Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Victoria Central Hospital Walk In Centre

Victoria Central Hospital, Mill Lane, Wallasey, CH44 5UF

Tel: 01516047296

Date of Inspections: 13 September 2013
12 September 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Wirral Community NHS Trust
Overview of the service	Victoria Central Hospital Walk-In Centre is one of three walk-in centres available on the Wirral. The provider for all the walk-in centres is Wirral Community NHS Trust. Victoria Walk-In Centre is a nurse led facility that provides assessment, treatment and advice for a wide range of minor injuries and illnesses.
Type of services	Remote clinical advice service Urgent care services
Regulated activities	Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 12 September 2013 and 13 September 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, reviewed information given to us by the provider and were accompanied by a specialist advisor.

What people told us and what we found

We spent the first day of our visit at Victoria Central Hospital Walk-In Centre talking to patients and staff. We followed up our findings by looking at documents and speaking to managers and directors at the head office of Wirral Community NHS Trust the following day.

We spoke with five patients who were happy with the care they had received. Comments included, "The staff are lovely" and "I am happy with the service." However, we did find first aid equipment out of date and identified issues around transfer times to hospitals in emergency cases.

We spoke with five members of staff on duty during our inspection who all expressed concerns at the level of staffing. However, we found all patient targets were met and there had been no incidents reported regarding patient's welfare needs not being met due to a lack of staff.

We found there were a variety of quality assurance systems in place to assess and monitor the quality of service provided. We also found quality assurance systems in place to assess and manage risks. However we found some minor improvements were needed to maximise the potential of these systems.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone

number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We spoke with five patients and their relatives who told us they were happy with the care they had received. One patient had not used the service before and told us they felt that it had been "A good experience". Another patient told us "The staff were lovely."

We found that patients were usually seen by a triage nurse first to assess their treatment needs. All the patients we spoke with told us their treatment had been clearly discussed with them and that they had understood any treatment options available.

We looked at five patient's notes which were computerised. We found that part of the record was completed by the triage nurse and then completed by the nurse practitioner or other health professional. The notes contained patient's details, medical history, and an event list which recorded waiting times from arrival at reception to triage and to discharge. The treatment notes also contained information about previous attendances at the walk-in centre. This was important because if for example, a child kept re-attending with minor injuries this information would prompt staff to ask further questions regarding the safeguarding of the child. There were further free text boxes available for notes for the history, exam, diagnosis and treatment. After a patient had attended faxes were sent to patients GPs to inform them that the patient had attended the clinic and what treatment had been received.

The walk- in clinic was situated at an old hospital site but the site no longer provided treatment for acute conditions. The walk- in centre was nurse led but did not have access to a GP until 9pm. We looked at the facilities the walk-in centre had in place for emergencies. We found there was a room called the 'resus' room that contained a first aid box, emergency drugs, a defibrillator and oxygen.

We looked at the first aid box and found some of the dressings to be out of date by several years. We asked the nurse about this and she was not aware of the first aid box, its contents or who was responsible for monitoring the contents, stating that if they required

any dressings these could be obtained from other parts of the clinic. However, the first aid kit and first aid information is for all employees and is a requirement of the Health and Safety (First Aid) Regulations 1981. We spoke with the lead nurse for the walk- in clinic who did not know about the first aid kit contents being out of date but did inform us that the clinic did have a first aider. We discussed our concern with the Director of Operations and the Director of Quality and Nursing the following day. We were subsequently shown an e-mail to state that the contents of the first aid kit would be replaced.

During our visit one patient had been admitted to the walk in clinic who needed to be referred to hospital urgently. The nurse told us in these cases 999 would be called. She told us that although the first response team had arrived within 15 minutes the ambulance was delayed for 45 minutes and the first response had called for the ambulance on more than one occasion.

Two members of staff said it was not unusual for ambulances to take longer than expected. They expressed concern that because the clinic had a room called the 'resus' room with access to a defibrillator, the ambulance service downgraded their response to the clinic on the assumption that the clinic had the ability to stabilise patients.

We discussed the incident of the delayed ambulance with the Director of Operations and the Director of Quality and Nursing on our second day of inspection at the trust's head office. They told us that if the information had been logged as an incident then they would have discussed their concerns with the ambulance service. We found that the incident had not been recorded even though the lead nurse for the walk- in clinic was aware of our concern. The directors agreed with us that perhaps the room name 'resus room' was possibly misleading and said they would reconsider the appropriateness and practicality of this room. They told us that the waiting time of this case should have been recorded as an incident. They have assured us that they will ask the staff at the walk-in clinic to report any delays in transferring patients to hospital in order for the trust management teams to be aware of any incidents. This would ensure that in the future the trust could raise any issues with the ambulance service to ensure the safety of the patient.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

We had previously received a complaint from a patient regarding the unacceptable waiting times for a vulnerable adult. They told us that reception staff had told them this was due to a shortage of staff at the walk-in clinic.

Patients we spoke with did expect to wait because of the fact the clinic was providing unplanned care. During our inspection patients were aware there was a delay in waiting times due to an emergency. Some patients had attended before and told us the clinic could become very busy. We were shown data to indicate that up to a 100 or more people per day could be seen at the walk-in facilities. One patient told us "It would be nice if there was more customer feedback explaining the length of waiting times."

During our inspection of the walk-in clinic we spoke with five members of staff. All of the staff expressed concerns at the level of staffing and pointed out that waiting times for patients would be decreased if there were more staff. They told us that they had raised this at their supervisions.

We discussed staffing levels with the lead nurse who told us she had been in post since February 2013 and had inherited the staff levels currently in operation. She told us that annual leave arrangements had been altered. She told us that staffing levels were safe and that the trust's key performance indicators (KPI) were met for waiting times. The walk-in clinic's KPI for waiting times was four hours.

She also told us that she was attending a meeting the week after our inspection to discuss staffing levels and the impact of supervisions and training on the availability of staff. We were shown an allocation rota for staff which showed four nurses on duty but did not specify their skill mix. We also saw that staff who worked in the walk-in clinic also worked in the affiliated minor injuries unit.

We discussed staffing with the Director of Operations for the trust who told us there was no staffing problem at the clinic and all the KPIs were met and we were shown documents to support this. We asked at what point staff levels would be addressed if patient attendance at the clinic started to increase. We were told that staff should report this so that contingency measures could be put into place. We were told that if staff felt there was

a staffing issue they should raise and evidence their concern in order for the trust to be able to deal with this.

We spoke with the Deputy Head of HR who showed us the trust had a 'Managing Attendance Policy' in place to try to prevent unauthorised absence and reduce risks of staff sickness levels on staffing numbers for the clinic.

Assessing and monitoring the quality of service provision ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider had a system to regularly assess and monitor the quality of service that people receive.
The provider had a system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

We found there were a variety of quality assurance systems in place to assess and monitor the quality of service provided. We also found quality assurance systems in place to assess and manage risks.

We spent the second day of our inspection at the trust's head office discussing quality assurance systems in place with staff and directors. We were shown the trust had a computer system for monitoring all complaints, concerns and comments received from patients called 'DATIX'. We found that the trust had a complaints policy and procedure in place. We spent time with the complaints manager for the trust discussing any complaints that had been received by the walk- in centre and the actions taken.

We saw the trust had timeframes to acknowledge the complaint and completion timeframes to respond. The complaints were investigated at the walk-in centre by the lead nurse before being quality checked by the Complaints Manager and the complaints team. Following a complaint we found learning and service improvement actions were logged on 'DATIX' and reported to the Divisional Governance Groups and the Quality, Patient Experience and Risk Group on a monthly basis and to the trust Board quarterly. The monitoring of actions took place at the Quality, Patient Experience and Risk Group. We saw examples for the walk-in centre of actions taken following a complaint. However, the provider may find it useful to note that we found examples where the Quality, Patient Experience and Risk Group had agreed to close down a complaint when the actions had not been completed. This meant there was a risk that actions may not be completed as the system to track the actions had been closed.

In addition to the complaints process, we found the trust also sought the views of patients through comments cards and questionnaires. The comments cards recorded compliments and concerns. Concerns were risk assessed to determine the level of investigation required.

We found the trust had 'patient experience' forms which were used to capture patient's feedback. Since April 2013 there had been 39 completed questionnaires for the walk-in centre. We saw the forms in the reception area however, when we spoke with five of the patients, they were not aware of these questionnaires and told us they would have completed the questionnaires if they had been given them. We found that up to 100 patients or more attended the walk-in facilities daily. Therefore the amount of returns available to analyse patient's feedback was very low to establish any meaningful information that could be used by the trust in order to consistently improve their services. We found the majority of concerns raised on these forms were around waiting times.

We found that the walk in centre carried out clinical audits. We were shown one of the audits for assessments of head injuries. However, when we tracked the action plan for this audit, it stipulated the audit would be followed up by another audit in 2013-2014 as there were still some concerns but we found that the follow up audit was not listed on a document which showed the planned audits for 2013-2014.

The Trust used DatixWeb for its incident reporting. This had been in place for just over a year and was supported with a training programme as part of its implementation. All staff we spoke with were aware of the system and felt confident in being able to report an incident. However, we found there were also examples of concerns raised by patients via the comments cards that should have been reported by staff as incidents.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

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

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

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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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