# Wirral Community NHS Trust

RY7

# Urgent Care core services

## Quality Report

RY7X3 Arrowe Park Walk In Centre
RY7X1 Eastham Walk In Centre
RY7X2 Victoria Central Walk In Centre
RY7Y4 Riverside Park Call Centre
Tel: 01515146311
Website:
www.wirralct.nhs.uk

Date of inspection visit: September 2014
Date of publication: 11 November 2014

This report describes our judgement of the quality of care provided within this core service by Wirral Community NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Wirral Community NHS Trust and these are brought together to inform our overall judgement of Wirral Community NHS Trust

# Summary of findings

## Ratings

| | |
|---|---|
| Overall rating for Urgent Care core services | Good |
| Are Urgent Care core services safe? | Good |
| Are Urgent Care core services effective? | Good |
| Are Urgent Care core services caring? | Good |
| Are Urgent Care core services responsive? | Requires Improvement |
| Are Urgent Care core services well-led? | Good |

# Summary of findings

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# Summary of findings

## Overall summary

Wirral Community NHS Trust provides urgent care services at three walk in centres: Arrowe Park, Eastham, and Victoria Central where a minor injuries unit is also provided. These services are provided as part of the trust's unplanned care division.

We visited all three walk in centres and the minor injuries unit, including an unannounced evening visit. We also visited the Riverside Park call centre. We spent time talking with patients and observing the care and treatment they received. We spoke with staff, including doctors, nurses at various levels, managers, and reception staff.

The walk in centres and minor injuries unit were open to all. Patients were pleased with the availability and location of the services. Feedback from patients and their relatives / carers was positive about the way they were treated by staff. We observed staff caring for patients with kindness and compassion. Staff ensured that patients understood the planned care and treatment and the advice given.

There were reliable systems, processes and practices in place to keep patients safe. Risks were assessed and monitored and appropriate action taken in response to changes in risk levels. This included individual patient risks, such as the risk of sepsis or pressure ulcers, as well as other risks, such as staffing levels.

The facilities and equipment in the walk in centres and minor injuries unit generally supported good practice and had a mostly positive effect on outcomes for patients.

The national performance target of 95% of patients per week to be discharged within four hours of their arrival at a minor injuries unit was met most of the time. Patients usually waited for less than two hours in total in the walk in centres and minor injuries unit.

Most of the staff we spoke with were positive about the trust's chief executive and director of nursing. Staff felt the chief executive was visible and approachable and they had confidence in him. Staff spoke highly of their local line managers and said they felt well supported.

There were plans in place to sustain and develop the service. This included plans for the minor injuries unit to become nurse led, and plans for the service to be more integrated with social care.

Patients were asked for their consent before care and treatment was carried out. However, staff lacked awareness and understanding of the Mental Capacity Act 2005. This meant that patients' legal rights may not be understood or upheld.

The time patients waited from arriving to being seen by the triage nurse, (the initial assessment prior to treatment), varied from a few minutes up to nearly an hour. Patients and staff did not have clear information about what the triage time should be.

Staff were not always supported to attend training that was specific to their role and the needs of patients using the walk in centres and minor injuries unit.

There was effective multi-disciplinary working with the local acute trusts, including ambulance services. However, there was little evidence of integrated working between primary care or social care and the walk in centres / minor injuries unit.

# Summary of findings

## Background to the service

The walk in centres are nurse-led services providing assessment, advice and treatment for minor illnesses, such as a sore throat or skin rashes, and some minor injuries, such as minor cuts or wounds. The three walk in centres saw a total of 69,018 patients from September 2013 to August 2014, an average of around 1,327 patients per week. Arrowe Park was the busiest walk in centre during this period. Eastham Walk In Centre has shorter opening hours than the other two sites and so had fewer patients attending overall during this period.

The minor injuries unit is a GP led service with x-ray facilities, providing assessment and treatment of minor injuries, such as sprains and strains and wounds requiring suturing. The minor injuries unit had 14,217 patients attending from September 2013 to August 2014, an average of around 275 patients per week.

Riverside Park is a single point of access service. This is a nurse led call centre providing signposting of care pathways for GPs and healthcare professionals who require treatment for one of their patients.

## Our inspection team

Our inspection team was led by:

**Chair:** Professor Siobhan Gregory, Director of Quality and Clinical Excellence, Hounslow and Richmond Community Healthcare NHS Trust.

**Team Leader:** Debbie Widdowson, Care Quality Commission

The team of 28 included CQC inspectors and a variety of specialists: District Nurses and Tissue Viability Specialists, Ward Matron, Community Matron and Nurse Practitioner, Health Visitor, Therapists, a NHS Managing Director with expertise in governance, GP and a Dentist and four experts by experience.

## Why we carried out this inspection

We inspected the trust as part of our comprehensive Wave 2 pilot community health services inspection programme.

The Wave 2 inspection model for community health services is a specialist, expert and risk-based approach to inspection. The aim of this testing phase is to produce a better understanding of quality across a wider range and greater number of service and to better understand how well quality is managed.

## How we carried out this inspection

To get to the heart of people who use services' experience 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?

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We also received comments from people who had attended a listening event prior to the inspection. We carried out announced visits on 2, 3 and 4 September 2014. We also visited the trust unannounced out of hours on 3 September 2014. We visited health centres, dental clinics and walk in centres. We went on home visits with district nursing, health visitors and palliative care specialist nurses. During the visits we held focus groups with a range of staff who worked within the service, including nurses, therapists and healthcare

# Summary of findings

assistants. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records.

## What people who use the provider say

We spoke with thirty patients, or their relatives / carers, during our inspection. The majority of people were positive about the service they had received at the walk in centres and minor injuries unit. Patients had experienced variable waiting times. They mostly accepted that they would have to wait to be seen and that patients with more urgent needs would be seen first.

## Areas for improvement

### Action the provider MUST or SHOULD take to improve

**Action the provider MUST take to improve**

- Triage assessments were not always completed as quickly and efficiently as possible. Patients were often waiting in excess of 30 minutes to be seen by the triage nurse. The trust must ensure that good practice guidelines for triage assessment are fully implemented and monitored to ensure patients are seen as quickly as possible for initial assessment.

**Action the provider SHOULD take to improve**

- Staff said they did not always receive feedback about incidents they had reported and so did not always know the outcome.
- Patients were not prompted to wash their hands or use hand gel on entering the walk in centres. Hand gel was available but there were no posters or other information for patients about when and how the gel should be used.
- The walk in centres and minor injuries unit were not included in the local pathway for falls in older people. Older people who came to the walk in centres as a result of a fall were not offered a referral to the falls prevention team.
- Staff were not appropriately trained and did not always understand their roles regarding the Mental Capacity Act 2005 (MCA). Some staff had attended training about the MCA but could not describe practices to follow in line with the MCA.
- There was low uptake of staff training specific to staff roles and patient needs. Bespoke training sessions were not well attended because staff reported having to do this in their own time.
- Poor performance of staff was not effectively managed.
- The walk in centre waiting areas did not make adequate provision for children.
- There was a lack of privacy for patients at reception desks in the walk in centres.
- There was no staff role identified within the service to promote good practice when caring for people living with dementia, such as a link nurse.
- Staff did not have easy access to information about the performance of the service.
- There was little evidence of integrated working between primary care or social care and the walk in centres / minor injuries unit.
- There was little evidence that staff actively promoted discharge from the service or follow up treatment in other community services.
- There was no allowance was made for the time needed to deal with patients arriving shortly before a unit's closing time, with the end time of late shifts being the same as the closing time of units. Consequently, staff were regularly working after the end of their shift to assess and treat patients who had arrived shortly before closing time.

Wirral Community NHS Trust

# Urgent Care core services

**Detailed findings from this inspection**

## The five questions we ask about core services and what we found

Good

## Are Urgent Care core services safe?

By safe, we mean that people are protected from abuse


**Summary**

There were effective arrangements for reporting safety incidents. Staff showed a good awareness of what to report and we saw a range of incidents reported. Incidents were investigated by managers, but some staff said they did not always receive feedback about the incidents they had reported.

There were reliable systems, processes and practices in place to keep patients safe. This included systems to ensure the cleanliness of the walk in centres and to reduce the risk of infection for patients. Also systems for the safe management of medicines in the walk in centres.

Risks were assessed and monitored and appropriate action taken in response to changes in risk levels. This included individual patient risks, such as the risk of sepsis or pressure ulcers, as well as other risks, such as staffing levels. There were plans in place in the event of a major incident.

Staffing levels were generally maintained as planned, though a high sickness absence rate meant that covering shifts was problematic at times.


**Detailed findings**

### Incidents, reporting and learning

- Staff knew how to report incidents using the electronic system. We spoke with a range of staff who all said they were encouraged to use the electronic reporting system. A receptionist told us, “It’s everyone’s business to report anything that’s not safe or could harm a patient.”
- Staff described incidents they had reported and gave examples of what they would report. This included patients who were inappropriately referred to the walk in centres, abuse of staff by patients, failure of electronic systems, and not having sufficient staff.
- Incidents reported were emailed to four managers within the unplanned care division, including two lead nurses. Although the lead nurse usually reviewed and responded to the incident reports, the process was not clear and potentially could cause confusion about who had actually dealt with the incident report.
- Staff said they did not always receive feedback about incidents they had reported and so did not always know the outcome. A nurse told us they had not received

Good

# Are Urgent Care core services safe?

feedback about an incident they reported. They said, "It's frustrating not to find out – you don't know if you've done right in reporting it, and you don't know if there was a good result for the patient."

- Where learning from incidents was identified, this was passed on to staff through team meetings, individual supervision and training. There was also information available on the staff intranet and through regular 'Learning from experience' bulletins. Staff told us about changes in practice due to learning from incidents. This included an incident where an oxygen cylinder ran out and there was no back up supply immediately available. Procedures were changed to ensure a new cylinder was ordered when the one in use was half full.

## Cleanliness, infection control and hygiene

- All areas visited and equipment seen appeared clean. There were systems in place for daily cleaning of all areas. The records of daily cleaning were mostly fully completed.
- A manager told us that infection prevention and control was, "A high priority within the trust." Staff told us they had 'essential learning' every year that included infection prevention and control.
- We saw nurses and doctors cleaning their hands when required, such as before and after contact with a patient. We saw that staff followed the trust's policies on 'bare below the elbow' and the use of disposable gloves and aprons as required.
- Managers told us there were regular audits of infection prevention and control systems to ensure their effectiveness. We saw the reports of these audits for two of the walk in centres. The reports included actions to be taken where issues were found. Staff told us there were checks of staff hand washing techniques carried out every three to four months. We saw the reports of the hand hygiene audits which showed that staff were 100% compliant and so no further action was needed.
- Patients were not prompted to wash their hands or use hand gel on entering the walk in centres. Hand gel was available but there were no posters or other information for patients about when and how the gel should be used. There is ample evidence that effective hand hygiene reduces the incidence and spread of infection.
- There was no sluice room within the Arrowe Park walk in centre. The trust had identified this as a risk. There were measures in place to mitigate the risk, including the involvement of the infection control team for advice, and the use of an absorbent product to dispose of urine.

## Maintenance of environment and equipment

- All areas visited appeared well maintained. Staff knew how to report any issues requiring repair or maintenance. Staff told us that repairs were usually carried out promptly.
- There were systems in place for checking equipment. We saw records of checks of emergency equipment. The checks of emergency equipment at The Victoria Central walk in centre showed that an item was missing at the time of our inspection. We saw that appropriate action was taken during our visit to address this.

## Medicines management

- Medicines were securely stored in a designated room in each of the walk in centres.
- The temperature of the room and of the fridge used to store medicines was checked and recorded each day. We saw that appropriate and timely action was taken when it was found the fridge temperature at Victoria Central walk in centre was higher than the safe range for a significant length of time.
- There were effective systems in place for monitoring the stocks of medicines and ordering new stock. Maximum stock levels were identified to prevent accumulation of excessive stocks of medicines. There was a designated member of staff to monitor medicine stocks at Arrowe Park and Eastham walk in centres. At Victoria Central this was carried out by pharmacy staff. Walk in centre staff told us that medicines were delivered from the pharmacy the next working day after ordering.
- Patient Group Directions (PGD) were in place. A PGD is a legal mechanism that allows named healthcare professionals to supply and / or administer medicines for specific conditions that fit the criteria laid out in the PGD. This enables the healthcare professional to supply or administer a medicine without the need for a prescription or an instruction from a prescriber. For example, a nurse in a walk in centre could supply an inhaler to a patient with a condition specified in the PGD, or could administer a medicine by injection.

Good

# Are Urgent Care core services safe?

- There were nurses working in the walk in centres who had undertaken additional training so that they could prescribe medicines. The competency of these nurses to prescribe medicines was monitored by a senior nurse.
- Prescription forms were kept securely. Blank forms were kept in locked cupboards or in a locked drawer of a printer. Forms were numbered and there was a tracking system that identified if forms were destroyed and the reason why.
- An audit carried out in October 2013 found that records of daily checks of emergency drugs were not always fully completed. We saw that action had been taken to address this. All records seen of daily checks of emergency drugs were fully completed and up to date.

## Safeguarding

- Staff gave examples of what they would consider abuse. Staff described the reporting procedures and said they would always alert the lead nurse as well as reporting to the safeguarding team.
- Staff said they did not always receive feedback about safeguarding incidents they had reported.
- Staff demonstrated safeguarding awareness with children attending the walk in centres. The relationship of the adult accompanying the child was checked by the reception staff when taking initial information. We observed a nurse carrying out an assessment checking directly with a child who the accompanying adult was.
- All staff working in the walk in centres and minor injuries unit had completed training in safeguarding adults and children at levels one and two. There were 45 staff in the centres that were required to have completed safeguarding training at level three. The recently appointed head of quality and nursing who had taken over responsibility for safeguarding told us that a recent audit showed that only six of these staff, (13%), had completed the training. The trust had an action plan in place for 85% of these staff to complete the training by Christmas 2014 and 95% by the end of March 2015. (Level three safeguarding training is for staff whose role means they are involved in more complex issues of safeguarding children).

## Records systems and management

- All patient records were held electronically. The electronic system had different levels of access to ensure security and confidentiality of information.
- Details of patients' previous attendance at the walk in centres could be accessed quickly. This meant patients did not have to go through all their details and recent medical history each time they used the service. It was also was helpful for staff to understand the history of the patient's health problems.
- A clinical review tool had been developed to use for auditing records. The review tool was adapted from the Royal College of GPs Urgent and Emergency Care Clinical Audit Toolkit (2010). The review tool was used to regularly audit a sample of records from each nurse and GP working in the walk in centres and minor injury unit. The audits were carried out as self-assessment, peer reviews or management reviews.

## Assessing and responding to patient risk

- Patients arriving at the walk in centres were greeted by a receptionist and brief details taken. The receptionists were able to respond to some risks. For example, a patient arrived who was very anxious and the receptionist offered them a quiet room away from the main waiting area; a child with a rash was also placed in a room away from the main waiting area in case they had an infectious condition.
- Receptionists responded to developing risks. For example, when a patient in the waiting area returned to the reception desk complaining of chest pain, the receptionist alerted a nurse and the patient was seen more urgently.
- At Victoria Central walk in centre patients were initially assessed by the triage nurse to be directed for treatment by walk in centre or minor injuries unit staff. The triage nurses used defined criteria and professional judgement to assess who the patient should be seen by and how urgently they needed to be seen.
- At Arrowe Park and Eastham walk in centres patients were seen by the triage nurse for initial assessment and a decision on how urgently they should be seen for treatment.
- Patients were referred to acute services if necessary, including accident and emergency.
- We looked at a sample of 10 recent clinical records and found that assessment of patients included appropriate observations and assessments based on risks. For example, staff carried out appropriate observations

Good

# Are Urgent Care core services safe?

using the Glasgow Coma Scale for a patient attending the minor injuries unit with a head injury. The Glasgow Coma Scale is used to check the neurological response in patients who have injuries that may affect the brain.

## Staffing levels and caseload

- The trust employed GPs to work in the minor injuries unit and also used other GPs working on a sessional basis and agency GPs. The medical director told us there had been problems recruiting GPs for the minor injuries unit and this had been recognised as a risk by the trust.
- The planned minimum staffing level for Arrowe Park and Victoria Central walk in centres was three nurses working from 8 am to 4pm, three nurses from 2pm to 10pm, plus a nurse working from 11am to 7pm. This allowed for anticipated busier periods in the late afternoon and early evening.
- Eastham walk in centre was open from 2pm to 10pm during the week, and 9am to 5pm at weekends. The planned staffing level was three nurses on each day.
- The planned staffing was always to have an advanced nurse practitioner, (band seven), on duty, usually working with a nurse practitioner, (band six), and a band five nurse. The bands relate to the level of skills, experience and seniority of the nurses, band seven being the more senior nurse who was able to prescribe medication.
- Most of the nurses rotated between the sites. This allowed more flexibility and meant that staff were familiar with all three sites.
- Staff and managers told us that there had been a high level of nursing staff sickness absence in the last six months and this had caused difficulty in maintaining planned staffing levels. Staff told us that the lead nurses spent a lot of their time trying to sort out cover for the staff rotas. Staff said that there were sometimes problems getting the right skill mix of staff, for instance, making sure there were staff that could apply a plaster of Paris or carry out suturing at each site.
- Information provided by the Trust showed that the level of sickness absence of staff in the unplanned care division had increased from 6.68% in April 2014 to 11.47% in June 2014. The most recent figure available was 10.64 % in July 2014. This was high compared with the average rate of 4.7% for community provider NHS trusts in England in 2012 / 2013. It was also higher than the overall sickness absence rate for this provider of 4.86 % in April 2014.
- The Trust had identified sickness absence of staff as a risk and had introduced measures to reduce this.
- There were two lead nurses for the service who were responsible for organising staff rotas. One of the lead nurses told us they could usually cover shifts by using supernumerary or agency staff. The two lead nurses were supernumerary and could cover shifts at any of the sites in the event of staff absence. However, this meant that they would not have time for their managerial and other responsibilities. One manager told us, “There’s no-one to cover my work, so if I do a shift, it’s all still waiting for me the next day.”
- A contingency measure used to cover nurse shifts was to move staff from the site they were due to work at to where cover was needed. This caused frustration for some staff as they said they were not always given enough notice of moves, and were sometimes moved after they had arrived at work.
- Nurses working the 11am to 7pm shift were sometimes asked to change to a late shift and / or moved to another site to provide cover. This sometimes meant the 11am to 7pm shift was not covered.
- There were receptionists at each of the walk in centres, usually two on duty up to 4pm. After 4pm, there was one receptionist at Victoria Park and Eastham walk in centres, with support available from a security person on site. At Arrowe Park, there was one receptionist after 4pm plus the shift manager for the GP out of hours service who shared the walk in centre facilities.
- The receptionists told us they felt there should be two on duty into the evenings as this was often a busy period. They said they had raised this with their managers but felt that no action had been taken. One receptionist said there were times when they were unable to take a break during the evening as it was so busy.

## Managing anticipated risks

- Risks relating to the unplanned care division were identified on the trust’s risk register. There were specific risks related to the walk in centres, such as the lack of sluice facilities at Arrowe Park, and the problems with recruiting GPs for the minor injuries unit.

Good

# Are Urgent Care core services safe?

- The nurse consultant and the lead nurse we spoke with were able to clearly describe the current risks and the action planned to address them.

### Major incident awareness and training (optional)

- The trust had a major incident plan in place. This included specific details of the role of the unplanned care division in the event of a major incident.
- Some staff from the unplanned care division had taken part in a mock-up exercise of a major incident with the local acute trust in 2013. Managers had also attended a commissioner led table top exercise looking at the response to a major incident by all of the local health services.
- Some staff we spoke with were not aware of the major incident plan or where to find it.

Good

# Are Urgent Care core services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.


**Summary**

Most patients told us they were satisfied with the care and treatment they received. There was full and accurate assessment of patients' needs. Treatment was mostly planned and delivered in line with local and national guidance.

Patients were asked for their consent before care and treatment was carried out. However, staff lacked awareness and understanding of the Mental Capacity Act 2005. This meant that patients' legal rights may not be understood or upheld.

There were competent staff with appropriate skills and experience. Staff were generally supported to undertake mandatory training. However, staff were not always supported to attend training that was specific to their role and the needs of patients using the walk in centres and minor injuries unit.

The facilities and equipment in the walk in centres and minor injuries unit generally supported good practice and had a mostly positive effect on outcomes for patients. However, there was a lack of privacy for patients when giving their details on arrival, and a lack of designated waiting areas suitable for children.

The walk in centres and minor injuries unit were not included in the local pathway for falls in older people. This meant that older people who came to the walk in centres as a result of a fall were not offered a referral to the falls prevention team. This may cause delay in patients receiving appropriate support to reduce the risk of falls.


**Detailed findings**

## Evidence based care and treatment

- Patients we spoke with, or received comments from, were generally satisfied with the care and treatment they had received. They told us, "I was treated well – it was for mental health issues.", "We've seen the same nurse each time, (for a wound dressing), so she can see how it's getting on. It's a bit better each time.", and "We've used this service before and we've always been happy with the treatment."
- Staff carried out full and accurate assessments of patients' needs. We observed assessments of 15 patients in total and looked at the clinical records for another 10 patients who had recently attended. Assessments included asking the patient about their reason for attending the service, their current symptoms, relevant medical and social history, and any allergies.
- Staff carried out appropriate physical examinations and monitoring of relevant vital signs as part of the assessment.
- Pathways for the assessment and treatment of various conditions were in use, such as patients presenting with symptoms of a stroke, chest pain, or head injury. The pathways were in line with guidance from the National Institute for Health and Care Excellence, (NICE).
- Care and treatment was mostly planned and delivered in line with national and local guidance. We saw that patients were provided with appropriate treatment. Patients needing further treatment where referred appropriately to acute health services, such as patients requiring surgical assessment.
- Staff followed agreed patient group directions when prescribing medication for specific conditions and types of patient.
- We found that the walk in centres and minor injuries unit were not included in the local pathway for falls in older people. This meant that older people who came to the walk in centres as a result of a fall were not offered a referral to the falls prevention team. Managers told us that the onus was on GPs to read and act on the information sent to them regarding the patient's attendance and treatment at the walk in centre or minor injuries unit. This meant that patients may not have a timely referral to appropriate services to reduce their risk of falls
- Patients were asked for their consent before examinations or treatment. They were also asked for their consent to share information about them with others, such as GPs. When treating children, staff always checked the relationship of the person accompanying the child and sought parental consent.

Good

# Are Urgent Care core services effective?

- Staff were not appropriately trained and did not always understand their roles regarding the Mental Capacity Act 2005 (MCA). Some staff had attended training about the MCA but could not describe practices to follow in line with the MCA. The MCA provides the legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. Everyone working with adults who may lack capacity to make specific decisions must comply with the MCA.
- There was a practice development nurse and consultant nurse who were both involved in developing new protocols and procedures. One example of this was the clinical review tool developed from an existing tool to make it relevant to the walk in centres and minor injuries unit. The tool was being used to check that assessment and treatment of patients was in line with trust policies and national guidance.
- Protocols for the treatment of minor injuries were currently being developed by a doctor recently appointed to do this. Patient information leaflets regarding knee and ankle injuries were also being developed.

## Pain relief

- Staff told us they asked patients about their level of pain during clinical assessments and we observed this in practice. However, we saw from a sample of 10 clinical records that patients' level of pain was not always recorded when relevant to their presenting problem. Assessment of pain is important in assessing the patient's condition and determining effective treatment. Patients are usually asked to use a scoring system to indicate their level of pain. A record of the level of pain can be used comparatively if the patient's condition deteriorates.
- Patients were given appropriate advice about pain and pain relief. For example, a patient with a knee injury was advised on an appropriate medication to take to relieve pain and swelling; a patient with back pain was advised about exercise and the use of heat treatment and appropriate medication.
- A Patient Group Direction was currently being developed for the use of the medical gas 'Entonox' for pain relief. This would provide fast acting and strong pain relief for patients when needed.

## Nutrition and hydration

- Fresh water was easily available to patients and those accompanying them from water dispensers in all three walk in centres. There was a snack bar run by volunteers within the walk in centre at Victoria Park and a café in the main hospital building near to the walk in centre at Arrowe Park.
- Patients were reminded not to eat or drink before they were seen by the doctor or nurse.

## Patient outcomes performance information

- The national performance target of patients in minor injuries units being discharged within four hours was being monitored by the trust and the local commissioners of the service. The national NHS target is for 95% of patients per week to be discharged within four hours of their arrival at a minor injuries unit. Information provided by the trust showed that they had met or exceeded this target from April to August 2014.
- The trust reported that in the period April to July 2014, 75% of patients at the walk-in centres were seen within two hours. 38% of patients were referred back to their GP or to the emergency department following attendance at the walk-in centre during the same period.
- The trust carried out an audit in January 2014 to monitor compliance with consent standards in their own policy and in line with national standards. The audit identified that staff were not always recording that patients had been given the information they needed about the risks and benefits of treatment. Managers told us that action had been taken to address this. We saw that staff had recorded in the clinical notes when they had discussed the risks and benefits of treatment with patients. This was monitored by the use of the clinical review tool.

## Competent staff

- The GPs recruited for the minor injuries unit were required to have had experience in accident and emergency in the previous 12 months. Their training needs were assessed and relevant training provided. The GPs were expected to take responsibility for maintaining their skills and competence, such as in ophthalmology and radiology. There were suitable arrangements in place for monitoring their performance.

Good

# Are Urgent Care core services effective?

- There was an advanced nurse practitioner working on every shift. They had all completed additional training to be non-medical prescribers. Their competence as prescribers was regularly monitored.
- There were induction programmes for all staff, medical and nursing. Agency nurses and GPs received the same induction as permanent staff.
- Staff told us they had received a comprehensive induction and sufficient opportunity to shadow experienced staff. One nurse told us they had been supernumerary for six weeks and had received a bespoke induction: "I have had one of the best inductions I have ever had for any post."
- Managers told us that agency nurses were interviewed before working in the walk in centres to ensure their skills and experience were appropriate. There were agency nurses who worked regularly in the walk in centres and so were familiar with the routines and procedures. Agency nurses were included in mandatory training provided by the trust and were offered the same additional training as permanent staff.
- There were two nurses who were qualified children's nurses. This meant they were able to provide advice and support to other nurses regarding the care and treatment of children.
- Staff learning needs were identified and training relevant to their roles and to the needs of patients was put in place. This included training such as the application of plaster of Paris, respiratory conditions in adults and children, infectious diseases, and how to take a history for adult and child patients.
- However, information provided by the trust showed there was a low uptake of this training by staff. There were 57 staff listed, two of these were on long term leave and another one had left. Of the remaining 54 staff, approximately 47% had attended the plaster of Paris training. Other training had a much lower uptake. For example, five staff had attended a training session about ear, nose and throat conditions; nine staff had attended an emergency contraception update; and nine staff had attended training about asthma in children. No staff attended a training session in wound closure that was organised in October 2013.
- Staff told us they were often expected to attend training in their own time which they were reluctant to do.
- There were effective systems in place to ensure staff had appropriate levels of supervision and appraisal. The clinical review tool was used by staff for self-appraisal and also by managers to check and monitor performance.
- There were processes in place for managing poor or variable performance of nursing staff. However, these were not currently being used effectively. Managers had identified that some staff were taking too long to carry out triage assessments. They were developing a tool designed to take into account the complexity and acuity of the patient's clinical needs and the actual time taken by staff to carry out the assessment. The plan was to use the tool for all staff and then to discuss performance individually. Managers were not clear about how poor performance was to be managed where this was identified.

### Use of equipment and facilities

- The facilities and equipment in use generally reflected good practice and mostly had a positive impact on outcomes. The centres were all fully accessible for patients using wheelchairs or who had limited mobility. There was equipment available to ensure that appropriate action could be taken for medical emergencies, such as a patient suffering a cardiac arrest. The clinical rooms were suitably equipped.
- There was a partly screened off area at one end of the waiting area at Victoria Central walk in centre for use by children. Otherwise, there were no designated waiting areas for children in any of the walk in centres. We saw that parents of children who might have an infectious condition or who were very anxious or upset were directed to use one of the clinical rooms to wait in.
- The design of the centres did not allow privacy for patients when they were speaking to the reception staff on arrival. Patients and staff told us this was a concern for them.
- The details given by the patient to the receptionist could be easily overheard by other patients in the waiting area, although the receptionists were careful not to ask for or disclose personal information where possible.
- At Victoria Central walk in centre there was a line for patients to stand behind to allow privacy for the patient at the reception desk. This was not always observed by patients. At Arrowe Park and Eastham walk in centres

the reception desk was shared with other services. This meant there were often two patients at the reception desk at the same time, each giving their details to receptionists.

### Multi-disciplinary working and coordination of care pathways

- Patients were referred to the accident and emergency department when more urgent or complex treatment was required. Patients were occasionally referred to the walk in centres from the accident and emergency department, though staff told us this did not happen very often.
- Patients using the walk in centre or minor injuries unit at Victoria Central Hospital were referred for x-rays in the adjacent building.
- When patients attended the minor injuries with (minor) fractures, they were treated there initially, often with a plaster cast or splint. Patients were then referred to the fracture clinic in the acute hospital for more specialist orthopaedic care. Appointments could usually be arranged before the patient left the minor injuries unit.
- A pathway had been developed to enable the minor injuries unit to accept patients by ambulance. The patients had to meet very specific criteria to ensure they could be treated safely and effectively at the minor injuries unit rather than going to the acute hospital.
- Staff liaised with colleagues in the medical and surgical assessment units of the acute trust so that patients could be transferred if necessary.
- A report of the patient's attendance at the walk in centres / minor injuries unit was sent to their GP, if the patient agreed to this. Staff said they sometimes contacted GP's individually if there were particular concerns about a patient.
- There was little evidence of integrated working between primary care and the walk in centres / minor injuries unit. This led to inappropriate referrals by GPs to the walk in centres. Examples of this were a patient sent to the walk in centre for ear syringing because the GP's own equipment for this was not working, and a patient needing assessment of an eye complaint using specialist equipment that was not available at the walk in centre.
- The lack of integrated working was also partly responsible for patients returning to walk in centres for follow up of their treatment, such as redressing of wounds or removal of sutures. Patients could go to their GPs and community nurses for this kind of follow up.

Good

# Are Urgent Care core services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.


**Summary**

Feedback from patients and their relatives / carers was positive about the way they were treated by staff. We observed staff caring for patients with kindness and compassion. We saw that staff treated patients with respect and upheld their dignity.

Patients were involved in making informed decisions about their care and treatment. Staff ensured that patients understood the planned care and treatment and the advice given.


**Detailed findings**

## Compassionate care

- We spoke with 30 patients, (or their parents or relatives), during our inspection and nearly all were positive about the way staff had treated them. Most patients told us that staff were caring and sympathetic. One patient was annoyed at waiting to be seen and said staff were off-hand with them when they asked for an explanation.
- We observed compassionate care of patients by all staff. We saw a patient in the waiting area who was clearly distressed and in pain. The receptionist went to comfort the patient and then alerted the nurse so that the patient was seen very quickly. After treatment the patient said, “The nurse was very nice, really reassuring.”
- We saw staff assisting a patient who needed help to get home after being treated. The patient was on crutches as a result of their injury and so felt unable to use public transport. Staff made sure that the person was able to contact a family member.

## Dignity and respect

- Patients at a focus group held prior to our inspection said they felt staff generally responded to carers rather than patients, assuming that if someone has a physical disability they would not be able to communicate their needs.
- We observed staff speaking respectfully to all patients, including those with disabilities. We saw a receptionist speaking to a patient with a learning disability, asking them directly for information rather than their accompanying support worker.
- We saw another receptionist checking several times on an older patient, making sure the patient was comfortable and explaining why they were waiting.
- There was information in each of the treatment rooms at Arrowe Park for patients wanting to request a chaperone if they wanted someone with them during assessment and treatment. This information was not displayed at the other walk in centres.

## Patient understanding and involvement

- Patients were asked if they understood and were happy with the advice and treatment given. This was noted in the clinical records. A patient told us, “The doctor explained everything. I know what to look out for.”
- Staff explained the risks and benefits of treatment and other options with patients. For example, we observed a nurse discussing and explaining the pros and cons of giving antibiotics to a child with an infection. The parent of the child was happy with the explanations and agreed on a plan of care with the nurse.
- Patients were given ‘safety net’ advice, such as what symptoms may develop, possible unwanted effects of medication, and when to seek further medical help.

## Promotion of self-care

- We saw that advice was given to patients about self-care. Examples of this were advice given to a patient about using ear drops, and advice to the parent of a child patient about preventing the spread of a contagious condition.
- The trust’s website offered advice on self-care and seeking advice from a pharmacist for minor illnesses and injuries.

Requires Improvement

# Are Urgent Care core services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.


**Summary**

The walk in centres and minor injuries unit were open to all. Patients were pleased with the availability and location of the services.

Patients using the service were usually treated and discharged within four hours. However, patients frequently waited too long to be seen by the triage nurse for an initial assessment of their clinical needs.

We were told that best practice guideline was for patients to be seen by the triage nurse within 15 minutes of arrival. Some staff told us the triage time was 20 minutes and others said 30 minutes. We found that triage times were very variable and patients frequently waited more than 30 minutes, sometimes up to 50 minutes.

We saw that triage assessments were not always completed as quickly and efficiently as possible. This caused a backlog of patients at busy times.

Patients were attending for follow up care and treatment that could have been delivered at their own GP practice. This was having an adverse effect on waiting times for all patients in the walk in centres and minor injuries unit.

There were effective arrangements when patients were transferred to acute health services. However, the lack of integrated working with primary medical and social services meant that patients were not always referred for further support as required.


**Detailed findings**

## Service planning and delivery to meet the needs of different people

- The walk in centres were open to everyone – this was made clear in information provided for patients within the walk in centres and on the trust's website.
- The walk in centres provided care and treatment for patients close to their homes. This was helpful for patients who would have to travel further to use the accident and emergency department if the walk in centre or minor injuries unit was not available.
- We saw that the service was also used by patients who were not local residents, such as people on holiday or in the area or those working away from home.
- Staff had received training about how to support patients who were living with dementia. We saw staff respond with kindness and compassion to patients with dementia. However, there was no staff role identified within the service to promote good practice when caring for people living with dementia. Having a link nurse with specific responsibility for raising awareness of dementia can ensure the practice of all staff improves patient outcomes.
- Staff recognised the need for some patients to wait in areas other than the main waiting area. We saw that quieter areas, or separate rooms, were used for patients who were very anxious.
- Staff told us that most patients could speak or understand sufficient English without the need for translation or interpretation. A telephone translation service was available for staff to use to communicate with patients who did not have English as their first language. Staff also told us about using an on-line translation service where patients typed in details of their medical problem in their own language and this could be instantly translated into English.

## Access to the right care at the right time

- Victoria Central and Arrowe Park walk in centres were open from 8am to 10pm every day and the minor injuries unit was open from 9am to 9pm. The Eastham walk in centre was open from 2pm to 10pm during the week, and 9am to 5pm at weekends and on bank holidays.
- The GP out of hours service, also provided by the trust, used the same facilities as the Arrowe Park walk in centre and continued after the walk in centre had closed. Patients still waiting in the walk in centre at 10pm were then given an appointment to see an out of hours GP.
- Staff told us there was no cut off point for patients booking into the walk in centres. Patients could be booked in right up to 10pm. Staff told us this sometimes meant they had to continue working after 10pm to see patients. Otherwise, patients were asked to wait to be seen by the out of hours GP service at Arrowe Park or go home and return the next day or go and see their own GP.

Requires Improvement

# Are Urgent Care core services responsive to people's needs?

- The service was working with the local ambulance trust so that paramedics could bring patients to the minor injuries unit, rather than accident and emergency, if they met specific criteria.
- Patients told us they were pleased to have local walk in services, but they had varied experiences of waiting times. One patient told us, "It's a good service. I'm here on holiday but I needed stitches out so I came here. I didn't have to wait too long and the nurse was very good." We saw that sometimes patients were treated and discharged within an hour of attending. For example, a patient who had trapped their finger, causing a deep cut requiring suturing, was treated in the minor injuries unit and discharged within 50 minutes. However, other patients told us felt they had waited too long for their initial assessment by the triage nurse.
- Information provided by the trust showed that at least 95% of patients were treated and discharged within four hours in most weeks between April and August 2014. This information was for patients attending the walk in centres and the minor injuries unit. The information showed that the total time from arrival to discharge for most patients was less than two hours.
- We observed and noted from records that patients in the walk in centres were often waiting in excess of 30 minutes to see the triage nurse. Triage is used to make an assessment of patients' presenting problems to prioritise those in most urgent need. The triage assessment should quickly identify those patients who are safe to wait longer to be seen by the doctor or nurse practitioner. If patients are waiting longer than 15 to 20 minutes to see the triage nurse there is a risk of delay in urgently needed treatment for patients most in need.
- Information provided by the trust showed that 56% of patients attending the minor injuries unit from April to August 2014 waited more than 15 minutes from arrival to seeing the triage nurse. We asked the trust for the same information relating to patients attending the walk in centres, but this was not provided.
- The head of the unplanned care division told us the best practice guideline was for patients to be seen by the triage nurse within 15 minutes of arrival at the walk in centre or minor injuries unit, (referred to as the triage time). However, some staff told us the triage time was 20 minutes and other staff said 30 minutes. This meant a lack of clarity for patients and staff, and staff were not working towards the same objective. We found that triage times were very variable and patients frequently waited more than 30 minutes, sometimes up to 50 minutes.
- We saw that triage assessments were not always completed as quickly and efficiently as possible. This caused a backlog of patients at busy times.
- There were usually one or two nurses allocated to carry out triage assessments on each shift. We saw that other nurses stepped in and carried out triage assessments when they could see that the triage queue was becoming lengthy. However, this meant that these nurses were not then available for providing treatment and so patients would have to wait longer for this.
- Managers we spoke with were aware of the issues around the time waited by patients for triage and the time taken to carry out triage assessments. A tool was being developed to measure and monitor the performance of individual staff regarding triage.
- The head of unplanned care for the trust told us that patients should go to their own GP practices if follow up treatment was required after a visit to the walk in centres. They said that if patients return to the walk in centres for follow up treatment, this was through choice as they should not routinely be advised to do this.
- However, we found that some patients were advised to return to the walk in centres for follow up treatment. Examples of this were a patient requiring redressing of a wound who had been returning to the walk in centre every two days for the previous two weeks; and a patient with a leg ulcer who came to the walk in centre each week for dressings. Treating these patients added to the waiting times for all patients.
- We saw that even when patients had been advised at the walk in centre to return to their own GP for follow up treatment they often returned to the walk in centres. Patients told us this was because it was usually quicker and easier for them to be seen at the walk in centres rather than at their own GP practice. It was not clear what the trust was doing to manage this so that resources were used appropriately.

### Discharge, referral and transition arrangements

- On discharge from the walk in centres or minor injuries unit patients were provided with information leaflets, if applicable. Patients were given information about when to seek further medical advice and what follow up treatment would be required.

Requires Improvement

# Are Urgent Care core services responsive to people's needs?

- We saw that staff, including reception staff, made sure that patients knew where to go if they were being sent to other services, such as x ray or accident and emergency.
- There were effective arrangements in place where patients needed referral to acute health services. For example, appointments for the fracture clinic were usually made before the patient left the walk in centre or minor injuries unit; patients were transferred to surgical or medical assessment units in the local acute trust and transport was arranged if needed.
- The lack of integrated working with primary medical and social services meant that patients were not always referred for further support as required, such as referrals to the falls prevention team.

## Complaints handling (for this service) and learning from feedback

- Patient experience forms were available in all the waiting areas and at the reception desks. There were posting boxes for completed forms so that patients could comment anonymously.
- Information for patients about how to make a complaint was not so prominently displayed in the waiting areas.
- The trust's website had information about how patients could raise concerns, complain or make comments about their care and treatment. Patients could make comments online through the trust's website.
- We saw that patients were asked to complete patient experience forms before leaving the service. Some patients we spoke with were aware of the trust's Patient Experience Service and knew they could use this to complain more formally.
- We saw that concerns and complaints received were dealt with promptly and effectively by managers. An example was a person who complained about the attitude of a member of staff when the person was accompanying a patient. Managers had responded to the person in writing and had also met with them. The person was satisfied with the response and the action taken.

Good

# Are Urgent Care core services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

## Summary

Managers and staff understood the strategy for this service and the current challenges and key risks.

The quality of the service was measured through routine monitoring of key processes, such as waiting times, incidents and complaints. Managers could describe the detail of recent performance information but this was not easily accessible for staff.

Most of the staff we spoke with were positive about the chief executive of the trust and the director of nursing. Staff felt the chief executive was visible and approachable and they had confidence in him. Staff spoke highly of their local line managers and said they felt well supported. Staff felt more senior managers were not visible enough and did not fully appreciate the challenges faced by operational staff.

Patients were regularly and routinely asked for their feedback on the service they had received. Information about making complaints was not prominently displayed in waiting areas.

There were plans in place to sustain and develop the service. This included plans for the minor injuries unit to become nurse led, and plans for the service to be more integrated with social care.

## Detailed findings

### Vision and strategy for this service

- The medical director and the head of unplanned care described the vision and strategy for this service. This included the effects of the planned reorganisation of localities and the introduction of a model of integrated care. They also spoke about their plans for addressing identified risks, such as shortage of doctors for the minor injuries unit and the high rate of staff sickness absence.
- Staff and managers were aware of the challenges and key risks to the service they provided.

### Guidance, risk management and quality measurement

- There were systems in place to monitor the service. This included routine audit and monitoring of key processes such as waiting times, incidents and complaints. Staff performance was reviewed and monitored in addition to mandatory training, sickness absence and staffing levels.
- Managers were able to talk through the detail of recent performance information and the action they were taking in response to it. They said this was shared with staff through team meetings and group and individual supervision. We saw some evidence of this in team meeting minutes.
- However, performance information was not otherwise readily available to staff. It was not routinely displayed for them to see and respond to.
- There were regular governance meetings to discuss the performance of the service, issues affecting performance, and current risks. We saw that recent governance meetings had noted the upward trend of staff reporting incidents. This was viewed as positive, showing improved staff awareness and confidence in reporting incidents.

### Leadership of this service

- Most of the staff we spoke with were positive about the chief executive of the trust. Staff felt the chief executive was visible and approachable and they had confidence in him. One member of staff said, “We met in the lift! He was easy to talk to and was interested in what I had to say.”
- Staff told us that they felt that locally their managers understood the issues they faced, but did not feel engaged with more senior managers. Staff said they did not see senior managers often enough.
- Staff spoke highly of their local managers and said they felt well supported. One member of staff told us, “I have been overwhelmed by the level of support I’ve had.” Another member of staff described a manager as, “Exceptionally good.”

Good

# Are Urgent Care core services well-led?

## Culture within this service

- We found highly motivated, committed and caring staff working in this service. However, staff were tired of working with high levels of staff sickness absence. One member of staff said, "It's continual fire-fighting just to cover shifts. It takes up so much time for managers just sorting out the off-duty."
- Staff were keen to develop their roles and the service to provide better outcomes for patients. Examples of this were staff developing bespoke training and group supervision sessions to promote staff skills and knowledge. However, staff felt they were not always supported to take part in these sessions as they were expected to attend in their own time.
- Managers we spoke with said they felt there was an open culture within the trust, from operational staff up to the board. They felt able to raise concerns and to encourage staff to do the same.

## Public and staff engagement

- Patients were encouraged to complete patient experience forms before leaving the walk in centres or minor injuries unit. A new, interactive system was just being put into use at the time of our inspection. It was hoped this would encourage more patients to feedback about their experience of using the service.
- The trust board undertook regular 'walk rounds' of services. This provided the board with the opportunity to meet patients and gain an understanding of the patient journey through services. There had been three walk rounds in walk-in centres between April and June 2014, though no visits to Eastham walk in centre. We saw the reports of the walk rounds. The key themes arising included: staff feeling under pressure due to workload and staffing levels; staff reporting that their teams are well led; and positive patient feedback about the delivery of care but waiting times could be improved.
- The trust was using the Friends and Family test but the response numbers were low for the walk in centres and minor injuries unit. The overall trust score had risen each month since April 2014, as had the number of responses received.
- Staff told us they felt that patients views were taken seriously and action was taken to improve services.
- The majority of results for the trust from the NHS 2013 staff survey were better than the national average. There were two areas where responses were worse compared to the previous year: work related stress and work pressure felt by staff. These results were, however, still better than the national average.

## Innovation, improvement and sustainability

- A model of integrated care with local community, social and primary medical services had been developed by the trust and agreed with the local commissioners. There were plans to put this into action.
- Managers told us about plans for the minor injuries unit to become nurse led. This was in response to the difficulty in recruiting doctors for this service.
- Managers and staff were working with a similar trust in Shropshire where nurse led minor injuries units had recently been introduced. Arrangements had been made for a lead nurse from the Shropshire service to visit and a date was set for a reciprocal visit by staff. The two services had already shared work done on assessment of patients.