Inspection Report

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

Queen's Medical Centre

Derby Road, Nottingham, NG7 2UH

Tel: 01159249944

Date of Inspection: 19 July 2013

Date of Publication: August 2013

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Consent to care and treatment	✓ Met this standard
Staffing	✗ Action needed

Details about this location

Registered Provider	Nottingham University Hospitals NHS Trust
Overview of the service	Nottingham University Hospitals NHS Trust is one of the largest trusts in England and it provides services on three locations. This report focuses on one of these locations, Queen's Medical Centre, which provides a range of acute and specialist services to the local population of Nottingham as well as across the wider East Midlands area.
Type of services	Acute services with overnight beds Diagnostic and/or screening service Rehabilitation services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies 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 in response to concerns that one or more of the essential standards of quality and safety were not being met.

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 19 July 2013, 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 and talked with staff.

What people told us and what we found

We visited two wards during the inspection. We looked at staffing levels on ward D57 and consent processes on ward F22. We spoke with 14 patients, one relative and nine staff. We looked at five patient records.

Patients told us that they were asked for their consent before they received any care or treatment. All patients told us they signed a consent form. Three of the four patients told us they had not received a copy of the consent form. A patient said, "Yes, they sit and talk to me, they make sure I understand what is happening. They tell you properly and ask me if I have any questions. Yes, I have had to sign a few consent forms. They go through it on this ward, tell me any complications and ask if I have any questions then I sign it. I don't get a copy."

Nine of the ten patients we asked told us they felt there was enough staff to meet their needs. A patient said, "They have time to care." Another patient said, "There are enough staff and they have been respectful and caring. The staff are spread evenly." The patient who did not feel their needs were met said, "I think there are enough staff but they need to be better organised."

We found that before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. However, we also found that there were not always enough qualified, skilled and experienced staff to meet people's needs on ward D57.

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

What we have told the provider to do

We have asked the provider to send us a report by 27 August 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

We inspected this standard due to information received regarding consent processes at the hospital.

We spoke with four patients. Patients told us that they were asked for their consent before they received any care or treatment. All patients told us they had signed a consent form. Three of the four patients told us they had not received a copy of the consent form.

A patient said, "Yes, they sit and talk to me, they make sure I understand what is happening. They tell you properly and ask me if I have any questions. Yes, I have had to sign a few consent forms. They go through it on this ward, tell me any complications and ask if I have any questions then I sign it. I don't get a copy." Another patient said, "I was told exactly what is happening. The doctor came in for 30 minutes to explain fully."

We spoke with four staff. All four staff could explain the process they went through to ensure that patients were happy with the care to be provided and consented to it. Staff told us that they obtained verbal consent for most care but written consent for significant medical procedures.

One staff member said, "We are all responsible for seeking consent from the patient. I always ask a patient if they are happy for me to help them." Another staff member said, "When doing blood tests I always make sure the patient knows what the test is for. Some people put their arm out before receiving information, but it important to make sure the person knows what we are doing and why. I check whether the patient can understand, retain and evaluate the information I am providing. This is all part of the process of seeking consent."

We looked at five patients' care records. We saw consent forms had been fully completed

by staff and had been signed by the patient consenting to the care and treatment. The provider may find it useful to note that the white copy of the completed consent form, which should be given to patients, was in the medical records for 11 of the 13 consent forms that we inspected. This meant that there was a greater risk that patients would not have a copy of the information that they received prior to providing consent for a procedure.

The provider may also find it useful to note that we saw in one patient's notes that an assessment of capacity had been made and the patient had been assessed as lacking capacity. This assessment had not been supported by best interests' documentation. This meant that there was a greater risk that the patient's rights were not protected.

The Mental Capacity Act 2005 protects patients who lack capacity to make a decision for themselves because of permanent or temporary problems such as mental illness, brain injury or learning disability. If a patient lacks the capacity to make a decision for themselves, staff can make a decision in their best interests. The MCA sets out care providers' responsibilities, including a two stage test of the patient's capacity to make particular decisions.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not always enough qualified, skilled and experienced staff to meet people's needs on ward D57.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There were not always enough qualified, skilled and experienced staff to meet people's needs on ward D57.

We inspected this standard due to information received regarding staffing levels on ward D57 at the hospital.

Ward D57 is a 42 bedded medical assessment unit admitting patients from the Emergency Department and GP assessment. The ward consists of five single side rooms, one double side room and six bays of six beds each. Two of these bays have three Level 1 beds (three female and three male). Level 1 beds are for patients requiring additional supervision from staff due to higher needs.

The ward staffing levels varied. Staffing levels could be seven registered nurses, four auxiliaries and one clinical support worker. This would allow one nurse and one auxiliary to care for six patients in four of the bays and one nurse and one auxiliary to care for nine patients in the two other bays and side rooms. The additional nurse and clinical support worker supported the other staff and were not responsible for specific bays.

Staffing levels were more commonly six registered nurses, four auxiliaries and one clinical support worker. This would allow one nurse and one auxiliary to care for six patients in two of the bays, one nurse and one auxiliary to care for nine patients in two other bays and the side rooms and one nurse and one auxiliary to care for 12 patients over two bays. The additional nurse and clinical support worker supported the other staff and were not responsible for specific bays.

At the time of our inspection we were told that there were two vacancies for registered nurses and one vacancy for a clinical support worker. We were told that that the ward would be fully established by September 2013. We also saw a copy of a paper going to the board in July 2013 which had identified that ward D57 was under staffed in comparison with staffing levels calculated using a patient dependency tool. We were told that the ward

had submitted a business case to increase their staffing levels for the ward. We also saw that the trust had an action plan in place to address issues identified with care provided on the ward.

We spoke to 10 patients about this standard. Nine patients told us they felt there was enough staff to meet their needs. A patient said, "They have time to care." Another patient said, "There are enough staff and they have been respectful and caring. The staff are spread evenly." The patient who did not feel their needs were met said, "I think there are enough staff but they need to be better organised."

We spoke with five staff. We had mixed feedback regarding staffing levels. One staff member said, "When I first started staffing levels were spot on. We have dipped, staff leaving, each day is different dependent on the rotas. People going off sick does not help. Ward manager has requested extra trained and auxiliary nurses. [Ward manager] has made the ward a lot better. We used to have to do transfers [of patients] to other wards which left the ward short in the afternoon. There is now a transfer team to do it; it has made a huge difference. Some transfers took 20-30 minutes." However, another staff member said, "I think up here in relation to other wards, it is good. Nurse to patient ratio is good here."

No staff felt that care was compromised due to poor staffing levels. One staff member said, "No. I think the care comes first ? it may take longer if we are short staffed. The numbers will be safe but care can take longer." Another staff member said, "I would say if you want to give 110%, where it has been very low due to sickness, then they may not have been given the personal touch, but the care would not have been compromised. The basic care would always be done."

A staff member raised concerns regarding the monitored bay on the ward. One staff member said, "We have a monitored bay on the ward. There is a wall between three male and three female monitored beds. I know it has to be single sex but you need to be able to see all six patients especially when the alarms go off. There is no central monitoring unit. The matron has said she has plans to improve that area. I think there are new monitors coming."

We observed lunchtime on this ward. We did not see any issues regarding staffing levels during our observations. Staff were caring and supported people to eat and drink where appropriate. However, we could see that staffing levels and the layout of the ward could make it more difficult for adequate observation of the patients in the monitoring beds requiring higher levels of support.

We saw an example of where staffing levels were at risk of dropping below minimum levels. We saw that the ward manager had escalated appropriately and had been able to resolve the issue.

We looked at performance data for the ward. This suggested that current staffing levels were potentially affecting care provided on the ward.

The trust provided us with information regarding patient falls on ward D57. We saw that there had been 54 falls on the ward since January 2013. While most of these falls resulted in no harm to the patient, 13 falls resulted in low harm to the patient and three falls resulted in moderate harm to the patient.

The trust provided us with detailed information regarding each patient fall in the last three

months. The details for one fall stated that, "Staff nurse at time of incident was caring for 12 patients."

We saw a summary report of June Acute Medicine Performance. This stated that there had been an increase in falls in June and stated, "We believe the high volume of falls occurring at the bedside is partly due to low staffing levels."

The summary report also stated that D57 had an 88% achievement of completed VTE (Venous Thromboembolism) assessments. This was against a target of 95% and a ward average of 94%. We saw that one patient had suffered a VTE in June 2013. A VTE is a condition in which a blood clot forms in a vein.

The report also stated that D57 sickness levels are currently 5.48% against a target of 3.2%. We also saw that there had been an increased turnover of nursing staff in 2013 compared with 2012.

The trust provided us with information regarding patients suffering hospital acquired tissue damage for the last quarter. We saw that 2 people had acquired moisture lesions, two acquired stage 1 pressure ulcers and 1 had acquired a stage 2 pressure ulcer. We saw that the NUH Pressure Ulcer report commencing 8 July 2013 showed that D57 initial risk assessments were 80% against a target of 100%, appropriate care plan was 25% against a target of 100% and staff training was 95% against a target of 100%.

We saw the D57 Staff Meeting minutes for March 2013 which stated, "2pm observations not consistently completed owing to time pressures." We also saw the minutes for the D57 Nurse Meeting 4 July 2013 which stated, "The ward has completed 2 RCAs including pressure ulcers (?stage 2/stage 3). Ward documentation was not completed. Therefore not able to determine whether the patients had developed pressure ulcers whilst on D57."

We looked at the nursing metrics data for the ward. There had been recent improvement in the figures for the ward; however, the ward was still rated red for its performance in the areas of pain, patient observation and pressure ulcers.

There had been no complaints received by the trust in the last three months regarding staffing levels on D57. However, there had been one issue raised with the Patient Advocacy Liaison Service. This stated, "Patient is unhappy with the delay in responding to a buzzer."

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The registered person has not taken appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 27 August 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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.

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