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By Email and Recorded Delivery

Mr Mark Newbold
Heart of England NHS Foundation Trust
Bordesley Green East
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20 December 2013

The Care Quality Commission
The Health and Social Care Act 2008
WARNING NOTICE:
Heart of England NHS Foundation Trust
Regulated Activity: Treatment of Disease, Disorder or Injury

Our reference: RGP1-1144748531.
Account number: RR1

Dear Mr Newbold,

This notice is served under Section 29 of the Health and Social Care Act 2008.

This warning notice relates to your registration to carry on the above regulated activity at or from the following location:

Good Hope Hospital,
Rectory Road,
Sutton Coldfield,
Birmingham,
B75 7RR

We are notifying you that you are failing to comply with the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (the Regulated Activities Regulations 2010).

The Regulated Activities Regulations 2010

You are failing to comply with Regulation 10(1)(a)(b) and (2)(b)(iii)(iv) which states:

10.—(1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by

means of the effective operation of systems designed to enable the registered person to—
(a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and

(b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

(2) For the purposes of paragraph (1), the registered person must—
(b) have regard to—
(iii) the information contained in the records referred to in regulation 20,
(iv) appropriate professional and expert advice (including any advice obtained pursuant to sub-paragraph (a)),

Why you are failing to comply with this regulation:

1. On 11, 13 and14 November 2013 the Care Quality Commission inspection team led by Fiona Allinson (see appendix A) visited Good Hope Hospital, Rectory Road, Sutton Coldfield, Birmingham, B75 7RR. On 23 November 2013 Fiona Allinson Head of Hospital Inspection led a team consisting of Andrea Gordon, Regional Director Operations, Bethan Graf, Clinical Fellow to Sir Mike Richards, Amanda Hennessy and Debbie Williams, Compliance Inspectors to inspect AMU, MAU, critical care services and the A&E unit.
2. During the inspection we inspected the accident and emergency department (A&E) and the ward area known as Ward 20/AMU. In both areas we found breaches of Regulation 10.
3. As the registered provider for the regulated activity of treatment of disease, disorder or injury at the Good Hope Hospital location of Heart of England NHS Foundation Trust, you have a legal duty to ensure that service users are protected against the risks of inappropriate or unsafe care and treatment. You are required by Regulation 10 of the Regulated Activities Regulations 2010 to protect service users against the above risk by means of the effective operation of systems designed to enable you to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity of treatment of disease, disorder or injury against the requirements set out in the relevant Part of the Regulated Activities Regulations 2010 and identify, assess and manage risks relating to the health, welfare and safety of service users who may be at risk from the carrying on of the regulated activity of treatment of disease, disorder or injury . You are failing to comply with this regulatory requirement.
4. This Notice sets out the detailed grounds upon which you are in breach of this Regulation.

Regard to appropriate professional and expert advice

3. The current guidance about triage within the A&E department from the College of Emergency Medicine position statement on triage 2011 states that "Well defined red flag presentations, for example crushing chest pain or profuse bleeding may be recognised by non–registered health care workers such as Emergency Department (ED) reception staff who should seek the immediate assistance of a registered clinician. Assessing urgency in other presentations is a more complex process, and requires the skills of a trained health care professional." This process is known as streaming. Furthermore this guidance goes on to define "Triage" as "a face to face encounter which should occur within 15 minutes of arrival or registration and should normally require less than 5 minutes contact. Triage should be viewed as a brief intervention - it is not a consultation." We spoke to staff and patients at Good Hope Hospital and found that whilst you currently employ "streaming " by the receptionists who are non-registered healthcare workers i.e. an initial assessment of needs, this is not followed up within the recommended 15 minutes by a trained health care professional.

4. Your own patient pathway in the emergency department states that your nursing team will triage designated major patients within 15 minutes of being notified of their arrival. It also states that "On occasions due to the volume of critically ill/ life threatening patients attending we may not be able to do the initial nurse assessment in this timeframe." The pathway does not give a length of time that patients categorised as minors by the receptionist should wait. This means that someone miscategorised by the receptionist may not receive timely treatment and may suffer harm as a result of the delay.

5. We spoke with a patient in the waiting room who had chest pain. The guidance referred to above indicates such a presentation should be trigger the immediate request for assistance of a registered healthcare worker. However, the patient explained to us they were surprised they had not been seen by a health care professional quickly because they had chest pain. They were told to wait in the waiting room to be seen. We also found that other patients in the waiting room were waiting as long as two hours before being seen by a health care professional. One patient who had been waiting for two hours told us they had not been asked any questions about their condition when they booked in at reception. In the absence of such questioning, reception staff may miss the red flag presentations described in the guidance referred to above. It was therefore unclear as to whether this person had been designated a "minor" or "major" and consequently how long they could expect to wait to be seen by a trained healthcare professional.

6. We saw that because A & E cubicles were occupied during our visit, additional patients brought in by ambulance were waiting in the corridor on

trollies. We spoke with a relative of one patient who told us their relative had been waiting in the corridor on a trolley for one hour and 20 minutes. They told us that none of the A&E staff had assessed them or spoken to them and did not seem to be aware that they were there. The patient commented that their bottom was becoming sore. Another patient waiting on a trolley in the corridor had been waiting in excess of two hours. On reviewing their care records it was clear that they had not been assessed nor had any physiological observations checked during this period.

7. We asked the nurse in charge to explain who was responsible for the patients waiting on trolleys or in chairs on the corridor. They told us that at the time the hospital and ambulance liaison officer was responsible. However, we then discovered that that this member of staff had left the department and had not informed the nurse in charge. One patient had been left on an ambulance trolley. Nursing staff in the A&E department were not trained to use ambulance trollies. Staff had to ask another paramedic crew to assist them to move the patient.

8. The national guidance entitled Standards for clinical practice and training, June 2008, from the Resuscitation Council states that staff should check the emergency equipment every day to ensure that it is ready in case of an emergency. However we found that both on A&E and on Ward 20/AMU these checks were not taking place. We looked at the resuscitation trolley in the minor injury department. We saw that staff were required to check this trolley every day. We looked at records of signatures to demonstrate that the trolley had been checked for the last three months and saw that the defibrillator had not been checked every day. On ward 20/AMU there was an emergency trolley which had only been checked on 7 November after the ward opened and not again up to the date of our inspection. We saw this through checking the log on the trolley where staff sign to state that they have checked the trolley. On this check it had been identified that there was no A4 mask or spare roll for the ECG on 7 November 2013. The senior nurse checked the trolley during our inspection and found a mask and spare roll. This indicates the check is not being performed correctly or with the required frequency as the check log did not accurately record the current condition of the equipment on the trolley on the date of our inspection. .

9. The patient pathway in the emergency department also states that “We also have an overnight stay called the Clinical Decisions Unit [“CDU”] where patients are kept in overnight for observation.” However we observed one patient we spoke with had been delayed in the A&E department and was waiting within the CDU for a medical bed to become available. This patient had been in CDU for 26 hours.

10. There is evidence that a systematic approach to rounding can improve patients’ experience of care and build their trust, ensure that care is safe and

reliable, and alleviate pressure on nurses. Intentional rounding involves health care professionals carrying out regular checks with individual patients at set intervals and is described by a number of authors including Firth-Cozens J, Cornwell J (2009) Enabling Compassionate Care in Acute Hospital Settings. London: The King's Fund. It is accepted practice at a number of NHS Trusts.

11. Whilst in the A&E department we observed two patients calling for help in a distressed manner, both of whom were disorientated to time and place. We saw that two staff walked past and did not respond to their calls. We spoke with staff about how they met patients' needs. The staff we spoke with demonstrated a good understanding of patients' basic needs but told us they were too busy to always meet them. We asked if comfort or intentional rounding was carried out. We were told that this would happen if patients were in the department for a long time. We were told staff were too busy to do this at the time of our visit. We visited the A&E department at Good Hope Hospital on three occasions on three different days and could not find any evidence of comfort rounds or intentional rounding being carried out.

12. The best practice guidance the Safe and secure handling of medicines: a team approach, March 2005, includes guidance on the safe storage of medicines. This also includes the physical security of medication within hospital settings. This guidance state that the cupboards should be locked when not in use and Conform to BS2881:1989 and BS 3621:2007 and that the medicine trolley should be immobilised when not in use .

13. We visited ward 20/AMU on 13 November 2013 and saw that medicines were not stored securely in that they were stored within the clean utility room. There was a keypad on the door to the clean utility room. We saw the key number was written on the whiteboard in the office and when questioned about this the band 7 nurse said the number was there so all staff could access the room. She said this had been done because of the changes in staff as there was no regular ward staff. In the store room there were two drug trolleys, but only one in use. This was not secured to the wall, as required by the Medicines Act 1968, and there was no way to do this. There were medicines in cupboards which were not locked. They had been locked but because the latch was short of the locking pin the lock was ineffective as the doors could be pulled open. The fridge was not locked and contained medicines. We asked staff to lock the fridge: they explained that they were unable to do so as there was no key. There were three bags of medicines left on the cupboard. The drug trolley was very full with bags of patients' own medicines in it. We spoke with the operations manager who assured us that these issues would be addressed. However on our visit of 23 November 2013 we found that these issues were still present and that the fridge, despite having a notice on it stating do not use was in fact being used to store four insulin products.

14. Therefore our evidence demonstrates that you are in breach of Regulation 10(1)(a)(b) and (10 (2)(b)(iv) in that there are not systems operating effectively as required by Regulation 10(1) so as to protect patients against the risks of inappropriate or unsafe care and treatment and for the purposes of Regulation 10(1) you are failing to have regard to professional and expert advice in that patients are not assessed nor are they seen by the appropriate personnel in A&E: you are not checking resuscitation equipment to ensure that it is ready for use: you are not undertaking intentional rounding or similar processes: your audit processes have not identified that you are storing medicines which are not secured.

Managing the risk.

15. We asked to see a risk assessment on the reopening of Ward 20/AMU which supported information given to us by the operations manager, however this was not presented to us. We were supplied with two emails detailing the deficiencies on ward 20/AMU dated 7 and 8 November 2013. These emails suggest that the management team was aware of the issues on ward 20/AMU at that time and was working to put systems in place to address these issues and manage the risks. It states " I am sure that most of these issues you are already aware of and as I write you would be working on these issues to be resolved asap. You would however agree that as move of AMU Female Short Stay to ward 20 was planned in advance therefore one would have thought that most of these issues should have been ironed out in advance avoiding un-necessary stress for the staff." It lists the issues which include: only one drug trolley, one notes trolley, no bedside lockers, and tables amongst the issues. This highlights that the issues in respect of medicines management are not being addressed which is a risk to patient safety.

16. We visited the ward on 13 November 2013 and checked the ward to see whether patients had all the equipment they needed. There were two patients without lockers. One patient's belongings were in a hospital plastic bag on the floor behind their chair (Bed 7). The patient in Bed 10 which was a side room had their belongings in a cardboard box on a chair in their room. The patient in Bed 12 had no easy chair to sit out in. Unoccupied beds also had no lockers: beds 5, 6 and 14. There was no bed for the space marked bed 17. We also saw that patient notes were not stored in a notes trolley. You are failing to have regard to the information contained in the records that you maintain in relation to the management of the regulated activity in the AMU under Regulation 20 in this respect.

17. Therefore our evidence demonstrates that you are in breach of Regulation 10 (1)(b) and 10(2)(b)(iii) in that you are not managing the risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity, in that you are failing to manage

the risks identified to you in an email of 7 and 8 November 2013 in relation to the management of the regulated activity in the AMU and that you are not following your own policies and guidance.

You are required to become compliant with Regulation 10(1)(a)(b) and (2)(b(iii))(iv) by 21 February 2013.

Please note: If you fail to achieve compliance with the relevant requirement within the given timescale, we may take further action to make sure that you achieve compliance.

We will notify the public that you have been served with this warning notice by including a reference to it in the inspection report. We may also publish a summary more widely, but will not do so if there is a good reason not to.

If you think that the notice has been wrongly served on you, you may make representations to us. This could be because you think the notice contains an error, is based on facts you consider to be inaccurate, that it should not have been served, or is an unreasonable response to the situation it describes. You may also make representations if you consider that for these or any other reason, the notice should not be more widely published.

Any representations should be made to us in writing within 10 working days of the date this notice was served on you. To do this, please complete the form on our website at: www.cqc.org.uk/warningnoticerepresentations and email it to: HSCA_Representations@cqc.org.uk

If you are unable to send us your representations by email, please send them in writing to the address below. Please make it clear that you are making representations and make sure that you include the reference number <CRM process ID >.

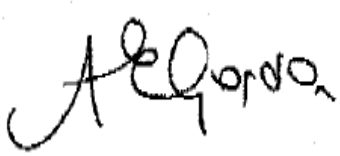
If you have any questions about this notice, you can contact our National Customer Service Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Representations@cqc.org.uk

Write to: CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote our reference number (<CRM process ID >) as it may cause delay if you are not able to give it to us.



Dr Andrea Gordon
Regional Director Operations (Central Region)