

Stockport NHS Foundation Trust

Shire Hill Intermediate Care Unit

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook this unannounced inspection of Shire Hill Intermediate Care Unit as a follow up to our previous inspection which took place on 22nd September 2015. The inspection we undertook on 22nd September was in response to concerns that were raised with us. Shire Hill Intermediate Care Unit is a 36 bedded unit situated in Glossop and offers inpatient rehabilitation services to patients over the age of 18 in the Tameside and Glossop areas. Care is delivered over two inpatient units; the Ludworth and Charlesworth units. These units are situated in the same building on two separate floors.

We inspected the unit during the evening of 18th November 2015. We visited the following areas:

- Ludworth Unit
- Charlesworth Unit

Our key findings were as follows:

We found that patients at Shire Hill Intermediate Care Unit were receiving timely and appropriate care during our visit. Nurse staffing levels had improved since our last inspection. There were still periods of understaffing however we found evidence that senior managers had taken appropriate steps to try to address periods of understaffing. These steps included offering staff that work at the unit extra shifts and the increased use of agency staff to mitigate last minute absences.

During our last inspection we found evidence that although an early warning score system was used on both units to identify patients who were at risk of deterioration, staff were not applying this system correctly in some cases. During this follow up inspection we found that staff were still not applying the system in some cases and were not undertaking observations of patients at the correct frequency.

During our last inspection we found that patient records were not stored securely and some records lacked important information. During this follow up inspection we found that patient's records were securely stored in a locked room. We also found that some records still lacked important information and contained some discrepancies.

During our last inspection we found that some patients experienced a delay in receiving their medication including pain relief and the section regarding the recording of allergies was not completed in some records. During this follow up inspection we found that patients were receiving their medications in a timely way and all medication charts reviewed, contained the appropriate allergy information.

There were still some issues of concern on both units regarding the standard of checks made on equipment.

Infection control processes and procedures were in place.

Medical staffing on the unit was adequate to ensure patients received timely and safe care. Staff were able to access medical advice when they needed to.

Importantly, the trust should:

- Continue to ensure that staff undertake and record patient observations consistently and accurately.
- Ensure that equipment is checked thoroughly on a regular basis.
- Remove out of date resuscitation guidance and policies and ensure staff have access to up to date guidelines and policies on resuscitation.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Shire Hill Intermediate Care Unit

Detailed findings

Services we looked at

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Detailed findings

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Background to Shire Hill Intermediate Care Unit

Shire Hill Intermediate Care Unit is a 36 bedded unit situated in Glossop and offers inpatient rehabilitation services to patients over the age of 18 in the Tameside and Glossop areas. Care is delivered over two inpatient units; the Ludworth and Charlesworth units. These units are situated in the same building on two separate floors.

Rehabilitation services are provided by a team of nurses, general practitioners and therapists. Occupational therapy and physiotherapy are available on the inpatient units.

Our inspection team

The team that inspected this service included one CQC inspection manager and two CQC inspectors.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about Shire Hill Intermediate Care Unit and Stockport NHS Foundation Trust.

As part of the inspection we carried out an unannounced visit on 18th November 2015 between 10pm and 12am to:

Shire Hill Intermediate Care Unit

We looked at a range of policies, procedures and other documents relating to the running of the service.

We spoke to four staff members, 2 patients and reviewed 2 patient records, 10 observation charts and 3 medication charts.

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Information about the service

Shire Hill Intermediate Care Unit is a 36 bedded unit situated in Glossop and offers inpatient rehabilitation services to patients over the age of 18 in the Tameside and Glossop areas. Care is delivered over two inpatient units; the Ludworth and Charlesworth units. These units are situated in the same building on two separate floors.

Rehabilitation services are provided by a team of nurses, general practitioners and therapists. Occupational therapy and physiotherapy are available on the inpatient units.

Summary of findings

Nurse staffing levels had improved since our last inspection. There were still periods of understaffing however we found evidence that senior managers had taken appropriate steps to try to address periods of understaffing. These steps included offering staff that work at the unit extra shifts and the increased use of agency staff to mitigate last minute absences.

We found that staff completed appropriate risk assessments for patients in all the cases we reviewed. Staff were still not applying the early warning score system and this had led to some patients not receiving a timely review by a doctor or closer observation.

In all records reviewed, staff had completed records in legible and clear handwriting. During our last inspection we found that patient records were not stored securely and some records lacked important information. During this follow up inspection we found that patient's records were securely stored in a locked room. We also found that some records still lacked important information and contained some discrepancies.

Patients were receiving their medications in a timely way and all medication charts we reviewed, contained the appropriate allergy information.

There were still some issues of concern on both units regarding the standard of checks made on equipment. These included out of date resuscitation guidelines and some equipment which was visibly dirty.

Infection control processes and procedures were in place.

Medical staffing on the unit was adequate to ensure patients received timely and safe care. Staff were able to access medical advice when they needed to.

Medical care

Are medical care services safe?

Incidents

- Incident reporting systems were adequate and staff were able to use the incident reporting system effectively.
- Staff told us that following our last inspection they had been encouraged by senior managers to report any concerns regarding staffing using the incident reporting system. Staff felt confident using this system and told us they had no concerns about raising an incident.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing harm to people and 'harm free care'. Monthly data is collected on pressure ulcers, urinary tract infections (for people with catheters), blood clots (venous thromboembolism or VTE) and falls.
- The unit displayed safety calendars, which gave information on pressure ulcers and falls. This information was displayed on the wall at the entrance to each unit and in the staff office on each unit.
- The information displayed on the Charlesworth Unit showed that there were seven incidents of patient falls in the month of October and five incidents of patient falls from 1st November to 18th November.

Cleanliness, infection control and hygiene

- Infection control processes and procedures remained in place that helped safeguard patients from avoidable infections.
- Staff followed infection control and prevention guidelines during patient contacts, including washing their hands and changing their personal protective equipment.
- We observed staff caring for patients with infections in isolation rooms. These rooms had clear signage to indicate that additional infection control measures were to be used on entering and leaving the rooms.

Environment and equipment

- There were emergency resuscitation trolleys on both Charlesworth and Ludworth units. There was a checklist for staff to complete on a daily basis to check all the

parts of the emergency resuscitation trolleys. This checklist included sections to check that all the equipment in the trolley was in date and in good working order.

- We reviewed four weeks of checklists on both units and checks were undertaken daily, apart from on one occasion when there was no check undertaken on the emergency resuscitation trolley.
- We checked all pieces of equipment contained in the emergency resuscitation trolleys on both units.
- On the Ludworth unit, all equipment contained in the emergency resuscitation trolley was found to be in date and in good working order with the exception of one face mask which was visibly soiled and damaged.
- On the Charlesworth unit, all equipment contained in the emergency resuscitation trolley was found to be in date and in good working order with the exception of one face mask which was visibly soiled and damaged.
- In the trolleys on both units we found guidance for staff on how to undertake resuscitation was out of date. The guidelines from the resuscitation council were dated 2005. There have been a number of changes made to the guidelines for resuscitation since 2005. In the 2015 guidelines it states that oxygen should be administered at an earlier stage than was specified in the 2005 guidelines. The depth (how forcefully the chest compressions should be undertaken) and the speed of the chest compressions has also changed from the 2005 guidelines. Additionally the 2015 guidelines offer further guidance to staff on issues including allowing the chest to recoil fully and the use of a precordial thump (an intervention to try to restart the heart). The resuscitation council issue guidelines on resuscitation following ongoing research and evidence based review. Using out of date guidance could therefore affect the efficacy of resuscitation attempt.
- We also found that both units were using a policy for the resuscitation and care of the deteriorating patients which was from a legacy trust. This Policy was noted to be dated 2003 and was due for review in 2006.

Medicines

- We observed staff undertaking part of the night time medication round. Staff undertook appropriate checks when administering medication including checking the patient's name, date of birth and allergy status.

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- Staff told us that the time it took to complete this medication round had decreased since our last inspection. We observed the medication round being completed within approximately one hour.
- We reviewed three medication charts and in all three cases, the allergy section was fully completed. They were also completed legibly and all medications had been administered as prescribed.

Quality of records

- We reviewed two sets of patient records, ten observation and intentional rounding charts and three medication charts.
- In all the records reviewed, staff had written entries in clear and legible handwriting.
- Patient records were securely stored in a locked room. We also found that some records still lacked important information and contained some discrepancies.
- In one of the two patient's records we found that it was not clearly identifiable that they had suffered a fracture and required regular analgesia. The section on the intentional rounding chart where staff would indicate that pain had been assessed was blank. This was despite it being noted that the patient was at times awake at night with pain.
- In one of two patient's records we reviewed; we found that it was documented that the patient was stable with an early warning score of zero. When we reviewed this patient's observation chart it indicated that a score of one was recorded. It was further noted that one of the observations on the same date was incorrectly scored with an early warning score of zero and it should have been one. This meant that the patient should have had an increased frequency of observations but this was not completed as it was not correctly reflected in the nursing records.
- We reviewed ten charts which recorded how often patients were checked and repositioned by staff, offered fluids and the opportunity to use the toilet. These were completed and signed when checks had been undertaken in eight cases. In two of the cases we found that checks had not been undertaken at the frequency specified, with one patient having no documented checks for six hour period.
- We reviewed 10 observation charts, which are used to record patients vital signs. In nine of these charts, there

were entries which did not indicate the time staff had taken the vital signs. This could have resulted in patients not receiving observations within an appropriate timescale.

Assessing and responding to patient risk

- There was an early warning score system used on both units to identify patients who were at risk of deterioration. An early warning score system is used to identify patients who are at risk of deterioration and it prompts staff to take appropriate action in response to any deterioration. This scoring system included clear and easy to follow guidance for each score value. This scoring system and guidance sheet was printed and attached to each patient's record.
- Staff had not applied this system correctly in some cases and this had led to some patients not receiving a timely review by a doctor, or closer observation; despite the early warning score indicating the need for this.
- A printed handover sheet was provided to all staff on duty. This sheet identified which patients on the unit were at risk of falls, deterioration and pressure ulcers.
- Nine out of the ten observation charts reviewed showed that patients had experienced a delay in staff taking their observations, as indicated by the early warning score guidance for the unit. These delays could have led to a delay in patients receiving a timely review and treatment from a doctor.
- Six out of the ten observation charts reviewed showed staff had recorded incorrect scores and totals of the early warning score. This resulted in staff recording a lower score than should have been recorded. In three of these cases there had been a further deterioration in the patient's observations and early warning score.
- The early warning score (EWS) guidance for all patients stated that they should have a minimum of once daily observations if their condition was stable. In eight of the ten records we reviewed, staff had not taken observations for patients on one, two and three days. In one of these cases the patient's early warning scores had increased when staff took subsequent observations. This meant that the patient's condition had deteriorated in the intervening time.
- The trust has provided us with assurance that this issue is being addressed through a formal weekly audit and additional bespoke teaching sessions on the use of EWS. The trusts has provided us with the results of this audit from 17th to 23rd November 2015. This data

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showed that in 10% of cases reviewed by the trust a EWS had not been recorded. It also showed that in 13% of the cases the EWS score had been incorrectly calculated. As a result of this audit; the trust has taken the decision to only allow registered nursing staff to undertake observations until compliance has improved significantly. We will be monitoring this issue closely with the trust.

Nurse staffing

- Nurse staffing levels had improved since our last inspection.
- During our visit, there were three registered nurses and four health care support workers on duty to care for 36 patients over two units; this gave a nurse to patient ratio of one registered nurse to care for 12 patients. These staff included one registered nurse and one health care support worker from a nursing agency, both of whom had received an appropriate induction to the ward area. The unit is not required to meet the national staffing guidelines as it is a community service. However the unit must still provide a safe level of registered nursing staff to care for patients.
- Staff told us that although staffing remained a challenge they had noticed a significant improvement since our last inspection. They told us that there had not been any recent occasions where there was only one registered nurse on duty for both units and there were usually three nurses on duty. The staff rota also showed that the staffing establishment of three nurses on each night shift was consistently being achieved.
- We reviewed checklists for weekly and daily cleaning tasks. We reviewed the checklist records for every day since our last inspection. On 16 days, staff had not undertaken the checks. On one of these occasions, staff had stated the reason for not completing the checks as lack of staff. The staffing figures provided by the trust for

these dates showed that on four of the dates the unit was short staffed by one registered nurse, on one of the dates the unit was short staffed by one registered nurse and one health care support worker.

- We observed staff on both units at all times and there were no occasions where staff were not visible during our inspection.
- We spoke with two patients who told us that the staff at the unit were kind and responded quickly to their needs.
- The staffing figures from the trust showed that between October 5th 2015 and November 5th 2015 there were six night shifts, which were short staffed by at least one registered nurse.

Medical staffing

- Medical staffing on the unit was adequate to ensure patients received timely and safe care. Staff were able to access medical advice when they needed to.
- Local general practitioners provided medical cover for patients on the units during the week from 9am to 6pm.
- Nursing staff had access to medical staff at Stepping Hill Hospital for advice on patient treatment and care including out of hours.
- Staff confirmed that medical advice was easily accessible.
- There was evidence in all records of regular medical reviews for patients.

Are medical care services caring?

Compassionate care

- We observed staff interacting with patients.
- Staff treated patients with dignity and respect during all interactions we observed.
- We checked five patients to see if their call bells were to hand and in all cases their call bells were to hand.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The trust should continue to ensure that staff undertake and record patient observations consistently and accurately.
- The trust should ensure that equipment is checked thoroughly on a regular basis.
- The trust should remove out of date resuscitation guidance and policies and ensure staff have access to up to date guidelines and policies on resuscitation.