Care Quality Commission

Update from CQC Hospitals Directorate in Bradford and District

Airedale NHS Foundation Trust

We carried out a comprehensive inspection on 15-18 March 2016 and unannounced inspections on 31 March and 11 May 2016 as part of our comprehensive inspection programme.

The report was published on 10 August 2016.

We previously inspected Airedale General Hospital in September 2013. This was part of our pilot for the comprehensive programme. The hospital was not rated at that time.

We included the following locations as part of this 2016 inspection:

- Airedale General Hospital
- Community services including adult community services, community inpatients and end of life care.

Following our inspection in March 2016, the Trust informed us of a serious incident that had occurred on the critical care unit at Airedale General Hospital. On further analysis of other evidence, we undertook a further unannounced focussed inspection on 11 May 2016. The focus of the inspection was staffing levels, training and competency of staff, equipment checks and patient care within the critical care unit.

We rated Airedale General Hospital overall as requires improvement. We rated caring, effective and responsive as good. Safe and well-led were rated as requires improvement.

We rated emergency and urgent care, maternity and gynaecology, services for children and young people, end of life care and outpatients and diagnostics as good. We rated critical care, medical care and surgery as requires improvement.

Within the community services, we rated adult community services, community inpatients and end of life care as good. We rated well-led for adult community services as outstanding.

Our key findings were as follows:

- The trust was inspected in September 2013 and our inspection report at the time demonstrated good quality of services generally with some concerns relating to critical care in particular.
- Our inspection of March 2016 showed that whilst the majority of services were good, the trust requires improvement and we have seen deterioration in some services namely critical care, surgery and medicine.
- Most staff reported a positive culture and we found that staff were caring and treated patients and their families with dignity. However, we saw evidence that there were areas of the trust that whilst staff reported feeling proud to work at Airedale, some staff described a less open and positive culture. We had some concern over leadership and the relationship with and management of staff, particularly in critical care.

Care Quality Commission

- Nurse staffing levels in many clinical areas within Airedale General Hospital were regularly below the planned number. This was a particular concern in critical care, medical care, surgery and children's services. Planned nurse staffing levels in critical care were below the levels recommended in national guidance.
- Medical staffing numbers did not meet national guidance in the emergency department and there were insufficient intensivists in critical care. We saw the trust were committed to further recruitment of ED consultants and had five intensivists employed.
- We found a culture of continual service improvement and innovation in adult community services. There were several examples of enhanced integration between health and social care within community services for adults.
- The management of medicines required improvement in several areas across the hospital.
- We had concerns about the escalation process of deteriorating patients particularly with medical care and surgery; systems used were not always effective.
- We found governance systems and processes were not always effective and, in some areas within Airedale General Hospital. Risks were not always identified and where these were, there was not always sufficient assurance in place.
- Mandatory training compliance did not meet the trust's target of 80% in several areas including medical care and surgery. This was monitored within business groups, at the Mandatory Training Group and at the Executive Assurance Group.
- We found the hospital was clean and observed that most staff adhered to infection control principles. Between March 2015 and March 2016 there were three incidents of MRSA at the trust. Incidents of MSSA and Clostridium difficile had been mainly in line with the England average.
- Mortality indicators showed no evidence of risk.
- We found that patients were assessed and supported with food and drink to meet their nutritional needs.
- A new emergency department had been opened to meet the increase in patient numbers and new models of working.
- The trust had a 'Right Care' vision. The majority of staff understood the vision. Directorate plans were in place which supported the trust's vision and strategy.

We saw several areas of outstanding practice including:

- Telemedicine services provided at the digital care hub were outstanding. The telemedicine service provided remote video consultations between Airedale staff and patients in their own homes, care homes and in prisons. Clinical staff in the hub speak to residents directly whilst viewing them on the screen. They provided advice and support on the most appropriate action to take. If necessary, they could call for emergency services on the patient's behalf whilst continuing to give advice and reassurance. This service was available 24 hours a day 365 days a year.
- The community-based collaborative care teams were an outstanding example of multidisciplinary team working. The teams worked across acute and community services and in collaboration with other agencies to provide a responsive service for patients 24 hours a day, 7 days a week. The teams aimed to support patients in crisis to remain in

their own homes and avoid unnecessary hospital admission as well as supporting early discharge from hospital.
- Within end of life care, there were innovative ways to ensure care was patient centred for example the Gold Line Service, and 'flags' on electronic records; when patients with additional needs were admitted at the end of life, specialist staff were alerted and could respond in a timely way.
- Through the use of an electronic record and an integration system, a shared record could be accessed securely by partners across all the care settings to obtain a tailored view of an individual's information.

However, there were also areas of poor practice where the trust needed to make improvements. Importantly, the trust must:

- The trust must ensure that, during each shift, there are a sufficient number of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of the patients.
- The trust must ensure that the remote telemetry monitoring of patients is safe and effective.
- The trust must review the governance arrangements and management of risks within critical care to ensure that arrangements for assessing, monitoring and improving the quality and safety of the service are effective.
- The trust must review the effectiveness of controls and actions on the local and corporate risk register, particularly in medical care and children and young people's services.
- The trust must continue to improve engagement with staff and respond appropriately to concerns raised by staff.
- The trust must ensure that staff complete their mandatory training including safeguarding training.
- The trust must ensure that guidelines are up to date and meet national recommendations within NICE guidance or guidance from similar bodies.
- The trust must ensure that physiological observations and NEWS are calculated, monitored and that all patients at risk of deterioration are escalated in line with trust guidance.
- The trust must ensure the safe storage and administrations of medicines.
- The trust must improve compliance in medicines reconciliation.
- The trust must ensure records are stored and completed in line with professional standards, including an individualised care plan.
- The trust must ensure an effective system is in place to ensure that community paediatric letters are produced and communicated in a timely manner.
- The trust must ensure that resuscitation and emergency equipment including neonatal resuscitaires, is checked on a daily basis in line with trust guidelines.
- The trust must ensure the five steps for safer surgery including the World Health Organisation (WHO) safety checklist is consistently applied and practice audited.
- The trust must ensure that were the responsibility for surgical patients is transferred to another person, the care of these patients is effectively communicated.

- The trust must ensure there are sufficient numbers of intensivists deployed in accordance with national guidance.
- The unit must ensure a minimum of 50% of nursing staff have a post registration qualifications in critical care.
- A multi-disciplinary clinical ward round within Intensive Care must take place every day, in accordance with national guidance, to share information and carry out timely interventions.

Following our inspection in March 2016, the Trust informed us of a serious incident that had occurred on the critical care unit. A further unannounced inspection showed insufficient action had been taken to prevent recurrence. Consequently, we spoke with the Chief Executive to gain assurance that additional actions were taken to ensure safety.

Inspection carried out on 5 Sept 2016

The Care Quality Commission (CQC) carried out an unannounced inspection of Airedale General Hospital on the 5 September 2016. The purpose was to look at specific areas in relation to the safe and well-led domains on the Critical Care Unit (CCU) and on some of the medical wards.

The areas inspected in September 2016 included a selection of wards/departments that were identified as a concern during the March 2016 comprehensive inspection, as well as areas where concerns were not identified during the previous inspection but where local intelligence suggested that risks may have increased in those areas. This included concerns regarding risks of patients deteriorating without appropriate monitoring or escalation, and nurse staffing levels.

CQC will not be providing a rating to Airedale General Hospital for this inspection. The reason for not providing a rating was because this was a very focused inspection carried out to assess whether the trust had made significant improvement to services within the prescribed time frame.

In Medical care our key findings were:

- Daily checks of emergency equipment on ward 15 had not been completed daily when patients had been cared for on the ward. The resuscitation trolley had not been checked for the previous six days and there was no oxygen on the trolley. This had been recently replaced and was stored elsewhere on the unit, which meant in an emergency situation staff may not have all the appropriate equipment available for them to use.
- On the ward there was a signposted male toilet area and a disabled toilet and shower cubicle. There was no dedicated female bathroom on the ward on the day of inspection.
- Ward 15 did not store controlled drugs; these were provided by ward 14. Therefore if a patient on ward 15 required controlled drugs the nurse would be given assistance of a registered nurse from ward 14 to check and administer the drug. If ward 14 was busy, the nurse would bleep for the assistance of a matron.

- On the day of inspection we found records were not stored securely on ward 15. Medical and nursing notes were stored in cardboard boxes on the nurses' station, and were left unattended whilst staff cared for patients.
- Monitoring of patients on the ward with telemetry varied dependent on clinical need and the patients National Early Warning Score (NEWS). The ward would undertake their own observations of a patient and record on a NEWS chart; however, staff told us there was no guidance as to how often this would be done other than the nurses clinical judgement. We found there was no set guidance from the trust on what ward monitoring should be undertaken for these patients.
- Staff described NEWS and clinical judgement as factors when escalating concerning patients. All staff we spoke with were able to describe the process they would follow. However we found in six patient records that clinical observations had not always been completed in the specified time-frame.
- Following the inspection the trust informed CQC that ward 10 had opened on one occasion on 29 September 2016. The opening of the additional 4 beds was in response to a surge in acute activity. To ensure the area was staffed safely, the decision was made to open the doors between the wards 9 and 10. Ward 9 staff had cared for the four patients located on ward 10 in addition to the patients on ward 9. This meant there were two registered nurses with support from Health care assistants for a total of 33 patients for the night shift.

In Critical Care our key findings were:

- Staff told us that sharing information and learning from incidents had improved on the unit.
- The unit had closed beds since our inspection in March 2016 to support safer nurse staffing levels. We reviewed staffing data for three months and saw there was a general improvement in nurse staffing levels however there still remained shortfalls on some shifts and the unit did not have a supernumerary co-ordinator.
- There had been a process of two person equipment checks introduced in critical care following a serious incident in April 2016. Staff were required to check 'high risk' equipment with another nurse at the beginning of each shift or for each new admission. However we observed three care charts and one chart did not have a countersign for one shift out of three opportunities to do so.
- Since our inspection in March 2016 the trust had introduced a new process for the monitoring of telemetry patients and the nurse co-ordinator on the critical care unit had oversight of telemetry patients.
- The unit had developed a process for monitoring staff compliance with medical device training. The ward educator was managing the training and the lead nurse had oversight of this. We saw there was a good level of compliance with the training.
- Changes had been made at a senior leadership level and support had been put into place on the unit. There was now a dedicated lead nurse, matron and nurse consultant working on the unit.

Care Quality Commission

- Staff we spoke with felt that safety had been given greater priority and that incidents and lessons learnt had been shared in an open and transparent way at staff meetings. Staff spoke positively about the new management team.
- There was an improved process and system for appraisal of staff across the unit. The new lead nurse and nurse consultant had achieved 81% of all staff appraisals over three months, with planned dates in place for the remaining team.
- The clinical nurse educator had been given more time to fulfil the expectations of the role and worked alongside staff or released staff to attend training. There was co-ordination of all staff commencing and completing the critical care STEPS training programme in order to evidence competence and knowledge of the team.
- Following our inspection in March 2016 the trust had put in place a critical care action plan. We reviewed the action plan and found that of a total of 23 recommendations, 19 had been delivered, three were on track to be delivered and one was partially delivered.

Ruth Dixon
Inspector
March 10 2017.