Review of compliance

Wirral University Teaching Hospital NHS Foundation Trust Arrowe Park Hospital	
Region:	North West
Location address:	Arrowe Park Hospital Arrowe Park Road, Upton Wirral Merseyside CH49 5PE
Type of service:	Acute services with overnight beds Community healthcare service Diagnostic and/or screening service Hospice services Long term conditions services Rehabilitation services
Date of Publication:	May 2012
Overview of the service:	Arrowe Park Hospital is a large acute

	hospital situated in the Upton area of Birkenhead, on the Wirral. It is one location of Wirral Universities Teaching Hospitals NHS Foundation Trust and is one of the biggest and busiest acute trusts in the North West, serving a population of 400,000 across Wirral, Ellesmere Port and Neston. At the last inspection we found concerns with one of the 16 essential standards. The trust implemented an action plan to address these concerns.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Arrowe Park Hospital was not meeting one or more essential standards. Action is needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether Arrowe Park Hospital had taken action in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 09 - Management of medicines

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 24 April 2012, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We visited Arrowe Park Hospital and spoke to patients and relatives. Patients told us they felt they were well cared for and were well looked after. Comments made included: "Everything is great, I have no complaints", "I am very well cared for", "They are very good and the staff are very nice", "The care is good and so is the food".

Patients told us the staff treated them with dignity and respect and the food was very nice with good choices. We were told they usually answered the call bell in a timely manner, however on occasions they had to wait as staff were busy with other patients.

Relatives of patients told us they were pleased with the care as their relatives had told them they were well looked after. Two of the relatives we spoke with felt communication between the ward staff and they should have been better. They said they were disappointed in having to ask for information regarding their relatives on a number of occasions before the information was forthcoming. Other family members felt they were kept informed as their relative had told them what was happening and gave them the information they needed.

We spoke with five patients about their medicines. None of them raised any direct concerns about the way their medicines were handled. One patient said they were looking after their own medicines and they were "pleased" that they could do this as it helped them retain some of their independence. They also said this meant they could take them when

they wanted to and so they didn't have to wait for nursing staff to give them.

Other patients said that they had been given information regarding their new medicines and said they had been well looked after and the new medicines had helped.

What we found about the standards we reviewed and how well Arrowe Park Hospital was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The provider was meeting this standard.
People experienced care, treatment and support that met their needs by having needs and risks assessed and care planned accordingly. Action plans were implemented to address areas of lack of compliance with care documentation.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

Patients were not fully protected against the risks associated with medicines because the arrangements to manage the prescribing of medicines were not always followed.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We visited Arrowe Park Hospital and spoke to patients and relatives. Patients told us they felt they were well cared for and were well looked after. Comments made included: "Everything is great, I have no complaints", "I am very well cared for", "They are very good and the staff are very nice", "The care is good and so is the food".

Patients told us the staff treated them with dignity and respect and the food was very nice with good choices. We were told they usually answered the call bell in a timely manner, however on occasions they had to wait as staff were busy with other patients.

Relatives of patients told us they were pleased with the care as their relatives had told them they were well looked after. Two of the relatives we spoke with felt communication between the ward staff and they should have been better. They said they were disappointed in having to ask for information regarding their relatives on a number of occasions before the information was forthcoming. Other family members felt they were kept informed as their relative had told them what was happening and gave them the information they needed.

Other evidence
Staff were observed to be treating patients with respect. Patients on the ward we visited looked clean and well cared for. The ward appeared organised and during mealtimes those patients requiring assistance received it. We did notice however that one person who was highlighted as needing observation as to what and how much she ate, did not have a record of her food intake. This was acknowledged as needing attention.

We saw evidence in the form of audits that demonstrated continuing improvements in accurate completion and use of individual risk assessments for nutritional risk, risk of falls and risk of pressure ulcer development. Compliance was demonstrated by monthly audit reports; however the provider may find it useful to note that some wards remained poor performers and had not consistently achieved high compliance rates for nutritional screening assessment and pressure ulcer assessment records. Specific action plans were in place for poorer performing wards. Further statistical evidence submitted by the trust demonstrated a fall in patients with a new pressure ulcer from March to April 2012. However trust quality assurance audits for quarter three and four 2011/2012 (quarter four- January and February 2012 only) demonstrated a drop in compliance for wards in prevention and care of pressure ulcers.

Patients had their needs and risks assessed and care planned accordingly, where there was evidence of a lack of compliance with risk assessments these were highlighted and action plans implemented to address the issues by ward and department. We spoke to one Lead Nurse for the department, he told us how monthly audits and ward reviews identified the poorer performing wards with respect to care panning documentation. Lead Nurses and Matrons worked on action plans with the wards and ward managers to address these issues.Care planning documentation was identified as an important issue and continually monitored.

On our visit to the ward we examined a sample of six care records and nursing documentation. We found they all contained recently introduced nursing assessment and care documentation. This documentation was an improvement to previous versions, was more detailed in assessments and included personal preference details such as preferred name to be used and advanced decisions. Risk assessments for malnutrition, pressure ulcer development, falls, patient handling assessment, bed rails assessment and venous thromboembolism (VTE) were included in the standard documentation. There was evidence in most of the sampled records of these assessments being completed. Patient goals formed part of the care plans; these indicated whether or not the goal was being met on a twice daily basis. If there was a variance to the goal then evaluation of the care plan and variant care or treatment would be recorded on this document, however it was found that care plan evaluation and variance recording was not accurate or complete for most of the records sampled. For example nutritional needs should be met as per the Malnutrition Universal Scoring Tool (MUST) plan, however there was little evidence of the full MUST plan being used routinely as stated and poor recording of evaluation or variance. Ward review audits demonstrated 79% compliance for March 2012 for MUST assessments on this ward. On some of the records sampled the goal for displaying challenging behaviour was not met however the variance and evaluation record was not complete, nor was there evidence of a dementia care plan where it had been indicated for use. The Braden scale tool is used for predicting pressure ulcer risk and includes a plan for prevention and treatment of pressure ulcers. In most records the Braden scale tool was used however there was poor evaluation and detail to the care plan such as dressing type to be used for pressure ulcer prevention and treatment.

The provider may find it useful to note risk assessments and care plan goals were mostly completed however there was a lack of evidence demonstrating accurate and appropriately completed variance or evaluation of care plans.

The Malnutrition Universal Scoring Tool (MUST) was indicated to be used in the

assessment documentation. We found on the ward we visited that the tool was only used in part. Height, weight and body mass index (BMI) was recorded and used as an indicator for risk and referral to the specialist dietetic team. No other keys factors in assessing and treating risk of malnutrition were evident. We were told by staff the dietetics department accepted referrals based on the BMI of the patient, this had led to concerns being identified by staff for a patient who had lost weight but staff believed referral to the specialist dietetic team was not indicated as the BMI was not low enough. The provider may find it useful to note that limiting referral criteria to specialist teams and poor understanding of referral criteria by ward staff may increase the risk of malnutrition and pressure ulcer development to patients.

We found the record of communication in the nursing documentation was not always up to date or used in all records seen. This was corroborated by relatives commenting they did not feel they were fully informed in the care and treatment received by their family member. The provider may find it useful to note communication between ward staff and family members / relatives was poor.

We saw evidence of incidents and accidents recorded, and in some cases of falls, the individual care plan had been amended. However the provider may find it useful to note this was not consistent for all patient incidents of falls. We were told staff received feedback and learning from accidents, incidents and near misses at handover sessions and at ward meetings. The handover system in operation appeared inconsistent and did not address all staff uniformly, care assistants handed over to other care assistants whilst registered nurses received a formal handover report and then later updated care assistants with any relevant changes. Staff meetings took place on a regular basis and minutes of the meeting were produced. We were told staff were expected to read these notes if they had been unable to attend the meeting. They were available to all staff in the office. We were also advised that any information deemed very important would be mailed out to individual staff.

We saw evidence of and were told about the customer experience kiosks available for recording comments and complaints anonymously. These were computer terminals that were rotated and placed around different areas of the hospital and were easily accessible. People were able to input (anonymously if so wished) their views and comments on the service provided. The questions asked were in depth and allowed for personal comments to be added. We spoke to a Lead Nurse who told us how the comments for that department were collated and analysed on a regular basis and actions implemented where needed.

Information that we held showed some concerns regarding standardised hospital mortality rates for some categories. Hospital mortality rates can be used as an indicator by hospitals to help them better understand trends associated with patient deaths. They compare the observed number of deaths that actually occurred at a hospital with a statistical estimate of the number of deaths that might have been expected, based upon national average death rates and the particular characteristics of the patients treated in each hospital. For this location we identified an outlier against the expected rates in the category for:
Emergency admissions recorded with the category of complex elderly with respiratory system primary diagnosis (coded as HRG D99). The trust was asked to investigate and implement action plans where appropriate. It was established that a significant number of care home residents were admitted to the hospital in this category, we asked the

trust for further information. They submitted information on the trust's plans to work with local organisations in order to reduce the number of admissions from care homes led by a consultant geriatrician recently employed to work across the community and hospitals.

Our judgement
The provider was meeting this standard.
People experienced care, treatment and support that met their needs by having needs and risks assessed and care planned accordingly. Action plans were implemented to address areas of lack of compliance with care documentation.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

The provider is non-compliant with Outcome 09: Management of medicines. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke with five patients about their medicines. None of them raised any direct concerns about the way their medicines were handled. One patient said they were looking after their own medicines and they were ''pleased'' that they could do this as it helped them retain some of their independence. They also said this meant they could take them when they wanted to and so they didn't have to wait for nursing staff to give them.

Another patient said they were going home and that they had been given new medicines, they said nursing staff had explained and provided information about how to take them and what they were for.

Another patient said they he had been well looked after and the new medicines he had been given had helped him.

Other evidence
We carried out this review to make sure improvements had been made since our last review. We found significant improvements in the arrangements of medicines storage. Regular spot checks by ward managers and matrons had helped improve staff attitude to medicines security and we found all medicines to be safely kept throughout our visit.

We looked at a range of medicines records, checked medicines stocks and checked how medicines were prescribed. We found appropriate arrangements in relation to the

prescribing, recording and administration of medicines and on the whole found medicines were usually administered to patients correctly. When medicines were not given to patients, for example, if they refused them we found the reasons for this were clearly recorded.

We looked in more detail at how patient's medicines were checked when they were admitted to the hospital and although there were appropriate arrangements in place we found they were not always followed. Paperwork that was supposed to be used for recording patient's current medicines was not always used even though staff we spoke with clearly understood the correct procedures. As a result of this we saw a number of prescribing errors that may have happened because the correct paperwork and procedures had not been followed. One patient was given an extra dose of a heart medicine because it had been prescribed at the wrong dose and another person missed some doses of one of their calcium supplement because it had been prescribed incorrectly. Nursing, pharmacy and medical staff told us that the correct paperwork was not being used because some medical staff were not used to using it. This means patients were at risk of having the wrong medicines.

We looked at the service provided by the pharmacy team and saw a strong presence throughout the visit. Patient's medicines were usually checked by the pharmacist and/or technician within twenty-four hours and we saw numerous examples of when errors had been identified and corrected. This service was provided within normal working hours but at the weekends a less robust service was available so there was a greater risk that prescribing and administration errors would happen at these times. We saw evidence of regular staff training and information updates about improving prescribing and medicines administration and we saw appropriate arrangements that staff were aware of for the handling, reporting and learning from medicines errors.

We looked at how medicines were stored and, although secure, found some of the patient's medicines storage cupboards were not fit for purpose because they were not large enough to fit all the medicines in. Managers told us they were planning to replace these in the near future. One of the patients we spoke with was looking after and administering their own medicines. Their medicines were stored in a newer style cupboard that was more appropriate and allowed medicines to be better organised. We found this person was safely supported to look after their own medicines and the care plan paperwork to support this was properly completed.

Our judgement
Patients were not fully protected against the risks associated with medicines because the arrangements to manage the prescribing of medicines were not always followed.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: Patients were not fully protected against the risks associated with medicines because the arrangements to manage the prescribing of medicines were not always followed.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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