The Regulation and Quality Improvement Authority

Causeway Hospital Fact Finding Visit

9 – 10 February 2017

Summary of Findings

Contents

1. Introduction 3

2. Discussion with Staff and General Observations 4

2.1 Communication/Patient Flow/Movement 4

2.2 Infection Prevention and Control 5

2.3 Staffing and Support 6

2.4 Review of Records 8

2.5 Patient Questionnaires and Observations 8

3. Conclusion 9

1. Introduction

On 9 and 10 February 2017, Regulation and Quality Improvement Authority (RQIA) undertook an unannounced fact finding visit to Causeway Hospital in Northern Health and Social Care Trust (Northern Trust). This visit was in response to information received by RQIA on 8 February 2017, from the Northern Ireland Medical and Dental Training Agency (NIMDTA) as part of their 'NIMDTA Visit Grading Process and Escalation Policy. As part of their escalation procedures NIMDTA identified training issues which could have potential to impact on patient safety in Causeway Hospital.

This visit was carried out by inspectors from RQIA's healthcare team, led by RQIA's medical director. The focus of the visit was to gather information and seek assurance from Northern Trust regarding actions taken to address potential patient safety issues raised. The trust was asked to provide evidence to support its response.

The visit was conducted over a two day period. This included an evening and early morning visit to the hospital. The team visited a number of wards in the hospital including the Medical Assessment Unit, Medical 1 and 2, and Rehabilitation Wards 1 and 2. The team met with ward nursing and medical staff and engaged with patients, families and carers. The team assessed evidence of best practice relating to key areas of patient safety, observed delivery of care, reviewed documentation, attended safety briefings and handover meetings.

We did not identify critical patient safety related issues at the time of the visit; we did identify a number of areas and themes which have the potential to impact on patient safety in the hospital. These include organisation and delivery of team based care at ward level, ward staffing levels, pharmacy and phlebotomy service to wards, patient flow/movement, antimicrobial stewardship and information/evidence to assure best practice in patient care.

These areas were discussed with senior trust medical and surgical representatives at a feedback meeting on 10 February 2017. Senior staff present confirmed that the areas identified will be addressed, with work already progressing in some, to ensure that patient safety and quality of care is optimised.

This summary has been prepared to describe the findings of the visit and to set out areas of good practice and areas for improvement identified and outlined to the trust at the end of the visit. This summary has been shared with NIMDTA for information. In moving forward Causeway Hospital will be visited as part RQIA's Acute Hospital Inspection Programme. Areas identified for improvement during this visit will be followed up as part of this inspection.

2. Discussion with Staff and General Observations

2.1 Communication/Patient Flow/Movement

Areas of Good Practice

We observed and staff reported that there was a good team working culture in the hospital.

Nursing staff advised that unless dictated by clinical need, they ensure that internal transfers/movements of patients cease between 24.00 and 06.00. This reduces any unnecessary disruption to patients. An admission and discharge book is completed daily for each ward and collected at 24.00 by the bed manager. This records patient placement throughout the day and assists staff in managing bed flow. Tracking surgical patients who are placed in outlying wards has been identified as a challenge; this has improved with the appointment of a ward clerk who moves between areas at weekends to confirm patient placement.

A multidisciplinary daily safety brief is held at 08.30 where salient safety issues are identified, discussed, escalated as required and actions are agreed. We attended the safety briefing and found it very well attended, well structured, informative and helpful to coordinate the delivery of care.

A consultant-led medical handover is held at 08.45 every morning, with senior and junior medical staff in attendance. Patients admitted in the previous 24 hours are reviewed and assigned to a Consultant according to their current medical condition and past medical/healthcare history. Following this handover meeting medical staff undertake ward rounds.

We were told that in the Coronary Care Unit (CCU) and Rehabilitation wards there are established regular ward rounds which include medical and nursing staff; Medical Consultant, Staff Grade (if available), Foundation Year 1 and/or Foundation Year 2 doctors and a senior nurse. Regular scheduling of ward rounds assists in the delivery of planned and co-ordinated patient care. Rehabilitation wards also have a planned twice weekly multidisciplinary ward round. To assist with discharges an additional Foundation Year 2 doctor works 09.00-13.00 on Saturday and Sunday. This was highlighted by Foundation Doctors as a helpful development.

In the Medical Assessment Unit (MAU), a fully equipped bay and side room (up to five beds), are used when increased patient numbers exceed MAU commissioned bed numbers. This ensures patients are cared for in the appropriate clinical environment.

Areas for Improvement

In the MAU and Medical Ward 2, separate ward rounds often occur concurrently and may occur while multidisciplinary team (MDT) white board team meetings are in progress. As a consequence medical staff do not participate in the MDT white board meetings. This unscheduled approach to ward rounds has potential to impact on team communication and working, and may result in a lack of cohesive patient care.

In all wards visited we found that ward rounds are generally unscheduled for outlying patients. This does not always facilitate nurse attendance and means that junior medical staff spend a large amount of their clinical time attending separate ward rounds, which may leave less time to perform actual clinical duties.

We were informed that nurses are not always updated by medical staff if they were unable to participate in a particular ward round. In such instances, nurses proactively read patients' medical notes following the round, to ensure patients receive the prescribed treatment and care. We were told that on some occasions, initiating intravenous fluids has been delayed and blood transfusions are run overnight, as nursing staff had not been advised in a timely way that these treatments were required.

During our visit, nursing staff did not always know who the Foundation Year 1 doctor allocated to their ward was. We were told some Foundation Year 1 doctors stayed three days in a ward, while some stayed a maximum of one week. Staff reported that this level of movement among junior doctors has potential to impact on the continuity of patient care.

We observed that while most staff members had an identification pass on their person, they were not wearing an easy-to-read name badge. As a consequence we found it challenging to always identify which staff members we were interacting with during our visit.

We were told that during core working hours medical staff review patients with elevated National Early Warning Scores (NEWS) within the timeframe advised in the NEWS escalation algorithm. However we were told that outside core working hours, the recommended time for clinical response to an elevated NEWS[1] could not always be achieved by medical staff.

2.2 Infection Prevention and Control

Areas of Good Practice

The wards we visited were clean and in good repair, adaptations had been made for patients with disability and/or dementia. We observed frequent hand washing in line with best practice guidance.

[1] http://health.gov.ie/wp-content/uploads/2015/01/NEWSFull-ReportAugust2014.pdf

There was a comprehensive range of support leaflets available for patients and relatives. Hand wash sinks, consumables and alcohol gel dispensers appeared clean and in good repair.

A range of personal protective equipment (PPE) was available throughout the wards. We observed the infection prevention and hygiene (IPC) team carry out independent audits of best practice in medical wards.

The findings of up to date hand hygiene and environmental cleanliness audits were posted and demonstrated high compliance with best practice.

We observed the recently distributed posters on the regional 'line labelling' policy were displayed in medical wards. Ward staff advised that the regional policy was to be implemented when the labels/supplies became available (expected imminently).

Areas for Improvement

Improvements are required in staff adherence to the trust dress code policy and compliance with best practice in aseptic non touch technique (ANTT). This includes decontamination of hands before donning and after removing personal protective equipment (PPE).

We were informed that some patients are prescribed intravenous (IV) antibiotics for their entire hospital stay, (e.g. feedback indicated that one ward had a total of 52 IV antibiotics to administer in one day). We did not see evidence of an established system to monitor antimicrobial prescribing and assure stewardship activity at ward level. Medical staff have the trust prescribing guidelines on an application available on their mobile phones, which they used to guide their prescribing practice, however they were unaware of any planned or potential audit activity relating to antimicrobial prescribing.

Sepsis 6 posters were displayed in wards visited, however we did not see evidence to assure implementation of, or achievement of, the Sepsis 6 bundle within the advised timeframe from patient review/admission.

2.3 Staffing and Support

Areas of Good Practice

We were told the allocation of a ward-based Pharmacist, during normal working hours in MAU and Medical Wards 1 and 2 has been a positive step and assists in medicines reconciliation and in achieving timely discharge of patients.

Foundation Year 1 Doctors told us that their roles are busy; however they feel well-supported by their colleagues (Foundation Year 2 Doctors and Core Trainees) who are available and provide assistance when required.

Foundation Year 1 Doctors indicated they thought they would feel supported to raise an issue in the event of something not progressing as expected.

Junior medical staff (Foundation Year 1 and 2 Doctors) reported they had received training on the Datix incident reporting system and had experience in using it at ward level.

We were told that an additional Foundation Year 1 Doctor had recently been rostered to work during a very busy period to assist with patient discharges. This was highlighted by Foundation Doctors as a helpful development.

Areas for Improvement

We were advised that lack of phlebotomy staff impacts on the workload of Foundation Year 1 Doctors and nursing staff. Additional phlebotomy staff are currently being appointed to the hospital. This development is expected to facilitate a more timely phlebotomy service to all medical wards, earlier availability of patients' blood results to inform clinical care, and a reduction in the workload of Foundation Year 1 Doctors who currently assist if/when phlebotomy service is unavailable.

We were advised there was a nursing staff deficit of 5.93 whole time equivalent (WTE) nurses on the surgical wards. Although key performance indicators for these wards were reported as generally unchanged, staff did note an increase in falls and were concerned that staff shortage had the potential to impact on patient safety. Nursing staff highlighted a significant number of medical outlying patients placed in surgical wards. They highlighted the additional service and training requirements to ensure staff have appropriate skills to care for patients with complex co-morbid medical illnesses.

Junior medical staff reported that they are juggling paperwork, ward jobs and clinical patient care, and their roles are busy. They confirmed that clinical care of patients is prioritised, however they are aware of the need to facilitate patient discharge in a timely way.

Over weekends the Foundation Year 1 Doctor may not always be familiar with the patients for whom they are writing discharge letters. This may result in challenges related to accurate completion of patient discharge letters, in particular information relating to medications on discharge. We were reassured by senior medical staff who confirmed that they are aware of challenges relating to accurate completion of discharge documentation and in particular the important contribution of ward-based pharmacists in this regard. We were advised that this matter has been escalated within the trust as it is seen as an important patient safety issue. Systems to capture and share learning arising from errors in discharge documentation are in place and are supported through discussion with individual clinical staff and prescribers as appropriate.

It was clear from discussion that in wards where there was no ward based pharmacist, there was no integrated medicines management (IMM) service.

We were told at times patients can be discharged home and a family member return later to collect medication.

We were told that the discharge lounge is not open at the weekends due to shortage of relevant/appropriate staff. This results in patients remaining on the ward until discharge is fully completed.

2.4 Review of Records

Areas of Good Practice

We reviewed ward-based documentation on patients' NEWS charts, venous thromboembolism (VTE), the insertion and maintenance of intravenous cannulae and 'do not attempt cardio pulmonary resuscitation (DNACPR)'. In general, documentation available on wards was appropriately completed.

The findings of up to date hand hygiene and environmental cleanliness audits were posted and demonstrated high compliance with best practice.

2.5 Patient Questionnaires and Observations

During inspections the views and experiences of patients and service users are central to helping the inspection team build up a picture of the care experienced in the areas inspected. We use questionnaires to allow patients and relatives to share their views and experiences.

Findings are presented from a composite perspective, combining the patient and relative perceptions. Five patient and five relative questionnaires were completed. We observed staff treat patients and relatives courteously and with sensitivity. Staff explained clinical procedures and next steps in care to patients. We observed Consultant Medical staff taking time with patients and their family members, explaining the patient's condition and the planned approach to investigation and treatment.

Questionnaires

Patient Comments

Overall patients were happy with their care, some were not aware who their doctor was by name, but knew their face.

One patient spoke very highly of Dr Abdulla, commenting she saw him every day.

"He is very precise, lovely wee man. Everyone was more than good, nurses, doctors catering staff and domestics."

Relatives Comments

Some relatives had positive experiences and commented that staff took time to answer questions.

"I am happy."

"Dad has been MAU twice in the last three weeks. Staff have been very good and will answer any questions we have."

Information and advice on their relative's care was good, they were able to speak to doctors and good explanations were given.

Some relatives commented that at times staff were under pressure to care and treat their relative, that no one had spoken to them, they hadn't met the doctor and they were not aware of any plans.

"I feel that nurses don't have enough time to spend in order to give good patient care. More communication with relatives about their loved ones would be appreciated."

3. Conclusion

Members of the RQIA team met with senior Northern Trust medical and surgical representatives at a feedback meeting arranged for Day 2 of the visit (10 February 2017).

The three main themes for improvement arising from the visit were confirmed as:

i) co-ordination and planning of medical team ward rounds and patient reviews (to ensure multidisciplinary team working and cohesive care delivery at ward level)

ii) staffing levels and skills-set available to deliver care/services appropriate clinical need and location (including phlebotomy and nursing staff vacancies) and

iii) evidence to demonstrate and assure best practice in key patient safety areas (including sepsis management, antimicrobial stewardship and medicines management).

Senior trust staff present confirmed that areas identified for improvement will be addressed (work is commenced in some areas), to ensure that patient safety and quality of care is optimised.

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care