Inspection Report

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

Queen Elizabeth Medical Centre

Edgbaston, Birmingham, B15 2TH

Tel: 01216271627

Date of Inspection: 28 November 2014

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	University Hospitals Birmingham NHS Foundation Trust
Overview of the service	The Queen Elizabeth Hospital is part of the University Hospitals Foundation Trust. The hospital provides acute services to over 896,000 patients every year. The trust is a regional centre for cancer, trauma, burns and plastics, and has the largest solid organ transplantation programme in Europe.
Type of service	Acute services with overnight beds
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 Services in slimming clinics Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Queen Elizabeth Medical Centre had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Assessing and monitoring the quality of service provision

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 28 November 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We were accompanied by a specialist advisor.

What people told us and what we found

This was not an inspection of all of the services provided by the Trust.

When we last visited the trust in July 2013 we identified some concerns about how the care provided to patients, was checked and monitored by senior staff on wards and units. Whilst the hospital looked into all serious issues, some routine checking to ensure people received planned care and treatment was not evident.

When we visited the hospital on 28 November 2014 we found improvements had been made. We specifically focussed on how the hospital managed the care of patients at risk from pressure ulcers (an ulcer as a result of pressure damage) and we looked at how the risk of poor nutrition was managed. We found the trust had taken steps to reduce the incidence of preventable pressure ulcers. There were good systems of governance at board and at ward level to check patients were receiving the right care and treatment at the right time. Senior and middle managers, as well as ward staff were committed to these systems.

We followed the care and treatment pathway of 20 people across eight wards that included surgical, medical and the emergency department.

We found that the trust reported incidents of pressure ulcers and learned from adverse events in order to improve patient safety. There were standard procedures and treatment protocols in place and staff knew what these were. Care activities for each patient were recorded and monitored to support consistent care.

Patients were assessed to establish the care they needed and care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Risks of pressure ulcers and risk of poor nutrition were identified and managed. Plans of care and treatment were implemented and reviewed, including when patients transferred between wards and departments. There were systems in place to identify and ensure support at mealtimes for patients at nutritional risk. We found some care records about people's support with nutrition in some wards could be improved.

There was generally good multi-disciplinary team and mult-agency work to treat and support patients and staff had access to appropriate training and specialist nurses. There was appropriate and sufficient specialist equipment to ensure patient's safety and comfort.

People generally made very positive comments about the service including:

'Excellent care- even down to the cleaner'
"They look after him well but he doesn't like the food"
"The nurses have been brilliant"
'Nothing is ever too much trouble for them'
"They've all been polite and involved in his care"
"The staff are good and the food is OK"

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

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 were safe and benefited from appropriate arrangements to assess their needs and plan, provide and regularly review care and treatment that met their needs and protected their rights.

Reasons for our judgement

When we last visited the hospital in July 2013 we identified some concerns about how the care provided to patients was checked and monitored by senior staff on wards and units. Whilst the hospital looked into all serious issues, regular review checks to ensure patients received planned care and treatment for pressure ulcer and nutritional risk were not always carried out. The trust produced an action plan for improvement and we kept in touch with the trust to monitor its plan.

We visited the hospital again on 28 November 2014 to follow up progress and found improvement had been made.

We found the trust reduced the risk of people receiving unsafe or inappropriate care and treatment. Care and treatment was planned and delivered in a way that was intended to ensure patient's safety and welfare.

Staff on wards confirmed the trust had focussed on pressure ulcer prevention with a 'Think skin' campaign throughout the hospital. This is a national Programme to raise awareness with staff, patients and relatives of pressure ulcer prevention. This included using standardised protocols and care plans. We followed the care and treatment pathway of 20 patients across eight wards that included surgical, medical and the emergency department. We spoke with 6 patients, 5 relatives and 40 staff.

Patient's needs were assessed. The trust had a policy that all patients were screened for risk of pressure ulcers on admission, reassessed if the patient transferred to another ward or department and if their condition changed. We saw that patient's records included an assessment of the risks of developing pressure ulcers. This included patients who came to the emergency department and were then transferred to wards and we saw this on the day of our visit. We heard emergency department staff give 'handover' information together with patient records to ward staff. The verbal handover and written records included this

assessment. We then saw from the hospital's electronic patient's record system (PICS) that the patient had been reassessed on the ward.

Planning care and treatment that identified risks and how these would be managed and reviewed so that patients were safe. Trust policy was that any patient who scored ten or higher in the pressure ulcer screening assessment must have the pressure ulcer prevention plan put in place. This plan included repositioning the patients at certain intervals to relieve pressure on the skin. We saw that patients already on wards had pressure ulcer risk assessments updated weekly and their repositioning plans were also reviewed weekly. We noted that the majority of patients we focussed on had been commenced on a 4 hourly repositioning plan. One patient was on a 2 hourly plan due to their 'very high risk' of pressure ulcer development, immobility and general frailty. We saw that a repositioning care plan and the care activity to meet that plan were recorded on the PICS system. A back up system allowed paper copy to be produced in the event of PICS failing. This meant that ward managers and the trust had access to a 'real time' monitoring of the frequency of this patient's repositioning.

We followed how a ward level audit of assessment was undertaken on one ward. Staff told us this task was allocated by the ward manager to a different member of the nursing team each day. We saw that gaps in the assessment of one patient admitted during the night before our visit, had been identified at 10am by this audit. Action was followed through by the ward sister to establish if the assessments had been subsequently completed. We noted that they had been completed and a pressure ulcer care plan put in place by 11.30am. A clear and reasonable explanation for the delay had been documented on the patient's notes by the night sister. We went to see the patient and noted that they were lying on an airwave mattress which, is a special mattress that helped to reduce the risks of further pressure damage to their skin. We spoke with the patient's social care worker who was with them and they confirmed the reasons for the delay in assessing the patient during the night. They said the person had been well cared for despite being in a high state of distress on admission and presenting a challenge to the nursing staff.

All the patients we reviewed had appropriate equipment in place necessary to reduce the risk of pressure ulcers. For example one patient declined to sleep in bed and preferred to sleep in a recliner chair. The tissue viability team confirmed that pressure relieving gel was integral to the chair which provided low to medium pressure relief and therefore adequately met the patient's needs. The emergency department was trying out two new types of trolley that better supported patients with frail skin, with the intention to replace its current stock.

The trust learned from adverse events and incidents that had occurred within the service. Two of the wards we focussed on from data that the trust had sent us, had recently submitted incident alerts relating to grade 3 pressure ulcers. A route cause analysis (RCA) investigation had been carried out in each case. At the time of our visit staff told us they were awaiting the action plans to these RCA's in order to be involved in lessons learned to reduce the risk of a repeat incident.

Staff told us they had received up to date tissue viability training from a variety of sources. We asked staff about the difference between moisture lesions and pressure ulcers and they demonstrated a clear understanding of both. The trust may find it useful to note however that not all staff were sure about the trust policy for recording moisture lesions. All staff stated they were supported to access training and also received ad-hoc training from the tissue viability nurses when they attended to assess patients on the ward. This meant

ward staff were kept up to date with knowledge from a specialist practitioner.

Patients had malnutrition screening risk assessment completed weekly and recorded on PICS. Where they were identified as being at risk referrals to dieticians had been carried out in a timely manner. The medical notes had been updated with the dietician's recommendations which had been relayed to staff delivering care. We noted generally good multi-disciplinary working between the ward and the dieticians and speech and language therapists (SALT). The trust may find it useful to note however that for some patients who were able to eat independently, the SALT or dieticians advice had not always been fully understood by ward staff. We saw this led to some confusion with the wrong meals brought to some patients, who asked for them to be changed and therefore had their meal time delayed. On some wards some record keeping for nutritional support had gaps. For some patients whose condition had improved since admission, care plans did not always reflect the need to discontinue food intake records. This could lead to confusion about a patient's current needs. We raised these issues with the Chief Nurse and will follow them up at future inspections.

We noted there was a system in place for staff on duty to identify patients at risk from malnutrition. Each had a 'code red' circle above their bed to indicate they required assistance to eat. The PICS system identified these patients. Staff were made aware of who they were from their handover sheet and the white board displayed on wards which indicated nutritionally at risk patients with a red magnetic dot. Staff were able to tell us which patients required assistance to eat. Red trays and jugs were used as a visual prompt for staff to ensure these patients were supported at meal times. We saw during meal times patients who required assistance were supported by either staff or relatives.

The Trust may find it useful to note we identified that one patient, admitted to a ward while waiting for a bed to become vacant in a more appropriate ward, was not receiving the level of nutritional support from staff needed. They were heavily dependent on their relatives. We raised this with Chief Nurse and the patient was transferred to a more appropriate ward. The trust intended to conduct an RCA analysis to find out why the patient had not been transferred sooner.

Most patients were supported to eat with dignity and kindness. However on one ward staff told us that when they were very busy, they gathered patients around a table and one member of staff assisted two patients to eat at the same time. This did not promote patient's dignity. We raised this with the Chief Nurse and will follow it up at future inspections.

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 effective systems in place to identify, assess and manage risks to the health, safety and welfare of people using the service.

Reasons for our judgement

When we last visited the hospital in July 2013 we identified some concerns about how the care provided to people was checked and monitored by senior staff on wards and units. Whilst the trust looked into all serious issues, some routine checking to ensure people received planned care and treatment was not evident. The trust produced an action plan for improvement and we kept in touch with the trust to monitor its plan.

The trust shared data with us relating to hospital acquired pressure ulcers (an ulcer as a result of pressure damage) and the steps they had taken to reduce the incidence of preventable pressure ulcers. Pressure ulcers can be unavoidable under some complex conditions with severely ill patients; or patients unable to tolerate the preventative measures.

We visited the hospital again on 28 November 2014 to follow up progress and found improvement had been achieved.

We found the trust was led effectively to monitor the quality of service that people received. The patients information communication system (PICS) recorded Waterlow, which is a pressure ulcer risk score, and other observations on admission to each area of the hospital. The chief nurse told us that putting patients' skin assessments onto the system was under development by the trust and should be in place within six months. Senior managers told us that any gaps in the entries for each patient on the system would generate a red line in the patients' record. Ward staff could see at a glance if any patient had missed an assessment and ward managers were able to audit and take immediate action to improve the timeliness of patient assessments; "We don't like red lines" nurses told us.

The trust may find it useful to note that we found there were inconsistencies in the way some wards recorded patients who did not agree to have their skin checked. Some patients were considered by staff as more independent and self- caring. The records did not demonstrate what staff did or did not do to ensure these patients had suitable actions

taken to reduce the risk of pressure damage.

It was trust policy that the tissue viability team supported wards to carry out 'back to the floor pressure ulcer audit' for up to five patients per month. The trust may find it useful to note that there was some inconsistency in this practice among the wards we visited. For example, two wards had no audit results to show us and one ward audited 2 patients instead of five. We drew this to the attention of the Chief Nurse and will monitor this at future inspections.

We found the trust was led effectively to manage risk. Nursing staff told us about the trust's zero tolerance approach to patients developing pressure ulcers. Senior nursing staff told us that this meant: "Making it easy for staff to do the right thing" and making each member of staff accountable for actions they took or omitted to take.

We observed that a multi-disciplinary team approach was owned by all of the staff in the wards and areas we visited and every member of the team was involved in planning suitable care to prevent pressure ulcers. This meant that doctor, therapist and nurse along with support staff all worked together to provide the most appropriate care for the person.

We found that learning from incidents / investigations took place and appropriate changes were implemented. The senior hospital team led by the chief executive reviewed any root cause analysis (investigation) following a patient who developed a grade three or four pressure ulcer. Staff told us that they found being held to account a very powerful learning experience. Some staff told us that because the executive directors were part of the review this helped everyone understand the impact of quality on patient care. Actions required from these meetings were monitored and followed up by the medical director and quality development team.

We found decisions about care and treatment were made by the appropriate staff at the appropriate level. For example, we observed that a 'plastics' consultant was called to assess a patient who came to the emergency department with a pressure ulcer, before their treatment was planned and they were admitted to a ward. Staff told us that the trust was committed to having staff suitably trained in competencies which ensured they knew how to support patients to prevent the development of pressure ulcers. The electronic system used to record patient care generated an immediate e mail to the tissue viability nurses at the time any member of staff reported a pressure ulcer. This meant that specialist support and advice was immediately available to the patient and the staff treating them.

Some highly specialised areas such as neurology, theatres and critical care had worked with their multi-disciplinary teams to encourage every member of the team to consider reduction in pressure damage at every stage of the patients care. For example we saw that the theatre care plan included a clear record of actions taken. Critical care had changed the order of their recording chart to make a more effective record of patient care.

We found changes were made to treatment and care provided through the analysis of incidents that had resulted in harm to people. For example a dedicated start and finish group had been set up to review pressure ulcers under plaster of Paris, or synthetic plaster. The staff had reviewed the limited existing best practice and had built on this to ensure a clear audit trail of, which member of staff applied plaster and in which department. This process included a skin assessment prior to plaster application. At the time of our inspection the group were writing up their progress in order to share their

learning and best practice more widely. The trust had also considered the impact of equipment on the development of pressure ulcers. It had looked at both equipment which could contribute to causing a pressure ulcer and equipment needed to prevent a pressure ulcer.

This meant that every aspect of care had been considered with the multi-disciplinary team to work towards harm free care for people.

The trust submitted information to be collected as part of a mandatory national data collection system. Wards we visited submitted pressure ulcer data monthly as part of the national patient safety initiative.

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 other services less often. 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.

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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk