexibility with visiting hours was given to carers of patients with mental health problems. The trust was using the 'M' technique as a means of holistic communication by touching the hands and feet of older people. It included the repetition of stroking and conventional massage through slow, constant and rhythmical pressure.
- We saw there was a wide selection of information available to patients and visitors on the wards. All of the wards had document stands with information leaflets about the trust and its facilities, specialist information on specific conditions, and other material. Information leaflets and consent forms were not always available in easy-to-read formats. The trust used a commercially produced communications tool, presented in a book format with over 100 bespoke illustrations, to help patients to communicate Some items were available in multiple languages and an interpreting service was available and used.

Access and flow

- There were significant issues with flow and capacity within the trust. This meant patients spent longer in the emergency department than appropriate. The trust's performance had consistently fallen below the requirement for patients being discharged from the emergency department within four hours.
- There were challenges in discharging patients. Discharge arrangements needed to be better planned as many patients were being discharged later in the day than intended. During our inspection there were 133 patients within the trust who were medically fit for discharged, accounting for over 10% of trust beds. Some patients had delayed discharges due to waits for care home placements or care packages. This meant that patients were being cared for in areas that may not have been appropriate to meet their needs. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and the service overall and had developed several initiatives to improve patient flow. For example, a daily board round was introduced each morning and afternoon to coordinate patient care and prioritise discharge when appropriate.
- Overnight admissions and medical outliers (medical patient in none medical beds) had been constant issues for the previous 12 months, adding pressure to the surgical wards. This was affecting the trust's ability to treat patients in a timely manner and referral-to-treatment times for many services were exceeding the required 18-week wait. In the 12 months before our inspection, over 1,500 operations had been cancelled; 23% of these were cancelled on the day of surgery. Over half the cancelled operations (58%) were cancelled for non-clinical reasons.
- Senior managers in the surgery department were confident that new initiatives (recently started or about to start) would improve this long-standing problem and facilitate patient flow. At the time of our inspection, it was not possible to comment if these measures would be effective.
- Some patients arriving for their appointments waited a considerable time to be seen. Results of the trust's patient survey and regular monitoring showed waiting times were an ongoing issue.

Learning from complaints and concerns

- In the December 2014 Friends and Family Test, respondents reported concerns about parking, the standard of food and doing things on time: these were the lower scores for the trust. We also received many comments about difficulty in parking; the trust was taking steps to improve this.

Summary of findings

- There was information on the process for making complaints through the Patient Advise and Liaison service (PALS). The management of complaints was variable between the different services. The trust had set a response time of 25 days for complaints; 75% of complaints were being responded to within this target at the time of inspection. Of the overdue complaints, 59% were still unanswered at 60 days, with the longest still open at 178 days.

Are services at this trust well-led?

Requires improvement

The trust board was a stable team and most members had been in post for at least 18 months. The chair of the board had been appointed 13 months before our inspection.

Visibility among board members was variable.

The trust had a vision to be a 'world class service'. Most of the staff we spoke with recognised the vision but this was not well developed in that staff were unable to describe it in detail.

There was a disconnect between the risks and issues within the services and those that were on the trust risk register. We reviewed the trust risk register and found examples of risks within the register that need more effective management as well as better quality recording.

There were various unlikely risks that would be completely outside the trusts control that were included on the risk register, such as natural disasters. However, specific risks relating to infection control were not included and MRSA bacteraemia was added as a risk only on 23 February 2015 following another case being reported in spite of an emerging major and unexplained risk in this area requiring external review since the summer/autumn of 2014.

Action plans following serious incidents were not always completed in a timely manner.

We were not assured that the board had sufficient control of the complaints function or oversight of the quality of complaint responses.

Fit and proper person checks were in place.

There was a well-developed research programme and multidisciplinary education facilities.

Vision and strategy

Summary of findings

- The trust had a vision to be a 'world class service'. Most of the staff we spoke with recognised the vision but this was not well developed in that staff we spoke with were not able to describe how it would be delivered.
- Quality priorities had been set for the coming 12 months. These had been developed through the patient safety committee and were: to improve handover, to ensure appropriate end of life care including do not attempt cardio-pulmonary resuscitation (DNA CPR) and to implement 'Always Events'.

Governance, risk management and quality measurement

- We found at the time of the inspection that a number of action plans relating to serious incidents had not been completed; 15 action plans remained open and overdue from 2014 and 10 action plans remained open and overdue from 2015. There were also two action plans that had not been completed from 2013. This meant that robust action to prevent similar occurrences and potential harm to patients had not been taken. The trust board minutes of February 2015 stated that key members of the executive team had written to the clinical teams concerned, but there was no evidence that any other action was being taken to address this.
- Human factors training, which relates to the interaction of humans and technical systems was being delivered to trust staff to assist in reducing incidents.
- During our inspection we were informed that the corporate risk register was discussed and agreed at the Patient Safety Committee and then presented to the Quality Governance Committee and the board each quarter. We reviewed Quality and Governance Committee and board papers, but detailed discussion about the content of the risk register was not evident.

- We reviewed the trust risk register and found examples of risks within the register that needed more effective management as well as better quality recording. We found the register did not always reflect the risks that were present within the services being delivered. A number of risks had been on the risk register for a significant time, the mitigation actions lacked detail and in some cases the review date had passed.
- In addition, there were various unlikely risks that would be completely outside the trusts control that were included on the risk register, such as natural disasters. However, specific risks relating to infection control were not included on the first risk register we were provided with. An updated register was provided during the inspection and we noted that MRSA

bacteraemia was added as a risk only on 23 February 2015 following another case being reported in spite of an emerging major and unexplained risk in this area requiring external review since the summer/autumn of 2014.
- Never events were on the risk register as an overarching high level issue. However this lacked detail relating to areas of specific improvement and the effective actions required to address these.

The trust told us that specific never events were dealt with by the Trust as significant incidents via the Significant Incident Group.All never events are reported to Trust Board.

- Staff told us that the focus in the Patient Safety Committee and the other groups that met to review risk was simply to discuss risks and targets but not to take any action. They expressed frustration with the lack of direction and multiple meetings. We reviewed the notes of these meetings and found that there was limited evidence of any actions taken.
- We were informed that an action was in place to review the trust's systems for risk reporting but we were not provided with a project plan or evidence that the board had agreed this.
- We were not assured that the board had sufficient control of the complaints function or oversight of the quality of complaint responses. We were not provided with a plan to address the improvements required in ensuring complaints were managed in a timely manner.
- The chair of the Quality Governance Committee told us that he could not provide assurance that complaints were well managed. We talked to board members about complaints management and there was recognition that complaints were not well managed. We found that not all board members demonstrated an awareness of the importance of actively listening to patient complaints and acting on them.

Leadership of the trust

- The trust board was a stable team and most members had been in post at least 18 months. The chair of the board had been appointed 13 months before our inspection.
- Visibility among board members was variable, with the CEO, Medical Director and Chief Nurse being more widely known.
- There was lack of clarity on board-level leadership for infection prevention and control within the broader board team and lack of clarity between the executive team and microbiology as to how the role of director of infection prevention and control was being delivered.

Summary of findings

- We found that between April 2014 and February 2015 there had been 13 cases of MRSA bacteraemia (in 11 patients), nine of which had developed in patients who were under the care of the trust. We were informed that six of these cases of bacteraemia had been found to be unavoidable. However, we reviewed the investigations that had been undertaken, and they did not all provide assurance of detailed investigation and therefore it is unclear how this conclusion could be made. One of the cases had been within the critical care unit and the investigation had not identified the practice of using single bags of intravenous fluids for multiple intravenous drugs for different patients over a period of time as a risk. There was also no reference to MRSA screening rates within most of the investigations, other than the individual patient concerned. We found that MRSA screening rates were not being scrutinised at the time of the inspection to ensure they were in line with the trust's policy.
- We were informed that in the investigation of some of these cases there was lack of ownership within the clinical teams at senior level, with the investigation being seen as the role of the infection prevention and control team and not that of the clinical team providing care for the patient. This was confirmed in our discussion with the director of infection prevention and control.
- We were told by a board member that infection prevention was not a problem and so was rarely discussed by the board. Board papers did not provide assurance that this was discussed in robust detail and the trust risk register provided did not identify infection prevention as a risk.

Culture within the trust

- Most staff we spoke with were friendly and welcoming, and in most cases positive about working in the trust.
- Concern was expressed by both stakeholders and trust staff about the behaviours displayed by medical staff within one speciality. This was brought to the attention of the trust at the time of the inspection.
- The trust had a well-developed set of values. However, concern was raised that the values were chosen first and then staff were asked to say what the values meant to them, rather than the values being chosen by the staff.
- The trust took part in the national 2014 staff survey, which showed:

- a response rate of 37%, which was worse than average for acute trusts in England

- the trust scored better than the average in 14 of the 29 measures, with seven of these being in the best 20% of acute trusts
- the trust scored worse than the average in nine of the 29 measures, with six of these being in the worst 20% of acute trusts.

- Since the 2013 survey the trust has improved its scores in three measures:

- work pressure felt by staff (KF3)
- percentage of staff reporting good communication between senior management and staff (KF21),
- staff recommendation of the trust as a place to work or receive treatment (KF24).

- The results of the General Medical Council National Training Scheme survey were within expectations.
- Trust appraisal rates were variable and not in line with the trust's required level in all areas.
- The staff survey results for staff having had a well-structured appraisal in the last 12 months were in line with the England average.
- In the staff survey, the trust scored within the lowest 20% of trusts for agreeing that feedback from patients and service users is used to make informed decisions in their directorate or department. The trust scored better than the England average for recommendation of the trust as a place to work or receive care.
- Theatre staff told us there was a culture among clinical staff of arriving late for theatre. They believed this had come about because theatres rarely started on time because of pressures on beds.

Fit and proper persons

- There was an awareness among the executive team of the need to have in place 'fit and proper person' checks. There was a process to ensure compliance with the requirement for fit and proper persons for executives and board members; the necessary checks were found to be in in place.
- We met with the interim human resources director and were assured of the trust's compliance with fit and proper person legislation. This is covered by Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014, which ensures that directors of NHS providers are fit and proper to carry out this important role.

Public and staff engagement

Summary of findings

- The trust also collated real-time patient feedback through its vital pack system, an electronic system in place to monitor patients' views. Questions were asked of each patient at the time their blood pressure, pulse and other observations were recorded. This information was collated electronically and made available on a daily basis to both the executive team and the clinical teams. This gave the trust valuable patient feedback to address issues in a timely manner. However, there was no strategy for how this information would be used in the longer term to influence developments. There was discussion recorded within the trust's February board minutes outlining the need for this to be developed.
- Patient feedback was obtained through routine patient experience surveys. Data for July 2014 to September 2014 showed that the majority of patients responded positively about their involvement in care and treatment and about whether staff treated them with dignity and respect.
- In the staff survey, the trust scored within the lowest 20% of trusts for agreeing feedback from patients and service users is used to make informed decisions in their directorate or department. The trust scored better than the England average for recommendation of the trust as a place to work or receive care.

Innovation, improvement and sustainability

- There were significant issues with flow and capacity within the trust, meaning that patients spent longer in the emergency department than appropriate. The trust's performance had consistently fallen below the requirement for patients being discharged from the ED within four hours.
- The trust had developed a specialist teaching centre that was using technology to allow staff to have enhanced training in surgical techniques. This unit is the only one in the UK and is accessed by staff from many organisations across the country.
- We found advanced practice in respect of trauma care: for example, the fracture patient pathway that encompassed effective pain management, and integrated daily and weekend physiotherapy sessions to develop improved outcomes for patients.
- The trust was working to improve the experience of older patients. Various initiatives included blue pillowcases, the screening of all patients aged 75 and over for risk of dementia, and the development of a 'care bundle'.

Overview of ratings

Our ratings for University Hospitals Coventry and Warwickshire NHS Trust

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

Our ratings for Hospital of St Cross, Rugby

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Requires improvement	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Overview of ratings

Our ratings for University Hospitals Coventry and Warwickshire NHS Trust

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients.

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- Outstanding practice in respect of trauma care: for example, the fracture patient pathway that encompassed effective pain management, and integrated daily and weekend physiotherapy sessions to develop improved outcomes for patients.
- The trust was working to improve the experience of older patients. Various initiatives included blue pillowcases, the screening of all patients aged 75 and over for risk of dementia, and the development of a 'care bundle'.
- The trust was adopting the 'VERA' technique as a means of communicating with a person with later-stage dementia.
- The trust was using the 'M' technique as a means of holistic communication by touching the hands and feet of older people. It included the repetition of stroking and conventional massage through slow, constant and rhythmical pressure.
- The electronic monitoring system used in the hospital for monitoring patients' vital signs enabled staff to review patient information in real time.
- The neuroendocrine tumour service was accredited as a European Centre of Excellence in March 2015 and is one of only eight centres in the United Kingdom to achieve this accreditation.
- Critical care had appropriate and innovated equipment to meet changing patient needs which was replaced and upgraded on a regular basis.
- GCCU had an excellent comprehensive multidisciplinary daily handover daily and effective multidisciplinary working which enhanced the patient care provided within critical care.
- The head of midwifery had won the Healthcare Hero and Lifetime Achievement Award 2013/14 at the Coventry Telegraph's Pride of Coventry and Warwickshire Community Awards ceremony.
- The specialist bereavement midwife had received the National Maternity Support Foundation Award for Bereavement Care at the Royal College of Midwives Annual Midwifery Awards 2015. They had provided sensitive photographs for parents who had lost their baby in late pregnancy or soon after birth.

Areas for improvement

Action the trust MUST take to improve

The hospital MUST :

- Ensure that its systems to review equipment and audit compliance are effective relating to checking resuscitation equipment.
- Improve the ability of the emergency department to consistently respond safely to the demands placed on it and to respond to patient needs in a timely way once they have arrived at the hospital and in a way that promotes patients' privacy and dignity.
- Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance, including Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training.
- Ensure all staff have a clear understanding of Mental Capacity Act 2005 and deprivation of liberties as they apply in practice to the service provided.
- Review and reinforce staff knowledge of the 'Assessing mental health in ED' policy in order to better support staff to protect the rights of patients when any restraint power is used.
- Review medicines management within the medical division to ensure that controlled medicines are stored securely.
- Ensure the practice of multi-use administration of intravenous infusions is stopped until assurance can be made that it is safe and appropriate practice.
- Ensure that people who use services and others are protected against the risks associated with the unsafe management and storage of medicines. The trust

should ensure that there is a system in place to prevent medicines of different patients being confused and/or ensure that patients receive or have access to all their medication when it was required.
- Implement robust processes in place to ensure that intravenous fluid expiry dates were checked to ensure that they were within date prior to be administered.
- Ensure all patients attending for elective operations, including caesarean section, are routinely screened for MRSA before surgery.
- Ensure that its systems to review equipment and audit compliance are effective so far as they relate to checking resuscitation equipment and medical gases.
- Ensure there is a robust policy for transporting patients with an infection or who may be at risk of acquiring an infection in the hospital, so that staff are aware that special precautions need to be put in place to protect the patient and the public.
- Ensure that 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms are completed accurately.

Action the trust SHOULD take to Improve

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

Outstanding practice and areas for improvement

- Ensure that all doctors (including those outside of the palliative care team) feel confident in discussing end of life care and DNA CPR decisions with patients.
- Consider how the waiting areas, particularly for radiology 'bed' areas could be used more appropriately.
- Consider the need for a more suitable waiting area for ambulatory patients whilst awaiting a CT/MRI.
- Plan caesarean section lists before the day of operation whenever possible.
- Ensure that staff carry out and document assessments of patients' needs so that the planning and delivery of care meet those needs.
- Ensure that there is a handover of 'bed' patients to staff when they arrive from the ward into the radiology department.
- Ensure that there is a process in place so that vulnerable patients waiting for imaging are cared for as their needs dictate and this is recorded.
- Ensure that the nurses in imaging receive adequate scrub training from someone qualified to do so and that it is maintained.
- Ensure that all staff complete their mandatory training, particularly child safeguarding training, level 3 in the ED.
- Ensure that community midwives receive regular and formal safeguarding supervision.
- Ensure that fluid scores are completed and recorded appropriately so that patients who are at risk of dehydration are correctly escalated.
- Provide information leaflets and signs in other languages and easy-read formats.
- Develop robust processes to meet the estimated discharge dates.
- Ensure that they have robust arrangements in place to meet referral-to-treatment times.
- Ensure that learning from incidents is shared across all staff groups.
- Ensure that nurse staffing levels comply with NICE's 'Safe staffing for nursing in adult inpatient wards in acute hospitals'.
- Consider improving GP support within the RUCC.
- Review the frequency of senior leader presence at the RUCC and assess its effectiveness in the monitoring of risk.
- Define its vision and strategy for the RUCC, and more effectively inform the local public about the limitations of the service.
- Ensure that all ENP staff at the RUCC undertake child safeguarding training at level three.
- Ensure that local people receive a clear message about what the RUCC offers.
- Ensure that the access and flow of medical patients is improved and delayed patient discharges are managed appropriately, including robust processes in place to meet the estimated discharge dates.
- Ensure that patients accommodated over weekend periods have access to a choice of suitable and nutritious food and hydration. This should include the provision of hot meals where this is the patients preferred choice. This is something which is required as part of regulation 14(1)(a, b & c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Protecting patients from the risk of inadequate nutrition. However it was considered that it would not be proportionate for the finding to result in a judgement of a breach of the Regulation overall at the location
- Review the anomalous reporting structure within the radiology department, so that reporting lines are clear.
- Review the arrangements for communication within the radiology department to ensure that staff receive essential information in a more methodical and regular manner.
- Review the radiography arrangements for regular late operating lists, so that the on-call radiographer is not restricted or delayed in undertaking urgent x-rays.
- Review and update the environment in both outpatients and radiology.
- Consider the use of wasted space in the outpatients department, currently containing obsolete x-ray equipment.

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	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision [Now Regulation 17 including Regulation 17(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.] The provider did not operate effective systems to identify, assess or monitor risks relating to the health, safety and welfare of people who use services and staff. This included risk management processes for the maintenance of equipment in the division of medicine.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control [Now Regulation 12 including Regulation 12(2)(b)(g)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.] The provider did not operate effective systems designed to prevent, detect and control the spread of infection and did not maintain appropriate standards of cleanliness and hygiene in relation to equipment. Staff did not always follow infection prevention and control guidance in all services. There was no robust process for identifying in patients, with an infection, which could contaminate other patients, during transfers around the hospital.

Requirement notices

	People who use services and others were not protected against the risks associated with the unsafe management and storage of medicines in the division of medicine. The trust did not have a system in place to prevent medicines of different patients being confused and or to ensure that patients received or had access to all their medication when it was required on surgical wards.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records [Now Regulation 17 including Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.] (1) The provider had not ensured that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of: (a) an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user. Documentation relating to patients' 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) records across the trust were not always accurately completed. Incomplete or incorrect DNA CPR forms can lead to patients being subjected to resuscitation attempts when this is not appropriate or in line with their wishes.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

This section is primarily information for the provider

Requirement notices

[Now Regulation 18 including Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and other staff working services to meet the needs of service users, including Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training, across the trust particularly in the emergency and outpatients department