Review of compliance

Frimley Park Hospital NHS Foundation Trust Frimley Park Hospital	
Region:	South East
Location address:	Portsmouth Road Frimley Camberley Surrey GU16 7UJ
Type of service:	Acute services with overnight beds
Date of Publication:	April 2012
Overview of the service:	Frimley Park Hospital is a leading NHS foundation trust hospital serving more than 400,000 people across north-east Hampshire, west Surrey and east Berkshire. The hospital is also host to a Ministry of Defence unit, with military staff working alongside NHS staff providing care to patients in all specialties.

	This inspection visit was carried out as a result of the Commission receiving information of concern in respect to staffing, infection and mortality rates and records management.

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

Our current overall judgement

Frimley Park Hospital was not meeting one or more essential standards. Improvements are 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 because concerns were identified in relation to:

Outcome 08 - Cleanliness and infection control
Outcome 13 - Staffing
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 15 March 2012, checked the provider's records and talked to staff.

What people told us

We were only able to speak to only one patient during this visit. The patient told us that he felt extremely well cared for and nothing was too much trouble for the staff. Staff were said to have explained all aspects of care to him and gave him appropriate choices.

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

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

The registered provider had ensured that there were effective systems and processes in place for infection prevention and control.

Overall, we found that the trust was meeting this essential standard.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The senior managers had recognised that there were staff shortages within this specialist unit and had in place appropriate assessment and monitoring of the care needs of patients and available skilled staff. There was an action plan in place to safeguard the health,

safety and welfare of people receiving care. However, we found that there were times that the staffing levels fell below the recommended guidance.

Overall, we found that the provider was not meeting this essential standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The registered provider had ensured that there were effective monitoring and risk assessment processes in place to enable the safe delivery of quality treatment, care and support to people using the services.

Overall, we found that the trust was meeting this essential standard.

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 to improve. We will check to make sure that the improvements have been made.

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.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

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

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

The provider is compliant with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
On this occasion, we did not speak to patients who were being cared for in the intensive care unit (ICU) about this area.

Other evidence
The ICU is a locked unit divided into two areas. ICU A has 4 beds and two side rooms and ICU B has 5 beds and 1 side room. Overall there are nine level III beds and three level II beds. These levels correspond with the amount of nursing care and support required. For example, a level III bed would be required for a patient who was dependent on one to one care for continuous monitoring of their condition and to ensure that prescribed treatments were delivered promptly. Level II beds were used for patients that required less close monitoring and frequency of nursing interventions. These beds are often described as 'step down' beds.

The side rooms were in use for isolated patients at the time of our visit, with signage attached to the doors to advise visitors and staff of this.

We made observations of the environment and checked the cleanliness of equipment used by patients. We found that the environment was suitably clean, which was reflected in the most recent trust monitoring results. These were displayed on the infection prevention and control notice board (IPC). Patient equipment, including items close in proximity to patients and other items, including commodes were all found to be clean and free from visible contamination. Such items were labelled as having been cleaned and ready for use.

We saw that the disposable curtains around each bed area were clean and that a date

was written on these to indicate the day that they had been put up. Within the sluice areas, we saw that there was a full range of correct colour coded cleaning equipment for separate areas of the department. Sharps and clinical waste were seen to be managed correctly. One clinical waste bin in sluice A had a broken lid, which the nurse in charge was aware of, indicating that this would be followed up.

Staff were all bare below their elbows and were not seen to be wearing any inappropriate jewellery or wrist watches. There was access to a full range of personal protective equipment, such as gloves and aprons. There was access to hand wash facilities, with basins and non touch taps in each bed area, as well as other facilities in the sluice areas.

We spoke with the director for infection prevention and control (DIPC) about the arrangements that were in place for managing and monitoring cleanliness and infection control. We were told that the trust had an active IPC committee and nominated individuals in each area to oversee practices and compliance with policies. Minutes of the trust clinical governance committee (CGC) meeting were shown to us for March this year. We saw that there had been a formal report in respect to IPC from the ICU, including feedback on antibiotic compliance and general infection control results. In addition to this, we saw that the trust board meeting which took place in January 2012 had included a formal quarterly IPC report.

We asked to review the recent infection data and were provided with a summary for the period January to March this year. There were no reported infections, such as meticillin resistant staphylococcus aureus (MRSA) or Clostridium difficile for the ICU. We saw too that the IPC team had carried out an audit of the correct screening processes for MRSA in February 2012, with findings to indicate that 95% of patients had been screened within 24 hours of admission to the ICU.

During our discussion with the DIPC, we were told that there had been investigations into an infection which occurred last year between October and December, and a further case in January this year. This was isolated as Stenotrophomonas maltophilia (STM), and sourced to a cooled water drinking unit. The trust took appropriate action, including ongoing surveillance of patients to ensure the outbreak was over, with regular updates at weekly IPC team meetings and at the monthly hospital infection control committee (HICC).

We saw a range of IPC audits, including a report for December 2011, which outlined areas for improvement, such as temperature checks not always having been completed for fridges. We saw too that auditing had taken place to check that hand gel was available at each bed. Compliance with this was 100% for the period of November 2011 to February 2012. The commode cleaning audit was seen to be 100% compliant. Hand hygiene audit results for the period 28 February to 7 March 2012 were shown to us and these demonstrated 100% compliance.

The ICU staff had also carried out audits of compliance in relation to specific patient care, referred to as 'care bundles.' For example, we saw that monitoring took place in respect to ventilated patients, scoring an audit result of 99% for January and 93% for February this year respectively. The care of central lines, used for the administration of fluids into the patient circulation had also been audited, scoring 99% for January and 94% for February 2012. According to the data supplied to us there had not been any

infections recorded related to central lines for the first three months of this year.

Our judgement
The registered provider had ensured that there were effective systems and processes in place for infection prevention and control.

Overall, we found that the trust was meeting this essential standard.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We were only able to speak to one patient during this visit. The patient told us that he felt extremely well cared for and nothing was too much trouble for the staff. They explained his care to him and gave him appropriate choices.

Other evidence
We undertook our inspection visit to the ICU during the evening hours at the time that evening staff were conducting patient bedside handover to the oncoming night staff. We noted on arrival that the unit was found to have a very calm and quiet atmosphere. Some staff were busy behind screens and with patients. People's privacy was being respected.

We were advised that the unit was funded for 11.5 beds. We saw that the unit was occupied by 11 patients, eight of whom were said to be level III, and three patients level II dependence. Level III patients were ventilated and therefore were expected to have one to one nursing care. This level of care is agreed best practice, as per the Staffing levels guidance 2009, jointly agreed by British Association of Critical Care and the RCN (BACCN).

The gender of patients on the unit was mixed, and we saw that there were good arrangements in place for divisions of each bed area.

On enquiry with the nurse in charge we were told that there were eight staff plus herself as the clinical lead. There was a duty doctor in the unit and a consultant providing direct

clinical support. Medical support was said by staff to be continuously available. All the qualified staff on duty were said to work regularly in the ICU. We were told that there was someone with an ICU post qualifying award in charge of the ward each shift. This person was responsible for coordinating clinical care.

We spoke to a number of staff working in the unit including different grades of staff nurse and student nurses, as well as the nurse in charge. The time that staff had worked on the unit varied from five weeks to 14 years. In general staff all liked working in the unit, indicating that staff worked well as a team. Staff felt well supported by one another, including support from the consultants.

Two of the staff who spoke with us were each looking after two ventilated patients. This meant the patients were having assistance with their breathing through the aid of technical equipment. Both staff felt that this was not ideal; indicating that one to one care would be best practice. One staff member raised a concern of increased patient risk because of this.

Staff told us that staff shortages had worsened recently as four of the permanent staff had left and it had been difficult to recruit people with appropriate skills. One nurse said to us that most of the time there had been sufficient staff to care for people but, occasionally that would mean that staff were caring for more than one person on a ventilator.

Student nurses commented to us that they enjoying working in the ICU, feeling that they were learning a lot about caring for seriously ill people. There was good support from their mentors, for example being shown how to do checks on equipment and monitoring the patient. Staff were said to be very supportive of students and were happy to answer questions.

The trust had a policy for rostering staff, a copy of which was provided to us. We saw that this included guidance on the agreed total number of staff and skill mix for each shift. Staff were said to rotate between nights and days. We were told by staff that there was a shortfall of band six grade nurses in the unit. Despite this, the unit did not use any agency staff. Temporary 'bank' staff were said to be used if required and there was flexibility in shifts. For example, staff may have been asked to work a shorter shift covering hours over the early part of the night into the early morning hours.

Staff told us how the needs of each patient were assessed before making a judgement of dependency. This information was then used in agreeing staffing levels. We saw dependency records and were sent summarised information for the period December 2011 up to the 29 February 2012. The figures initially presented to us suggested that there were occasions where staffing levels fell below the recommendations across all three months. However, we were informed that this data did not include the nurse in charge, any ICU bank staff on duty, or any staff transferred in from other areas, such as the recovery unit in Theatres.

Further detailed information was subsequently presented to us, which included additional staff, such as temporary 'bank' staff. We were told that in addition to the rostered staff on the unit, that there was a clinical care matron based in the unit and a head of nursing. Both of whom were said to support the nurse in charge, providing clinical leadership and management of the unit. Additionally, we were informed that

there were a number of supernumerary qualified nurses on duty as part of their induction who were not included in the staffing numbers.

On review of the updated information provided to us we saw that during December 2011, six shifts had slightly below the required dependency levels. This ranged between 0.5 and 1.0 nurse on a specific shift. For example, on the night shift of the 28 December 2011, there was one nurse less than would be expected. During January 2012 there were no occasions where staff available hours did not match with patient dependency.

We were advised by senior staff that during February the trust received increased numbers of acute admissions from the community to the ICU. This placed additional strain on the department, who itself experienced staff sickness. The dependency figures provided to us demonstrated this factor clearly. We saw that there were 26 separate shifts during the month where staff available did not meet the required patient dependency. The deficit ranged between the equivalent of 0.5 and 2.5 nurses respectively. For example, on the late shift of the 26 February 2012 there were 2.5 less nurses available to meet the dependency needs. The use of appropriately skilled 'agency' staff did not appear to have been considered as a means of reducing the deficiencies during these periods.

With regard to the staff shortages, we were advised that there were four staff on maternity leave, two of whom were soon to return to work, and two new recruits were due to start in April. We were provided with information in respect of staff vacancies, including whole time equivalent (WTE) posts by band as follows; 2.4 band 7; 5.73 band 6, and 3 posts at band 2. Interviews for bands 6 and 2 had been planned for dates in March.

We asked staff if there had been any formal review of the reasons for staff turnover and what actions had been identified to resolve this or improve matters. We were told that the trust had undertaken a full review of the turnover in respect of this department, with exit interviews undertaken with each leaver. We were provided with a summary of this, noting that during 2011 up to 12 January 2012 that 13 staff had left. Reasons for leaving were indicated and ranged from promotion, through change of location, work life balance to child dependents.

We were provided with a copy of an action plan which detailed the actions requiring intervention and the processes to be used to resolve the issues. This included immediate management and longer term commitments to recruitment. For example, additional support was to be provided through the practice development committee, critical care technicians and staff at band level 7, as well as the head of nursing undertaking clinical shifts. Other actions focussed on the development of untrained staff to support those with specialist qualifications, and increased support for junior staff at the bed side, opportunities for increased recruitment included open days and jobs fairs.

Our judgement
The senior managers had recognised that there were staff shortages within this specialist unit and had in place appropriate assessment and monitoring of the care needs of patients and available skilled staff. There was an action plan in place to safeguard the health, safety and welfare of people receiving care. However, we found that there were times that the staffing levels fell below the recommended guidance.

Overall, we found that the provider was not meeting this essential standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
On this occasion we did not ask patients to comment on this particular outcome.

Other evidence
During our inspection visit we spoke to staff across various grades and positions of responsibility. We discussed how the trust assessed and monitored standards of service and were told that there were a range of activities to support this process.

Staff indicated that there were various nursing scores to be monitored and reported on and we saw copies of the reports for three previous months. We saw that these assessments covered a range of areas, ranging from completion of patient observations, their care records and risk assessments. For example, we saw that risk assessments covered areas related to pain management, falls, pressure areas, privacy and dignity, medication and the patient experience. Compliance scores were appointed to each area. It was noted by us that there had not been any serious incidents requiring investigation and no complaints related to ICU for the period.

We saw a copy of the quarterly report to the trust board for September to November 2011. This included evidence of presentations of figures and discussion related to critical care services, such as information related to audit outcomes and training in respect of IPC. We saw that there was 100% compliance with this training across all staff, including consultants, clinical and non clinical staff. There was evidence of action taken where audit scores were less than previously achieved. For example, that staff would focus on central venous catheter care, part of a 'care bundle.'

We were provided with a copy of the recent critical care report which was discussed as part of the clinical governance committee (CGC) meeting that took place on 13 March 2012. We saw that there was detailed evidence and discussion around relevant areas pertaining to the ICU. For example, we saw information about the transfer arrangements between the unit and general wards. There had also been discussion about the changing demands and capacity of the ICU.

There was evidence that the trust benchmarked itself with other Surrey wide critical care providers. Information reported to us in documentation indicated that 85% of admissions to the unit were acute admissions as opposed to elective post-operative patients. This had led to a higher requirement for level III beds and longer lengths of stay. Despite this, the trust indicated that mortality and infection rates were of a consistently low rate. and that patients were successfully managed in-house.

The trust produced continuing analysis of activity within the ICU. This looked at a range of information, for examples, the numbers of patients treated and what level of care was required, bed occupancy by days, discharges and transfers. According to data supplied in respect of deaths in the ICU, there had not been any related to infections for 2012 thus far.

Data was said to be submitted to the Intensive Care National Audit & Research Centre (ICNARC), and corresponding quality information fed back. We were provided with a copy of the ICNARC report for the period April to June 2011. The trust achieved a low percentage of unexpected deaths, with a rate of 0.66. This reflected a good position compared with the national average and in comparison with all similar units. Information reported to the commission through the national patient safety agency (NPSA) had not given us any particular concerns related to unexpected deaths or other serious events.

We saw information to demonstrate that members of staff undertake walks around the hospital, with members of the Council of Governors and the chief executive. This opportunity provided time for direct discussion with staff and people using the service, as well as review of the environment and practices.

The trust demonstrated to us other methods for assessing and monitoring the standards of adherence with polices and procedures. For example, we were shown the policy for records keeping and the auditing of these. We also saw the electronic patient records used in the ICU and staff explained how these were used and updated. Staff, including nurses and doctors had to use a secure personalised log to access the system, therefore any changes made would be reflected back to the person completing the record. Entries made in respect to the condition of the patient, for example, their fluid intake and output, temperature and heart rate was entered by the nurse and this was then update the record. Entries were seen to be validated as part of the electronic system and were automatically linked to the nurse who was logged on at the time. We could not see how any tampering with such information could happen without being identifiable. Staff said to us that the consultant rounds included a review of patient records, which could be accessed at the bed side or by a mobile data base.

During our observations we saw that all computer screens were blank and were not displaying information about patients, most had screensavers on display.

We asked if there had been complaints raised in respect to treatment and care within

the ICU. We Were advised that there has been one complaint relating to critical care delivered in January/February 2011.

We saw that information about compliance with polices was discussed at the trust board. For example, the minutes of the meeting held on the sixth of January 2012 discussed the positive results related to antibiotic use. We saw that there were monitoring processes in place, which had been discussed. This was through a daily review of every drug chart on the Unit by an ICU consultant, a consultant microbiologist, and a pharmacist.

As part of the monitoring of quality, the trust had recognised the staffing issues within the ICU. The risk register contained information that outlined the risk to patients if insufficient staff were available to deliver care. There was evidence that actions had been taken, including the production of a briefing paper, weekly senior team meetings to review the situation and fortnightly meetings with the clinical matron and director of nursing.

Our judgement
The registered provider had ensured that there were effective monitoring and risk assessment processes in place to enable the safe delivery of quality treatment, care and support to people using the services.

Overall, we found that the trust was meeting this essential standard.

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
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: The senior managers have recognised that there are staff shortages within this specialist unit and have in place appropriate assessment and monitoring of the care needs of patients and available skilled staff. There is an action plan in place to safeguard the health, safety and welfare of people receiving care. However, we found that there were times that the staffing levels fell below the recommended guidance. Overall, we found that the provider was not meeting this essential standard.	
Maternity and midwifery services	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: The senior managers have recognised that there are staff shortages within this specialist unit and have in place appropriate assessment and monitoring of the care needs of patients and available skilled staff. There is an action plan in place to safeguard the health, safety and welfare of people receiving care. However, we found that there were times that the staffing levels fell below the	

	recommended guidance. Overall, we found that the provider was not meeting this essential standard.	
Surgical procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: The senior managers have recognised that there are staff shortages within this specialist unit and have in place appropriate assessment and monitoring of the care needs of patients and available skilled staff. There is an action plan in place to safeguard the health, safety and welfare of people receiving care. However, we found that there were times that the staffing levels fell below the recommended guidance. Overall, we found that the provider was not meeting this essential standard.	
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: The senior managers have recognised that there are staff shortages within this specialist unit and have in place appropriate assessment and monitoring of the care needs of patients and available skilled staff. There is an action plan in place to safeguard the health, safety and welfare of people receiving care. However, we found that there were times that the staffing levels fell below the recommended guidance. Overall, we found that the provider was not meeting this essential standard.	

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.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, 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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