## University Hospitals of Leicester NHS Trust
### Leicester Royal Infirmary

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<th>Region:</th>
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| Location address: | Infirmary Square  
Leicester  
Leicestershire  
LE1 5WW |
| Type of service: | Acute services with overnight beds  
Community healthcare service  
Diagnostic and/or screening service  
Long term conditions services  
Hospital services for people with mental health needs, learning disabilities and problems with substance misuse  
Prison Healthcare Services  
Rehabilitation services |
| Date of Publication: | May 2012 |
| **Overview of the service:** | Wards 15 and 16 of the Leicester Royal Infirmary operated as one ward known as the medical admissions unit. The ward received medical in-patient admissions from the hospital's emergency department and from the clinic which operated on the ward. |
Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Leicester Royal Infirmary was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services

How we carried out this review

We reviewed all the information we hold about this provider and carried out a visit on 16 March 2012.

What people told us

During our inspection visit we spoke to a number of patients on the ward. None of these people had experienced any lengthy delays in being allocated a bed but they had been surprised to arrive on the ward without a bed being available. Those we spoke to told us that this had not been explained to them when they left the emergency department.

What we found about the standards we reviewed and how well Leicester Royal Infirmary was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

Patients were not properly informed about the arrangements for their admission to the medical admission unit and were not told they may have to wait on trolleys for lengthy periods.

Some patients were transferred to the ward on trolleys, or to wait on chairs, when it was inappropriate to do so because they had specific needs which could put them at greater risk.

There were no reliable arrangements in place to properly monitor the length of time people waited on trolleys or to help understand the full impact on patients.

Whilst patients waited on trolleys, or on chairs, for lengthy periods of time they
experienced a lack of privacy and dignity.

Medication supplies were not stored securely enough.

There were no proper arrangements in place to demonstrate how staff concerns had been addressed. There were limited arrangements in place to support ward staff and keep them properly informed.

The area which received ambulatory patients direct from GP’s was unsuitable for its purpose and there was a lack of consideration of patient's privacy and dignity.

**Actions we have asked the service to take**

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

**Other information**

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*
Outcome 04: Care and welfare of people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement
There are major concerns with Outcome 04: Care and welfare of people who use services

Our findings
What people who use the service experienced and told us
Prior to our inspection visit CQC had received concerns that patients were subject to lengthy delays on trolleys while they waited for an available bed. We had been told that people waited for lengthy periods and that there were occasions when there were up to 10 people at a time waiting on trolleys in the corridor of the ward. We were also told this resulted in people’s personal care and healthcare support being provided to them whilst they were on trolleys, in corridors, without proper regard for their privacy and dignity.

We visited the ward late on a Friday afternoon. During our inspection visit we spoke to a number of patients on the ward. Most of these people had been admitted to a bed when we spoke to them, but some were waiting for a bed to become available.

The people we spoke to told us they had not experienced any lengthy delays in being allocated a bed but they had been surprised to arrive on the ward without a bed being available. Those we spoke to told us that this had not been explained to them when they left the emergency department.

During our visit one person arrived on the ward unexpectedly. The ward staff were unaware that the patient was being transferred to their ward and had therefore not planned for this. The process for managing beds and admissions had not worked effectively and caused some delay and confusion for the patient. This person waited on the ward, on a trolley, for approximately one hour until a bed was available.

Another person, who had a learning disability, was seated at the end of one of the bed
bays eating a meal while waiting to be admitted. He was very anxious and tearful and had missed some of his regular medication because of the length of time he had been at the hospital. He had arrived at the emergency department on that day at 1.45pm and transferred to the medical admission unit at 5pm. When we left the ward at 7pm the patient was still sitting in a chair, at the end of the bay, still distressed. Staff explained to us that when people were transferred to the ward from the emergency department there was not a reliable process to ensure that people’s specific support needs were taken into account or whether it would be appropriate for them to be cared for on a trolley.

The patients we spoke to told us they were satisfied with the care the nursing staff provided. One told us; "They have all been very good" and another said; "I can’t complain at all".

**Other evidence**

The trust had a policy in place for the care of patients on trolleys. Their intention was that there would be no more than six patients on trolleys in this ward at any one time. During our visit there were small numbers of people on trolleys or waiting on chairs for a bed at any one time. The trust policy of no more than six trolleys was not exceeded at this time.

We spoke to a number of staff that worked on the ward. They told us that the limit of six trolleys was regularly exceeded and patients continued to arrive on the ward even when there were already six patients waiting. Staff we spoke to were aware of the escalation plan. This was in place to try and avoid the trolley limit being exceeded, although at times this plan was not actioned.

There was an arrangement in place where staff could alert senior managers if there were more than six trolleys on the ward and these managers then had the authority to review and suspend further admissions if necessary. It was not clear that this arrangement worked effectively as on some occasions the number of trolleys exceeded the specified level of six.

The ward did not keep any accurate records of how long people waited on trolleys. They had recently introduced a recording mechanism but acknowledged this was ad hoc and the information was incomplete. We looked at a sample of these records which confirmed people waited on trolleys for lengthy periods. For example, on one date we found that one person had waited on a trolley for eight hours and another had waited for six hours. These people had been admitted from the emergency department where they would also have waited on a trolley prior to transferring to the medical admission unit. There was no mechanism in place to properly monitor how long people were on trolleys on the medical admission unit or to monitor the total amount of time people were cared for on trolleys whilst a patient at the hospital.

The managers we spoke to acknowledged that there needed to be better arrangements in place to monitor the length of time people waited on trolleys and explained they had plans in place to address this.

The absence of this information meant it was difficult to understand how great the impact was on patients or to know how regularly the numbers of trolleys on the ward exceeded.
Because patients were on trolleys for lengthy periods of time this meant their privacy and dignity was not properly supported. We were told that on occasions staff would put screens around trolleys on the corridor so they could assist someone with a personal care task with some privacy. People also had to eat their meals on trolleys in the corridor.

The ward was divided into bed bays. During our visit we noted that trolleys were placed at the top of these bays. Staff told us that on occasions when there were more trolleys than they would also be placed in the ward corridor.

There were five medication trolleys for the ward. When not in use these should have been secured to the wall with a cable and lock to ensure the stock of medication was safely stored. When we visited none of the medication trolleys were secured to the walls and all could be moved around freely. There had previously been suitable brackets in place to secure these trolleys, but these brackets had been removed as patient trolleys were now often in the place where the medication trolleys had previously been stored. We raised the lack of security of medication trolleys with senior managers and they assured is that this would be remedied straight away.

The cabinet of one of the medication trolleys was also unlocked, meaning the medication within it could have been easily accessed by someone other than a key holding member of staff. We were assured by managers that this was a rare occurrence and was due to an isolated error by a member of staff.

During our visit we looked at the staff communication book which had been introduced for staff to record any concerns and bring these to the attention of the ward matron. We were told the book had been missing for a period of time and the last entry in this was dated 15 February 2012. There were many comments in this book showing staff were concerned about the numbers of patients who were cared for on trolleys for lengthy periods of time and concerned about the quality of care they received during these times. Managers had added some comments in response to concerns raised in the book. We were also told that managers fed back to staff and shared concerns with the Emergency Department. Despite these steps it appeared staff remained concerned and it was not clear if the issues they had raised had been properly addressed.

We were told by managers of the ward that there were meetings with staff but these were ad hoc and not recorded or minuted. There were no ward meetings held or any other opportunities for staff to meet together with managers to discuss concerns and share information. Some of the staff we spoke to told us these meetings had happened in the past and thought they had ceased because everyone was too busy to attend these. Staff were working in a highly pressured environment but there were limited arrangements in place to support them and keep them properly informed.

At the time of our inspection building work was underway and a trolley bay was being established. This was to accommodate six trolleys in a private area, adjacent to the main ward. Compared with the current arrangements this would improve people's privacy and dignity whilst they waited for a bed to become available. However, this could mean people continued to be cared for on trolleys for lengthy periods, which were uncomfortable and undignified for people.

Staff we spoke to were pleased arrangements were in hand to improve patient's privacy
and dignity but did have concerns about whether there would be an adequate level of staffing for this bay.

There was an area on the ward (known as the bed bureau) which people were referred to by their GP for assessment for admission. On the day of our visit this service was very busy. The room was cramped, hot and the overall atmosphere was chaotic. Some people sat on chairs in the ward corridor because it was too hot and uncomfortable within the clinic room. The flooring was badly soiled. This overall environment presented a hygiene risk.

Patients in this room were undergoing tests and treatments in full view of other patients with a lack of consideration for their privacy and dignity.

In view of the major concerns identified in this outcome area the Care Quality Commission served a Warning Notice on the Registered Provider on 10 April 2012.

**Our judgement**

Patients were not properly informed about the arrangements for their admission to the medical admission unit and were not told they may have to wait on trolleys for lengthy periods.

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What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called Guidance about compliance: Essential standards of quality and safety.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions:** These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action:** These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.
### Information for the reader

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