Stockport NHS Foundation Trust

Stepping Hill Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Medical care (including older people's care)	**Not sufficient evidence to rate**

Summary of findings

Letter from the Chief Inspector of Hospitals

Stepping Hill Hospital is the main location providing inpatient care as part of Stockport NHS Foundation Trust In total Stepping Hill Hospital has 833 inpatient beds.

We carried out an unannounced, focussed inspection of Stepping Hill Hospital on 22 and 23 June 2017.

We carried out this inspection to particularly look at the care and treatment received by patients in the medical care service at the hospital. We focussed our inspection on the safe domain, however, where we have found evidence in relation to other domains we have included this in the report. During the inspection we visited ward C2, A11 and the Coronary Care Unit.

We inspected these areas because of concerns identified through our ongoing monitoring and intelligence of the trust. We found that staff treated patients with dignity and respect, however, this was at times compromised due to a shortage of nursing staff and, as a result, patient safety was compromised.

We requested immediate assurance from the trust to address the areas identified during the inspection and following the inspection to assure patients safety. The trust responded to this and put a number of measures in place to address these concerns. Improvements were needed to ensure that all services were safe, effective, caring, well-led and responsive to people's needs. We are monitoring this service to make sure that the necessary improvements are secured.

Incidents

- We found that incidents were not consistently graded.
- Staff did not always report incidents in line with the trusts policy and procedure.
- There was insufficient oversight of incident data from the management team within the trust.
- Incident forms lacked meaningful data.

Nurse Staffing.

- Across the Medical services division there remained significant shortfalls in nursing staff.
- During the inspection we saw examples where this had impacted on the safety and quality of care patients received; for example patients waiting longer than expected to receive basic nursing care and medications.

Mental capacity and deprivation of liberty safeguards (DoLS)

- Across the medical services departments, staff still did not have a good understanding of the Mental Capacity Act (2005) (MCA) and its application, or the Deprivation of Liberty Safeguards (DoLS).
- When speaking with staff, there was a limited understanding of the trust's own policy regarding MCA and DoLS.
- The application of both the MCA and DoLs at ward and department level remained inconsistent and in the majority of cases we inspected records that were unclear and incomplete.

Records

- Records were not completed fully and were not secure

Assessing and responding to risk

- The early warning scoring system in use at the trust was not always followed and observations were frequently delayed.
- Risk assessments were incomplete and in some cases not completed.

In medical services:

Summary of findings

- The trust must ensure that records are securely stored, legible and completed fully.
- The trust must ensure that patients with diabetes receive safe and effective care.
- The trust must ensure that incidents are managed and reported in line with their own policy.
- The trust must ensure that medications are managed appropriately and secured safely.
- The trust must ensure there is an adequate skills mix on all medical wards and that staff have the right level of competence to effectively nurse the patients they are asked to care for.
- The trust must ensure that it is compliant with the Mental Capacity Act and that all staff have the required level of training in this area.
- The trust must ensure there is consistent categorisation of the same type of incident in the trust's incident reporting system.

Professor Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care (including older people's care)	Not sufficient evidence to rate	We did not rate this service, as the inspection undertaken was a focussed inspection. However, we found a number of areas for improvement.

Stepping Hill Hospital

Detailed findings

Services we looked at
Medical care (including older people's care);

Detailed findings

Contents

Background to Stepping Hill Hospital

Stepping Hill Hospital is the main location providing inpatient care as part of Stockport NHS Foundation Trust. It provides a full range of hospital services, including emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, a neonatal unit, children and young people's services, maternity services and a range of outpatient and diagnostic imaging services.

Stockport Foundation Trust provides services for around 350,000 people in and around the Stockport area, with approximately 912 inpatient beds. In total, Stepping Hill Hospital has 833 inpatient beds.

During this inspection we inspected the medical care services at the hospital that provide care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory and gastroenterology and a specialist stroke centre serving the south of Greater Manchester. The hospital also provides surgical services, critical care services, maternity and gynaecology services, paediatric services, end of life care (EOLC) and a range of outpatient and diagnostic services, which were not inspected as part of this inspection.

Our inspection team

Our inspection team was led by Stefan Verstraelen, Inspection Manager, Care Quality Commission.

The team consisted of an inspection manager and two CQC inspectors; Katherine Williams and Angela Parfitt.

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?

The inspection team inspected the following core services at Stepping Hill Hospital

- Medical care (including older people's care)

Following the unannounced inspection, we reviewed a range of information we held about the hospital and requested further data from the Trust. We talked with patients and interviewed staff from the ward areas.

Detailed findings

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 views and experiences of the quality of care and treatment at Stepping Hill Hospital

Facts and data about Stepping Hill Hospital

From March 2016 to February 2017, the trust had 89,659 medical admissions, including day case admissions. 28,390 of these admissions were from the emergency department. This averaged 7,472 admissions per month and with the exception on November 2016, remained around that average figure month on month.

There are a total of 833 beds at the hospital, which serves a population of 350,000 people.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	N/A	N/A	N/A	N/A	N/A	Not rated
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Medical care (including older people's care)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	**Not sufficient evidence to rate**

Information about the service

Stockport NHS Foundation Trust became one of the first Foundation Trusts in the country in 2004. They provide hospital services for children and adults across Stockport and the High Peak area, as well as community health services for Stockport, Tameside and Glossop. The trust works as part of the 'Stockport Together' partnership to integrate local health and social care more closely to people's homes.

Stepping Hill Hospital is the Trust's main acute site, which provides emergency, surgical and medical services. The trust serves a population of approximately 350,000 people. The medical services provided at the hospital included general medicine, endoscopy, cardiology, geriatric medicine, endocrinology, gastroenterology, rehabilitation, respiratory and stroke medicine. We inspected Stepping Hill hospital between 21 March 2017 and 22 March 2017.

From March 2016 – February 2017 the trust had 89,659 medical admissions including day case admissions. 28,390 of these admissions were from the emergency department. This averaged 7,472 admissions per month and with the exception on November 2016, remained around that average figure month on month.

During our inspection we visited A11, C2 and the coronary care unit. We reviewed nine complete (paper and electronic) patient records, 36 paper based patient records and a further 18 sets of electronic records, talked with 14 patients and 11 members of staff.

Summary of findings

We have not rated this service because the inspection undertaken was a focussed, responsive inspection. However, we noted the following areas for improvement:

- The trust had not responded appropriately to the risk expressed to them at our last inspection regarding the security of patients' records. We found unsecured patient records on both Ward C2 and A11. These records contained very sensitive patient information.
- The trust continued to move their own staff and had a heavy reliance on agency and bank staff, resulting in inappropriate skills mix and staff feeling they were nursing in wards where they did not have the required competence to care for patients.
- Decisions to move nursing staff were made on clinical judgment without a clear guidance document or minimum set standards.
- The nursing management of patients with diabetes was inconsistent and in some cases inappropriate.
- DNACPR orders were not completed fully and correctly.
- Records completion was not in accordance with best practice guidance.
- Incident reports did not have consistent categorisation for the same type of incident.
- We found that there was still inconsistency in how people's mental capacity was assessed and not all decision-making was informed or in line with guidance and legislation.
- We found that it remained that restraint and deprivation of liberty were not always recognised, or

Medical care (including older people's care)

less restrictive options used where possible. Applications to authorise a deprivation of liberty were not completed in three out of three cases we reviewed.
- Due to staffing pressures, patients' dignity was not consistently maintained.
- The arrangements for governance and performance management did not always operate effectively.
- Risks, issues and poor performance were not always dealt with appropriately or in a timely way. The risks and issues described by staff do not consistently correspond to those reported to and understood by leaders.

However, we also noted areas of good practice, including:

- All areas we inspected were visibly clean and tidy.
- Staff were caring and compassionate in their approach to patient care and were trying their best despite significant challenges.
- Patients on whole gave us positive feedback about the staff caring for them.

Are medical care services safe?

We did not rate this domain, as the inspection undertaken was a focussed inspection. We did, however, find the following points for improvement:

- Incidents were not managed effectively.
- Hazardous fluids and items were left available to vulnerable patients.
- Medicines were not managed effectively.
- Staff were not managing risks to patients' safety effectively.
- Risk assessments were absent or incomplete.
- There were not sufficient numbers of suitably qualified staff deployed.

Incidents

- We found that incidents were not being reported in line with the trust's own reporting policy and procedures. An example of this was that 21 incidences of hypoglycaemia of less than 3.5 mmols were found in the seven days prior to the inspection and zero of these 21 events had been reported in line with the trust's practice, protocol and alert.
- Staff on the ward had a mixed understanding of when to report incidences of hypoglycaemia and what actions to take.
- We found that incident reports lacked meaningful data and follow up. An example of this was an incident where a patient had ingested a hazardous substance and we found that there was no detail as to follow up actions contained in the incident report. We escalated this to the trust for immediate action.

Environment and equipment

- We found that the environment in one ward area was unsafe and posed a hazard to patients' safety.
- In this area we found that the sluice room was left open and unattended with hazardous substances available. There was a confused patient situated outside this room. When we returned on 23 June the room remained unlocked with items on the floor.
- We found that the cleaner's cupboard was also unlocked, with numerous hazardous cleaning fluids available.
- We found that stock room was also unlocked and a screw was placed in the lock. This was despite there

being a clear sign outside stating 'keep locked at all times'. This room was found in a state of disarray with sterile dressings and scalpels on the floor. When we returned on 23 June the room remained unlocked with items on the floor.
- We also found an incident reported in May 2017, whereby a patient was found with a cup of hibiscrub (a cleaning product which could be harmful if ingested) with a straw inside and had drank this. Appropriate action had not been taken in response to this.
- We observed approximately 20 boxes of needles that were out of date (Expired 2011) and we also found a box of intravenous cannulas, which were two years out of date.

Medicines

- We found that medicines were not being managed safely and effectively across the medical division.
- Staff on one ward told us that health care support workers would stop and amend the rate of intravenous insulin pumps when they recorded patients' blood sugars. This was not in line with the trust's policy on managing medicines.
- We observed an incident where a health care support worker called a nurse after taking a patient's blood sugar reading and advised the nurse to stop the pump and told her what rate to change the insulin infusion to. We observed that the nurse followed this instruction.
- The trust's policy on medication management states that all intravenous medication and insulin should be double checked. Insulin infusion pumps were not being double checked when the rate was changed.
- We observed that a medication trolley on ward A11 was left unattended for approximately five minutes. During this time it was observed that a patient with confusion was wandering in the ward. We were able to remove bottles of morphine and other medications and document their opened dates during this time unchallenged and without any staff in attendance.
- The door to the clean utility, which contained numerous unsecured medications and intravenous fluids, was left propped open on numerous occasions.
- We found two bags of intravenous fluids in the stock drawers with their tamper proof seal broken. In one case there was no obvious sign of rips or tears, but the tamper proof seal was broken and there appeared to be dry drops of fluid inside the bag. This was reported to the ward manager who proceeded to try and throw the bags away. We removed the bags and handed them to the governance lead, who was going to incident report this and instigate an investigation.
- Some liquid medication, including paracetamol and gaviscon did not have opened dates on them. One bottle showed signs of crystallisation.
- We found a bottle of liquid morphine had been opened over 90 days ago. Manufacturers guidelines stated this should have been discarded within 90 days.
- We found that medications that were prescribed to patients (no longer on the ward) were being used as stock items to administer to other patients.
- We escalated these issues to the trust for their immediate action.

Records

- In all records we reviewed we found that they lacked detailed and meaningful information.
- All records contained illegible signatures and it was not immediately obvious who had entered information into the records.
- There was no clarity on where or how to record ketone measurements and they were recorded in three different places.
- In four out of four records, where DNACPR orders were completed, we found there were errors in the completion, including incorrect or lack of dates, illegible signatures and no designations specified. Despite this, the orders had been used to withhold resuscitation when one of the these patients would have suffered a cardiac arrest.
- In two out of three DNAR forms there was no evidence of discussion with the patient or their family.
- In one out of two of the forms without a documented discussion with the patient or their family, this conversation was recorded in the nursing records, as a discussion between a ward sister and the family.
- All records we reviewed did not contain legible signatures and designations.

Safeguarding

- Staff did not always recognise incidents of a safeguarding nature. An example of this was a case where we found that a patient had potentially suffered harm as a result of an incident. This incident had not been highlighted to the safeguarding team and a referral had not been made.

Medical care (including older people's care)

Assessing and responding to patient risk

- We reviewed all diabetic patient monitoring charts (16 patients) on ward A11. We found that seven patients had experienced at least one hypoglycaemic (low blood sugar) event in the seven days prior to the inspection. In total there were 21 incidences of hypoglycaemia of less than 3.5 mmols in this time period. In nine out of 21 cases there was no documented action taken in response to the hypoglycaemic event. In a further eight cases the action taken did not match the action required by the hypoglycaemia protocol. In all 21 cases the repeat blood glucose test required by the hypoglycaemia protocol was not undertaken within the specified 10-15 minutes time frame.
- Three out of 16 patients had experienced at least one episode of hyperglycaemia (high blood sugar). The total number of hyperglycaemic events was 11 in the seven days prior to the inspection. In ten out 11 cases the hyperglycaemia protocol had not been followed and ketones had not been recorded.
- We observed that 9 out of 15 patient call bells were out of reach on one ward, which meant patients could not call for help. A patient's relative and staff member told us this was frequent and led to patients becoming incontinent.
- The National Early Warning Scoring (NEWS) system was not always followed in relation to timeliness and action when observations were required. In three out of three records we reviewed in relation to NEWS scores of over three in total, the observations had been delayed by at least one hour.
- We reviewed the records of two patients who had signs and symptoms of sepsis and found that there was poor recognition of sepsis in both patients. This had led to a delay in the patients receiving the appropriate care they needed.
- Risk assessments were not fully completed and mitigating actions were not recorded. We found that in 12 out of 18 records risk assessments, including bed rails, falls and pressure care, were either incomplete or out of date.

Nursing staffing

- Nurse staffing levels were below expected levels on a regular basis. Staff told us that this significantly impacted their ability to undertake their duties and provide safe care.
- Staff on the coronary care unit (CCU) looked after patients who needed level one and level two care. They assessed the acuity of the patients on a regular basis to determine if they were level one or level two patients. This was done to ensure appropriate skill mix of staff. Level two patients require higher levels of care and more detailed observation and intervention. However, staff told us that the unit was continually staffed by two nurses. This meant that staff were unable to leave the unit during their breaks.
- This was highlighted to the trust after our last inspection and they had not implemented any changes to rectify this on our return. During our inspection we observed that 50% of the patients on the unit were deemed to be level two.
- We observed impact on patient care in some ward areas, including delayed intentional rounding, observations and medications.
- In one ward area we reviewed records and spoke with staff members and we established that 15 patients required assistance of minimally two staff to attend to their basic care needs. Despite this the staffing for the area did not take account of this.
- Staff told us that this impacted their ability to care for patients. One example of this was that we found that some patients were not receiving washes until after their lunch and in some cases not at all.
- There were delays in taking patients to the toilet and as a result patients were awoken at 5am to be washed, as staff did not have enough time to undertake their duties.
- We found that student nurses and staff on supervised practice were counted in staffing numbers and were used as full staff members undertaking nursing duties unsupervised.

Medical staffing

- We found that patients received adequate and thorough medical input and reviews. The medical teams documented plans of care clearly and reviewed patients on a frequent basis.
- Staff told us that they did not have any issues in contacting medical staff and advised that they responded quickly when requested to attend the ward areas.

Major incident awareness and training

- Senior staff told us there was a business continuity plan and major incident plan.

Medical care (including older people's care)

- Staff were able could access the major incident policy via the intranet.

Are medical care services effective?

As part of the responsive review we had not planned to inspect this domain, as our inspection was focussed on safety, however, when we were onsite we found that patients' mental capacity was not always assessed and consent was not always informed.

Nutrition and hydration

- Patients' nutritional status and dietary needs were assessed using a recognised assessment tool and we saw evidence of this in all records. In one case we observed that this assessment contained incorrect information and as a result a patient was scored lower than they should have been. This resulted in the patient not receiving specialist dietary support.
- Fluid balance charts we inspected were not comprehensively completed and appropriately maintained.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff did not demonstrate a good understanding of the trust's policy regarding the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLs).
- We reviewed the records of three patients who had a history of dementia and impaired mental function. In all three cases we found that assessments of their mental capacity had not been undertaken for any decisions relating to their care.
- Staff told us that they 'did not do' capacity assessments.
- For all three patients we found that a valid deprivation of liberty application and order was absent.
- In one case, relating to a deceased patient, we found that for a 24 hour period prior to their unexpected collapse and death it was documented that he refused observations on four occasions and was noted to be too distressed on three occasions. This was out of pattern for the patient, who had documented observations at least daily for the five days prior to this period. Despite this there was no reference or evidence of a capacity assessment for this patient. This change in his condition was not escalated or highlighted to medical or senior nursing staff and no action was taken until he suffered a cardiac arrest.

Are medical care services caring?

As part of the responsive review we had not planned to inspect this domain, as our inspection was focussed on safety, however, when we were onsite we found that patients received compassionate care most of the time.

Compassionate care

- Medical services were delivered by caring and compassionate staff and they treated patients with dignity and respect.
- We spoke with 14 patients during our inspection. Most patients we spoke with were positive about their care and treatment. Some patients and their families told us that staff were always busy and this sometimes led to a delay in them receiving help and assistance, but that they thought staff tried very hard.
- We found that property belonging to deceased patients was not always treated in a caring and compassionate manner. We found 13 bags of deceased patients' property in the sluice room on one ward area stacked on the floor. Six of these bags were unlabelled and all bags had splashes of brown and yellow liquid, as they were next to a waste disposal unit.

Are medical care services responsive?

Are medical care services well-led?

As part of the responsive review we had not planned to inspect this domain, as our inspection was focussed on safety, however, when we were onsite we found the following areas for improvement:

- Senior staff did not have sufficient oversight of key governance and risk areas.
- Staff were happy to raise concerns, but told us they felt these would not be listened to or actioned.

Governance, risk management and quality measurement

Medical care (including older people's care)

- The medical services were part of the medical business unit, which included general medicine, endoscopy, cardiology, geriatric medicine, endocrinology, gastroenterology, rehabilitation, respiratory and stroke medicine.
- There was a governance structure in place, which ensured some risks to the service were captured and discussed.
- Incident reporting categorisation remained inconsistent across the medicine division. This meant that the board could not be assured that similar incidents were consistently reviewed or reported externally.
- We found that the incident reports were lacking meaningful data and follow up. This had not been recognised by the divisional, corporate or board governance leads and teams.
- The trust gave conflicting information about their governance arrangements; with this information being different to staff understanding. An example of the was that the corporate and divisional governance leads informed CQC that the trust did not monitor arrest and emergency calls and did not undertake mortality reviews. The clinical staff told us that cardiac arrest calls were not monitored, but there was an ad hoc process for reviewing patient deaths. The medical director and Director of nursing told us that they were under the impression that cardiac arrest calls were monitored and reviewed, but could provide no evidence of this.
- The trust governance team had not picked up any of the issues we found during our inspection.

Leadership of service

- Ward staff felt well supported by their line managers. However, they did not feel supported by nursing managers and the trust board.

Culture within the service

- Staff told us that they would feel comfortable raising concerns, but they had little confidence that these would be actioned.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- The trust must ensure that records are securely stored, legible and completed fully.
- The trust must ensure that patients with diabetes receive safe and effective care.
- The trust must ensure that incidents are managed and reported in line with their own policy.
- The trust must ensure that medications are managed appropriately and secured safely.
- The trust must ensure there is an adequate skills mix on all medical wards and that staff have the right level of competence to effectively nurse the patients they are asked to care for.
- The trust must ensure that it is compliant with the Mental Capacity Act and that all staff have the required level of training in this area.
- The trust must ensure there is consistent categorisation of the same type of incident in the trust's incident reporting system.

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 10 HSCA (RA) Regulations 2014 Dignity and respect 1. Service users must be treated with dignity and respect. The trust was not always ensuring the dignity and respect of the service users it was providing care for.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a. assessing the risks to the health and safety of service users of receiving the care or treatment; b. doing all that is reasonably practicable to mitigate any such risks; d. ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; e. ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; g. the proper and safe management of medicines;

This section is primarily information for the provider

Requirement notices

The trust was assessing and responding to risks to the safety of service users. The trust was not at all times managing medicines, equipment and the premises safely.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; c. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; d. maintain securely such other records as are necessary to be kept in relation to— i. persons employed in the carrying on of the regulated activity, and ii. management of the regulated activity; The trust was not monitoring and mitigating risks to service users effectively. Records were not always maintained and stored securely

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

1. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part.

There were not always sufficient numbers of suitably qualified persons deployed across the medical and urgent care area. This was observed to have a direct negative impact on patient care and experience.

This section is primarily information for the provider

Enforcement actions

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.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...