Guy's and St Thomas' NHS Foundation Trust

Astley Cooper Unit, Guy's Hospital

Quality Report

5th floor Borough Wing
Great Maze Pond
London
SE1 9RT
Tel: 020 7188 0001
Website: www.guysandstthomas.nhs.uk

Date of inspection visit: 26 March 2018
Date of publication: 04/07/2018

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.

Astley Cooper Unit, Guy's Hospital

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Detailed findings

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Our inspection team

The team that inspected this service comprised of a CQC lead inspector, another CQC inspector, and a specialist advisor with expertise in dialysis care. The inspection team was overseen by Helen Rawlings, Head of Hospital Inspection, and Stella Franklin, Inspection Manager.

How we carried out this inspection

We carried out an unannounced visit on 26 March 2018. During the visit, we focused on areas of concern identified through information sent to us. We observed how people were being cared for and reviewed care records of people who were using the service at the time. We reviewed the service's records such as policies, procedures and audits. We spoke with patients and staff on the unit, including the matron and ward manager.

Medical care

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Astley Cooper Unit, Guy's Hospital is operated by Guy's and St Thomas' NHS Foundation Trust. This is an outpatient facility, which enables patients to access routine dialysis treatment without the need for hospital admission. The unit has 27 dialysis stations which consisted of two bays of 12 dialysis stations and three isolation rooms.

The unit is open from 7.30am to 8.30pm and accessed by service users diagnosed with kidney disease and other associated problems.

Summary of findings

We found that:

- There was a number of concerns related to infection prevention and control practices. This included lack of attention to the cleanliness of the environment and equipment, and poor adherence to best practices.
- The fabric of the unit was in poor condition and in need of general refurbishment.
- There was poor practice with regard to some medicines storage and lack of checks on equipment.
- There was poor practice with regard to cross infection and isolation requirements.
- Patient records were not always completed to the required standards and sometimes lacked information.
- Staff did not always adhere to trust policy and best practice guidance, placing patients at risk of significant harm.
- The trust lacked oversight of the safety concerns we identified within the unit. The leadership had been made aware of these concerns several months prior to our inspection and had failed to take appropriate action as evidenced by our findings.
- Risks were not effectively identified, nor appropriately managed.
- Some policies had not been reviewed in line with the trust's guidelines.

Medical care

Are medical care services safe?

Cleanliness, infection control and hygiene

- On the Astley Cooper Unit, we found a number of concerns related to compliance with the Health & Social Care (HSC) Act 2008 Hygiene Code and a number of associated criterions.
- The environment was generally unclean. This was not in keeping with the required standards of the criterion two, which outlines the need of providers to maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
- We observed inadequate levels of attention to the cleaning of dialysis machines on the unit. We observed fresh and old splatters of blood on four out of 27 machines on the unit. This indicated to us that staff were not fully aware of and discharging their responsibilities in the process of preventing and controlling infection, as per criterion six of the aforementioned code.
- Criterion nine requires a service to have policies, designed for the individual's care and provider organisations that will help to prevent and control infections. Some of the practices we observed during our inspection indicated staff had a lack of awareness of policies and procedures related to the cleaning of equipment. We brought this to the attention of the trust and since the inspection, the trust have reviewed and updated their standard operating procedure for cleaning dialysis machines and other equipment pre- and post- treatment.
- We observed staff did not always adhere to the aseptic non-touch technique, which was against the trust's policy. This practice reduces the risk of contaminating equipment and the potential for patients to acquire an infection. According to part 6.3 of criterion six, where staff undertake procedures, which require skills such as aseptic technique, staff must be trained and demonstrate proficiency before being allowed to undertake these procedures independently. Since the inspection, we have seen evidence that the trust has reinforced the policy around this practice to staff. However, we would expect to see on-going evidence of the monitoring of staff compliance with best practices and associated competencies.
- We observed packaging of equipment was sometimes discarded on to the floors of the unit, rather than being placed in the bins provided. This posed an infection control risk and was not in line with the trust's IPC policy.
- The curtains surrounding each dialysis station were due to be changed in February 2018 but this had not been completed. We alerted the matron on the day of inspection to this and saw evidence this was actioned immediately.
- We saw evidence the trust undertook infection control audits and an annual 'deep clean', which had last been completed in September 2017. However, these practices were evidently ineffective, as the unit was visibly dirty during our inspection, and IPC best practice was not always followed. Since we raised our concerns at the end of the inspection, the trust assured us a further 'deep clean' of the unit had been completed.
- Staff did not always adhere to the '5 step' hand washing technique, which was not in line with recognised best practice and could pose a risk of cross contamination to patients receiving treatment and care. Although we saw evidence the trust undertook hand hygiene audits, the results did not reflect the practices we saw on the day of inspection.
- Staff did not always adhere to the trust's personal protective equipment (PPE) procedure. We observed, whilst administering dialysis, nurses did not always change their aprons and gloves at appropriate intervals. We also observed some staff not using protective visors when required. There was a potential risk of staff receiving splashes to their eyes by not following this safe practice.
- We observed poor practice with regard to cross infection and isolation requirements. For example, we saw an isolation room, which staff told us was specifically used for patients with hepatitis B, hepatitis C and HIV, was visibly unclean, the skirting board was pulled away from the wall and dust and dirt had collected in the area behind. There were medication

wrappers on the floor, as seen in the rest of the unit. Criterion seven requires the provision of adequate isolation precautions and facilities, sufficient to prevent or minimise the spread of infection.

- We observed some medical stock items were inappropriately stored in the unit's sluice room, where there was a risk of products becoming contaminated. We alerted the matron to this issue on the day of inspection and these were moved immediately.

Environment and equipment

- During the inspection, we observed the environment was in poor condition and in need of general refurbishment. For example, the plaster on some parts the walls was chipped, skirting boards were peeling away from walls and equipment had tape on it to 'fix' it.
- Equipment was not always serviced within the correct timescales. For example, there were two sets of weighing scales on the unit, one set was meant to be serviced in March 2017 and the other in November 2017, but neither of these services had been completed.
- The emergency resuscitation trolley on the unit had equipment which had not been serviced within the required timeframes. For example, both the defibrillator and suction kit were due to be serviced in February 2018, 6 weeks prior to our inspection, but this had not been completed. We alerted the trust to this on the day of inspection and this was actioned as matter of urgency. Since the inspection, the trust has implemented monthly audit checks of emergency equipment on the unit.
- We identified an emergency tracheostomy set which had equipment items in it, some of which was four years out of date. We alerted the matron to this on the day of inspection and it was disposed of and replaced immediately.
- Equipment was not always stored appropriately. For example, we observed a patient hoist which was cluttering the corridor of the unit and posed a trip hazard risk. Staff told us this was usually stored in the consumables room but it could not currently be accommodated in this room.
- On the day of inspection we overheard some staff ask each other loudly for the security codes for restricted access rooms. This could have been overheard by patients and visitors and posed a security risk.
- Some equipment which was required for the unit was not available. For example, we found there was no eye spillage kit available on the unit. We alerted this to the matron on the day of inspection and following our inspection one had been placed on the unit.

Medicines

- Medicines were not stored securely on the unit. For example, we found the drugs cupboard to be left unlocked on several occasions and some open packs of medication were left on the nurses' station, which was sometimes left unattended.
- We also observed some medical stock, including citric acid and biohazard kits, were inappropriately stored in the unit's sluice room, in unlocked cupboards. We alerted the matron to this on the day of inspection and these were moved immediately.
- Staff told us there was currently no COSHH (Control of Substances Hazardous to Health) cupboard to store the citric acid on the unit. This had been noted on the local risk register and a cupboard had already been ordered but had not yet arrived.
- We observed the door of the store room which contained hazardous substances was being propped open. This was despite there being a clear sign on the door informing staff to keep the door shut at all times.
- Saline solution required for dialysis was not appropriately stored. The solution bottles clearly stated they needed to be stored in a room below 25 degrees. However, the store room in which the solution was mainly kept was not ambient temperature checked. We also observed bottles of the solution were also regularly kept next to dialysis stations, which was against the trust's policy.
- On the day of inspection, we found some medical stock was out of date, for example, intravenous dressings. We alerted staff to these at the time and they disposed of the stock immediately.

Records

Medical care

- Patient notes were not well organised or kept securely on the unit. For example, we found patient notes kept on the nurses' station throughout the day of the inspection and these were noticeably disorganised. Since the inspection, the trust has placed a lockable cabinet on the unit and informed the staff of a new record keeping procedure on the unit.
- We also saw a set of patient's notes left on an empty bed at one of the dialysis stations. These notes were left on the bed for over an hour and were easily accessible to anyone who was close by.
- We found some patient notes did not include detailed care plans. In addition, during our inspection we observed there was no specific care plan in the notes of patients under police escort. The only way these types of patient could be identified was from their address.
- We found patient identifiable information on the desktop of one of the computers on the unit. The computer was left unlocked, and the document could be accessed without a password by anyone sitting at the computer. The document outlined a patient's medical and social history. This posed a risk of a data breach.

Safeguarding

- We observed staff used the 'dry needling' technique which was against the trust's policy. The 'dry needling' technique is where a nurse does not apply saline solution to a line which is to be inserted into a patient who is receiving dialysis treatment. Although, the risk of harm to a patient through this practice is unlikely, if it does create harm, then this harm is likely to be very severe. Since the inspection, the trust drafted new guidance to reinforce to staff the risks associated with this practice.
- We observed staff failing to ask patient's their names or date of birth prior to treatment, meaning that staff could not be assured they were treating the correct patient for the relevant procedure.
- During the inspection we spoke with staff around their treatment of patients. It was concerning that one staff member informed us a particular patient would be the unit's "least priority" based on their particular social situation.
- We saw one instance on the unit where a patient had arrived for dialysis late and so their dialysis treatment was cut short. They were an hour late to a morning slot due to patient transport issues, a service which was provided by a different organisation. This patient was meant to receive four hours of dialysis but due to being late only received three. When questioned, the staff told us they could have continued the patient's treatment as the station was not needed in the afternoon for another patient, but it was not normal practice on the unit to allow a patient to complete their allotted treatment if they had arrived late. The risk of shortened treatment is that patients do not receive the full procedure which has been prescribed by their consultant.

Assessing and responding to patient risk

- There were isolation rooms on the unit, for patients at increased risk of infection, or those who presented a risk of infection to other patients. During our inspection, two of the isolation rooms were in use. The doors to the rooms had signs indicating they should be kept shut, however, they were wedged open. When we asked staff why this was, they were unable to tell us why the patients required isolation. The patient notes indicated these patients had blood-borne conditions, and therefore did not require the doors to the isolation rooms to be kept closed. Nonetheless, it was concerning that the nursing staff were not aware of why the patients had been isolated and, further, they seemed unaware of the unit's isolation protocols.
- Patients under police escort were not appropriately risk assessed on the unit. On the day of inspection, we observed a patient under police escort. They had no risk assessment in place. Staff told us they were not aware of any handover information from the external services and only knew the patient was under police escort as they arrived with security and their notes stated their address. When asking staff what the policy or procedure was regarding treating a patient under police custody, they were unsure of any specific policy or procedure, and were unaware of risks the patient under police custody may pose to other service users, visitors, staff or themselves. However, staff did tell us a patient under police custody would always arrive on the unit with security staff, who were present on the day of inspection.

Medical care

- The trust informed us that, although they did not have a policy on patients under police custody, there was no policy around this nationally. Since the inspection, the trust's head of security has contacted NHS England to seek guidance around this.
- Since the inspection, the trust had implemented a patient management plan for patients under police escort on the unit, which included information on absconding, violence and aggression and self-harm.
- We observed some patients cancelling the alarm guards on their dialysis machines and this practice was not challenged by nursing staff. This meant nurses did not always respond to issues identified by a dialysis machine, thus creating a risk to patient safety.
- Staff we spoke with did not always understand the associated risks related to not following the aseptic non-touch technique. Since the inspection, we have received evidence the trust has reinforced the policy around this to staff.

Are medical care services effective?

Effective did not form part of this focussed inspection.

Are medical care services caring?

Caring did not form part of this focussed inspection.

Are medical care services responsive?

Responsive did not form part of this focussed inspection.

Are medical care services well-led?

Leadership of service

- The trust lacked oversight of the safety concerns we identified within the unit. We were told the leadership team for renal services performed daily checks. However, as we identified these safety concerns on the inspection, this did not assure us that the daily checks were thorough, effective or that actions were taken to mitigate risks identified.
- Further to this, we have evidence of the leadership having been made aware of these concerns several months prior to our inspection and had failed to take appropriate action as evidenced by our findings.
- The long standing safety concerns we have identified, a number relating to basic nursing practice, indicated that a lack of clear leadership on the unit. For example, it was concerning that the leadership team on the unit were unaware the dialysis fluid was being stored in an environment which was not temperature controlled, despite a clear indication on the fluid packaging that it should be stored below 25 degrees Celsius. As such, they had no oversight of the safety of the stock storage. Management lacked oversight of the temperature checks required for the store room on the unit and were not able to assure themselves medical stock was being stored safely.

Governance, risk management and quality measurement

- Whilst there was a specific risk register for the unit, it did not reflect the concerns we identified on the day of inspection. Further to this, risks were not effectively identified, nor appropriately managed.
- We found some policies had not been reviewed in line with the trust's guidelines. For example, the trust's security policy should have been reviewed in July 2016 but this had not been completed.
- The trust lacked clear governance around providing services to patients under police escort, but we did note there was an issue with a lack of national policy around this. Since our inspection, the trust's head of security had contacted NHS England to gain further guidance around this and also sent round a relevant Royal College of Nursing document, 'Supporting nursing staff caring for patients from places of detention', to provide some guidance to staff.

Culture within the service

- The nature of the environment evidenced a culture of complacency. In particular, we observed staff dropping packaging on the floor, in front of patients, and equipment was not appropriately cleaned. This suggested there was a culture that accepted poor nursing care practices and a lack of pride in the unit.

Medical care

- The culture was sometimes one of disrespect for patients and a degree of unfairness when it came to carrying out prescribed treatment timescales.
- We observed staff actively engaging in poor practices, for example dry needling practices. Staff were aware that this was not in line with their trust's policy but continued to do so and offered to demonstrate this practice to one of the CQC team.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must address the cultural behaviours within the team so that all patients are treated with due regard and respect, and receive the right duration of treatment.
- The provider must ensure all staff adhere to best practice guidance around hand hygiene.
- The provider must ensure the equipment and environment is kept clean and in good repair.
- The provider must ensure all medical equipment is serviced in accordance with best practice guidance and manufacturers' recommendations.
- The provider must ensure all records are kept securely and are well maintained.
- The provider must ensure all medicines are kept securely and are well maintained.
- The provider must ensure all staff adhere to the relevant guidance around safe, care and treatment, including dry-needling practices, cancelling alarms on dialysis machines, infection control practices around the aseptic non-touch technique and isolation practices.
- The provider must develop, implement and embed guidance with regard to risk assessment of patients under police custody.
- The provider must ensure staff follow the trust policy regarding appropriately identifying patients prior to treatment.
- The provider must ensure all patients are safeguarded against inappropriate care and treatment, including shortening patients treatment when this is avoidable.

Action the hospital SHOULD take to improve

- The provider should ensure all patients have an up to date and comprehensive care plan in place.
- The provider should ensure staff appropriately document risk assessments for patients under police escort.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance