

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

Eastham Walk In Centre

Eastham Clinic, Eastham Rake, Eastham, Wirral,
CH62 9AN

Tel: 01513273061

Date of Inspections: 13 September 2013
11 September 2013

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
Cleanliness and infection control	✓	Met this standard
Requirements relating to workers	✓	Met this standard

Details about this location

Registered Provider	Wirral Community NHS Trust
Overview of the service	Eastham 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. Eastham 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

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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 announced 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 11 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 Eastham Walk-In Centre talking to patients and staff. We followed up our findings at a second visit by looking at documents and speaking to directors and other staff at the head office of Wirral Community NHS Trust.

We spoke with four patients and their relatives. All the patients we spoke with had previously used the clinic before and were very happy with the care they had received. Comments included: "Always been really happy with the service" and "I am really impressed by the service." Two patients told us waiting times could vary and be as long as four hours and felt that the service could be improved if an explanation of the waiting times was given.

We found there were policies and procedures in place to follow the Department of Health's guidance on infection prevention and control. However, we found that the flooring in the clinic was in a state of disrepair and was potentially an infection hazard. This had been identified in April 2013 and reported as being difficult to clean but no further action had been taken. The Director of Infection Control advised us that this issue was now on the trust's estates risk register.

We found there were recruitment policies and procedures in place to ensure suitably skilled people were employed to look after patients at the walk in clinic.

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 four patients and their relatives who told us they had used the service before and were happy with the care they had received. One patient told us "I have always been really happy with the service" and another said "I am really impressed by the service."

The lead nurse told us patients were usually seen by the triage nurse first. This meant that people's treatment needs were assessed. 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 four patient's notes which were available on the clinic's computer system. We discussed details of these notes with the lead nurse. 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 was space available within the notes to add information about the history, exam, diagnosis and treatment. The lead nurse showed us notes from one consultation that demonstrated the patient's individual needs had been identified and reasonable adjustments to their care made. 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 lead nurse told us that all nursing staff in addition to regular training, received monthly

peer reviews using a document called the 'universal urgent and emergency care clinical review tool'. We found that this system checked the competency of nursing staff to ensure they could assess a patient, including identifying any emergencies, and could make appropriate clinical judgements.

We saw the walk-in centre had procedures in place for emergencies. One treatment room had emergency drugs, a defibrillator and oxygen. The lead nurse showed us emergency drugs were checked daily and we saw evidence to demonstrate staff received training in basic and intermediate life support. The lead nurse showed us they had put signs up to ensure patients knew that the clinic was nurse led and did not always have access to a GP. They told us in cases of emergencies the clinic could not deal with then the nurse would call 999 for an ambulance.

We discussed reporting incidents with the lead nurse and also at our follow up visit at the trust's head office. We found the trust used a 'DATIX' computer system to record any concerns, comments and complaints and incidents. We saw an example of where the clinic had raised a concern that the number of patients attending the walk-in clinic had increased substantially and as a consequence the number of staff available could not meet the demand of patients and complaints about waiting times had risen. In response the trust had employed extra staff to cover peak patient attendance times. However, the provider may find it useful to note that this had been in May 2013. We were shown a document relating to a subsequent 'walk around' by directors in June 2013 that clearly identified issues with waiting times but there was no record of any actions to be taken.

The provider may find it useful to note that two patients told us waiting times could vary and be as long as four hours. They told us that they thought the service could be improved if an explanation of the waiting times was given. One patient said "It would be helpful if we were advised of how many people were in front of us in the queue to be seen or given an indication of how long we had to wait."

During our conversations with patients, we saw all of them had been given 'patient experience forms' to complete but they told us they had not received these on previous visits. We saw at our second visit to the head office that only a total of 27 patient experience forms had been completed since April 2013 and most comments on these related to waiting times. The trust had systems in place to identify issues with patient care which could be escalated within the organisation to higher board levels to enable them to make any necessary changes. However, the mechanism for capturing patient's views on the service was not being used to its full potential.

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed.

Reasons for our judgement

We found that Eastham Walk- in Clinic had systems in place to follow the Department of Health's Code of Practice on the Prevention and Control of Infections. The lead nurse was responsible for infection prevention and control (the IPC lead) and was supported by the Infection Prevention and Control (IPC) team. We saw the trust had infection control policies and that staff could access these policies on the intranet. In addition staff received regular training about infection control as part of their mandatory training.

We found the waiting area and treatment rooms to be clean. We spoke with four patients who expressed no concerns regarding the cleanliness of the clinic. However the cleaning of the treatment rooms and waiting rooms and removal of clinical waste were the responsibility of another trust.

We looked at minutes from IPC team meetings in April 2013 which raised an issue with the flooring which was ripped in places and therefore presented an infection control hazard as it was difficult to clean. We saw the same issue had been raised in another meeting in June 2013. We observed the flooring during our inspection to be ripped in areas. The provider may find it useful to note that during our inspection visits, we spoke with the IPC team and The Director of Infection Control at the inspection. We could not ascertain at these visits who was responsible for the flooring in the clinic and what action had been taken as a result of the findings. We were assured by the Director of Infection Control that the matter had now been escalated to the trust's estate's risk register to resolve the issue.

Patients we spoke with told us that the nurses did wash their hands before any examination was performed. We saw hand gels were in place and appropriate protective equipment such as gloves were available. One patient we spoke with was very susceptible to infection and the nurses had made arrangements to let the patient wait in another room instead of the waiting room to reduce the risk of infection to the patient.

We discussed antimicrobial prescribing with the IPC lead. He showed us the guidance that was used in the clinic for prescribing medications and told us there were checks in place for all clinical staff with regards to the medicines they prescribed to ensure amongst other

things that antimicrobials were not being over prescribed.

The head of the IPC team told us audits were carried out. This was confirmed by the staff we spoke with. Audits included quarterly hand washing audits. We saw from the trust's latest board meeting minutes that annual audits had been suspended earlier in the year due to staff shortages within the team. The head of the IPC team assured us this was now not the case.

We had received one concern last year regarding the use of single use items in particular single use dressings. We looked at audits for the clinic and saw that one audit in June 2012 did highlight that single use items were being reused. We saw appropriate action plans had been put in place. We spoke with two nurses who told us that all the medical devices used were 'single use' items and therefore disposed of after use. We spoke with one patient who had been attending the clinic regularly to have dressings changed. They confirmed that the dressing remaining in the packet that was not used was discarded to prevent any infection.

Requirements relating to workers

✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

We spoke with the Deputy Head of HR about the recruitment policies and procedures in place at our inspection of the walk in clinic and also at the trust's head office. We saw the trust had a recruitment policy and that checks were carried out for new employees. These checks included identity, entitlement to work within the UK, qualifications, professional registration, medical and immunisation clearance and a Disclosure and Barring Service Check (DBS). We were also shown evidence that an explanation was required from the interviewee if there were any gaps in their employment history.

We looked at the policy for DBS checks and found bank staff only required a standard check. We discussed this with the Deputy Head of HR who told us she would amend this document to reflect that some bank staff may be health care professionals that would require an enhanced check. The Deputy Head of HR told us if there were any issues arising from the DBS checks then risk assessments would be carried out to ensure the candidate's suitability for the job role.

We looked at recruitment records for three members of staff who were on duty on the day of our inspection. We found that DBS checks had been obtained and references were requested. In addition, there were checks for those staff that were required to be registered with a statutory regulatory body such as the Nursing and Midwifery Council. Staff we spoke with confirmed that their registration status was always checked at their appraisals. We saw that the trust had a policy for professional, clinical and medical registration. This policy also outlined disciplinary procedures in place if an employee had not kept their registration with the appropriate professional body.

We saw that there was an assessment and interview process in place. We spoke with two members of staff who confirmed that they had received job descriptions. We saw that the trust had a disciplinary procedure in place and the Deputy Head of HR told us that this was currently under review.

The Deputy Head of HR told us there was no probationary period in place for new employees. We saw policies and spoke to clinical staff who confirmed that they received supervisions on a regular basis. However it was unclear when newly employed non clinical staff received their supervisions and therefore there was a risk that a new employee may

go without supervision for some time.

We found that the trust had an induction policy in place. The Deputy Head of HR told us that key performance indicators for corporate and local induction were within a six week time frame. However the policies in place did not determine whether a new employee would necessarily receive the induction relevant to their work place from day one. In discussion with the Deputy Head of HR we were told that policies surrounding local induction would be reviewed to ensure that no new employee was without an introduction to their working environment from day one of their employment.

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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