

Southport and Ormskirk Hospital NHS Trust

RVY

# Urgent care services

## Quality Report

Skelmersdale Walk in Centre,  
Wigan Rd  
Ormskirk  
L39 2AZ  
Tel:01695 577111  
Website: [www.southportandormskirk.nhs.uk](http://www.southportandormskirk.nhs.uk)

Date of inspection visit: 29 April 2016  
Date of publication: 15/11/2016

# Summary of findings

## Locations inspected

<b>Location ID</b>	<b>Name of CQC registered location</b>	<b>Name of service (e.g. ward/ unit/team)</b>	<b>Postcode of service (ward/ unit/ team)</b>
RVY30	Skelmersdale Walk in Centre		L39 2AZ

This report describes our judgement of the quality of care provided within this core service by Southport and Ormskirk NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Southport and Ormskirk NHS Trust and these are brought together to inform our overall judgement of Southport and Ormskirk NHS Trust

# Summary of findings

## Ratings

Overall rating for the service	Requires improvement	●
Are services safe?	Requires improvement	●
Are services effective?	Requires improvement	●
Are services caring?	Good	●
Are services responsive?	Good	●
Are services well-led?	Requires improvement	●

# Summary of findings

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# Summary of findings

## Overall summary

Overall we have rated urgent and emergency services at the Skelmersdale walk in centre as requires improvement.

This is because:

- We were concerned that the process of reviewing and approving Patient Group Directives (used to enable some registered health professionals to provide certain medicines to a pre-defined group of patients, without them having to see a doctor), was not robust. We saw that the anti-microbial guidelines (2015) contained dosing information that differed from the PGD relating to the treatment of urinary tract infections which was out of date.
- Processes to manage patient risk were in place but not used routinely. When processes (such as triage, including the measurement of clinical observations) were used they were not undertaken by registered healthcare professionals. This was not in line with a Triage Position Statement written collaboratively by the College of Emergency Medicine, Emergency Nurse Consultant Association, Faculty of Emergency Nursing and Royal College of Nursing (2011)
- Not enough staff were up to date with statutory training topics such as duty of candour and consent.
- Patient outcomes and adherence to local care pathways had not been routinely measured by the department. For example, the urgent care directorate contributed to national audits run by the College of Emergency Medicine (CEM), the walk in centre was not listed as contributing data to them. Despite this, we saw evidence that managers were starting to focus on this with some local audits recently commenced or planned for the future. However, the lack of completed audits reaffirmed our concerns that measuring outcomes or adherence to pathways was not an embedded process.
- Access to information gathered during previous attendances such as allergies, was limited by the lack of electronic records and reliance on paper records which were not scanned onto systems.
- Although efforts were made to encourage the public to rate services, the response rate was very low and therefore not a robust measure. Nevertheless the results produced gave an average score of only 44%.
- Managers did not have a regular presence at the centre as they were based at another location. Staff meetings were not held regularly. We were concerned that opportunities to relay important information such as outcomes following incident investigation might be missed because of this.
- Managers were limited in what changes they could make whilst involved in a tender process which would not be complete until September 2016. However this was not something that the department or the trust could control.

However:

- Incidents were reported and learning was shared following investigation. Most incidents reported resulted in low or no harm to patients. Equipment was properly maintained and medicines were stored and checked correctly.
- Staffing was adequate and sickness levels were lower (better) than average.
- Major incident policies were in place which included information about pandemics.
- Despite pockets of low compliance in statutory training, staff were up to date with mandatory training topics.
- Efforts were made to maintain privacy and dignity for patients. Chaperones were available if required. Patients and visitors told us they were happy with the care and advice provided.
- We saw staff interacting with patients. They were polite, respectful and compassionate in their approach and people said they would come back to the centre if they needed medical attention again in the future.
- Leaflets were available with information for people to take away with them about a range of conditions such as sore throats.
- Staff were familiar with their local population and the centre provided free car parking, adequate seating and unisex toilet and baby changing facilities.
- Translation and sign language services were available if required and staff described how they adjusted their communication style to cater for patients with complex needs or learning disabilities.

# Summary of findings

- Complaints were rare; however, staff explained how they managed verbal complaints before escalating to the trust's patient advice and liaison service (PALS) if issues could not be resolved. Learning was shared following complaints to limit recurrence.
- The centre managed risk through a risk register. Governance reports were generated on a monthly basis which detailed a number of items such as training and infection control.
- Senior staff told us their line managers were approachable.

# Summary of findings

## Background to the service

Urgent care services are provided at the Skelmersdale Walk in Centre (SWIC) which is run under the trust's urgent care directorate.

Based in a shopping centre and led by nursing staff, the Skelmersdale Walk in Centre is open 365 days a year between 7am and 10pm on weekdays and between 9am and 5pm on weekends.

Between April 2015 and January 2016 the centre saw 22,891 patients, of which 4673 were children (up to 16 years old). On average, 60 adults and 15 children attend the walk in centre each day.

Patients wait to be seen in the main waiting area before being triaged in a bay or referred to a nurse in one of five treatment rooms.

During the inspection we spoke with four patients and carers and seven staff from different disciplines including clinical directors, matrons, nurses and reception staff. We also reviewed ten patient records and observed daily activity and clinical practice. Prior to and following our inspection we analysed information provided by the trust about the service.

## Our inspection team

Our inspection team was led by:

**Chair:** Professor Iqbal Singh;

**Head of Hospital Inspections:** Ann Ford, Care Quality Commission

The service was inspected by an inspector and an emergency care doctor and nurse.

## Why we carried out this inspection

The inspection was completed as part of the follow up comprehensive inspection of Southport and Ormskirk NHS Trust.

## How we carried out this inspection

To get to the heart of patients' experiences 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?

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. We interviewed staff and talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment.

# Summary of findings

## Areas for improvement

### Action the provider **MUST** or **SHOULD** take to improve

The provider must;

- Ensure records are stored safely and that information necessary to deliver safe effective care is accessible.
- Ensure relevant risk assessments are completed for patients attending the centre.
- Ensure levels of statutory training compliance meet the trust target of 90% where there are pockets of low compliance and improve the appraisal rates for staff so that the trust target of 90% is reached.

- Ensure that clinical practice and patient outcomes are measured, and that performance is monitored, with poor practice identified and improved where required.

The provider should;

- Improve the response rate for the Friends and Family questionnaire, so that results generated are representative of the local population
- Improve visibility of managers at the centre
- Reconsider the benefits of a daily 'huddle' meeting to ensure information is shared more regularly.
- Check that all staff are proficient in efficiently releasing secure seals on resuscitation trolleys.



## Southport and Ormskirk Hospital NHS Trust

# Urgent care services

### Detailed findings from this inspection

Requires improvement 

## Are services safe?

By safe, we mean that people are protected from abuse

### Summary

We have rated urgent and emergency services as requiring improvement in relation to keeping people safe from abuse or harm.

This is because:

- Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe.
- We were concerned that the process of reviewing Patient Group Directives (used to enable some registered health professionals to provide certain medicines to a pre-defined group of patients, without them having to see a doctor), was not as robust as it should have been. We saw that the anti-microbial guidelines (2015) contained dosing information that differed from the PGD relating to the treatment of urinary tract infections which was out of date.
- When processes (such as triage, including the measurement of clinical observations) were used they were not undertaken by registered healthcare professionals. This was not in line with a Triage Position Statement (2011) written collaboratively by the College

of Emergency Medicine, Emergency Nurse Consultant Association, Faculty of Emergency Nursing and Royal College of Nursing which states that triage should be completed by a clinical member of staff.

- Not enough staff were up to date with statutory training topics such as duty of candour and consent.
- Handovers did not take place in the centre. Senior nurses told us this was because patients were cared for individually and were not in the centre for long enough for care to be transferred to other staff. However, with staff meetings only occurring every few months, we were concerned that staff were not being provided with the opportunity to share information regularly.
- Patient records were only in paper form without being scanned into trust systems. This led to challenges sharing important information with other departments of external agencies such as local safeguarding teams. Patient records were also being stored unsafely. They were in boxes piled high in a storage room which placed staff visiting the area at risk.

However:

- Incidents were reported and learning took place following investigation. Most incidents reported resulted in low or no harm to patients.

## Are services safe?

- Equipment was properly maintained and medicines were stored and checked correctly. Pain was measured routinely and relief provided when required.
- Staffing was adequate. Staff were up to date with most mandatory training topics and competencies were monitored with new starters undergoing induction to ensure they were familiarised with day to day practice.
- Major incident policies were in place which included information about pandemics.

### Incidents

- There was a culture of reporting and learning from incidents amongst staff.
- Incidents were reported electronically and staff received automatic email receipts following submission.
- Between October 2015 and January 2016, the centre reported 16 incidents, 12 of which resulted in low or no harm. Four were reported as near misses, however only one of these related to the actions of staff in the centre.
- No serious incidents or never events were reported by the trust since as far back as February 2015. Never Events are serious incidents that were wholly preventable because guidance or safety recommendations to protect patients were available and should have been implemented.
- Senior medical and nursing staff were aware of the Duty of Candour. This is a legal duty to inform and apologise to patients if mistakes in care have led to moderate or significant harm. The matron confirmed that she knew of no incidents since commencing post in August 2015 that fit the criteria for implementing Duty of Candour. However we saw that a meeting was scheduled to discuss the care of one patient which the matron confirmed may meet the criteria.
- Mortality meetings were not held routinely within the directorate. Senior medical staff explained these had stopped but instead patient deaths were discussed on an ad hoc basis during other meetings. Despite reviewing minutes of a number of departmental meetings, we found no evidence that mortality was discussed formally. Reviewing mortality helps promote learning and provides assurance that patients are not dying as a result of unsafe care. Without this, we were concerned there was a lack of assurance of safe care and that staff may not identify areas for improvement if required.
- Following incidents, learning was shared in regular staff meetings or on the monthly directorate bulletin.

However, we noted that meetings were only held every three months (meetings took place in November 2015, February 2016, and one scheduled in May 2016). We were concerned that meetings were not frequent enough to allow important information about incidents to be shared in detail in a timely way.

### Cleanliness, infection control and hygiene

- All the areas we inspected were visibly clean and tidy.
- Cleaning regimes and checklists were used to help staff clean areas effectively. Separate checklists were used for decontaminating equipment such as probes or blood pressure cuffs.
- We reviewed daily cleaning schedules and checklists completed between January and April 2016 which were all completed correctly.
- Monthly infection prevention and control audit reports were completed by the trust which covered, hand hygiene, and prevalence of hospital acquired infections; Clostridium Difficile (C-Diff) and Methicillin-resistant Staphylococcus aureus (MRSA). However, none of the reports we reviewed (September 2015 to February 2016) included findings from audits at the centre. We asked the trust about this. Whilst they did not provide any comments about the inclusion of the centre in monthly infection prevention and control audits, they did send us copies of reports measuring staff adherence to the World Health Organisation's Five Moments of Hand Hygiene. These showed that staff hand hygiene practice was observed in February, March and April 2016. However the only score visible was in March which showed staff scored 100%.
- Hand sanitizers were available in reception and treatment areas. Staff also had access to other protective items such as aprons and gloves if required.
- We observed staff washing hands between seeing patients. Staff providing treatment adhered to bare below elbows guidance.
- A link nurse within the centre was assigned to infection prevention and control. Link nurses share and provide specialist information with staff in the clinical area. This helped to ensure standards were maintained.

### Environment and equipment

- The infrastructure was fit for purpose with light and spacious waiting and treatment areas.

## Are services safe?

- There was no area available for mental health patients to await assessment, care or treatment. This was because the centre did not provide mental healthcare for patients. Instead patients were signposted to other facilities such as the main ED.
- Resuscitation equipment was stored in an organised way on a trolley in the main treatment area. The trolley was sealed to prevent items being removed, and remained so until equipment was used or checked. Records of checks done between January and April 2016 showed that checks were completed daily. The nurse who showed us the trolley had difficulty releasing the seal. We were concerned that, if items were required in an emergency, delays may occur.
- All other equipment such as automatic electrical defibrillators, suction machines and fridges containing drugs requiring storage at low temperature, had records showing that daily checks were completed to ensure they were in working order.

### Medicines

- Medicines were stored in an organised way in locked cupboards in consultation or store rooms. Access was limited with swipe card entry or digital locks.
- No controlled drugs were stored or used by staff at the centre.
- Medicines were checked weekly to ensure stocks were correct and out of date items were removed.
- We checked a sample of medicines stored in an emergency drugs cupboard. These were within expiry date except for one bag of fluid which had breached its expiry date. We told staff who immediately removed the item.
- Seven senior nurses out of eight were trained to prescribe medicines. Those without prescribing qualifications used Patient Group Directives (PGDs). PGDs allow some registered health professionals to provide certain medicines to a pre-defined group of patients, without them having to see a doctor. We checked a sample of PGDs and found that review dates had expired. At the front of these we found a cover note signed by the chief pharmacists authorising the extension of PGDs past the documented review date. Senior staff in the centre were concerned that the information in the PGDs did not necessarily tally with more up to date guidelines. For example, more recent guidelines about medicine administration (such as the anti-microbial guidelines, 2015) contained dosing

information that differed from the PGD relating to the treatment of urinary tract infections, which was out of date. We found evidence that the trust was in the process of undertaking a review of all PGDs, prioritising those where the review date had passed within the previous 12 months.

- A pharmacy was located in the adjacent shopping centre where patients could obtain medication if required. This was open from Monday to Saturday between 9am and 5:30pm.

### Records

- NHS England state that using electronic records “is key to making services safer, more effective and more efficient” (September 2015). However, the majority of patient records were in paper format with only basic information (for example name, age and presenting complaint) about patients seen in the last 12 months stored electronically. The paper records were stored securely behind the reception desk, or in a locked room in a secure area of the centre.
- Managers confirmed that the current electronic system would cease in July 2016 and be replaced with a new system (the same system as used in the main ED). The managers hoped this would produce more collaborative working; however this system was not the first choice for staff in the centre. They felt it would not meet their needs as well as systems used in local GP surgeries which would improve collaborative working where it was most needed.
- We viewed the record storage room. Here we saw boxes piled on top of each other. We were concerned that it was not safe to enter. The matron confirmed she did not allow staff to search the room and had escalated her concerns to the governance team. We were also told that records dating back to 2010 had not been scanned onto electronic systems. This meant staff could not share important information with other departments or agencies, or to identify trends in attendance which could indicate people at risk, for example, of domestic violence.
- We immediately escalated our concerns about storage and scanning issues to executive managers. They confirmed that quotes had been obtained for scanning of records. This would then limit the need to store paper records. In the meantime, we saw that the issue relating to records was recorded on the risk register. Whilst the associated risk of fire and actions to mitigate this (such

## Are services safe?

as a sprinkler system) was included, there were no other actions in place to reduce the risk to staff, or the risk of information not being shared with other departments or agencies until scanning began.

- We reviewed ten patient records during the inspection, five relating to children. The records were legible and included treatment plans as well as previous attendances to the ED. However, only one child's record contained a child risk assessment. Completing risk assessments helps staff to ensure potential issues are identified.

### Safeguarding

- Staff used safeguarding flow charts to support them in referring concerns to other agencies about vulnerable children and adults. These were visible on staff noticeboards and provided clear instructions for staff to follow.
- Safeguarding training for children and adults was mandatory with a compliance target of 90%. Staff completed one of three levels of training based on the level of contact with patients. NHS England guidance states that all non-clinical staff should complete level one safeguarding training and that clinical staff should complete level two training as a minimum. Figures showed that all nursing staff were up to date with safeguarding training for children and adults level one. No nursing staff had completed level two training but 75% were up to date with level three. All non-clinical staff were up to date with safeguarding adults level one, but only 60% were up to date with safeguarding children level one. Despite this, we saw that 60% of non-clinical staff had also completed level two training for children.
- The centre stored up to date details about child protection cases in a folder. One staff member was responsible for ensuring this remained up to date. Due to the issues with record storage, this was the only information staff could easily access about vulnerable children and there was no easily accessible information about vulnerable adults. To try to manage this, staff reviewed case notes weekly to identify potential victims of abuse and share details with other agencies, where appropriate. We were concerned that the capacity for identifying trends in attendance which might indicate people were at risk of abuse was limited and not robust enough.

- Two safeguarding link nurses worked in the centre to provide support and share knowledge with staff, when required. Staff could also access information from line managers during office hours. Out of hours advice was available via the bed manager or on call manager.

### Mandatory training

- Training was described as mandatory or statutory depending upon the topic. Statutory training such as resuscitation, consent, Mental Capacity Act and Duty of Candour topics ensured the trust met legislative duties. Mandatory training topics such as hand hygiene, infection control and information governance helped limit risk and maintain safe working practice.
- Personal training compliance could be viewed easily by each staff member via the intranet.
- Link nurses and matrons worked to ensure staff training was up to date. We saw minutes of staff meetings where training was discussed such as introducing rolling programmes for prescribing.
- The overall target for mandatory and statutory training was 90% (95% for information governance training). Overall, 92% of nursing staff in the centre were compliant with mandatory training with full compliance in infection control, information governance, hand hygiene and basic resuscitation. The lowest compliance for mandatory training was in conflict resolution (75%) and moving and handling (75%). Figures were less reassuring for statutory training amongst nurses. Here we saw an overall compliance figure of only 56%. Only 12.5% staff had completed duty of candour, and 50% had completed consent training. For administrative staff, 92% were up to date with mandatory training but only 80% were up to date with statutory training. Despite these figures being well below the target of 90% we saw that the issue was not addressed in any staff meetings held in February 2016 or October 2015.

### Assessing and responding to patient risk

- Some processes were in place to manage potential risks for patients. For Example, baseline clinical observations were taken to measure how poorly patients were if clinically required. For example, we saw observations recorded for unwell children attending the department.
- In the ten records we reviewed, no patients had early warning scores or triage categories documented. Early warning scores (EWS) systems analyse clinical observations within set parameters to determine how

## Are services safe?

unwell a patient may be. When observations fall outside parameters they produce a higher score, requiring more urgent clinical care than others. Triage systems help staff prioritise patients based on how unwell they are and how quickly they need to be seen. Despite this, we saw there was a small triage area. Staff confirmed that, when required, initial observations were taken by healthcare assistants. A document was displayed which prompted staff to alert nurses when observations fell outside normal parameters which followed the principles of an early warning score system despite the fact that scores were not regularly noted.

- Managers confirmed their model of care was similar to a GP surgery where ambulatory patients attended who were not necessarily as unwell as patients attending emergency departments where these tools were more commonly used. However, we saw minutes of a staff meeting in February 2016, which documented the introduction of an EWS system. When we inspected in April 2016, the system had not yet been implemented.
- Resuscitation trolleys were located in suitable areas of the centre so that staff could obtain them quickly, if required. However, a senior nurse found it difficult to release the seal on the trolley, which we were concerned might delay help for someone should items be required.
- The majority of staff (96%) were trained in paediatric intermediate life support, to ensure that care could be provided in the event of a sick child attending the centre.
- When staffing levels were low, services were limited to ensure care remained safe. This involved switching from providing care and treatment, to triaging patients and signposting them to services that could provide further treatment, if required, such as the main ED or other local walk in centres.
- Staff had a process for managing patients suffering with sepsis (a potentially life threatening condition triggered by infection or injury) which included requesting an emergency ambulance to transfer them to the main ED at Southport Hospital.

### Nursing staffing

- Staff were assigned to different areas of the department in an organised way, for example healthcare assistants worked in the triage bay and nurse practitioners worked in the treatment rooms.

- In total, eight nurse practitioners, four healthcare assistants and five receptionists worked on a full time or part time basis.
- Managers told us that staffing establishment had not been reviewed in the last five years but, based on this, there were no vacancies. Acuity was judged to be sufficient based on average waiting times being low (44 minutes between April 2015 and March 2016), and because there were few incidents logged relating to delays. The aim was to have one healthcare assistant and two nurse practitioners on duty during the day which was in line with guidance. Rotas were planned four weeks in advance. We saw that staffing was adequate but there was little flexibility in the system. This meant that if staff were absent there were not always sufficient staff to meet establishment. Instead, absence was covered with overtime or agency staff. In April 2016 the absence of two nurses led to 16 gaps in the rota which were covered through overtime and agency nurses.
- Despite this, managers said no further changes to staffing levels could be authorised during the tender process, ongoing until September 2016.
- Sickness absence rates were monitored. Between May 2015 and April 2016 the average sickness rate was 2%, which was below the NHS average sickness rate of 4.2% (between May 2015 and March 2016).
- Handovers did not take place in the centre. Senior nurses told us this was because patients were cared for individually and were not in the centre for long enough for care to be transferred to other staff. However, with staff meetings only occurring every few months, we were concerned that staff were not being provided with the opportunity to share information regularly.

### Medical staffing

- Medical staff did not work at the centre. Instead care was provided by nurses. Patients requiring medical review were referred to other centres such as the main ED at Southport.

### Major incident awareness and training

- The trust had an up to date policy and plan for major incidents, including pandemics, but the department was not a designated receiving site for major incident patients. This meant that any patient involved in a major incident would be referred to the main ED.

## Are services safe?

- Mandatory training provided a basic knowledge of major incidents and was provided for all staff. All administrative, and additional clinical staff (healthcare assistants), and 88% of nursing staff had completed this training against a target of 90%.

## Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

### Summary

We have rated urgent and emergency services as requiring improvement in providing effective care for patients.

This is because:

- Although people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation, the outcomes of people's care and treatment was not always monitored.
- For example, although the directorate contributed to national audits run by the College of Emergency Medicine (CEM), the walk in centre was not listed for contributing data to them. Some local audits were in progress or planned for the future, but there were no completed audits available at the time of inspection.
- Systems to manage and share care records and information were cumbersome and uncoordinated due to a lack of electronic records and reliance on paper records which were not scanned onto systems. This meant that staff did not always have had the complete information they needed before providing care and treatment (such as previous attendances, or information about allergies or social circumstances).
- Only 75% of nurses and 80% of administrative staff were up to date with appraisals against a target of 90%.

However:

- Pain was measured routinely and relief provided when required.
- Staff competencies were monitored and new staff underwent induction to ensure they were familiarised with day to day practice.
- Multi-disciplinary work was undertaken in the department as part of day to day processes such as referrals to other hospitals.

### Evidence-based care and treatment

- Staff followed guidelines issued by the National Institute of Health and Care Excellence (NICE) (such as head or neck injury guidelines), and the Resuscitation Council

(such as resuscitation guidelines) to help care for patients. Guidelines were accessible on the trust intranet with paper copies in folders or on staff noticeboards.

- A number of standard operating procedures were in place to support staff working in the centre. These included procedures for managing missing children and clinical records. Review dates were listed as well as a form for staff to sign and confirm they had read the procedure. All the procedures we reviewed were within their expiry date except the procedure for managing clinical records which should have been reviewed in October 2015. Documents showed that some staff had signed the procedures but not all. For example, out of 17 staff, 12 had signed the procedure for managing visitors to the centre and 13 had signed the procedure for checking patient records (SOP 22)
- Updates to pathways were disseminated in staff meetings but these were not held frequently (every few months). However, they were also promoted through staff notices.
- Despite asking, we were told there were no records of completed audits to measure adherence to care pathways or record keeping. This posed a risk that mistakes or poor care may not be identified because managers had not monitored these through a formal audit process. However, more recently an audit of record keeping practices amongst individual staff had begun and so far two staff had been audited. An audit of the antibiotic prescribing pathway for treating sore throats and coughs had been assigned to a senior nurse and was due to commence in the near future.
- Senior nurses told us that the care provided by staff was reviewed as part of daily practice. For example, each time a senior nurse prescriber was asked to prescribe medicine they reviewed the care provided by the relevant staff member. We did not feel this was a robust way to measure effective clinical practice.

### Pain relief

## Are services effective?

- Pain was assessed using a score based system where zero indicated no pain and ten indicated significant pain. This allowed staff to quantitatively measure pain and provide appropriate pain relief, if required.
- Pictorial pain score charts were used if available for younger children but when we spoke to one nurse providing care the chart could not be found. Pictorial pain charts use happy and sad faces to depict the level of pain. Staff told us that if these were not available they drew faces to help children explain their pain.
- In five records we reviewed belonging to patients requiring pain assessments; pain scores and pain relief medication provided were appropriately recorded.

### Nutrition and hydration

- The centre did not provide food or refreshment services for visitors or patients. However, it was based in a shopping centre where visitors could readily obtain food or refreshment if they wished.

### Patient outcomes

- We saw that some clinical audits to measure patient outcomes were scheduled in the directorate in the year ahead, starting in April 2016. However the walk in centre was not listed as providing data for any of these. Additionally, the topics were not relevant to the centre because the care being audited was not provided there. The audits focused more on emergency department care. For example, audit topics included; procedural sedation, re-attendance of elderly patients to the ED and treatment for paracetamol overdose.
- The trust monitored how many patients unexpectedly re-attended the centre within seven days of discharge. It is good practice for less than 5% of patients to re-attend a centre. Between February 2015 and March 2016 less than 1% of patients re-attended within seven days.

### Competent staff

- Processes were in place to ensure staff were competent in their roles.
- New nursing and medical staff underwent a formal trust induction where information ranged from IT access to safeguarding principles.
- Managers explained that informal local inductions were provided for new agency staff, where verbal details about fire safety and arrangements for breaks were provided. However the manager told us that the majority of agency staff were regular workers and

therefore already familiar with the centre. Information about who had undergone induction was not recorded which meant we could not corroborate what we were told.

- Staff evidenced competencies in individual 'competency books'. Peer review was used to confirm competency in areas such as interpreting x-rays.
- Staff received annual appraisals via their line manager. The trust target for staff to receive up to date appraisals was 90%. The matron told us they were not up to date with appraisals and this was reflected in trust figures showing 75% of nurses and 80% of administrative staff were up to date with appraisals. However, more appraisals were booked with staff. We saw that two staff were booked to attend appraisals in April and a further two in May 2016.
- Nurse revalidation was discussed during staff meetings where support and documentation was provided about the process. However staff meetings were infrequent (every few months) which left us concerned about how much information sharing took place with staff.
- Managers told us staff had opportunities to develop professionally. For example, the matron told us that staff nurses had opportunities to study minor injury and illness at a local university. However, during further enquiries about this, the trust confirmed that no staff were currently enrolled.

### Multidisciplinary working

- Staff worked together to provide care for patients.
- The matron described networking internally to build links and enhance knowledge. Work was undertaken with ED staff to build links, and we saw meetings scheduled with ophthalmology staff to organise training.
- One staff member working in the centre told us there was not enough integration with other services such as NHS 111 or GP practices. A senior nurse confirmed that efforts to obtain shared systems with local GP practices had not been possible.
- Externally staff liaised with other local hospitals who provided specialist care for patients in areas such as ear, nose and throat, and maxillofacial care.
- We saw evidence of a one off meeting scheduled with pathology colleagues, to help improve processes.

### Seven-day services



## Are services effective?

- The centre was open seven days a week, 365 days a year.
- There were no x-ray facilities at the centre. Instead patients requiring x-ray were referred to the walk in centre at Ormskirk District General Hospital or the local ED.

### Access to information

- Due to the use of paper systems, there was no way for staff to enter information highlighting important details about patients, such as medical history, allergies, or known aggression. However the situation was expected to improve once the centre moved to using the new IT system in 2016, despite this system not being the preferred option amongst staff.
- Nurses accessed a variety of operating procedures for areas of healthcare such as dermatology, minor injuries, and ear, nose and throat care.
- A Picture Archiving and Communication system (PACS) allowed designated staff to view scans of patients taken anywhere in the region.
- Staff had access to a national database by the National Poison Information Service to locate details about potentially harmful substances. A 24 hour telephone advice service was also available.

- Staff could access specialist information from link nurses in areas such as tissue viability, blood glucose monitoring machine use and infection.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in the centre worked on the principle of implied or verbal consent; however this was not always recorded in records. In the records we reviewed, consent was documented in only two out of four cases, where required.
- The trust had a process for assessing and recording mental capacity and documenting decisions made in the best interests of patients. The matron told us it was rare for patients to attend who lacked capacity or required best interest decisions. None of the patient records we reviewed belonged to patients who lacked capacity when they attended, and staff did not routinely monitor the frequency of attendance of patients lacking capacity, or assessments or best interest decisions made on behalf of patients. This meant it was not possible to corroborate what staff told us.
- We asked the trust to provide the number of deprivation of liberty safeguards applications at the centre. However we did not receive this information.

## Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

### Summary

We have rated urgent and emergency services as good in the caring domain.

This is because:

- Feedback from people who use the service was positive. Although during our inspection we only saw four patients in the centre, they told us they were happy with the care and advice provided and that they would return to the centre if they needed to access services again in the future.
- We saw staff interacting with patients in a polite, respectful way. Efforts were made to maintain privacy and dignity. Chaperones were available if required.

However:

- We spent time sitting in the main waiting area and found that conversations in progress between reception staff and visitors could be heard.
- Although efforts were made to encourage the public to rate services, the response rate was very low and therefore not robust. Responses produced an average score of 44%.

### Compassionate care

- We saw signs in the reception area asking those waiting to check in to stand back to allow the person ahead of them privacy when speaking with staff. However we spent time sitting in this area and noted that we could hear conversations between visitors and reception staff.

- We witnessed staff interacting with people. They were polite and spoke to people with respect and compassion. We also saw staff being mindful to maintain a patient's dignity whilst in the department.
- Four patients and their carers told us they were happy with the care provided for them.

### Understanding and involvement of patients and those close to them

- Patients we spoke to were happy with the advice given at the centre and would return again if they needed to.
- The trust asked patients to rate their experience of the service provided in the NHS Friends and Family test. The average results between May 2015 and March 2016 showed that only 44% of patients would recommend the centre to friends and family. However we noted that results changed dramatically between months (95% in August 2015 and 9% in November 2015) and the response rate was low (on average 4%). Both these factors meant results were not robust. We saw minutes of staff meetings which confirmed efforts were made to boost the response rate by placing a poster in the waiting area and handing comment cards to patients. We saw the poster displayed there during our inspection.

### Emotional support

- Chaperones were available upon request and we saw notices explaining this to patients. Chaperoning enables staff to provide support for patients undergoing examinations or procedures.

# Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

## Summary

We have rated urgent and emergency services as good in providing responsive care.

This is because:

- Staff were familiar with their local population and the needs of different people were taken into account when planning and delivering services. For example, the centre provided free car parking, adequate seating, unisex toilets and baby changing facilities.
- Reasonable adjustments were made to remove barriers when people found it hard to use or access services. For example, translation and sign language services were available, if required, and staff described adjusting their communication style to cater for patients with complex needs or learning disabilities.
- Leaflets were available with information for people to take away with them about a range of conditions such as sore throats.
- Complaints were rare; however staff explained how they managed verbal complaints before escalating to the trust's patient advice and liaison service (PALS) if issues could not be resolved. Learning was shared following complaints to limit recurrence.
- Waiting times and delays were minimal and managed appropriately with national targets met consistently.

## Service planning and delivery to meet the needs of local people

- Staff were familiar with their local population. They described local ethnic minority groups living in surrounding areas.
- In the centre itself we saw free car parking available for up to four hours, as well as adequate seating in waiting areas, unisex toilets, hand sanitising facilities and a baby change area.
- Information was displayed throughout the waiting area to help signpost people to useful services, such as sexual health.
- Based on the ground floor of the shopping centre, the centre was accessible to wheelchair users.
- There was enough seating available for patients in the waiting areas.

- Leaflets were available containing information and advice about a range of conditions such as sore throat.

## Meeting people's individual needs

- Telephone or face to face translation services were available for those whose first language was not English. Sign language was also available if required.
- Staff were familiar with the needs of patients living with learning disabilities or complex needs. They explained that patients usually arrived with carers who could explain their needs. However when communicating directly with patients, staff described adjusting language to ensure understanding.
- Play specialists did not work in the centre. Play specialists use a range of therapies such as distraction to help children receiving care or treatment. Staff explained that, if there were difficulties providing care or treatment for children, they were referred to the paediatric ED at Ormskirk where play specialists were available.
- Mental health care was also not provided by staff in the centre. Staff were not trained to care for mental health patients and rooms were not designed to safely accommodate these patients either. Instead, patients with mental health needs were referred to more appropriate settings such as the main ED, if required, following initial assessment.
- We saw lots of information about care and treatment for different issues such as sore throats or sexual health, displayed for patients in the waiting area.

## Access and flow

- The Department of Health target for urgent and emergency services is to admit, transfer or discharge 95% of patients within four hours of arrival. The centre met this target with an average of 99.9% of patients admitted, transferred or discharged between February 2015 and April 2016.
- The centre did not record the average time taken to complete initial assessments but did monitor the total average time patients spent in the centre. Figures showed that between February 2015 and April 2016, on average patients spent 68 minutes in the centre.

## Are services responsive to people's needs?

- In urgent and emergency care, the number of patients waiting between four and 12 hours from the point of decision to admit and actual admission is monitored. In the centre, we saw that no patients waited between February 2015 and April 2016.
- The Department of Health target for time taken to provide treatment is 60 minutes. Between February 2015 and April 2016, the time taken by the centre ranged between 31 and 55 minutes, (an average of 44 minutes).
- Managers at the centre told us that the centre received approximately one third of the number of patients seen at the West Lancashire Health Centre based at Ormskirk District General Hospital.
- Senior staff told us that complaints were rare and data supplied by the trust confirmed this. Between February 2015 and January 2016, five complaints were received. Three of these related to clinical care, one to staff attitude and the other to a delay being seen.
- Staff explained the process for managing complaints. If an explanation at the time did not resolve the issue, staff referred complainants to the patient advice and liaison service (PALS). Leaflets explaining the process were visible in the reception area.
- Complaints were discussed during staff meetings or individually with staff involved. Learning was shared following complaints in monthly directorate bulletins.

### **Learning from complaints and concerns**

## Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

### Summary

We have rated urgent and emergency services at Skelmersdale Walk in Centre as requiring improvement in the well led domain.

This is because:

- Although local managers verbalised aspirations about improving services, these were not well developed. This was partly because they were restricted by a tender process which was not due for completion until September 2016. Directorate leads did have a strategy but acknowledged that the majority of performance improvement was aimed at another department (the trust's main ED) rather than the centre itself.
- Whilst senior staff felt line managers were approachable, other staff felt that because line managers were not based on site, their availability was limited.
- Staff meetings were not held regularly. Instead they were every few months and not all staff attended. There were no daily meetings at the beginning of the day either. Having regular meetings ensures staff have regular opportunities such as learning about new developments, contributing to change or raising concerns.
- Staff felt uncertain about the future given that the centre was part of a tender process with the outcome expected in September 2016. Senior managers told us the process resulted in limitations to making improvements or changing the service to maintain sustainability.

However:

- Local managers had not been in place for very long (August 2015 and February 2016) and restrictions caused by the tender bid created limitations which they had little control over.
- There was an effective process in place to identify, understand, monitor and address current and future risks. The centre did this by contributing to the directorate risk register, and governance reports were generated on a monthly basis detailing useful information about training and infection control.

- Senior staff said line managers were approachable and met with them regularly.
- The directorate worked to educate the public about the centre and services available.

### Vision and strategy for this service

- Managers had visions for improving care. This included the development of IT infrastructure to enhance information sharing amongst staff and bring closer links to GP surgeries. Some, but not all, of these visions were in progress. Other ideas could not be implemented until the outcome of the tender bid for urgent care services which was due in September 2016.
- The directorate had a formal urgent care strategy, where objectives and outcomes were listed. However, the report stated that the majority of performance improvement would take place at the main ED in Southport Hospital.

### Governance, risk management and quality measurement

- A risk register was in place identifying risks within the department. Information such as the date the risk was first entered, the responsible staff member, description, risk rating and mitigating actions were included. Risks on the register tallied with concerns described by senior managers during our inspection. Risks were shared with staff in monthly directorate bulletins.
- Although meetings were held with staff, these were not regular, occurring every few months. For example, meetings were held in October and November 2015, then not until February 2016 following which a meeting was scheduled for May 2016. Daily meetings were not held either. This meant there was less opportunity for staff to receive important information such as changes in clinical care or updates about the service. Despite this, governance meetings held for senior staff such as directors and business unit managers were held on a monthly basis and we saw minutes of meetings which confirmed this.
- Directorate governance reports were completed monthly, with findings presented in a dashboard. Figures showed the frequency of identified infections

## Are services well-led?

each month such as clostridium difficile (C-Diff and MRSA), patient falls, staff training figures, performance in relation to department of health targets, complaints and compliments.

- At the time of our inspection security staff were not employed by the trust but were due to be commissioned in April 2016. Prior to this, staff were dependent upon police assistance via an emergency call. An external review of security in December 2015 concluded that “relying on police support does not provide a viable long term solution”. However the centre had not raised any incidents relating to issues requiring police attendance between February 2015 and January 2016.

### Leadership of service

- Although the matron worked in the centre occasionally (two dates in February 2016) she was not based at the centre and there was no schedule for her to visit staff on a regular basis. Staff we spoke to confirmed that managers were not always visible.
- Despite this, senior managers arrived to see us during our inspection. We saw staff approach them with questions about prescribing medicines to the patients they were caring for and one staff member said the matron made time for them if requested. However, another manager arrived who staff said was less visible than the matron.

### Culture within the service

- Managers had been in post for less than one year and described a culture which was beginning to show signs of positive change.

- Staff described sometimes feeling separated from the main sites and their managers who were based elsewhere.
- One staff member said there was little time for professional reflection or clinical supervision due to a lack of flexibility with staffing and that the culture was fragmented without enough integration with other services such as NHS 111 or GP practices.
- Senior staff reported an uncertain feeling about the future given the tender process.

### Public engagement

- The directorate worked to educate the public about visiting the centre appropriately, using web based information and posters.

### Staff engagement

- Following new managers starting in post, efforts were in progress to enhance staff communication through a shared computer drive on the trust IT system.
- We saw examples of executives engaging with staff. For example, a member of domestic staff was invited to attend an awards evening as a guest of the Chief Executive.
- We saw evidence that managers encouraged staff to attend meetings about the ongoing tender process where any queries or concerns could be addressed.

### Innovation, improvement and sustainability

- Staff were limited in what innovative changes or improvements could take place whilst the bidding process for services was in progress. Despite this managers were making steps to measure current standards and enhance information sharing within the centre and with wider colleagues internally.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p><b>17(2)(a): Good governance:</b></p> <p>Providers must have systems and processes such as regular audits of the service and must assess, monitor and improve the quality and safety of the service.</p> <p>Although we found evidence of planned audits, evidence of audits in progress were limited and there were no completed audits to assure us that regular work had been taking place to monitor quality or safety in the service.</p> <p><b>17(2)(c): Good governance:</b></p> <p>Records relating to the care and treatment of each person must be fit for purpose. Fit for purpose means they must be accessible as necessary in order to deliver people's care and treatment in a way that meets their needs and keeps them safe.</p> <p>Records had not been scanned into systems since 2010. Information stored on the system only included patients attending in the previous 12 months and did not include safeguarding information or details which might indicate people were at risk.</p>

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p><b>18(2)(a): Staffing:</b></p> <p>Persons employed by the service provider must receive appropriate support, training, supervision and appraisal.</p> <p>Levels of statutory training and appraisals did not reach the trust target.</p>

This section is primarily information for the provider

## Requirement notices

### Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

**12(2)(a): Safe care and treatment:**

Risk assessments relating to the health, safety and welfare of people using services must be completed and reviewed regularly.

In the records we saw, risk assessments were not routinely completed.