Wirral University Teaching Hospital NHS Foundation Trust

RBL14

Arrowe Park Hospital

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RBL14	Arrowe Park Hospital	Medical	CH49 5PE

This report describes our judgement of the quality of care provided within this core service by Wirral University Hospital NHS Foundation 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 Wirral University Hospital NHS Foundation Trust and these are brought together to inform our overall judgement of Wirral University Hospital NHS Foundation Trust

Summary of findings

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Overall summary

Arrowe Park Hospital is part of Wirral University Teaching Hospital NHS Foundation Trust. This is one of the biggest and acute trusts in the North West. Arrowe Park Hospital delivers emergency and acute services for children and adults.

The Care Quality Commission (CQC) conducted this focussed inspection in response to a number of concerns that were reported to us relating to the theatre recovery area being used as part of the trust escalation processes and procedures when they were short of inpatient beds. These concerns related to unsuitable facilities and inappropriate staffing and the medical wards 25 and 37 not having suitable staffing arrangements in place. Concerns had previously been raised that staffing numbers were not sufficient to meet people's needs and a requirement to address this had been made at the last inspection in September 2014.

We inspected the hospital in the evening of 18 May 2015. We visited five ward areas, spoke to staff of different grades and reviewed the care record of one patient.

We visited the following wards:

- Theatre recovery
- Medical assessment unit
- Surgical assessment unit
- Ward 25 – escalation ward
- Ward 37 – respiratory ward
- Ward 38 – respiratory ward

We found the hospital to require improvement. This was because we found limited assurance about safety and that systems and processes for escalation, were not always appropriate to keep people safe. Escalation processes was how the Trust dealt with variation in demand and adjustments to bed capacity. Theatre Recovery used for escalation was not suitable for the purpose for which it was being used. There were periods of understaffing or inappropriate skills mix, which were not addressed quickly.

Our key findings were as follows:

- There was general good practice with regard to infection control with documented action plans to address an outbreak of infection.
- The care delivered was person centred and staff interacted well with patients in their care. Staff knew each one by their name.
- The quality of service in the escalation areas of the trust requires improvement. There were appropriate processes and procedures for ensuring the safety of patients during periods of increased demand, however these were not always fully implemented and one area was being used that was not identified in the policy and were not suitable a suitable environment for the care and treatment of patients.
- Nurse staffing levels and skills mix in some of the wards we visited were varied. There were occasions when the wards were not suitably staffed to meet the care needs of patients in a timely way. The trust was taking action to address the nurse vacancy rate, but it remained evident that the wards were not always appropriately staffed.
- Staff were using a national Early Warning tool to help monitor deterioration in a patient's condition. However, these were not always completed appropriately.
- There were clear processes to identify fundamental standards of care but these were not being used consistently.

Importantly, the trust must:

- ensure sufficient numbers of suitably qualified and experienced staff in all areas to ensure patient needs are consistently met.
- ensure that all procedures to identify safe care are completed consistently and learning identified.

In addition the trust should:

- take action to ensure that areas used for escalation purposes are suitable for the service provided and that there are adequate support facilities and amenities.
- ensure that recruitment processes identified are fully implemented
- ensure that patient's privacy and dignity is maintained at all times as part of the bed management procedures

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to the service

Wirral University Teaching Hospital NHS Foundation Trust (WUTH) is one of the largest and busiest acute trusts in the North West of England. The Trust was formed under the provisions of the Health and Social Care (Community Care and Standards) Act 2003 (consolidated in the National Health Service Act 2006) and received its Terms of Authorisation from Monitor, the independent regulator of NHS Foundation Trusts, on 1 July 2007.

Arrowe Park Hospital is one of the locations of WUTH and is situated in the Upton area of Birkenhead on the Wirral Peninsula. It delivers a full range of emergency and acute services for children and adults in the main hospital building.

Our inspection team

Our inspection team was led by Head of Hospital Inspections

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included CQC inspectors

Why we carried out this inspection

We carried out an unannounced focused inspection on 18 May 2015 following concerns raised about the implementation of the escalation policy. This policy was in place for the Trust to deal effectively with variation in demand and adjustments to bed capacity. We also looked at previous compliance issues from a previous inspection, in relation to staffing on medical wards. This was also in response to recent concerns raised

We visited a number of areas including theatre recovery, ward 25, 37, and 38 which is a respiratory ward, medical assessment unit and the surgical assessment unit. We spoke with six nurses, a doctor and four senior members of staff. We also reviewed the care records of one patient.

How we carried out this inspection

We conducted this unannounced visit on 18 May 2015 at 7 p.m. to 9 p.m.

We talked to staff and senior management, visited ward areas and reviewed the care records of one patient.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the hospital MUST take to improve

- The trust must ensure sufficient numbers of suitably qualified and experienced staff to all areas to ensure patient's needs are consistently met.
- the trust must ensure that all procedures for identifying safe care are completed consistently and learning identified.

Action the hospital SHOULD take to improve

Summary of findings

- The trust should take action to ensure that areas used for escalation purposes are suitable for the service provided and that there are adequate support facilities and amenities
- The trust should ensure that recruitment processes identified are fully implemented
- The trust should ensure that patient's privacy and dignity is maintained at all times as part of the bed management procedures

Wirral University Teaching Hospital NHS Foundation Trust

Arrowe Park Hospital

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Staff knew how to report incidents and there was an appropriate trust response to patient safety incidents and concerns. The use of the safety thermometer to manage patient risk and improve performance was variable throughout the wards we visited . Although the environment was clean there were a number of urgent maintenance issues that had not been addressed.

Implementation of the escalation policy when there was an increased demand on the service resulted in inappropriate areas being used that were an unsuitable care environment that presented a potential risk to patients. There were areas on the wards we visited that were not properly maintained.

Systems were in place to manage risk but these were not robust. There were gaps in processes for staff to learn from findings to ensure the fundamental standards of care were met for each patient.

There were periods of under staffing that had not been addressed promptly and we found that staff were very time pressured. under pressure. Medical staff were positive about the support they received from their colleagues. They were well supported.

We also found that not all nursing staff had the knowledge and skills required to carry out their role effectively. The trust had identified this as a risk and had plans in development to address this

Incidents

- Staff were familiar with the trust's procedures for reporting incidents. Senior staff confirmed that junior trained nurses had raised several incidents regarding staffing levels and patient needs. .
- Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. The trust reported 5 never events between April 2014 and March 2015. Seeking to learn, the trust sought an independent review of these events . An action plan had been identified that included key priorities for improvement and areas for intervention.

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 was collected on pressure ulcers, urinary tract infections (for people with catheters), blood clots (venous thromboembolism or VTE) and falls.

- Safety thermometer results we received were variable. Only two wards recorded one month of 100% harm free care in the last 6 months which was above the trust target of 95%.
- The regularity of undertaking these audits was also variable across the wards.. This meant that the data held by the service was not robust and as a consequence opportunities for leaning and improvement could be lost.

Environment and Equipment

- The environment was visibly clean.
- There were patient toilet facilities that were out of order. Staff informed us that there was a staff toilet with a missing toilet seat. A shower facility on ward 38 was out of order. On checking maintenance records and talking with staff, the defective toilet on the medical assessment unit had been reported 13 days prior to the visit. The shower facilities on Ward 38 had also been reported a few days prior to the visit. Staff reported the broken toilets on ward 25 and ward 38 whilst we were there. The trust has since reported that the broken toilets have all been repaired. Information provided by the trust showed that there were a number of outstanding issues that needed to be addressed regarding urgent and routine maintenance issues. There was an action plan for ward improvements during 2015/16
- The medical assessment unit was cramped and the bays did not have doors on them which meant that privacy between male and female patients was not always maintained
- The recovery area contained six beds for patients recovering from surgery . This area did not have necessary facilities such as patient lockers, call bells, toilets or showers.. One toilet was available for patients use with access through the main theatre entrance door and a room used for storage of equipment. . This meant the recovery area was not fit for the appropriate management of patients due to the lack of necessary facilities to meet their needs. .
- Information provided by the trust showed that the issue of inadequate toilet or washing facilities in the recovery area was identified on the trust risk register and was reviewed on 5 May 2015 and due to be reviewed again on 1 July 2015. The Trust had put in place actions to reduce the risk.
- Staff on Ward 25 said that they had no dressing packs and no stationery. This was brought to the attention of the trust at the time of the visit and action was taken to address this issue.
- On Ward 38 there were 2 single rooms with shared ensuite facilities. These rooms were used for either male or female patients. Staff confirmed that there had been times when one room would be occupied by a male patient and the other one by a female patient but staff managed the use of the toilet and washing facilities. This meant patient's privacy and dignity may not always be maintained according to single sex accommodation national guidance.
- The trust have told us that since the visit the facilities department have assessed the area and reported that it would not be possible to change the layout and that nursing staff would need to review the use of these rooms.

Medicines

- On ward 25 medicines due at teatime18.00hrs were being administered one hour late Staff said this was due to 'having no time to do anything today.' This meant patients did not receive their medication on time. This may have been a risk if the medication was to have been taken with food.
- Staff said that there had been a patient who was ready for discharge from ward 25 in the morning but did not go home until the evening as pharmacy had not delivered the medication until then.
- Senior staff informed us the trust procedure was that nurses wore red tabards when they were administering medicines. Staff on ward 25 did not adhere to this procedure. This meant staff may be interrupted and medication not administered safely. Staff were also not following the trust's own policies and procedures.

Records

- Records were a mixture of electronic and paper records. The paper record we reviewed contained all the necessary information with the care plan held on the electronic system. Senior staff said that the electronic system was not fully embedded and there had been 'teething' issues regarding the new system.

Are services safe?

- Staff confirmed that the care plan was accessed and discussed during hand-over.

Accessing and responding to patient risk

- Staff were using a Medical Early Warning tool (MEWS) to help monitor deterioration in a patient's condition. However, these were not always completed appropriately.
- Staff told us they were aware that the matron completed a checklist but they had not seen the results or learning from the checklists as they were discussed with the ward sister.
- The matron ward round documentation for ward 25 showed that the overall score had increased from 40% to 78%. The documentation provided by the trust did not include any actions needed to improve the overall score and patient care.
- Staff, on ward 38 said the 2 hourly patient focused rounds had not always been achieved and they were often every 4 hours. This meant patients' needs may not always be responded to in a timely way.
- patients who stayed in the recovery area as part of the escalation plan were cared for by theatre recovery staff. Often this had involved discharging patients which the recovery nurses felt they were not trained or competent to do.. This meant staff did not have the skills, knowledge and experience to deliver effective care and assess patient risks appropriately.

Nursing staffing

- The medical assessment unit had 24 beds in four bays and a bay area for eight chairs. Numbers of nursing staff on the unit were appropriate with eight nurses on duty and one clinical support worker. This gave a 1:5 nurse to patient ratio. One nurse was supernumerary.
- The surgical assessment unit had 16 beds with a waiting room for eight chairs. The nurse to patient ratio was 1:8 and a clinical support worker to patient ratio of 1:8. There was also a co-ordinator for the unit. During the night there were three registered nurse plus two clinical support workers for the whole unit.
- Owing to the number of newly qualified staff that had recently started work on the unit, the co-ordinator said they were often more clinically involved and that managerial aspects of the role suffered as a consequence.
- At the time of our visit we observed that the nursing team on Ward 25 had a nurse to patient ratio of 1:10 and a clinical support worker to patient ratio of 1:10. Staff told us they did not have time to speak to us as they had been busy all day due to staffing levels on the ward.
- We observed that the orthopaedic team on Ward 25 had a nurse to patient ratio of 1:6 and a healthcare assistant to patient ratio of 1:12. Staff told us that they had been 'stretched' all day and had difficulties contacting medical staff when needed.
- Safe staffing for nursing in adult inpatient wards in acute hospitals national guidance states, that there is evidence of increased risk of harm associated with a registered nurse caring for more than 8 patients during the day shift. There is no national or trust guidance for the number of clinical support workers on each shift.
- Information from the trust showed that for Ward 25, the average fill rate of nurses for Ward 25,between January – March 2015, was between 74.3% and 99.4% in the day and 100% at night. The fill rate is the actual number of staff worked on a ward against the planned number of staff.
- Staff told us that the nurse to patient ratio on Ward 38 should be 1:8 and clinical support worker to patient ratio of 1:8. On the day of the visit we saw that the patient to nurse ratio was 1:12. Staff informed us this was due to sickness. Information from the trust showed us that average fill rate of nurses for ward 38 between February –April 2015 was between 86-93%
- The Trust informed us that they were aware of difficulties with recruitment and we saw plans were in place to increase staffing levels.
- We had previously inspected the medical services provided by the trust. We found there were insufficient nursing staff to provide appropriate and safe care. At this visit , although the trust had plans in place to increase staffing, there were still concerns regarding the numbers of nurses available to meet patient needs.

Medical Staffing

- There were two consultants on duty in the medical assessment unit at the time of our visit.
- Junior staff said they had regular access to senior medical staff and felt fully supported by them. They told us that their biggest pressure was the large volume of patients coming into the acute medical unit from accident and emergency and general practitioners.

Are services safe?

Escalation Management

- Escalation was part of the major incident procedures for the trust. A written escalation process was in place that outlined procedures for dealing with increasing levels of pressure on bed capacity within the trust. This process was being used at the time of the visit due to increased referrals to the trust and an outbreak of infection on the orthopaedic ward. Information provided to us by the trust showed appropriate actions had been taken to manage the outbreak of infection.
- Inspection of the theatre patient register showed that in the past month the recovery area had been used for escalation five times. This included three overnight stays.
- The trust escalation policy did not state that the recovery area was to be used as part of the escalation process.
- Following our last visit when concerns were raised regarding the suitability of another ward as part of the escalation processes, ward 25 had been opened for this purpose.
- The trust reported to CQC on 24th April that ward 25 was closed as wards had 'settled down'. However it was reopened on 4 May in response to an outbreak of vancomycin resistant enterococcus (VRE) on ward 10 and was being used at the time of the visit.

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
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust must provide sufficient numbers of suitably qualified and experienced staff to make sure that patients' needs are met.