

Countess of Chester Hospital NHS Foundation Trust

The Countess of Chester Hospital










Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement	
Urgent and emergency services	Good	
Medical care (including older people's care)	Good	
Surgery	Good	
Critical care	Good	
Maternity and gynaecology	Good	
Services for children and young people	Good	
End of life care	Requires improvement	
Outpatients and diagnostic imaging	Good	

Services for children and young people

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

Countess of Chester Hospital provides a range of paediatric and neonatal services within its Women and Children's building. Both the neonatal unit and children's unit are situated on the ground floor. The neonatal unit has 20 cots and provides critical care, high dependency care, special care and transitional care for newborn babies. The children's unit has 34 beds, which include a 22-bed ward area incorporating two high dependency beds and six adolescent beds. There is also a six-bed paediatric day surgery area and a six-bed acute assessment unit. A dedicated paediatric outpatient clinic is located next to the ward.

Hospital episode statistics data (HES) showed there were 4,343 children and young people seen between September 2014 and August 2015, 95.3% of cases were emergency admissions, 17% were day case admissions and 1.1% were elective admissions.

We visited the Countess of Chester Hospital between the 16 and 19 of February 2016 and performed an unannounced visit on the 4 March 2016. We inspected a range of paediatric services including the children's unit, the neonatal unit, surgical theatres and the paediatric outpatients department.

We spoke with ten patients and/or carers, observed care and treatment and inspected nine sets of records and seven prescription charts. We also spoke with 44 staff of different grades including nurses, doctors, consultants,

medical students, ward managers, specialist nurses, and play specialists. We received comments from people who contacted us to tell us about their experiences and we reviewed performance information about the trust.

Services for children and young people

Summary of findings

We rated services for children and young people as good because:

- We saw evidence that incidents were being reported and that information following clinical incidents was fed back to staff in daily safety briefings.
- Cleanliness and hygiene was of a high standard in areas we visited and staff followed good practice guidance in relation to the control and prevention of infection.
- Care was delivered by caring and compassionate staff and the differing needs of children and young people were considered when delivering care.
- Facilities were available for parents to stay with their children.
- 97.6% of children and young people were seen within the 18 week target time and correspondence with GPs following admission or treatment was sent in a timely fashion.
- The hospital at home service enabled children to be treated in their own home or reduced their stay in hospital.
- Managers had a good knowledge of performance and were aware of the risks and challenges to their service.

However,

- Nurse staffing levels on the children's unit did not reflect Royal College of Nursing (RCN) standards (August 2013) and nurse staffing levels on the neonatal unit did not meet standards recommended by the British Association of Perinatal Medicine (BAPM).
- The neonatal unit lacked storage space and resources for barrier nursing.
- There was not always a member of nursing staff on duty with Advanced Paediatric Life Support (APLS) on the children's unit. The unit ensures APLS trained staff are included for day duty and gaps at night-time are mitigated by nursing staff being PILS trained and medical staff being APLS trained.

Are services for children and young people safe?

Requires improvement 

We rated safe as requires improvement because:

- Nurse staffing levels on the children's unit did not reflect Royal College of Nursing (RCN) standards (August 2013) and had resulted in eight incidents between January 2015 and January 2016, of which two detailed direct impact to patients.
- We found nurse staffing levels on the neonatal unit did not meet standards recommended by the British Association of Perinatal Medicine (BAPM). Between January 2015 and January 2016, 11 incidents were recorded that related to the acuity of patients and staffing breaching BAPM standards and on seven occasions in that period the neonatal unit had been closed to admissions.
- Nurse staffing was recorded as a risk on the divisional risk register for both the children's unit and the neonatal unit however, the risk to the neonatal unit was first recorded in 2010.
- The neonatal unit lacked storage space and resources for the care of patients who required strict infection control measures.
- Patient's medical records were not securely stored on the children's unit.
- Emergency resuscitation equipment was in place but records indicated that daily checks of the oxygen, suction and the defibrillator were not consistently completed.
- Controlled medicines were stored correctly however not consistently checked as per the trusts policy.
- There was not always a member of nursing staff on duty with Advanced Paediatric Life Support (APLS) on the children's unit however, the unit was funded for four training places per year and plans were in place to train all nurses at band 5 and above. Most registered nursing staff on the neonatal unit were qualified in New born Life Support training (NLS) and plans were in place for the remaining staff to attend the course.

Services for children and young people

- The trust target for safeguarding adults training was not met by all staff however safeguarding policies and procedures were in place, staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.

However,

- Incidents were reported appropriately with the majority being low or no harm to the patient and lessons learned were shared with staff by the daily safety brief or group email.
- The wards and clinical areas were visibly clean. Staff were aware of and adhered to current infection prevention and control guidelines.
- We reviewed nine sets records, which were generally completed to a good standard.
- Staff were aware of the trusts Major Incident Policy and where to locate it.

Incidents

- Incidents were reported using an electronic reporting system. Staff could demonstrate the process and received feedback both individually and via the daily safety brief or group email sent to all staff within the children's unit.
- There were no never events or Serious Incidents reported by the trust between November 2014 and January 2016 within children's services. Never events are very serious, wholly preventable, patient safety incidents that should not occur if the relevant preventative measures have been put in place.
- One serious incident was recorded by urgent and emergency care between November 2014 and January 2016 that involved failure to obtain a bed for a child. Staff within the children's unit told us there had been a high demand for beds during the recent winter regionally and nationally as well as locally. During the incident medical staff cared for the patient in the accident and emergency department until a bed could be found.
- Between January 2015 and January 2016, 254 incidents were recorded by the children's unit, neonatal unit and paediatric outpatient's clinic. Of these, 252 were reported as low or no harm.
- Nineteen of the incidents classified as no harm related to staffing levels and acuity of patients within the units.

- Between December 2014 and November 2015, 11 incidents were reported that required further investigation. We reviewed documentation relating to three of the incidents and found actions identified because of an incident review.
- Safety thermometer was in use on the neonatal unit to monitor device related pressure ulcers and results as at January 2016 showed 100% harm free care. The NHS Safety Thermometer is a local improvement tool for measuring and monitoring 'harm free' care.
- Staff we spoke to were unfamiliar with the term 'Duty of Candour' (the regulation introduced for all NHS bodies in 2014, meaning they should act in an open and transparent way in relation to care and treatment provided) however they could describe the principle and the circumstances it was used.
- Perinatal and neonatal mortality and morbidity meetings were held separately to allow time for discussion and numbered five and two respectively in the last year. Key messages and learning points were then given to staff.
- Two paediatric mortality and morbidity meetings had been held in the last year and governance meetings were held monthly. Meeting minutes were produced and sent electronically to staff.
- All child deaths were reviewed by a named paediatrician from the Child Death Overview Panel (CDOP). This was a community paediatrician who sat with the Local Safeguarding Children's Board (LSCB).

Cleanliness, infection control and hygiene

- The wards and clinical areas were visibly clean. Staff were aware of and adhered to current infection prevention and control guidelines such as the 'bare below the elbow' policy. We observed staff using personal protective equipment such as aprons when delivering care.
- There had been no cases of MRSA blood stream infection on the children's or neo-natal unit.
- Hand washing facilities, including hand gel were readily available in prominent positions in each clinical area.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps.