

# United Lincolnshire Hospitals NHS Trust Grantham and District 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	Good	
Accident and emergency	Good	
Medical care	Good	
Surgery	Good	
Critical care	Good	
Maternity and family planning		
End of life care	Good	
Outpatients	Good	

# Summary of findings

## Letter from the Chief Inspector of Hospitals

The inspection of Grantham and District Hospital was carried out on 30 April 2014 as part of the wider inspection of United Lincolnshire Hospitals NHS Trust. The trust was chosen for inspection because it was an example of a high-risk trust. In 2013, the Keogh Mortality Review found significant concerns, and the trust was placed in 'special measures' as a result. We returned in February 2015 and inspected only those key questions where the service had been rated as requiring improvement or inadequate. We did not undertake a full comprehensive inspection on 2 February 2015.

In 2014 the hospital was rated as 'requires improvement' overall. Core services for accident and emergency (A&E) and medical care were found overall to require improvement. When we returned in 2015, we saw that significant improvements had been implemented, and that all services were rated as good.

Our key findings were as follows:

- There was significant improvement in clinical staff engagement, with senior clinicians sitting on the Clinical Executive Committee making decisions, and reporting directly to the trust board.
- There was an increase in the numbers of consultants and paediatric staff in A&E.
- Completion of patient records in surgery had improved.
- The service to paediatric patients attending the A&E department had improved, through recruitment of nursing staff and training of existing staff.
- The time taken for patients to be handed over from ambulance crews to the A&E department was in excess of targets set.
- The hospital had improved signage to meet the needs of the large Eastern European population in the county.
- There was an adequate supply of electronic profiling beds and other equipment in the Critical Care Unit.
- Staff throughout the hospital were observed to be kind, caring and compassionate.
- The hospital was clean, and hand-washing facilities and alcohol gel were available in all areas. Staff used gloves and aprons when providing care to patients. The infection control team were holding a hand-washing awareness session in the corridors. The infection control team were very enthusiastic.
- Patients were supported to have appropriate nutrition and hydration in most areas of the hospital.

We saw several areas of good practice including:

- The A&E department had a robust system for reporting incidents, known as IR1s. These were discussed and staff had changed their practices as a result of them.
- There was a designated and suitably decorated cubicle for children in A&E.
- Patients stated that they were cared for with compassion, and were very supportive of staff.
- Staff were using an assessment tool for pain, specifically designed for patients with dementia, where this was applicable.

However, there were also areas of poorer practice where the trust needs to make improvements:

The trust should:

- Review arrangements for the provision of medications and transport on discharge.

Following this focused inspection and in light of the significant improvements made by the trust I have recommended that the trust is removed from special measures.

**Professor Sir Mike Richards**

Chief Inspector of Hospitals

# Summary of findings

## Our judgements about each of the main services

### Service

#### Accident and emergency

### Rating

Good



### Why have we given this rating?

In May 2014 we found that some improvements were required to the service. There were not sufficient numbers of medical staff within the department to meet the needs of paediatric patients at all times. The consultant cover in the department was split between two members of staff. Exclusion tools were in place to ensure that patients who came to the department by ambulance were appropriate to the services offered. There were systems in place to transfer patients to other hospitals if they presented with conditions that the hospital was not able to cater for. In February 2015, we saw that the emergency department at Grantham and District Hospital had made significant improvement. The amount of medical staff within the department had increased. We saw that the department had improved its paediatric provision, and was capable and competent to deal with people that presented to use the services provided, either by walking into the department or arriving by ambulance.

In 2014, we saw that there was no dedicated resuscitation emergency call number, paediatric team, or paediatric bleep system. This meant that children and young people were at potential risk of harm, particularly out of normal working hours. During our inspection in February 2015, we found that the department had a dedicated emergency resuscitation number, and a resuscitation team was available. The emergency department was capable to manage a patient that required resuscitation from within its own team at any time. We saw that all of the doctors that work at the emergency department were trained in advanced paediatric life support, and all nurses were trained in paediatric immediate life support.

Staff were found to be caring and compassionate. Patients were complimentary about the care they received, and the NHS Friends and Family Test results for the A&E department in the hospital were above those of the national average. The service was not always responsive to all patients' needs. The trust struggled to maintain the 95% target for patients to be seen within four hours, and many times had been below the England average. We witnessed a slow handover from ambulance to A&E staff when trolleys were available,

# Summary of findings

and were informed that the processes in A&E did not encourage early turnaround times. A pilot scheme was in place in A&E, which would identify areas of delay for patients, and improve the throughput within the department.

In 2014, the signage in the department was only in English, despite there being a large population of people in the county from Eastern Europe. We saw that the translation service was not always offered to people who might benefit from its use. In February 2015, we saw that the department had signs displaying information in six different languages that were spoken within the demographics of the community the department provided services to. In 2014 There was no access on-site to a specialist Learning Disabilities nurse when required. In 2015 we were informed a visiting LD nurse visits the department. The service was well-led, with staff reporting that they felt supported and that the visibility of the trust senior management had improved.

## Medical care

Good



In 2014 we found that there was a good culture of reporting incidents and accidents amongst staff, and appropriate action was taken with learning being disseminated. Staff did not receive feedback from incidents they reported, so lessons were not being learnt from these. We found staff were given feedback on important issues raised during our visit in February 2015. Lessons were learned which had been disseminated across the sites. Cleanliness had recently improved, beds had been upgraded, and infusion pumps were readily available. Although some aspects of the environment required improvement, plans were in place to undertake this work. Numbers of qualified nurses were still below that required by the trust, although the trust were recruiting; agency and bank staff were used when required and available. Patients received effective care and treatment that met their needs. In 2014 care bundles had been developed, but these had only recently been implemented and required embedding in practice. However, in 2015 the use of care bundles was embedded in practice, and senior medical reviews were undertaken regularly. Staff were caring and compassionate. They interacted with patients in a respectful manner. Patients' privacy and dignity was maintained. In 2015 we found that transport arrangements for patients awaiting discharge were variable, and a pharmacy service was not available on

# Summary of findings

Saturday and Sunday afternoons. The service was well-led by senior nursing staff. Staff reported feeling supported by managers. There was a lack of shared learning across sites.

## Surgery

Good



In 2014 the service was good, but improvements were required in the safety of the service. This related to the records of specific areas of care (catheter care and cannulas), which were not completed in all cases. However, in 2015 we found that this had improved, with audits showing that 100% of records were completed. We rated this domain as good in 2015.

Care was effective in the service, with good outcomes reported for patients, and practice was in line with national guidance. Staff were caring and compassionate in their support for patients. Privacy and dignity was maintained. There were very good results from the NHS Friends and Family Test for Ward 2.

In 2014 the service was not always responsive to patients' needs. The trust was not meeting referral to treatment times for the surgical specialities operating at Grantham and District Hospital. We found a similar picture in 2015. In 2014 there were intermittent problems with the lifts servicing the ward, which meant that patients were sometimes cared for in the day surgery unit. However, in 2015 we found that this problem had been resolved. The unit was responsive to individual patient needs and translation services were available, if required.

The service was well-led. Managers had a clear strategy for the service, and staff reported feeling supported. Staff felt the senior management of the trust was more visible within the hospital over the last year.

## Critical care

Good



The unit provided safe and effective care, with a good safety record and outcomes for people. There were suitable numbers of staff to meet people's needs, and they had received training, which prepared them for working within the specialist environment. Staff were caring and compassionate, maintaining people's dignity and privacy. There were positive interaction between staff and patients, and their relatives.

While there was good access to the service, in 2014 we noted that the use of manual beds rather than electric profiling beds required improvement in order to meet people's needs. However, in 2015 we noted that the unit had been supplied with electric profiling beds, two of which could weigh patients whilst they were on the bed.

# Summary of findings

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The service was well-led. Staff reported feeling supported by managers in the department, and that senior leaders in the organisation were more visible and accessible. While performance on the staff survey in 2013 had been poor for many questions, all staff we spoke with told us that things had improved in the last year.

# Grantham and District Hospital

## Detailed findings

### Services we looked at

Accident and emergency; Medical care (including older people's care); Surgery; Critical care

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# Detailed findings

## Background to Grantham and District Hospital

Grantham and District Hospital is a small hospital with 115 beds. It is part of United Lincolnshire Hospitals NHS Trust formed in April 2000 by the merger of three acute hospital trusts in Lincolnshire. The trust is one of the largest in the country. The trust, as a whole, provides services to a population of 700,000 people in Lincolnshire.

The hospital provides services which include A&E, elective surgical procedures, critical care (level 1 and 2) medical care (including care to older people), end of life care and outpatient services. Until recently, there was a

midwifery-led birthing unit and an observation and assessment ward for children, taking admissions 10 am to 4 pm, Monday - Friday. However, only clinic services are provided for these areas of care now. The local birthing unit closed in February 2014.

We inspected the service in 2014 because the trust had been placed in special measures following the Keogh Mortality Review in 2013. The trust was seen as high risk in our Intelligent Monitoring. We recommended that the trust was kept in special measures for a further six months. We re-inspected the service in February 2015.

## Our inspection team

Our inspection team in 2014 was led by:

**Chair:** Professor Sir Mike Richards, Chief Inspector of Hospitals, Care Quality Commission (CQC)

**Head of Hospital Inspections:** Fiona Allinson, Head of Hospital Inspection, CQC

In 2015, our inspection team was led by:

**Chair:** Gillian Hooper, Improvement Director, Monitor

**Head of Hospital Inspections:** Fiona Allinson, Head of Hospital Inspection, CQC

The team of 33 included 11 CQC inspectors and two pharmacist inspectors, an oral and maxillofacial surgeon, a consultant in medicine, a cardiology consultant, a head of clinical services and quality, a senior theatre practitioner, a district nursing sister, a senior midwife and a senior paediatric nurse, and an 'expert by experience'.

## How we carried out this inspection

To get to the heart of the patients' experiences 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 and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), NHS Trust Development Authority, NHS England, and the local Healthwatch.

In April 2014 we held three listening events in Lincoln, Boston and Grantham on 29 April and 30 April 2014, where people came to share their views and experiences

of the trust. Some people who were unable to attend the listening events shared their experiences via email or telephone. At this inspection in February 2015 we did not hold a listening event, but spoke directly with patients and relatives at all hospitals.

We carried out an announced inspection visit from 2 February to 4 February 2015, with an unannounced inspection on 1 February 2015 at the Lincoln and Boston sites. We spoke with staff individually, as requested.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

# Detailed findings

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at United Lincolnshire Hospitals NHS Trust.

## Facts and data about Grantham and District Hospital

### Key facts and figures about the trust

Lincoln County Hospital: 601 beds

Grantham and District Hospital: 115 beds

The Pilgrim Hospital: 350 beds

Inpatient admissions: 152,760 2013/14

Outpatient attendances: 674,856 2013/14

A+E attendances: 144,239 2013/14

Births: 6,525

Deaths

Annual turnover

Surplus (deficit): £0.1m deficit

### Intelligent Monitoring

- Safe: Risks = 1, Elevated = 0, Score = 1
- Effective: Risks = 1, Elevated = 1, Score = 2
- Caring: Risks = 1, Elevated = 0, Score = 1
- Responsive: Risks = 1, Elevated = 1, Score = 2
- Well led: Risks = 6, Elevated = 2, Score = 8
- **Total:** Risks = 10, Elevated = 4, Score = 14

### Individual Elevated Risks

- All cancers: 62 day wait for first treatment from urgent GP referral
- TDA - Escalation score
- Whistleblowing alerts

### Individual Risks

- Proportion of patients risk assessed for Venous Thromboembolism (VTE)
- Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures
- Inpatient Survey 2012 Q23 "Did you get enough help from staff to eat your meals?"
- The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason

- Data quality of trust returns to the HSCIC
- NHS Staff Survey - KF7. % staff appraised in last 12 months
- NHS Staff Survey - KF9. support from immediate managers
- NHS Staff Survey - KF21. % reporting good communication between senior management and staff
- Composite risk rating of ESR items relating to staff sickness rates
- Composite risk rating of ESR items relating to staff support/ supervision

### Indicators By Domain

#### Safe:

- Never events in past year 2
- Serious incidents (STEIs) 173 Serious Incidents occurred at the trust
- Proportion of patients risk assessed for Venous Thromboembolism (VTE) one risk
- National reporting and learning system (NRLS)
- Deaths 20
- Serious 128
- Moderate 870
- Abuse 42
- **Total 1,060**

#### Effective:

- HSMR Within expected range
- SHMI Within expected range

#### Caring:

- Inpatient Survey 2012 Q23 "Did you get enough help from staff to eat your meals?" one risk

#### Responsive:

- Bed occupancy 79.6%
- All cancers: 62 day wait for first treatment from urgent GP referral one elevated risk

# Detailed findings

- The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason one risk
- Delayed discharges: No evidence of risk
- 18 week RTT: No evidence of risk
- Cancer wards: No evidence of risk

## Well-led:

- Staff survey: **below average**
  - Sickness rate: 5.2 % **above**
  - GMC training survey: **below average**
  - Data quality of trust returns to the HSCIC one risk
  - TDA - Escalation score one elevated risk
- NHS Staff Survey - KF7. % staff appraised in last 12 months one risk
  - NHS Staff Survey - KF9. support from immediate managers one risk
  - NHS Staff Survey - KF21. % reporting good communication between senior management and staff one risk
  - Composite risk rating of ESR items relating to staff sickness rates one risk
  - Composite risk rating of ESR items relating to staff support/ supervision one risk
  - Whistleblowing alert one elevated risk

# Detailed findings

## Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Good	Not rated	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and family planning	N/A	N/A	N/A	N/A	N/A	N/A
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good
<b>Overall</b>	Good	Good	Good	Good	Good	Good

### Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and emergency and Outpatients.
2. The rating for Well Led at the hospital is outside of the ratings guidance. This is because the leadership of the two core services which have been rated as requires improvement are at trust level and not based in the hospital.

# Accident and emergency

Safe	Good	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

## Information about the service

The emergency department within Grantham and District Hospital included A&E as well as the Emergency Assessment Unit (EAU). EAU admitted medical patients from both A&E as well as GP's. During our inspection we spoke to approximately nine patients and their relatives to obtain their feedback on the care they were receiving.

The A&E department saw both adults and children. Because of the small size of the department and lack of specialist care, East Midlands Ambulance Service (EMAS) were aware of the admission criteria for A&E and generally took those patients to Lincoln County Hospital or Pilgrim Hospital, Boston.

The out-of-hours service for patients not needing A&E services is operated by Lincolnshire Community Health Services from 6pm until 8am and worked adjacent to A&E. The patient pathway to the out-of-hours service appeared to be very effective. An ambulatory care pathway was being formed for the A&E department which saw between 80 and 100 patients per day.

## Summary of findings

In May 2014 we found that some improvements were required to the service. There were not sufficient numbers of medical staff within the department to meet the needs of paediatric patients at all times. The consultant cover in the department was split between two members of staff. Exclusion tools were in place to ensure that patients who came to the department by ambulance were appropriate to the services offered. There were systems in place to transfer patients to other hospitals if they presented with conditions that the hospital was not able to cater for. In February 2015, we saw that the emergency department at Grantham and District Hospital had made significant improvement. The amount of medical staff within the department had increased. We saw that the department had improved its paediatric provision, and was capable and competent to deal with people that presented to use the services provided, either by walking into the department or arriving by ambulance.

In 2014, we saw that there was no dedicated resuscitation emergency call number, paediatric team or paediatric bleep system. This meant that children and young people were at potential risk of harm, particularly out of normal working hours. During our inspection in February 2015, we found that the department had a dedicated emergency resuscitation number, and a resuscitation team was available. The emergency department was capable to manage a patient that required resuscitation from within its own

# Accident and emergency

team at any time. We saw that all of the doctors that work in the emergency department were trained in advanced paediatric life support, and all nurses were trained in paediatric immediate life support.

Staff were found to be caring and compassionate. Patients were complimentary about the care they received, and the NHS Friends and Family Test results for the A&E department in the hospital were above those of the national average. The service was not always responsive to all patients' needs. The trust struggled to maintain the 95% target for patients to be seen within four hours, and many times had been below the England average. We witnessed a slow handover from ambulance to A&E staff when trolleys were available, and were informed that the processes in A&E did not encourage early turnaround times. A pilot scheme was in place in A&E, which would identify areas of delay for patients, and improve the throughput within the department.

In 2014, the signage in the department was only in English, despite there being a large population of people in the county from Eastern Europe. We saw that the translation service was not always offered to people who might benefit from its use. In February 2015, we saw that the department had signs displaying information in six different languages that were spoken within the demographics of the community the department provided services to. In 2014 There was no access on-site to a specialist Learning Disabilities nurse when required. In 2015 we were informed a visiting LD nurse visits the department. The service was well-led, with staff reporting that they felt supported, and that the visibility of the trust senior management had improved.

## Are accident and emergency services safe?

Good



In 2014 we found that the services offered by the A&E department required improvement to ensure the safety of people using the services. We found that there was a lack of infusion pumps to ensure safe and controlled delivery of medicines and fluids to patients. We also found that there was no access to a paediatrician for sick children. Maintenance issues were not always being attended to promptly. During our inspection on 4 February 2015 we found that the trust had invested in equipment, and the department had sufficient infusion pumps available. We saw that the department had worked closely with the Nottingham paediatric intensive care unit, and multi-disciplinary team education was taking place. The department had increased its provision of paediatric-trained nurses by two whole time equivalents (WTE), with a further three nurses due to commence in due course.

Both units making up the emergency department were seen to be clean and tidy. Equipment was checked regularly, and staff were seen using appropriate alcohol gel, or washing their hands between patients. Staff treated patients in a caring manner, and across the emergency department there were systems in place to manage deteriorating and very sick patients. In February 2015 we noted that the maintenance of the department was good, and the environment that care and treatment was being provided in was of a standard that meets the needs of people using the services.

### Incidents

- The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports. Between March 2013 and February 2014, 66 incidents were reported to the NRLS from A&E departments across the trust. Of those, 47 were classified as having a moderate effect on patients, and three of them were deaths.
- The A&E department had a robust system for reporting incidents, known as IR1's. During monthly meetings these were discussed. Staff had changed their practices as a result of them.

# Accident and emergency

- In 2014, the manager of A&E informed us about learning from a serious, untoward incident in the department. Appropriate steps had been taken to prevent a recurrence.
- We found in 2014 that regular liaison between the hospital and personnel in the two other trust's A&E departments was not in place, and therefore concerns, lessons learned and good practice were not shared. During our inspection in February 2015, we saw that the managers within the department actively engaged through shaping the culture of the department. We saw that there was regular liaison and engagement across all three accident and emergency departments within the trust.
- In May 2014 staff explained to us that they reported, using the internal incident reporting system, any inappropriate paediatric care in A&E. Staff told us they were concerned about the lack of paediatric cover after 9pm. This meant that care could be compromised because staff did not have the necessary skills to care for children. In February 2015 we saw that paediatric education had taken place, with all doctors trained in paediatric advanced life support, and nurses trained in paediatric immediate life support. The department worked closely with Nottingham Hospital. We saw that the department had implemented the paediatric early warning scoring (PEWS) system from the 'track and trigger' system. (A paediatric early warning score is a guide used to quickly determine the degree of illness of a child. It is based on data from four physiological readings (systolic blood pressure, heart rate, respiratory rate, body temperature) and one observation (level of consciousness). The resulting observations are compared to a normal range, to generate a single composite score.)

## Safety thermometer

- In 2014, the A&E department did not use the trust's safety and quality dashboard to survey and monitor any potential harm to patients across the majority of inpatient areas. We spoke with the modern matron, who explained to us that they had reviewed Safety Thermometers specific to paediatric care across the NHS. A decision had been taken to adapt the Sheffield model. We were told all work had been completed and approved, and would shortly be piloted in the service.
- We saw in our inspection in February 2015 that the emergency department had completed audits within

the department, such as department performance, compliance with infection prevention control, and how long people waited to be seen. The first quality dashboard information was due to become available. We spoke to the department manager, who was very pro-active and keen for this information to be displayed for patients and staff.

## Cleanliness, infection control and hygiene

- Both A&E and EAU appeared clean and tidy and we saw staff washing their hands regularly and using alcohol gel between patients.
- Personal protective equipment such as aprons and gloves were available and being used appropriately.
- Medical and nursing staff were adhering to the trust's 'bare below the elbows' policy.
- Domestic waste, clinical waste and sharps bins were filled to an appropriate level and not over-filled.

## Environment and equipment

- The environment in both A&E and EAU was safe for both patients and staff, although a small water leak and maintenance on a wall in EAU were still awaiting attention.
- A designated cubicle for children was seen in A&E. This was suitably decorated.
- Equipment was checked and cleaned regularly, including resuscitation trolleys.
- In 2014 we found that call bells were not available to patients in A&E to request assistance. In February 2015, we noted that all cubicles had call bells available, which were working. We spoke with the department manager, who told us that the department was looking at having a remote call bell system. However, this was at its early stages, with no date for implementation.
- In 2014 the availability of electric beds in EAU was limited, and staff informed us that pressure-relieving equipment, such as special cushions, were not readily available, leading to a delay in pressure area care for patients. At our latest inspection we found that this was no longer a problem.
- In 2014 there were insufficient numbers of infusion pumps available to deliver fluids into a patient's body at a precisely controlled rate. We witnessed intravenous blood being given via gravity. While the trust's policy stated that it could be given either way, good practice dictates that controlled administration via an infusion

# Accident and emergency

pump is preferred. We noted at our inspection in February 2015 that there were sufficient infusion pumps, and all intravenous fluids were being administered through an infusion pump when required..

## Safety of admissions to A&E

- An exclusion protocol was in place in A&E because of its size and the availability of specialist staff.
- The protocol stated specific patient groups should not be taken [from] or sent to A&E. These included patients with major injuries, for example: high speed road traffic collisions, children with severe breathing problems and patients experiencing acute abdominal pain.
- We were informed the protocol did not stop members of the general public taking people there, especially young children who were very ill. As a result, staff cared for those patients and arranged their transfer to another hospital. Sometimes this took many hours.
- During our inspection in February 2015, we looked at the provision available, and spoke with staff, including two doctors and three nurses, of the capabilities of the department to deal with high-speed road collisions, acute abdominal pain, and a selection of varied injuries and illnesses that an emergency department could see. The department has agreed pathways with EMAS and some patients with significant injuries would not be brought to Grantham, however, We saw and were told by the department manager that the emergency department at Grantham and District Hospital was able to offer the full services of an emergency department if required pending transfer to a bigger unit.

## Medicines

- We looked at the way medicines were stored, managed and checked in A&E and EAU. We found there were good systems in place for storing and administering them.
- We saw the checks undertaken for controlled drugs. We checked them against the controlled drugs register and found them to be correct.
- Bi-monthly medicines management meetings were held to discuss incidents and learning required. The last meeting had been cancelled.

## Records

- All records were in paper format with A&E using an adhesive card system. Medical notes were recorded separately.
- We observed nursing documentation was completed well.

- A&E used their own pro-forma for detailing information required by EAU or any other ward in the hospital receiving patients from them. A&E notes stayed in the department.
- The trust's risk register acknowledged in 2007 that despite previous efforts, the physical merge of all the trust's records had never been completed, so approximately 40,000 of "current treatment" patients had multiple sets of records. This presented a clinical risk as there was no complete health record available for such patients when they attended each site. This item is ongoing on the risk register.
- Do Not Resuscitate (DNR) forms were seen on EAU. They had been appropriately completed and signed with clear rationale for the decision documented. Information from the trust evidenced completion of the forms had improved since September 2013.
- In 2014 we found that there was no evidence of risk assessments being undertaken in A&E. Risk assessments were in place in EAU. In February 2015, we saw that the emergency department undertook risk assessments, and we saw a recent risk assessment around the standard of getting patients onto pressure mattresses.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their verbal consent before procedures were undertaken.
- Staff were aware of correct procedures if patients did not have the capacity to make informed choices about their treatment or future care.
- Medical staff used a mental capacity assessment online if patients required it.

## Safeguarding

- In February 2015 we found that a safeguarding lead for adults had been appointed.
- The A&E department and EAU had an adult safeguarding champion.
- A&E had a children's safeguarding lead. They had undertaken extended training in relation to this to equip them with the appropriate skills.
- There was a process in place for referring children who were at risk to the relevant authorities.
- Staff we spoke with knew how to raise their concerns about adults and children who may be at risk.

# Accident and emergency

## Mandatory training

- In 2014 not all staff had undertaken their mandatory training for fire and infection prevention. The figure given by the trust was 55% for A&E, and 71% in EAU for March 2014. The A&E department lead was aware of this and addressing the issue. In February 2015, we saw an improvement in the compliance of mandatory training. We looked at the subjects, and found that the fire training was 100% compliant, staff appraisals were 100% compliant, and infection prevention and control was at 100% compliance.

## Management of deteriorating patients

- The unit used a recognised early warning tool for ill patients. Staff were aware of the procedures to follow if a patient's condition deteriorated.
- At our inspection in February 2015, we saw that the emergency department had moved to the national early warning scoring (NEWS) system and the paediatric early warning scoring (PEWS) system from the 'track and trigger' system. (A national early warning score is a guide used to quickly determine the degree of illness of a patient. It is based on data from four physiological readings (systolic blood pressure, heart rate, respiratory rate, body temperature) and one observation (level of consciousness). The resulting observations are compared to a normal range to generate a single composite score.)
- We did not see any deteriorating patients during our visit.
- In 2014 the A&E department had no designated triage nurse for each shift. In February 2015, we saw that there was a dedicated trained triage nurse on each shift and we observed correct triaging of patients taking place.
- In 2014 there was no dedicated paediatric cover out-of-hours for children admitted to the A&E department. We saw in February 2015, that the consultant cover had improved, which facilitated cover for out-of-hours provision.
- In 2014 staff explained to us that there was no dedicated resuscitation emergency call number, paediatric team, or paediatric bleep system. This meant that children and young people were at significant risk of harm, particularly out of normal working hours. During our inspection in February 2015, we found that the department had a dedicated emergency resuscitation number, and a resuscitation team was available. The emergency department was capable to manage a

patient that required resuscitation from within its own team at any time. We saw that all of the doctors that work in the emergency department were trained in advanced paediatric life support, and all nurses were trained in paediatric immediate life support.

## Nursing staffing

- Staff reported, and we saw from the off-duty rotas, agency nursing staff were not used or required in the A&E department.
- On A&E nursing staff undertook the booking-in of patients to the department at night. No administration staff were available during this time. Ambulance staff informed us this delayed handover of their patients as only two trained nurses were on duty at night.
- Skills mix was appropriate for adult patients.
- A&E was fully staffed.
- We spoke with staff, in 2014, and asked them if they had enough staff to meet the needs of their patients. All told us that they felt they did not have the required amount of staff to cover the paediatric beds in A&E. We saw in February 2015, that the emergency department had improved the education of doctors and nurses, to improve the provision of cover for paediatrics in the department. The department had an uplift of staff after using the RCN 'BEST' acuity tool, with an increase of three whole time equivalent (WTE) staff.
- Handover between shifts was robust.
- Handover of patients to wards was thorough and documented.
- All medical staff in A&E had received an appraisal within the last twelve months.
- Nursing staff we spoke with had all received appraisals.

## Medical staffing

- We were informed by a consultant in A&E the department was fully staffed with doctors.
- In 2014 there was one whole time equivalent A&E consultant in post, and one part-time consultant. In February 2015, we spoke with the lead consultant, who informed us that there are now three consultants, with a further two identified.
- Staff grade doctors completed the cover 24 hours a day.
- During sickness and study leave, locum doctors were used.
- Annual leave was covered by doctors already working in the department.

# Accident and emergency

- There was no qualified paediatric doctor working in the department and a paediatrician was not available in the rest of the hospital. This left staff vulnerable and children at risk.
- Junior doctors (FY1 and FY2) worked in the A&E department.

## Major incident awareness and training

- The Grantham and District Hospital is not a receiving centre for major accidents or trauma. Such patients are taken to Lincoln County Hospital or Pilgrim Hospital, Boston.

## Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Staff were aware of clinical guidance for patients with specific needs or diseases. Assessment of pain was undertaken as part of the admission process and dealt with effectively. Care bundles, for example fractured neck of femur, asthma and sepsis were in place and being used appropriately. There was access to x-ray and scanning facilities every day.

The patient pathway to the out-of-hours service adjacent to A&E appeared to be very effective. Patients told us they were very confident in the way staff treated them although staff felt uneasy treating sick children brought to the department because of the absence of paediatricians.

**We did not re-inspect this aspect of the service in February 2015.**

## Evidence-based care and treatment

- Specific care 'bundles' were available for management of patients presenting with, for example stroke, fractured neck of femur, asthma, sepsis and heart failure. These are yet to be embedded.
- A&E had quick and easy access to x-ray and scanning facilities.

- We were informed the A&E department used National Institute for Health and Care Excellence (NICE) guidelines where appropriate, for example in the care and treatment of head injuries and fractured neck of femur.
- However, the policies did not reflect the service provided at the time of inspection. This is because the acute paediatric unit closed in February 2014.

## Pain relief

- An assessment of pain was undertaken on a patient's arrival in the A&E department.
- Patients we spoke with in A&E and who informed us had been in pain told us pain relief had been given very quickly on arrival in the department.
- We did not see any patient in pain during our inspection.
- There was a trust-wide paediatric pain policy which has been in use for some years. The document had recently been revised and was awaiting final ratification through the clinical records committee.

## Competent staff

- Patients we spoke with felt confident in the staff who had treated them.
- All the nursing staff we spoke with felt competent to undertake their role.
- We were informed by members of medical and nursing staff they felt uneasy about caring for sick children because of the lack of specialists available.
- Nursing staff were trained in basic life support and received regular updates. More senior staff received training in paediatric life support.

## Multidisciplinary working

- Where appropriate, patients were transferred to different hospitals for treatment within the trust facilities, for example Lincoln County or Pilgrim Hospital Boston. For specialist treatment it could be necessary to send patients further afield, for example Nottingham.

## Seven-day services

- All areas of the emergency department were open seven days a week serving the population of Grantham and those living on the Lincolnshire/Leicestershire border.
- Out-of-hours services were operated by Lincolnshire Community Health Services from 6pm until 8am and worked adjacent to A&E. The patient pathway to the out-of-hours service appeared to be effective.

# Accident and emergency

- A&E and EAU had access to x-ray and scanning facilities at all times.
- The A&E department had two dedicated beds for paediatric admissions. However, children did not receive paediatric, medical or nursing cover out-of-hours.

## Are accident and emergency services caring?

Good 

Patients felt they were involved with their care, listened to by health professionals and were cared for with compassion and kindness. Pain relieving medication was offered quickly when needed although call-bells were not available for patients to call for assistance.

A facility was available for relatives to use when needed and plans were in place to improve it.

**We did not re-inspect this aspect of the service in February 2015.**

### Compassionate care

- All the patients we spoke to in A&E and EAU were complimentary of the care they had received. One person told us, "They are all absolutely wonderful."
- We saw examples of caring professional interactions with patients.
- Call bells were not available to patients to summon assistance.
- In A&E we saw nurses asking patients if they were comfortable or wanted anything.

### Patient understanding and involvement

- Patients understood why they were in hospital and had been consulted about their treatment and felt involved in their care.
- We heard doctors explaining their findings to patients in A&E

### Emotional support

- One family member told us they were very impressed with the care and went on to say: "My child is needle-phobic and the staff are particularly skilled at dealing with the fear of families."

- Staff shared with us a particular event, which was very distressing for the parents of a baby. The staff remained on duty to care and support the parents throughout their stay in A&E.

## Are accident and emergency services responsive to people's needs? (for example, to feedback?)

Good 

Waiting times in A&E between 5 August 2012 and 23 February 2014 across United Lincolnshire Hospitals NHS Trust showed that the trust had struggled to maintain the 95% target for patients to be seen within four hours, and many times has been below the England average. However, the Grantham site year to date indicator, in 2014, was 96.3%, and the hospital had achieved the 95% target during the previous year. We witnessed a slow handover from ambulance to A&E staff when trolleys were available, and were informed that the processes in A&E did not encourage early turnaround times. We inspected in February 2015, and found that as with many departments in the country, the 95% target had not been met on a number of occasions.

A pilot scheme was in place in A&E, which would identify areas of delay for patients and improve the patients journey within the department.

In 2014 we saw that signage in the department was only in English, despite there being a large population of people in the county from Eastern Europe. This is less of an issue at the Grantham site than at Boston. We saw that the translation service was not always offered to people who might benefit from its use. During our inspection in February 2015 we saw a good level of service improvement to support patients whose English was not their first language, with clear signage and telephone translation services. There was no access on-site to a specialist Learning Disabilities nurse when required.

### Access and flow

- Trusts in England are tasked by the government with admitting, transferring or discharging 95% of patients within four hours of their arrival in the A&E department.

# Accident and emergency

- Waiting times in A&E between 5 August 2012 and 23 February 2014 across United Lincolnshire Hospitals NHS Trust showed the trust had struggled to maintain the 95% target.
- The trust was performing better than the England average for patients waiting 4-12 hours to be admitted to a ward.
- The percentage of patients leaving the trust's A&E departments before being seen, showed there was a lower than average amount of patients leaving up till one hour after arrival. This changed at the four hour mark where it increased to 18.4%, then fell to be in line with the national average from the five hour mark to the 11 hour mark.
- EAU had separate single-sex bays to which patients could be admitted for a limited period of time.
- We saw a delayed handover of a patient from an ambulance crew; the patient had to wait for 35 minutes for a cubicle, even though a side room was available.
- We were informed the process in A&E at Grantham and District Hospital did not encourage early turnaround.
- During our visit to A&E, we saw a pilot scheme in place tracking patients from admission to discharge or other areas of the hospital.
- The pilot was going to identify areas of delay for patients and improve the journey of patients.
- In February 2015, we observed the process within the emergency department, and found the patient pathway to be effective and clear. Patient flow was maintained.

## Meeting people's individual needs

- Lincolnshire had a high number of people in the community from Eastern Europe. The hospital had access to translation services through the use of specialist telephones. Staff were aware of this and knew how to use them.
- When we spoke to a patient in A&E who came from Eastern Europe, they told us they had not been offered the translation service.
- Signs and notices in A&E and in EAU were only written in English. We did not see any printed information for patients in any language other than English.
- In February 2015, we saw that the department had improved its signage. Each sign was translated into six different languages, including picture signage, from the demographics of the community the emergency

- department served. These were displayed within and outside the department. We saw that the language line in use provided a translation service in eighteen different languages.
- In 2014, we did not speak with any patient who had a learning disability (LD). A&E staff informed us that they had no access to a specialist learning disability nurse on-site. In February 2015, we were told that there is now a learning disability nurse that provides two drop-in sessions per month for awareness and safeguarding. The senior sister in the department told us that this was an excellent and effective link.
- We spoke with staff about their ability to help patients with dementia when they needed to go to the department.
- A&E had a member of staff designated as a dementia champion to help support those people admitted with dementia.
- There was a process in place when the department needed to refer patients to the mental health crisis team, which was provided by Lincolnshire Partnership NHS Foundation Trust (LPFT).

## Learning from complaints and concerns

- Staff knew how to inform patients or relatives who wished to make a complaint.
- Complaints were handled in line with the trust policy.
- Posters were seen in A&E and the hospital advising people how they could take their concerns forward.
- A&E staff were kept up-to-date of complaints the department had received and their outcomes on a regular basis via their team meeting. Staff not present could refer to the minutes.
- Staff were briefed on the complaints received and how they could prevent a similar occurrence.

## Are accident and emergency services well-led?

Good



The units forming the emergency department had strong leadership at local level with staff feeling supported in their roles. The rapport between staff groups appeared good and staff felt confident in taking any issues to their line manager in the knowledge it would be addressed.

# Accident and emergency

The medical and nursing leads for A&E were knowledgeable about the services they delivered and proud to work in their departments.

**We did not re-inspect this aspect of the service in February 2015.**

## Vision and strategy for this service

- There was a document entitled Future Health and Care Services in Lincolnshire in circulation which involved all of the major stakeholders in Lincolnshire. It was considering the future provision of services across the county.
- In addition, a further document entitled “Shaping Health for Mid-Kesteven” included the future provision of healthcare in Grantham and District Hospital.
- It was unclear what the future of emergency care in Grantham and District Hospital would be.
- Staff caring for adults knew the trust’s strategy.
- The paediatric staff were not clear on the trust’s vision and strategy. However they were aware there was a sustainability service review being undertaken and that this would lead to the ultimate vision and strategy for the Child Health Service.
- The majority of staff we spoke with were concerned about the future of the paediatric service at Grantham and District Hospital. They explained to us that communication from the board, regarding the sustainability review, was poor.

## Governance, risk management and quality measurement

- We asked staff if or how they would raise issues about safety concerns or poor practice in their department. They felt confident about taking any concerns to their line manager and felt it would be dealt with.

- Risks to the delivery of high quality care were identified, analysed and controls put into place. Key risks and actions were reported through the governance structure and reported to the board. On the risk register, however, children remained at risk in the A&E because insufficient controls had been put into place to mitigate the risk.

## Leadership of service

- All staff felt supported in their roles and felt able to access their line managers to raise concerns at any time.
- Nurse leadership was strong in A&E.
- The medical lead for A&E services in the trust always worked at Lincoln County Hospital.
- Regular liaison between the three A&E departments in the trust was not in place at the time of our visit. We were informed such liaison would be useful in imparting lessons learned from incidents and communicating good practice.
- The medical and nursing leads for A&E were knowledgeable about the services they delivered and proud to work in their departments. They appeared to be passionate about giving good quality care.
- Staff appeared to work well together with obvious respect across the disciplines.

## Culture within the service

- Staff were willing to speak with the inspectors.
- Staff informed us it was a “happy” place with a “cottage hospital” atmosphere.
- Staff felt disconnected from staff working in Lincoln County Hospital and Pilgrim Hospital, Boston.

# Medical care (including older people's care)

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

## Information about the service

Grantham and District Hospital provided care on two wards, which provided general medical care to patients. This included a ward for people who had had a stroke and people with cardiology problems and a ward for people with gastro-intestinal and respiratory problems.

In 2014 we visited both medical wards, and spoke with seven patients, three visitors, and five members of staff.

The emergency assessment unit (EAU) was used by all specialties, including medicine. In February 2015 we visited EAU as part of the medicine specialty, as well as the two wards we visited previously.

We spoke with six patients and 22 members of staff.

## Summary of findings

In 2014 we found that there was a good culture of reporting incidents and accidents amongst staff, and appropriate action was taken, with learning being disseminated. Staff did not receive feedback from incidents they reported, so lessons were not being learnt from these. We found that staff were given feedback on important issues raised during our visit in February 2015. Lessons were learned, which had been disseminated across the sites. Cleanliness had recently improved, beds had been upgraded, and infusion pumps were readily available. Although some aspects of the environment required improvement, plans were in place to undertake this work.

Numbers of qualified nurses were still below that required by the trust, although the trust were recruiting; agency and bank staff were used when required and available. Patients received effective care and treatment that met their needs. In 2014 care bundles had been developed, but these had only recently been implemented and required embedding in practice. However, in 2015 the use of care bundles was embedded in practice, and senior medical reviews were undertaken regularly.

Staff were caring and compassionate. They interacted with patients in a respectful manner. Patients' privacy and dignity was maintained. In 2015, we found that transport arrangements for patients awaiting discharge were variable, and a pharmacy service was not available

# Medical care (including older people's care)

on Saturday and Sunday afternoons. The service was well-led by senior nursing staff. Staff reported feeling supported by managers. There was a lack of shared learning across sites.

## Are medical care services safe?

Requires improvement 

In 2014 we found there was a good culture of reporting incidents and accidents amongst staff. Appropriate action was taken to analyse incidents and accidents, so that lessons could be learned and further risk reduced. However, feedback was not always given to staff so that they could embed the learning. Improvements to services at other sites, was not shared across sites, and not implemented. During our inspection in February 2015, we found that this had changed, and staff did receive feedback from incidents, and good practice was shared across sites. Safety Thermometer, and patient safety and quality audits, were carried out at ward-level, and the results of these were displayed. Action plans were developed to address any shortfalls. Patients received regular senior medical reviews, and the use of the sepsis care bundle was embedded into practice.

Cleaning audits had shown no improvement until the month prior to our 2015 visit. Environmental issues remained on Ward 1, and the day room had been utilised as an additional patient area. Plans were in place to upgrade the ward in March 2015. The infection control team were actively reviewing practice, and making improvements to infection control issues. There was sufficient equipment in place to provide care.

Staff told us they had received the mandatory training they required. Staffing numbers for nursing and medical staff were appropriate to meet the needs of patients. The trust had carried out an acuity study to establish actual numbers required. There was an ongoing recruitment drive, but some wards were not yet staffed to the required numbers. Bank and agency staff were used to cover any shortfalls.

### Incidents

- Staff were aware of the need to report incidents. They told us they used an electronic reporting system to report incidents.
- In 2014, staff told us that they did not usually receive any feedback about the incidents they reported. However, in February 2015, staff informed us that they now received individual feedback on important issues they had reported, but not on issues relating to, for example, staff shortages. We were told about one incident that had

# Medical care (including older people's care)

been raised by a ward clerk, relating to an important document not being correctly completed by a doctor. They had received notification, via an email, that the matter had been closed; there was no indication about what action had been taken, or the measures taken to prevent its re-occurrence.

- In 2014, we asked staff how they learned from mistakes that had occurred. Some staff told us that lessons learned would be communicated during ward staff meetings. This seemed to be Grantham and District Hospital-specific and did not include incidents. We found no other evidence that lessons were consistently shared across specialities and sites to improve practice.
- In 2014, we were told that there used to be a 'lessons learned' meeting for senior staff, but these meetings had not been held for some time. During our inspection in February 2015, we saw ward meeting minutes that showed staff were kept informed of lessons learned, and actions taken to reduce similar occurrences when incidents had occurred. Staff not present at those meetings were expected to read the minutes and sign to state that they had read them. We saw a staff newsletter produced bi-monthly that also mentioned incidents that had been raised.
- In 2014, the matron for medicine looked at all incident reports, and these were discussed at monthly ward manager meetings. We saw evidence that the matron for medicine was investigating incidents that were of particular concern.

## Safety thermometer

- Safety Thermometer audits and patient safety and quality audits were carried out monthly.
- The results of the patients' safety and quality audits were displayed. Results for April 2014 recorded that medical wards had scored highly for the majority of metrics measured. Sepsis and patients receiving a senior medical review were recorded as below target. We were told that action plans had been developed.
- We saw that wards and departments were scoring highly in the majority of metrics measured.
- In February 2015, audits for the use of the sepsis care bundle were meeting the trust's targets, and staff we spoke with were knowledgeable in its use. We found patients on medical wards were receiving a senior medical review within 18 hours of admission, including weekends. No discharges were undertaken unless patients had received a senior medical review.

- Monthly audit results were discussed at ward manager meetings. Action plans were developed at ward-level to address any shortfalls identified by the audit.
- During our visit in February 2015, we found a Listening into Action™ group (LiA) at the hospital had ensured that care bundles were well established. 'Bundle champions' were in place on each ward and e-learning packages on their use have been redeveloped for staff to access.

## Cleanliness, infection control and hygiene

- We found that ward 6 was clean and tidy. We observed that staff wore appropriate protective equipment such as gloves and aprons and washed their hands between each patient contact. There was hand washing facilities and hand sanitiser available on the ward but at the end of patients' beds. Hand sanitiser at the end of patients' beds assists staff to clean their hands between each patient contact.
- We observed a staff member taking a clean trolley containing equipment for taking blood into the sluice. We pointed this out to the nurse in charge, who quickly challenged this staff member.
- Ward 1 was mostly clean and tidy but we found dust underneath trolleys and high dust on curtain rails. During our inspection in February 2015, Ward 1 was clean and tidy, with no dust observed underneath trolleys or on curtain rails.
- We saw that barrier nursing was carried out where required and this protected patients from the risk of cross infection.
- Staff we spoke with demonstrated a good awareness of expected standards regarding infection control.
- In 2014, we looked at the hospitals figures for MRSA and C. difficile in the medical directorate for the last six months. The trust reported that there had been no incidents of MRSA or C. difficile during this period.
- We looked at the trusts cleaning audits from January to April 2014. The trust were performing below their expected standard of 95% for these audits.
- In February 2015, information received from the trust revealed cleaning audits for Wards 1, 6 and the emergency admission unit (EAU) showed that none of those areas had achieved the trust's target of 95% in December 2014. Wards 1 and 6 achieved 85% and 84% respectively, with EAU achieving only 79%. In January 2015, Ward 1 had achieved 95%. Staff informed us that a

# Medical care (including older people's care)

new cleaner had been employed, but cleaners were not always available to clean bed spaces in the afternoon and evenings. This meant that healthcare support workers had to undertake the task.

## Environment and equipment

- The environment/premises on Ward 1 were old. In 2014 we noted that there was plaster and paintwork peeling off the wall. There was limited space to store equipment. This resulted in hoists being stored outside the patients' dayroom. This did not create a pleasant environment for patients, and made it difficult for staff to access the equipment.
- During our visit in February 2015, we found that Ward 1 was still experiencing difficulties in the storage of hoists because of the lack of space. We observed that some of the paintwork on doors and walls was chipped, and bed curtains were difficult to use as curtain tracks did not run smoothly and sometimes required considerable effort from staff to pull them. We found a large mobile electric heater in use outside a patient's bedroom; it was being used safely. The patient informed us that they were cold and there was a draught coming through the window in their room; we heard the noise that the wind made. The patient had to keep one window curtain drawn in order to shield them from the draught. The trust informed us that the plans for refurbishment of this ward would commence in March 2015.
- We looked at resuscitation and emergency equipment on the medical wards we visited. We saw that all required equipment was in place. We saw that staff were recording daily checks on resuscitation equipment.
- In 2014 we found that the lifts near maternity, and leading to Wards 1 and 2, were frequently out of order. We were told that new parts were being made and would be ready in the two weeks following our inspection. There was a business continuity plan in place to manage this while repairs were ongoing. This involved patients and visitors having to use the stairs if both lifts were not working. If patients were in theatre, they would be cared for in the day care unit rather than returning to Ward 2. When we re-inspected in 2015, we found that the lift leading to Wards 1 and 2 had been repaired, and was in working order.
- We saw that equipment for the prevention of pressure sores was being used appropriately. Staff reported that access to pressure-relieving equipment was good.

- At our first inspection, we noted that there was a shortage of electronic profiling beds. These beds are essential for patient comfort and staff safety when caring for patients' with mobility problems. When we revisited the medical wards in February 2015, all the beds had been replaced with an electric profiling model. On Ward 1 this sometimes caused an issue, because of the lack of available electric sockets if other pieces of equipment were required for the patient, such as an infusion pump or air-flow mattress. Newly-supplied infusion pumps were also available.
- On Ward 6, the day room had been used as additional bed space for two patients. Although privacy curtains, oxygen, and suction equipment were available, staff could not access both sides of either of the beds in an emergency situation, as they were both pushed against the wall. Other patients did not have access to day space or a television.

## Medicines

- We looked at medicine administration records and spoke with staff about medication management on the medical wards.
- We saw that medicines were clearly and correctly prescribed.
- Medication administration records were accurate and up to date.
- Staff had their competency assessed for medicines.
- Staff had received additional training and had their competency assessed for administering intra-venous medicines.

## Records

- We looked at nursing and medical records in all the wards and departments we visited.
- We saw that risk assessments and care plans were in place for all identified risk and needs.
- We saw that all Do Not Resuscitate records had been completed appropriately and this included a record of discussion with the patients and or their relatives.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had completed training about the mental capacity act and Deprivation of Liberty Safeguards. Staff knew how to recognise the signs of abuse, when to raise concerns and who to report them to.
- Mental health liaison nurses were based at the hospital.

# Medical care (including older people's care)

## Safeguarding

- A safeguarding link nurse role had been developed for each ward.
- The safeguarding link nurses attended annual safeguarding champion meetings as well as local meetings with the matron.
- Staff demonstrated a good knowledge of safeguarding policies and procedures and knew who to report their concerns to.
- All staff had completed safeguarding training level 1 and 2, and this was repeated annually.

## Mandatory training

- Staff reported they had good access to mandatory training and were up to date.
- We asked the trust to supply figures for the actual training received but they have not been able to supply this information.

## Management of deteriorating patients

- At the time of our 2014 visit, the trust was using a system known as 'track and trigger'. An intervention protocol was in place for staff to follow when patients' physiological observations were not within normal range. We were told there was a 'high intervention' team for staff to call when patients were deteriorating. In 2015, we saw that the national early warning score tool was now established and common practice amongst staff.
- We saw that staff were monitoring patients' physiological observations and following the intervention protocol.
- Evidence of escalation, if required, was included in monthly patient safety and quality audits.
- We were told that a nationally recognised early warning score system was being introduced and would replace 'track and trigger'.

## Nursing staffing

- The required staffing numbers and actual staffing numbers for each shift were displayed on all the wards and departments we visited. Staffing numbers were appropriate to meet patients' needs. Both medical wards had vacancies for nursing staff and recruitment was ongoing.
- Patients we spoke with told us they did not have to wait for staff to attend to them and had received the care and treatment they required.

- Staff we spoke with told us there were usually enough staff on duty. Bank staff were used to cover any shortages.
- Because of the trusts latest review of staffing, patient numbers in each area had previously been reduced to reflect funded nursing establishment levels based on safer staffing levels for a ward. For example, on Ward 1, the number of patients had been reduced to 22 to reflect the initiative. In the previous few weeks, this had risen to 28 because of the increased demand for beds, although staffing levels had not.
- On Ward 1, because of the vacancy rate of 5.65 whole time equivalent qualified nurses, the ward was relying on bank and agency staff to provide support on a regular basis, especially at night. A patient informed us that the quality of agency staff varied.
- Prior to our inspection in February 2015, we had been alerted to the fact that some members of the nursing staff had serious concerns relating to the improving time to care shift systems that had been introduced by the trust in August 2014. The new system had resulted in the majority of nursing staff being required to complete a combination of shifts, some of which meant undertaking 'long days', such as 13 hours, sometimes as many as three a week. Some of those staff had informed us that those shifts made them extremely tired; this was also evidenced when we spoke to staff during our visit. We received information from a member of staff that this had led to their area losing nurses as a result. The trust informed us the system would be reviewed in April 2015.

## Medical staffing

- Consultants carried out ward rounds three times a week and also carried out board rounds to discuss each patients care and treatment.
- There was consultant cover seven days a week. Consultants' were on-call out-of-hours.
- Staff we spoke with reported that medical staffing was appropriate to meet patients' needs.

## Are medical care services effective?

Good



In 2014, we found that patients' needs were assessed, and care was planned and delivered to meet individual needs. Risk was also assessed, and management plans were

# Medical care (including older people's care)

implemented. Patients had their nutritional and hydration needs met, but staff were not fully engaged in protected meal times. Care bundles had recently been introduced, but required further embedding into practice.

When we inspected in February 2015, the use of care bundles had been embedded into practice, and the trust had no mortality outliers. A full seven-day service, relating to the availability of medicines for patients to take home, was only available Saturday and Sunday half days.

## Evidence-based care and treatment

- Staff were aware of care bundles but these were not routinely being used in 2014. The trust had developed care bundles for patients with specific conditions such as sepsis and heart failure. However, we did see that patients were receiving the care and treatment they required.
- During our inspection in February 2015, we found that the use of care bundles/pathways by staff had been embedded into practice, such as those in respect of sepsis, pneumonia, acute heart failure, and chronic obstructive pulmonary disease. Staff were aware of the need to use the bundles as routine for patients with specific illnesses.
- Nursing care plans were in place for all assessed needs.

## Pain relief

- Staff were using a pain assessment tool specifically designed for people with dementia where this was applicable.
- Staff carried out hourly intentional rounds. Assessment of pain was included in the intentional round. Staff took appropriate action when pain was identified. For example, staff assisted the patient to change their position and or administered prescribed analgesia.

## Nutrition and hydration

- We observed the lunch time meal served during our inspection.
- We saw that staff collected the meal from the trolley but instead of using a tray they carried the plate to the patient. This did not comply with food handling or hygiene best practice and may have been off-putting for patients.
- In our inspection in February 2015, trays were still not being used to take plated meals to patients. On Ward 6 at lunchtime, we found one patient having to balance their meal on their knee with a newspaper underneath it. No table or tray had been given to them to use.

- Not all staff were fully engaged in the serving of meals and assisting of patients who required this. Some staff members did not become involved in the serving of the meal or with assisting patients.
- In our inspection in February 2015, we observed all staff engaged in the lunchtime service. On one ward we observed a student nurse standing over a patient to support them to eat lunch, which is not good practice; they did not appear confident in their actions, and qualified staff were not available to help them.
- Patients had their risk of malnutrition assessed. We saw that where risk was identified, appropriate management plans were in place.
- Patients told us that the meals provided were good.

## Patient outcomes

- At the time of the Keogh Review, the trust was flagged in respect of mortality outliers; however, at the time of this report, the trust SHMI and HMSR data is within expected limits.
- Since our last inspection, we had been alerted to two mortality outliers. However, the trust reviewed the information they held for both outliers, and put actions in place to reduce risks to patients. As a result, the outliers were considered closed in January 2015. At the time of this report, the summary hospital-level mortality indicator (SHMI), and hospital standardised mortality ratio (HSMR) were within the expected limits.
- Staff were using a system known as 'plan for every patient'. This meant that staff were planning for patients to be discharged as soon as possible after admission. Any issues delaying the patients' treatment and increasing length of stay were considered each day, so that staff could take the appropriate action required.
- We spoke to ward staff about discharge arrangements for patients when we inspected the hospital in February 2015; we received mixed feedback. Doctors were encouraged to plan and complete the electronic discharge document (EDD), and order medicines for patients to take home, in a timely way to prevent delay.

## Competent staff

- Staff reported that they were up to date with all mandatory training.
- We were told that dementia care was now included in the induction training for all healthcare assistants. Not all staff had received training about dementia care.
- Staff told us they had an appraisal with their line manager.

# Medical care (including older people's care)

- The hospital employed clinical nurse specialists for cardiac care, respiratory care and diabetes.
- We spoke with a patient who had respiratory problems. They told us about the clinical nurse specialists for respiratory care and said they could contact them at any time and they had been a great help.

## Multidisciplinary working

- We saw examples of good multidisciplinary working. We saw that physiotherapists, occupational therapist and social workers were involved in the care and treatment of patients.
- Nursing staff made appropriate referrals. For example, we saw that a patient with dementia had been referred to the mental health liaison nurse. We saw that social workers had been asked to assess patients' who required ongoing care and support when they left hospital.
- We were told there was a two day delay to access a speech and language therapist. This potentially delayed the treatment patients required and resulted in a longer than necessary hospital stay.

## Seven-day services

- At the time of our visit, physiotherapists and occupational therapists were on duty seven days a week. We were told that this arrangement was temporary and would revert back to a Monday to Friday service. However, physiotherapists would continue to support patients' with respiratory problems at weekends.
- Consultants carried out ward rounds three times a week and also carried out board rounds to discuss each patients care and treatment.
- There was consultant cover seven days a week. Consultants were on-call out-of-hours.
- There was no pharmacy available at weekends. If a patient was discharged at the weekend they could be supplied with a prescription to take to their local chemist. This did, however, result in the patient having to pay for their prescription. In February 2015, we found that medicines could be obtained from pharmacy each week-day, as well as Saturday and Sunday mornings. On the emergency admissions unit (EAU), FP10's were used if the pharmacy was not open. FP10 prescriptions are the prescriptions that can be taken to any community pharmacy to be dispensed.

## Are medical care services caring?

Good



Patients' reported that staff were caring and kind. We observed that staff interacted with patients respectfully and appropriately. Patients had their privacy and dignity maintained.

**We did not re-inspect this aspect of the service in February 2015.**

## Compassionate care

- Nursing staff carried out hourly intentional rounding. This meant that staff had contact with each patient at least hourly and attended to their comfort and needs.
- We spoke with patients and visitors on all the wards and departments we visited. The majority of patients and visitors were complementary of the care, treatment and support they received.
- The NHS Friends and Family Test was used on all wards and departments we visited. The results of this were displayed in the wards and departments we visited. These were mostly positive.
- We saw examples of staff responding in a flexible way to meet the individual needs of patients. For example, staff had enabled a patient to sleep through the lunchtime meal and had ensured they got their meal at a later time. This was because the patient had not slept well on the previous night.

## Patient understanding and involvement

- Patients told us they were involved in making decisions about the care and treatment they received.
- Comments made included, "The staff are very good," and, "Staff are kind."
- We saw that staff maintained patients' privacy and dignity. Curtains were pulled around the bedside and signage was in place to alert staff and visitors not to enter.

# Medical care (including older people's care)

## Are medical care services responsive?

Good 

Patients had their individual needs met. Suitable arrangements were in place to meet the needs of patients with dementia.

**We did not re-inspect this aspect of the service in February 2015.**

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

- The medical wards had specialised beds for patients who had had a stroke.
- Plans were in place for a hospice within the hospital. This was a joint venture with the local hospice.

### Access and flow

- The trusts' figures for bed occupancy at the time of our visit was at 94%. 5.65 % of medical patients were receiving treatment on wards in other directorates during this time. We were told that patients were only moved to another ward once they were medically fit and getting ready for discharge. There were no patients classed as outliers on different wards during our visit.
- We looked at processes for discharging patients and informing the patient's GP. We saw that medicines to take home were checked by two nurses and a GP letter was sent detailing the care and treatment provided.

### Meeting people's individual needs

- Face-to-face translation services and telephone translation services were available at the trust.
- There was a site lead for dementia care and ward link nurses. Staff we spoke with knew how to contact them for advice and guidance. Staff also had access to mental health liaison nurses.
- There was no dementia-specific care planning process in place. The trust had developed a dementia-specific 'this is me' form for staff to use to gather important information about the person and therefore improve communication with the patient. This form was not routinely being used at the time of our visit. However, we did see that patients with dementia on the ward during our visit were receiving appropriate care and treatment and staff were meeting their needs.

## Are medical care services well-led?

Good 

Governance systems were in place to assess and monitor risk and effectiveness. Responsibilities were clear, and problems were detected, understood and addressed. Staff felt supported, and managers were visible, approachable and accessible. However, there was little evidence of the sharing of good practice across the hospital trust. In February 2015, there were initiatives in place, which encouraged the hospital to work more collaboratively across the trust. Some staff did not feel comfortable raising issues with their managers, but action was taken by the trust executive team if they were alerted to any issues.

### Vision and strategy for this service

- The matron and ward managers for medicine were clear about their roles and responsibilities.
- They told us about the strategies that had been introduced such as the dementia care strategy and the use of care bundles. They were aware of the actions they needed to take to fully implement and embed these.
- There was very little evidence of pan-trust collaborative working or of the sharing of lessons learned.
- In February 2015, we found there were initiatives in place, which encouraged the hospital to work more collaboratively across the trust. In March 2015, the trust were intending to hold a day of celebration to mark the achievements of Listening into Action™. This will be held in Sleaford, and for those who cannot attend a video will be recorded and placed on the trust's intranet site for staff to access.

### Governance, risk management and quality measurement

- Safety Thermometer and patient safety and quality audits were carried out monthly.
- Monthly ward manager meetings were held with the matron for medical care. Safety, risk and audit results were discussed and action plans developed. Each ward manager then cascaded important information to other staff at ward meetings.

### Leadership of service

- We observed that matrons and ward managers were highly visible on the wards and departments we visited.

# Medical care (including older people's care)

- Staff we spoke with told us they felt supported and their managers were approachable and accessible.
- Medical and nursing staff spoke highly of each other and reported that working relationships were effective and supportive.

## **Culture within the service**

- Staff we spoke with were well motivated and positive about their roles. They told us they were confident in raising concerns with their managers.

- In February 2015, most staff we spoke with felt confident about raising concerns.

## **Public and staff engagement**

- Staff we spoke with were aware of the Listening into Action™ initiative and were able to provide examples of improvements made.

# Surgery

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

## Information about the service

The surgical unit at Grantham and District Hospital comprised a 28 bed ward, four theatres and a day ward.

The unit carried out elective (planned) general surgery and elective orthopaedic surgery for knee and hip replacements. It also undertook trauma surgery for fractured neck of femur.

We observed care in theatres and on the ward and in the day unit. We examined records and spoke with staff and patients using the service.

## Summary of findings

In 2014 the service was good, but improvements were required in the safety of the service. This related to the records of specific areas of care (catheter care and cannulas), which were not completed in all cases. However, in 2015, we found that this had improved, with audits showing that 100% of records were completed. We rated this domain as good in 2015.

Care was effective in the service, with good outcomes reported for patients, and practice was in line with national guidance. Staff were caring and compassionate in their support for patients. Privacy and dignity was maintained. There were very good results from the NHS Friends and Family Test for Ward 2.

In 2014 the service was not always responsive to patients' needs. The trust was not meeting referral to treatment (RTT) times for the surgical specialities operating at Grantham and District Hospital. We found a similar picture in 2015. In 2014, there were intermittent problems with the lifts servicing the ward, which meant that patients were sometimes cared for in the day surgery unit. However, in 2015 we found that this problem had been resolved. The unit was responsive to individual patient needs, and translation services were available, if required.

The service was well-led. Managers had a clear strategy for the service, and staff reported feeling supported. Staff felt that the senior management of the trust was more visible within the hospital over the last year.

# Surgery

## Are surgery services safe?

Good 

The unit carried out audit, and displayed the results of its Safety Thermometer. The environment was clean and audits showed that cleanliness was maintained. Infection rates were within statistically-acceptable limits. PPE was available for people working in and using the unit. Records were maintained, and all staff used the same documentation to promote continuity of care.

Staff had received appropriate training in safeguarding, and were aware of the MCA and Deprivation of Liberty Safeguards. There were guidelines in place for managing deteriorating patients, and staff were aware of how to escalate concerns. In 2015, we saw that the national early warning score had been implemented. Staff told us that staffing had improved in the last year, and there were adequate nursing and medical staff. In 2015, the ward area was to increase the number of nurses on duty following a staffing review.

In 2014, audits showed that some assessments were not completed. Specifically, audits for catheter care and cannula care had poor completion rates in the most recent period we looked at. In 2015, we saw that audit data showed that catheter and cannula care was documented 100% of the time, and records reviewed reflected that. We saw that the ward was to undergo a significant refurbishment in Spring 2015, and that the lift servicing the ward was more reliable.

### Incidents

- There were no 'never events' reported for surgery at Grantham and District Hospital in the last two years, and 214 incidents for surgery had been reported across the trust in 2014.
- Staff on the ward and in theatres were able to describe the steps to take in the event of a serious incident, the role of investigation and potential change in practice.
- Staff we spoke with were aware of the importance of incident reporting and told us they were encouraged to report incidents. Staff told us that they received feedback on incidents when they occurred.

### Safety thermometer

- The Safety and Quality Dashboard was clearly displayed on the ward and could be seen by staff, patients and visitors. We were told it was completed monthly.
- Most of the results were positive, however, some elements of care scored poorly on the Dashboard.
- We saw that venous thromboembolism (VTE) assessments had been completed.
- In 2014 only 50% of catheter records had been completed, and data that we had prior to the inspection, showed that the trust had a higher level of catheter-associated infections than the England median. In 2015, four records we reviewed showed that all documentation relating to catheters had been completed. Audits demonstrated an improvement in recording of catheter care.
- In 2014, none of the records audited, relating to patients with a cannula, had been completed on every shift, or the patient demographics completed. The use of cannulas, particularly for longer than several days, is associated with a greater risk of infection. In 2015, we found that eight records we reviewed, relating to cannulas, were properly completed. Staff told us that, on occasions, they had to remind medical staff to complete the records. Audits showed an improvement in the recording of cannulas.
- Further results of the Dashboard are available under other sections.

### Cleanliness, infection control and hygiene

- Data we reviewed prior to the inspection, showed that MRSA bacteraemia infections were within statistically acceptable levels (with one case reported). Clostridium difficile rates were shown to be above statistically acceptable levels for a trust of this size. In 2015, we saw that there had been no recent C. difficile infections on the ward.
- The ward was clean and we saw staff regularly wash their hands between patients and between interventions. Staff were bare below the elbows in line with trust policy and national guidelines.
- We saw environmental cleanliness audits were regularly completed and scored highly. Hand washing audits were also completed and showed a high level of compliance with hand washing across different staff groups.

# Surgery

- PPE was readily available for staff and visitors, should it be required, and alcohol hand gel was placed at the entrance/exit to the ward and around the clinical environment.
- Patients who required barrier nursing or isolation were managed in a side room and the isolation policy was adhered to. At the time of our inspection, two people were being barrier nursed and we saw staff taking appropriate precautions with PPE and other equipment.
- Cleanliness audits were completed in theatres and the most recent audit achieved 98%.
- The unit participated in the ongoing surgical site infection audits run by Public Health England.

## Environment and equipment

- The environment on the unit was safe, with sufficient space for the safe movement of patients, staff and visitors. In 2014, in some areas of Ward 2, there were drill holes in walls where noticeboards had been removed and not replaced. In 2015, we found that the environment had not changed. However, we were aware that a large scale refurbishment of the ward areas was to commence in March 2015, and would address concerns regarding the environment.
- Side rooms were available if required, and again, there was sufficient space to ensure safe movement of patients who may require the use of lifting equipment, such as hoists.
- Equipment on the unit was clean and maintained at regular intervals, as instructed by the manufacturer.
- In 2014, staff reported that the lift servicing the wards was regularly out of service, the last occasion being on the Good Friday prior to the inspection. We were told by staff that when this occurred, surgical patients would be cared for on the day surgery unit until the lift was repaired. Staff said the repeated failure of this lift was impacting on the surgical care that people received. This also had implications for people with limited mobility accessing the wards. In 2015, we found that the lift was in use. Staff reported that it had been repaired, and now was functioning correctly. Information we reviewed confirmed this, and also that the issue had been managed on the risk register.
- The resuscitation equipment was checked daily. We saw that where an item on the resuscitation trolley was going out of date on the day following the inspection, this had been noted on the checklist. The nurse in charge told us that this had not been reported to her,

but that there was a stock of equipment in the high dependency unit (HDU), where equipment could be replaced 24-hours a day. Emergency equipment in theatres was all checked regularly, and found to be correct.

## Medicines

- Medicines were stored correctly and kept locked. Medicines that required refrigeration were kept in a locked fridge and the temperature of the fridge was checked daily.
- We saw one member of staff giving medication and checking the prescription and patient details correctly.
- Three drug charts we examined had allergies properly recorded.

## Records

- All records were paper-based. Medical notes were kept in designated trollies and other records such as observation charts and drug charts were kept at the end of beds or outside isolation rooms.
- All staff used the same documentation to ensure good communication and consistency in care provision.
- Record audits were completed for some elements of the records such as DNA CPR forms. The latest audit of DNA CPR forms (as part of the Safety Thermometer/SQD) showed that 50% of the forms had the healthcare professional details captured and only 67% had the decision also recorded in the medical notes in line with policy.
- We saw that the majority of risk assessments and associated tools such as pressure area assessments and falls were completed.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were no patients on the ward that were subject to Deprivation of Liberty Safeguards.
- Staff we spoke with demonstrated a good understanding of the MCA and were aware of the need for assessments and the constituents of best interest decisions.

## Safeguarding

- Staff had received training in safeguarding and were aware of the actions they should take, and the team they should contact, if they were concerned about a safeguarding concern.

# Surgery

## Mandatory training

- Staff received mandatory training in elements of care such as moving and handling, basic life support and infection control. Staff we spoke with on the ward and at focus groups told us they were up to date with mandatory training, which was a mixture of classroom-based and e-learning.
- Evidence from a training matrix showed that junior doctors had also completed mandatory training.
- Theatre staff were all up to date with intermediate life support training.

## Management of deteriorating patients

- In 2014, the unit used the 'track and trigger' method to identify deteriorating patients. We were told that the national early warning score (NEWS) system was to be implemented by the trust, which is the current best practice. In 2015, we saw that NEWS had been implemented across the surgical pathway. Records we reviewed showed that it was used correctly, and that patients were escalated for review if they scored highly on the tool. Three staff we spoke with told us that they were confident in using the tool.
- In 2014, if a patient caused concern on 'track and trigger', the HDU provided an outreach service six days a week. Staff we spoke with felt well supported by the outreach team, who always visited when requested. Outside of these hours, ward staff were supported by the EAU doctor. In 2015, we saw that the outreach team now supported the ward area 24 hours a day, seven days a week. Staff spoke highly of the support they received from the outreach team.
- If the patient required further care, there were level 2 beds available at the hospital, and further specialist care would require transfer.

## Nursing staffing

- In 2014, Ward 2 had been formed comparatively recently from the amalgamation of two other wards. Staff we spoke with told us that it had been beneficial to move wards, as the unit was now better staffed than in the past. In 2015, we saw that there was low vacancy rate in surgery. Staffing levels were maintained through a variety of shift patterns, and use of bank staff. A recent review meant there would shortly be an increase in the number of nurses on duty.

- The Keogh Mortality Review in 2013 had concerns regarding the level of staffing. This had now been addressed by the restructuring of the surgical ward and staffing numbers were now maintained.
- The ward did not routinely use an acuity tool to monitor the level of need of their patients. A senior member of staff told us they had used an acuity tool during March 2014 to determine if they required more staff, but it was no longer in use.
- The skills mix of the ward had been improved due to the ward restructure. The ward manager was aware that an influx of new staff and some from Europe would require management to maintain the skills mix on a shift to shift level.

## Medical staffing

- Medical cover was primarily provided by a consultant orthogeriatrician – in line with best practice for patients with fractured hips. Medical outlier patients were also looked after by the orthogeriatrician. Surgical patients were cared for by their respective teams.
- In 2014, the ward team were concerned that the consultant orthogeriatrician was soon to leave the service, and although the post had been advertised, a replacement was not in place. As the care would then be provided by the medical teams, staff were concerned that care may have less continuity until a new consultant was in place. Staff also told us that the consultant was responsible for the falls clinic, and that this would not continue once the consultant had departed. In 2015, we saw that, despite an ongoing recruitment campaign, an orthogeriatrician had not been recruited.
- Out-of-hours cover was provided by the on-call team, but all patients received senior review at weekends.
- There was limited locum consultant cover as reported by senior staff on the unit and at focus groups.

## WHO Checklist

- There were two WHO champions in theatres. Briefings before surgery always happened in line with best practice.
- WHO forms, when completed, were audited in recovery. Recent data indicates that for February 2014, 100% compliance was achieved for the WHO checklist.

**Are surgery services effective?**

# Surgery

Good



The unit practiced evidence-based care and treatment. Patients with fractured neck of femur were treated quickly, in line with NICE guidance and best practice. The service was soon to commence a recognised enhanced recovery pathway for patients requiring total knee replacements. People received adequate pain relief and nutrition and fluids, though not all people who required their diet monitored had that done. Patient outcomes were improved for people undergoing surgery for fractured hips and staff were competent to carry out their roles. The team had a strong multidisciplinary team (MDT) ethos and some services were available seven days a week.

**We did not re-inspect this aspect of the service in February 2015.**

## Evidence-based care and treatment

- The service treated fractured neck of femur patients in line with NICE guidance. The latest data showed that all patients were treated within the 72 hours target and according to best practice.
- Other guidance and best practice, included guidelines in monitoring unwell and deteriorating patients and the use of care bundles.
- We saw that the service was about to commence a recognised enhanced recovery pathway for elective patients undergoing total knee replacement, which is intended to speed recover, reduce length of stay and result in less complications post-surgery. This operation had been the only outlier on the E5-QD health status questionnaire.
- Staff followed local policy and procedure for the management of falls and pressure area care.
- There were no outliers on the National Joint Registry.
- In theatres, an audit was undertaken one half day every month; the following months' planned audits was for safeguarding and intermediate life support training

## Pain relief

- Patients were seen regularly on the unit by senior staff and assessed for pain. We saw that pain relief was administered in a number of ways such or oral tablets, injection or patient-controlled analgesia, dependent on the best method for the patient.

- We saw that patients were asked about their pain prior to physiotherapy input and one therapist told us they delayed physiotherapy until patients had had pain relief.
- Though there was no dedicated pain service, the outreach team also advised on acute pain relief. One patient we spoke with told us their pain had been well controlled following their operation.

## Nutrition and hydration

- Where patients were able to eat and drink, we saw that they were supported to do so. We saw one nurse assisting a patient to drink. An audit of documents showed that in the most recent period, three quarters of patients who were deemed to require a food chart actually had one started.
- Following surgery, patients' hydration needs were met with intravenous fluids, if required.

## Patient outcomes

- The unit maintained an audit of fractured neck of femur comparing recent data to last year. The results showed that, due to changes made on the unit, patient outcomes were better. Mortality for this group of patients was reduced, as were length of stay and readmissions.
- The changes, in line with NICE guidance, improved admission assessments, ensured patients were discussed at MDT and a full falls assessment completed.
- The unit also participated in national clinical audits, such as the National Hip Fracture Database.
- All patients were seen by the OT preoperatively, so that a full assessment, including falls assessment, could be completed, problems identified and plans made for patients recovery and discharge. The OT also provided group education for patients prior to their surgery.

## Competent staff

- The staff survey showed that some staff across the trust were not receiving appraisals or supervisions. We spoke with staff, who told us that they had received appraisals in the last year and the unit manager confirmed that 76% of staff were appraised and the remaining were booked. In theatres, 80% staff had received an appraisal.
- Professionally registered staff were supported to maintain their continuous professional development for registration with their professional bodies.
- The unit supported staff, where possible, to undertake further training.

# Surgery

## Multidisciplinary working

- The MDT undertook a ward round daily with input from other disciplines.
- A formal MDT meeting was held weekly and highlighted concerns and priorities for the staff.
- All patients on the ward were screened by the OT and physiotherapist to ensure patients who required their input were seen promptly and a plan of care made. We saw a referral made to speech and language therapists and that the patient had been seen.
- At focus groups, senior staff told us that there was limited MDT working between sites in the trust, which has potential to impact on care.
- In theatres, the MDT held a daily trauma meeting to discuss patients for that day's trauma list.
- The unit ran a "plan for every patient", which showed staff clearly what care each patient required to permit their safe discharge.

## Seven-day services

- There was medical and anaesthetic support out-of-hours. Staff told us that allied health professionals were available for the unit at weekends.
- Senior medical staff reported that they were able to get routine radiology services out-of-hours and at weekends.
- Other specialist staff such as microbiology and pharmacy were available by telephone if their input was required.

## Are surgery services caring?

Good



We saw staff providing compassionate care maintaining people's dignity and privacy. There were positive interaction between staff and patients and their relatives. Patients were kept informed of their treatment and their future plan of care which was discussed with them prior to surgery. The NHS Friends and Family Tests were very positive for Ward 2.

**We did not re-inspect this aspect of the service in February 2015.**

## Compassionate care

- We saw patients treated with dignity and respect. Curtains were drawn to maintain people's privacy and

dignity. Staff told us that if patients were unwell, wherever possible they were moved to side rooms so that the patients and their family had a greater degree of privacy.

- We saw allied health professionals discussing a patient with a nurse and doctor. The staff spoke with respect about the patient and showed genuine interest and concern for their welfare.
- The NHS Friends and Family Test results were very positive for ward 2.

## Patient understanding and involvement

- Patients had signed consent forms for procedures. Consent forms clearly described the risks and benefits of the procedure. In preoperative notes, notes demonstrated that people had been given options about their care and recovery.
- Information about their procedure and what to expect was available for patients to take away.

## Emotional support

- Staff told us how they supported patients and their carers during their stay in the unit, which emphasised a collaborative approach to care.
- We saw that intentional rounding was carried out to provide care and support for patients staying on the unit.
- One senior member of staff told us that visiting times were quite open and flexible out-of-hours if people were unwell.
- In day surgery, patients' relatives were able to stay and accompany them to theatre reception.

## Are surgery services responsive?

Requires improvement



The ward accepted patients of different specialities, and this meant that there were a number of intra-ward movements during the week. Patients had a pre-operative assessment by the MDT, and preparation for safe discharge was commenced at an early stage. In 2014, the trust was not meeting referral to treatment times for the surgical specialities operating at Grantham and District Hospital. In 2015, we saw that referral to treatment times were still not meeting national targets for specialities and operations being carried out at Grantham.

# Surgery

The unit was responsive to individual patient needs, and translation services were available if required. Complaints were handled in line with local policy, and learning from complaints was cascaded to staff through formal and informal meetings.

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

- The unit accepted a mixture of elective general surgery, emergency and elective orthopaedic and some medical patients if the hospital was busy.
- To prevent the risk of cross infection, it is good practice to keep elective 'clean' orthopaedic patients separated from patients who have had 'dirty' surgery (though there is no bowel surgery conducted at Grantham and District Hospital). Staff told us that because of limited beds and throughput of patients, it was necessary to move people intra-ward to ensure they were nursed with similar patients. We were told that these moves could happen throughout the week. The four-bedded bays on Ward 2 allow staff to segregate patients and maintain clean bays.

## Access and flow

- Bed occupancy for the trust was 82.3% against an England average of 85.9% and below the 85% target.
- Patients were assessed by the MDT, including an anaesthetist prior to admission. This allowed staff to highlight patients care needs before their operation and have plans in place for their recovery.
- Discharge planning began at preoperative assessment for elective patients and on admission to the unit for trauma or emergency patients.
- Following audit, all patients with fractured neck of femur were admitted and received treatment within 76 hours, as per national guidance.
- In 2014, the trust was not meeting referral to treatment times (treatment within 18 weeks) for inpatient general surgery at 85.6%, and trauma and orthopaedics at 72.3%, against a target of 90%. These figures are for February 2014 and produced by NHS England. In 2015, the last three months available data (September, October and November 2014) showed that, other than on one occasion, the trust continued to fail to meet referral to treatment time targets.

- Staff reported it was rare to have a surgical outlier at Grantham and District Hospital, as the surgical ward regularly had medical outliers. In this event, a swap of patients between wards would occur.
- We were told that some operations were cancelled due to damaged wraps on surgical instrument trays in theatre that had been sterilised outside of the hospital. There were few cancellations related to bed availability. Patients who were cancelled were given a new operation date before they left the hospital.
- If patients in day surgery were assessed as being unfit for discharge, they were transferred to the ward to ensure they received the correct care.
- The day unit operated a system of nurse-led discharge for some surgical procedures to ensure smooth flow and prompt discharge of patients.

## Meeting people's individual needs

- The unit provided support with additional needs such as those required for bariatric patients and patients with dementia.
- Interpretation services were available for people who required support with communication, and was available by telephone.
- Staff were aware of the needs of people from different faiths and religions and that representatives of other faiths could be contacted to meet people's spiritual needs.
- We saw that where people needed ongoing support, the unit had completed NHS Continuing Healthcare assessments.

## Learning from complaints and concerns

- Complaints were handled in line with the trust complaints policy and the new Patient Advice and Liaison Service team. Information on how to make a complaint was available for patients and carers.
- Outcomes and actions from complaints were disseminated to staff through formal and informal meetings. There had been no recent complaints about the unit in line with the NHS Friends and Family Test results.

# Surgery

## Are surgery services well-led?

Good



The ward area had recently been reconfigured to ensure sustainable and safe staffing. Leadership on the unit had managed this change and supported staff. Since the reorganisation, the staff felt the unit was heading in a positive direction. Medical staff on the unit had been responsible for audit and service improvement particularly in relation to fractured neck of femur.

The unit had an open culture and staff felt able to raise concerns. Though results in the 2013 staff survey had been poor, staff we spoke with said matters had improved in the last year and most had had appraisals. Staff said that medical and nursing leadership was approachable but we were told there was concern that a senior member of medical staff would soon be leaving the service and no replacement was yet in place.

**We did not re-inspect this aspect of the service in February 2015.**

### Vision and strategy for this service

- The ward manager demonstrated a clear vision for the future of the service. The inpatient unit had been recently reconfigured into one ward to improve staffing and better support patients undergoing surgery. The ward manager described this process and how they had supported staff through this difficult time. Staff we spoke with told us of the difficulty of the ward move, but that it had resulted in sustainable staffing on the ward and a clearer future for the service.

### Governance, risk management and quality measurement

- The unit leadership, both nursing and medical, had completed audits designed to calculate the quality of the measurement. Senior medical staff had undertaken

a significant audit of fractured neck of femur patients, adherence with NICE guidelines and patient outcomes that demonstrated sustained improvement against benchmarks.

### Culture within the service

- Staff told us that the manager of the service and senior medical staff were visible and approachable on the unit.
- Unit level staff survey data was not available, but we saw the results for the most recent staff survey (2013). The trust performed within the bottom 20% of trusts nationally for questions relating to effective team working and work pressure amongst others. All staff we spoke with told us that things had improved in the last year and that board-level managers were now more visible at Grantham and District Hospital.
- Staff told us that they received appraisals and team meetings as well as being supported to develop their role and undertake further education and training.
- The culture clearly supported staff in raising incidents or concerns. The unit was open and transparent about the incident reporting and staff we spoke with said they felt able to raise concerns.
- Staff we spoke with were positive about the quality of care they provided and the future of the service. When we asked staff what the best part of their job was on the unit and in focus groups, they responded that providing excellent patient care is what motivated them.

### Innovation, improvement and sustainability

- Staff told us that staffing was now more sustainable than prior to the reorganisation of the ward and they felt more positive about the future.
- There was concern that the consultant orthogeriatrician was leaving the service. They had lead service improvement measures through the unit to improve outcomes for patients and developed innovative ways of bringing the MDT together. Staff were concerned that a new consultant had yet to be appointed and the resulting medical leadership vacuum would have a negative impact on patients.

# Critical care

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

## Information about the service

Grantham and District Hospital has a six bed level 2 HDU/CCU unit. The unit provides care for a mixture of people requiring level 2 care for a medical, surgical or coronary care problem. The unit provides an outreach service for the rest of the hospital six days a week.

We spoke with four members of staff on the unit, three patients and one carer. We observed care in the main unit and reviewed information available.

## Summary of findings

The unit provided safe and effective care, with a good safety record and outcomes for people. There were suitable numbers of staff to meet people's needs, and they had received training, which prepared them for working within the specialist environment. Staff were caring and compassionate, maintaining people's dignity and privacy. There were positive interactions between staff and patients, and their relatives.

While there was good access to the service, in 2014, we noted the use of manual beds rather than electric profiling beds, which required improvement in order to meet people's needs. However, in 2015 we saw that the unit had been supplied with electric profiling beds, two of which could weigh patients whilst they were on the bed.

The service was well-led. Staff reported feeling supported by managers in the department, and that senior leaders in the organisation were more visible and accessible. While performance on the staff survey in 2013 had been poor for many questions, all staff we spoke with told us that things had improved in the last year.

# Critical care

## Are critical care services safe?

Good



The HDU/CCU provided safe care to people who used the service. There had been no recent serious incidents or Never Events on the unit. The unit was clean and data showed that infection rates were within acceptable limits. PPE was available for people working in and visiting the unit. Records were managed and completed correctly to ensure continuity of care provision.

Staff had received mandatory training and also had received additional training for working in a specialist environment. Staff demonstrated safe medicines management and were aware of their responsibilities for safeguarding and under the Mental Capacity Act 2005. There was adequate medical cover for the unit both in and out-of-hours. Nursing staff numbers were planned on the unit having six beds open. Staff reported that they opened additional escalation beds if required, though they would have to manage the additional beds with no extra nurses until the shortfall could be filled by bank/agency staff. Staff were able to manage the deteriorating patient locally or by transfer to other Critical Care Units to facilitate safe care.

**We did not re-inspect this aspect of the service in February 2015.**

### Incidents

- Information available to us showed that there had been eight serious incidents reported for Critical Care across the trust, but we were told none were in relation to Grantham and District Hospital HDU.
- There had been no recent Never Events attributed to the HDU.
- Staff understood the mechanisms and importance of reporting incidents within the department. The HDU manager fed back any incidents or concerns and what action to take to staff on the HDU via meetings and informal supervisions.

### Cleanliness, infection control and hygiene

- Information from the Intensive Care National Audit and Research Centre database (ICNARC) audit and provided

by the trust showed that infections of MRSA and MSSA were within statistically acceptable limits. ICNARC data showed there had been no recent unit-acquired MRSA bacteraemia infection.

- The HDU appeared clean. We saw staff regularly wash their hands between patients and interventions and alcohol gel was also available.
- PPE was readily available to staff. PPE was also available to visitors if they required it when visiting.
- Single-use equipment was used to prevent cross infection, for example tourniquets.

### Environment and equipment

- The environment on the unit was safe with sufficient space for the safe movement of patients, staff and visitors.
- Equipment on the unit was clean and maintained at regular intervals as instructed by the manufacturer.
- The resuscitation equipment was checked daily and other specialist equipment was checked at handover of shifts.

### Medicines

- Medicines were stored correctly and secured where necessary.
- Fridge temperatures were checked daily to ensure medicines were properly stored. We checked a selection of medicines and found them to be in date.
- A member of staff we spoke with described the process of stock rotation to ensure medicines and equipment did not go out of date.
- We saw staff double-checking medicines correctly, prior to administering them to a patient.

### Records

- The HDU used different documentation to ward areas, as is common in Critical Care Units.
- Records were kept at the end of the bed. Information, including observations, assessments completed (such as pressure area risk assessments) and clinical examinations was easily accessible and formed the patients care plan.
- Records were paper-based and used by a number of staff including doctors, nurses and physiotherapists.
- Staff we spoke with told us that single documentation made for reliable and quick information sharing.
- Though information and patient notes were easily accessible, confidentiality was maintained.

# Critical care

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that people had signed consent forms prior to surgical or medical intervention. They detailed the risks and benefits associated with the procedure and were signed by the patient.
- Staff we spoke with had had training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and were aware of their responsibilities.

## Safeguarding

- Staff had received mandatory training in safeguarding. Staff we spoke with were aware of the procedure should they be concerned about a safeguarding issue and how to contact the safeguarding team.

## Mandatory training

- The majority of staff had received and were up to date with mandatory training including moving and handling, basic life support and infection control.
- The HDU supported staff to develop and enhance their clinical skills by undertaking degree level courses in Critical Care nursing.
- There were lead members of staff in the HDU for tissue viability, moving and handling and infection control, amongst others. The leads were responsible for disseminating good practice and providing teaching sessions (both formal and informal) on their lead subject.

## Management of deteriorating patients

- Critical Care provided an outreach team to the wards for six days a week during the day either by telephone or by visiting the patient. The team were able to escalate unwell patients to the on-call anaesthetist. Out-of-hours, the support was provided by the on-call medical team and night sister.
- Staff said they felt well supported by the outreach team who responded quickly in the event of a referral based on the patients 'track and trigger' score.
- The HDU/CCU were able to transfer patients to level 3 beds (for the most unwell patients) at either Lincoln or Boston or elsewhere if required. On the small number of occasions it was required, patients would only be ventilated once a level 3 bed transfer had been confirmed.

## Nursing staffing

- The HDU/CCU was staffed for six beds. Nurses were responsible for two patients and were supported by

healthcare support workers and senior staff. Staff told us that they could open more beds in the event of an emergency and that these were staffed by bank or agency staff. During busy periods, staff on the unit may have to manage additional patients until further cover could be arranged.

- Staff told us that clinical staff did not make the final decision in accepting new patients onto the unit in busy periods and that they could be 'overruled' by managers.
- We spoke with staff, who told us that the unit did not use an acuity tool to determine the needs of their patients.
- Staffing was maintained for the six beds on the unit. Staff we spoke with told us that, sickness aside, staffing numbers were maintained and that staffing had improved in the last twelve months.
- The unit, at times, used bank and agency staff to support staffing numbers. A member of staff we spoke with told us how they supported staff to work on the unit if they had not worked there previously.

## Medical staffing

- The consultant cardiologist covered the unit seven days a week for cardiology patients, and also covered the Lincoln site. The consultant anaesthetist covered the unit for seven days and also undertook the ward round for surgical patients. All patients would be seen at least daily for senior medical review.
- Out-of-hours cover was provided by the on-call anaesthetist, though the cardiologist may have been at Lincoln at weekends. The unit had access to the cardiologist by mobile phone during these periods and staff said there had been no concerns about this arrangement.
- Due to the nature of the small unit, the consultant to patient ratio was within acceptable limits.

## Are critical care services effective?

Good



The unit used evidence-based care and treatment in line with best practice. The unit was a member of the local critical care network, sharing best practice and ensuring

# Critical care

patients were looked after in the correct facility. ICNARC data showed no outliers for the unit. Patients were given pain relief in a way best suited to them and their condition and received adequate fluids and nutrition.

Staff received appraisals and were supported to keep up to date with clinical practice and undertake higher education in specialist nursing. The MDT worked well together to provide effective, holistic care to patients and some services were available seven days a week.

**We did not re-inspect this aspect of the service in February 2015.**

## Evidence-based care and treatment

- The HDU/CCU used national guidance to determine care provided. We saw that the unit was actively engaged with the Mid Trent Critical Care Network and shared best practice with other critical care units.
- Staff told us that they were updated at team meetings of any changes to guidance that would impact on the care they were providing.
- We saw that the unit carried out audit regularly and saw the results of a recent infection control audit. Audit results were posted prominently throughout the unit.
- The unit contributed to ICNARC, which showed no outliers for the unit.

## Pain relief

- Patients were seen regularly on the unit by senior staff and assessed for pain. We saw that pain relief was administered in a number of ways such as oral tablets, injection or PCA, dependent on the best method for the patient.

## Nutrition and hydration

- Where patients were able to eat and drink, we saw that they were supported to do so.
- For patients unable to eat and drink, nutrition and hydration was supported by other means such as intravenous fluids or percutaneous endoscopic gastrostomy (PEG).

## Patient outcomes

- The Unit took part in clinical audit, specifically the ICNARC.
- ICNARC data indicated that there had been no unplanned readmissions to the unit in the first quarter of 2014 or cancelled elective surgery.

- Mortality data suggests that the unit is within expected mortality rates. For January to March 2014 the SMR was 0.85%.

## Competent staff

- The staff survey showed that some staff across the trust were not receiving appraisals or supervisions. We spoke with staff who told us that they had received appraisals in the last year and the unit manager confirmed that.
- Professionally registered staff were supported to maintain their continuous professional development.
- The unit regularly supported staff to undertake the critical care nursing course at a local university.

## Multidisciplinary working

- The local MDT undertook ward rounds which included medical, nursing and allied health staff. We were told other support such as pharmacy was available by telephone.
- Physiotherapy staff-assessed patients early in their stay on the ward to plan rehabilitation needs.
- More widely, the critical care network provided a supportive MDT and was essential for transferring patients requiring specialist care.

## Seven-day services

- There was medical and anaesthetic support out-of-hours. Staff told us that allied health professionals were available for the unit at weekends.
- Senior medical staff reported that they were able to get routine radiology services out-of-hours and at weekends.

## Are critical care services caring?

Good



We saw staff providing compassionate care maintaining people's dignity and privacy. There were positive interaction between staff and patients and their relatives. Patients were kept informed of their treatment and their future plan of care. There were pleasant facilities for relatives and carers to have conversations with medical and nursing staff away from the ward. The NHS Friends and Family Tests were positive for the unit.

**We did not re-inspect this aspect of the service in February 2015.**

# Critical care

## Compassionate care

- We saw patients treated with dignity and respect. Curtains were drawn to maintain people's privacy and a sign attached so staff were aware not to enter the bed space.
- Staff had found that because nightshifts started at 9pm, patients had little time to get used to staff on night shift. Night shifts were brought forward to 7.30pm so that patients had more time to get used to and build a rapport with staff.
- The NHS Friends and Family Test results were positive for the unit.
- We saw one patient being helped by a member of staff. The member of staff showed genuine care and concern for the patient, taking time to assist them with their drink and maintain eye contact.

## Patient understanding and involvement

- We spoke with three patients on the unit. Two we spoke with told us that they had been consulted about their care and that they were aware of the plan for their recovery.

## Emotional support

- Staff told us how they supported patients and their carers during their stay in the unit.
- People were given information regarding their care and support available.
- A comfortable room was used for discussion with relatives that gave them time and space away from the clinical area.
- One member of staff told us how they had arranged counselling services for a patient who required them.

## Are critical care services responsive?

Good



The unit was sometimes required to open additional beds to meet demand for higher level care. Access and flow was managed through the unit. There were no readmissions or transfers out in the most recent period, and no elective operations cancelled because of a lack of HDU beds.

The unit was able to care for patients requiring specific support, such as bariatric patients, and those requiring interpretation services. However, in 2014, patients were cared for in manual beds, which meant that staff found it

difficult to be responsive to patients needs when moving acutely unwell people. At our inspection in 2015, we found that the unit had been supplied with electric profiling beds, two of which were able to weigh patients whilst they were on the bed. There was only one toilet facility for patients who were able to get out of bed, which meant that patients of different sexes would have to share.

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

- The unit was staffed for six beds but on some occasions it was necessary to open additional beds. Staff told us that they staffed the beds by a bank and agency staff to ensure adequate staffing provision. Staff told us that, in cases of emergency, they had to look after more patients than they were staffed for. Staff reported that some managers would 'overrule' them in opening beds on the unit. We were told that incident forms had been completed on these occasions, but staff had not received feedback on these. There was a plan in place to close the escalation beds safely, by transferring patients who no longer required the higher level of care, or by transferring patients to other critical care units.

## Access and flow

- Critical care Critical Care bed occupancy across the trust was 81.7% compared to 81.4% nationally. The HDU bed occupancy fluctuated between 80% and 100% between May and December 2013. The Royal College of Anaesthetists (RCA) makes recommendations for occupancy levels only in level 3 beds.
- For the final quarter of 2013, the unit had no non-clinical transfers out and no readmissions. A low level of readmission is indicative of correct treatment and discharge plans. A unit of below 5% readmissions such as this, is considered to be performing well according to RCA.
- There were no cancelled elective operations because of the lack of an HDU bed in the last quarter of 2013.
- Of 51 delayed discharges across the trust in March 2014, 47 were due to a lack of ward beds.

## Meeting people's individual needs

- The unit provided support with additional needs such as those required for bariatric patients.
- Interpretation services were available for people who required support with communication, and was available by telephone.

# Critical care

- In 2014, we found that the unit was using manual beds to care for patients, rather than electric profiling beds. Staff we spoke with told us that the beds were unreliable and not immediately responsive to people's needs. Due to the nature of the critical care unit, it may be necessary to move very unwell patients in a quick and safe manner into a position for treatment that may not be possible with manual beds. At our inspection in 2015, we found that the unit had been supplied with electric profiling beds, two of which were able to weigh patients whilst they were on the bed.
- We found that for ambulatory patients there was only one toilet, meaning male and female patients might have to use the same facilities.

## Learning from complaints and concerns

- Complaints were handled in line with the trust complaints policy and the new Patient Advice and Liaison Service team. Information on how to make a complaint was available for patients and carers.
- Outcomes and actions from complaints were disseminated to staff through formal and informal meetings. There had been no recent complaints about the unit.
- There was a suggestion box available for patients and relatives.

## Are critical care services well-led?

Good



The ward manager demonstrated a clear vision for the service. Staff said they felt supported by nursing and medical colleagues at a local level but often felt removed from middle management, who they described as a 'barrier'. We were told that board-level managers had become more visible at Grantham and District Hospital and on the unit. The unit worked well with other wards and departments within the hospital and critical care units in other hospitals. While performance on the staff survey in 2013 had been poor for many questions, all staff we spoke with told us that things had improved in the last year. Staff were supported to undertake further training, including the unit manager, and all felt local management was approachable.

## We did not re-inspect this aspect of the service in February 2015.

### Vision and strategy for this service

- The ward manager demonstrated a clear vision for the future of the service. Staff we spoke with told us that locally, they felt supported in the direction of travel of the unit but were unsure as to the strategic direction from middle management.

### Culture within the service

- Staff told us that the manager of the service and senior medical staff were visible and approachable on the unit.
- Unit level staff survey data was not available, but we saw the results for the most recent survey (2013). The trust performed within the bottom 20% of trusts nationally for questions relating to effective team working and work pressure amongst others.
- The unit provided an outreach service to other parts of the hospital; staff told us that they worked well with other departments and wards within the hospital and neighbouring trusts.
- We saw staff from different disciplines talking about a patient. They did so with respect for each other and demonstrated understanding for their roles.
- Staff told us that they received appraisals and team meetings as well as being supported to develop their role and undertake further education and training.
- Decision-making and responsibility for some corporate management tasks such as sickness management has been devolved from to ward/HDU level meaning senior clinical staff have more control over their clinical environment.
- Staff have fed back via the trusts' Listening into Action approach. As a result, it is now quicker to get management agreement to recruit new staff.

### Innovation, improvement and sustainability

- The ward manager was being supported to undertake a clinical leadership course that would enable them to continue to effectively manage and support their staff and develop the service.
- A service improvement sister worked on the unit to support staff and the service.

# Maternity and family planning

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

## Information about the service

The Grantham and District Hospital provides antenatal care only. The Midwifery Led Unit (MLU) recently closed in February 2014 following a review of the service and public consultation by commissioners. There are no facilities for babies to be born at this hospital.

In addition to the antenatal care delivered at this location, there are also teams of community midwives and maternity care assistants (MCA) who delivered antenatal and postnatal care in women's homes, clinics and general practitioner locations, as well as supporting women to give birth at home. Last year 2.85% of women experienced a home birth.

## Summary of findings

We spoke with 17 members of staff, including midwives, student midwives, maternity support workers and administration staff. We also spoke with three women who used the service and three family members.

We were not assured learning from incidents and complaints were being cascaded to staff. Some staff were unaware of the monthly quality report, which detailed all relevant quality issues for the service.

Not all equipment was fit for purpose or repaired in a timely manner.

The trust was still advertising a birthing facility that had closed in February 2014. There were no specialist midwives for bereavement, substance misuse or safeguarding. When questioned, staff explained to us these specialist posts were needed to meet the needs of the women using the service. There was inequality in the ultrasound scanning facilities offered to women. The head of midwifery post had been vacant for three months. We found no evidence to show us that a formalised system had been put into place to ensure the head of midwifery post was temporarily covered until a replacement head of midwifery employed. The majority of staff told us they felt isolated from the trust and felt decisions were made without consultation.

# Maternity and family planning

## Are maternity and family planning services safe?

The bed in the MLU being used to provide antenatal care was old and not fit for purpose. This posed a significant risk to women and to staff using the bed. Community midwives were unable to assure us that learning from incidents and complaints was cascaded to them. They were also unaware of the monthly quality report, which detailed all relevant quality issues for the service. Staff working in the antenatal clinic told us that the cleaning service to the unit had been reduced since the birthing unit had been closed in February 2014.

Information available to the public, student midwives and the university in the form of the trust website and signage in and outside of the hospital indicated there was a birthing unit at Grantham and District Hospital. This posed a risk as the birthing unit had been closed since February 2014. There were no facilities available should a woman in labour attend unannounced.

### Incidents

- There was an effective mechanism to capture incidents, near misses and Never Events. Staff told us they knew how to report both electronically and to their manager. We saw a robust governance framework which positively encouraged staff to report incidents and information on how to complain was visible to the people using the service.
- We asked staff to explain how learning from incidents and complaints was cascaded to all staff. The responses we received were mixed. Staff in the antenatal clinic indicated to us that learning and trends from incidents and complaints was disseminated to staff. However, the community midwives providing antenatal care in the MLU were unable to assure us this was the case in the community.
- Since March 2014 we saw that the business team compiled a monthly quality report. This meant that staff had access to monthly quality data, which included information on incidents, complaints, patient experience and recent changes to practices. This demonstrated that the provider disseminated learning. This report was clearly displayed in the antenatal clinic, however, the community staff were not aware of this document.

- We also saw that a monthly perinatal mortality meeting was held. The head of service explained to us these meetings were used to present complex cases and were used as a forum for staff to discuss good practice and learn and improve on less good practice.

### Cleanliness, infection control and hygiene

- The data we reviewed suggested that maternity infection control rates were within a statistically acceptable range. During our inspection, we saw that the environment was clean. However, the majority of staff we spoke with explained to us that they did not have access to a routine domestic service in the afternoon.
- Staff working in the antenatal clinic told us that the cleaning service to the unit had been reduced since the birthing unit had been closed in February 2014.
- We saw that a robust infection prevention and control audit programme was undertaken. This included weekly audits, which monitored hand hygiene, the environment, drug prescribing and the use of urinary catheters and cannulas. We also saw an extensive annual audit was carried out between January and March 2014. We spoke with the infection prevention and control lead who also explained that ad hoc 'glow and tell' checks were carried out at least once a year on each area. This test showed how well staff wash their hands by using an ultra violet scanner.

### Environment and equipment

- We saw that the environment was clean and tidy in the antenatal clinic.
- The antenatal clinic, currently housed in the old MLU looked dull and in need of refurbishment. The senior midwife explained the small antenatal service provided by the community midwives in the MLU was being moved to the antenatal clinic. A timescale for this move was unknown.
- The bed in the antenatal clinic within the old MLU being used to provide antenatal care was old and not fit for purpose. This posed a significant risk to women and to staff using the bed. We saw the bed had a sticker displayed on it which stated the bed had been reported as faulty on 24 April 2014. We could find no detail of when this was to be repaired. The bed was still in use on the day of our inspection.

# Maternity and family planning

- We also saw a toilet in this area had been reported as faulty on 24 April 2014 and was still out of action on the day of our inspection. We could find no detail of when this was to be repaired.
- We saw that faulty equipment was reported in a log book. Out of 430 reported faults in this area only 45 were logged as being completed.
- Information for the public, such as the trust's website, road signage and signage within the hospital indicated that there was a birthing unit and facilities for labouring women. The information, supplied to the CQC, also detailed that there was a birthing unit situated at the Grantham and District Hospital. This posed a risk, as the birthing unit had been closed since February 2014. There were no facilities available should a woman in labour attend unannounced.
- We spoke with a student midwife who had recently completed their placement at the old MLU. They explained their learning outcomes had included low risk births and they had expected to gain learning experience of women in labour. Neither the university or student midwives were aware there were no birthing facilities available.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We asked a number of staff if they had attended training on mental capacity assessment and consent. All confirmed they had.
- We observed consent being sought from patients by staff appropriately and correctly.

## Safeguarding

- We asked a number of staff to describe the training they had received in relation to safeguarding the vulnerable adult and child. All staff told us they had received the appropriate training.
- We reviewed the Women and Children's Division mandatory training figures. The data shared with us was of poor quality. This meant that we were unable to determine the exact number of staff who had accessed the training.
- The community midwives we spoke with had a very good understanding of the safeguarding process and were able to describe with confidence the recent changes to the safeguarding referral process.

- We saw a safeguarding folder was held by the senior midwife. The folder contained important information for community midwives, who may require information out-of-hours in the community. Staff told us this was communicated well to them.

## Mandatory training

- We reviewed the Women and Children's Division mandatory training figures. The data shared with us was of poor quality. This meant that we were unable to determine the exact number of staff who had accessed the training. However the senior midwife in the antenatal clinic demonstrated a manual system, which identified what training had been completed, which staff required training and which staff would be shortly out of date with their training.
- We asked a number of staff to describe the mandatory training they had received. Staff told us they had received appropriate training including safeguarding, obstetric emergencies, infection control, and breastfeeding.
- We spoke with a senior midwife and they were able to tell us the attendance figures for midwifery mandatory training, trust-wide mandatory training and the skills and drills training. We saw there was good attendance.

## Midwifery staffing

- We reviewed the staffing establishment and vacancy rate and found the staffing to be adequate to meet the needs of the women using the service.
- We spoke with a number of staff and asked them if they felt competent and supported to meet the needs of the women they care for. All told us they did and were all able to identify their supervisor of midwife. The senior midwife told us the supervisor of midwife ratio to midwives was one in 15, which was within national guidelines.
- We saw an escalation policy, which detailed the process to follow should there be an increased demand. In busier periods we saw that community midwives were asked to work in labour wards at other hospitals within the trust.
- In some areas we were told that the community midwife ratio to women was between 130-160 women to one midwife. This was over the national guideline of one to 100 women. However, none of the community midwives we spoke with voiced any concern regarding their caseload.

# Maternity and family planning

## Major incident awareness and training

- We saw a maternity services escalation policy, which was current and up to date. The policy detailed what to do in the event of a situation which could affect the safe care of women and their babies. The community midwives we spoke with also explained how they would work in the high priority areas, such as the labour ward.

## Are maternity and family planning services effective?

There was a specialist midwife with responsibility to ensure all clinical effectiveness was embedded in practice and all policy and standards were evidence and research-based. The provider had robust systems in place for the ratification of new policies and guidance.

All relevant NICE guidance was reviewed in the Maternity Guidelines Group and at the trust's clinical excellence steering group.

## Evidence-based care and treatment

- We saw policies, protocols and guidance were based on and referenced nationally recognised guidelines and standards.
- We saw there was a specialist midwife with responsibility to ensure all clinical effectiveness was embedded in practice and all policy and standards were evidence and research-based. The provider had robust systems in place for the ratification of new policies and guidance.
- We saw regular review, and updating of policies and guidance. We spoke with staff and asked them if they were engaged in the development of policies and how new guidance was communicated to them. All the staff we spoke with told us they were notified when new policies or guidance were introduced.
- We saw the trust's intranet contained all policies and staff were able to access the documents. All the documents on the intranet contained a clear review date and version control. This demonstrated that all policies, protocols and guidance were current and up to date.
- The old intranet was still accessible to staff and contained extremely outdated national guidance. While this was not the current intranet used by the majority of staff, staff were still able to view documents that were up to 12 years out of date. We raised our concerns with

the clinical risk midwife who showed us evidence of emails sent requesting the old intranet site be removed. This demonstrated the service had identified this as a risk, however the trust had not acted upon the request.

- All relevant NICE guidance was reviewed in the Maternity Guidelines Group and at the trust's Clinical Excellence Steering Group. The clinical risk midwife explained that when new NICE or national guidance was published the maternity guidelines group discussed implementation or demonstrated the rationale as to why the guidance was not implemented.

## Patient outcomes

- We saw a monthly quality report was produced and reported through the division and on to the trust board. This meant the trust were able to action performance concerns and staff were able to understand what they were doing well and where improvements were required. We also saw a maternity dashboard which measured performance against key performance indicators. All quality performance measures were discussed at the clinical governance meeting. None of this information was available for us to view in the MLU.

## Competent staff

- Women told us they were cared for by suitable qualified and competent staff.
- Staff told us they were able to access a variety of mandatory training and there were opportunities for further development. This training included formal courses and emergency skill drills. We spoke with maternity support workers who explained they were very supported within their role.
- We reviewed the Women and Children's Division mandatory training figures. The data shared with us was of poor quality. This meant that we were unable to determine the exact number of staff who had accessed the training and had received an annual appraisal.

## Multidisciplinary working

- We saw a robust governance committee structure which included multidisciplinary working. The governance meetings reported into the governance committee. The governance committee was accountable to the Trust Board and had responsibility for risk management and governance. The head of service explained to us that the

# Maternity and family planning

specialty governance meetings were open to all and attended by midwives, obstetricians, human resources staff, anaesthetists, paediatricians and paediatric nurses.

- We also saw perinatal mortality meetings were held weekly. These meetings were held to discuss complex cases or areas of concern. These meetings were also multidisciplinary, and involved staff with particular expertise.
- These meetings were held on the Boston site, which was a one hour drive from Grantham and District Hospital. Staff indicated that it was difficult to access these meetings. However, the senior midwife told us they attended and fed back relevant information through team meetings. We saw that regular team meetings were held.

## Are maternity and family planning services caring?

All the women we spoke with told us they were happy with their care. We saw women and their families were able to comment about their experiences. The NHS Friends and Family Test and women's comments were documented in the monthly quality report.

All women were seen about a month before they were due to give birth and a joint discussion was held to discuss women's hopes, wishes and plans for the birth and postnatal period. Women also had the contact details of their community midwife and the hospital should they require support and guidance during their pregnancy, birth and postnatal period.

## Compassionate care

- All the women we spoke with told us they were happy with their care. One woman told us: "I am really happy with everything. I find the midwives friendlier than other places I have received care." The women we spoke with told us that they had developed trusting relationships with the staff and that their individual needs and wishes were known and acknowledged.
- We saw evidence that the NHS Friends and Family Test was carried out in the community and the results displayed in the antenatal clinic. The results were also

documented in the monthly quality report which was accessible to staff and reported through the clinical governance committee structure. Dissemination of this report to community midwives was poor.

- The CQC maternity survey results for 2013 showed that performance against the national average was better than other trusts for the question: 'At the start of labour did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?' In all other areas the trust performed the same as other trusts

## Patient understanding and involvement

- The women we spoke with told us they felt involved in their care. Women and their partners told us they had taken part in making decisions and felt supported in their care. We saw that antenatal patients had their maternity notes to hand when in the hospital.
- Women were all given the contact details of their community midwife and the hospital should they require support and guidance during their pregnancy, birth and postnatal period.

## Are maternity and family planning services responsive?

There were no specialist midwives for bereavement, substance misuse or safeguarding. When questioned, staff explained to us these specialist posts were needed to meet the needs of the women using the service.

As part of the Shaping Health for Mid Kesteven review and advice from The Royal College of Midwives the local birthing unit closed in February 2014.

Women who chose to have their babies at Lincoln were offered an ultrasound scanning service at Grantham and District Hospital. However, if they chose to have their babies at the Boston Hospital, they were not offered a local scanning service. No senior management could explain this disparity in the service.

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

- The staff we spoke with had a good understanding of the population who used the service and were all able to explain with confidence the requirements of the people who were inpatients.

# Maternity and family planning

- At busy times staff were redeployed to the delivery suite at Lincoln Hospital. We discussed this with a senior member of the midwifery team. They explained when there was a peak in activity, clinical care was prioritised and staff were moved to ensure the safest care possible was delivered.
- There was an escalation policy and the staff we spoke with understood the process. We spoke with a number of community midwives who were very clear where they would be deployed to and how many hours they were able to work to ensure they remained in the limits of safe working.

## Meeting people's individual needs

- Staff had access to interpreters and could access the language line service. The majority of staff told us they used this service when required and found it useful. The staff were able to explain with confidence the most common languages used in the area. When asked how useful these services were, the majority of staff told us they were very useful.
- We saw a variety of information leaflets in departments. We asked how staff accessed leaflets in different languages. We were told that leaflets were easily accessible in different languages. One community midwife explained that information was sent out to women in specific languages, prior to their first antenatal appointment. However, all the signage we saw was in English, which did not cater for people whose first language was not English.
- We asked what specialist midwives or services were available for people with complex or challenging needs. We were told that satellite clinics were held in areas where women would find it difficult to travel to hospital locations for their care and treatment. The head of service explained to us midwives, consultant obstetricians and an ultrasound service was available at these clinics.
- Antenatal clinics had been expanded to accommodate increased demand. For example, we noted that a clinic had been developed for women with an increased Body Mass Index.
- There were no specialist midwives for bereavement, substance misuse or safeguarding. When questioned, staff explained to us these specialist posts were needed to meet the needs of the women using the service.
- The local birthing unit closed in February 2014.

- Staff also explained those women who chose to have their babies at Lincoln were offered an ultrasound scanning service at Grantham and District Hospital. However, if they chose to have their babies at the Boston Hospital, they were not offered a local scanning service. No senior management could explain this disparity in the service.

## Learning from complaints and concerns

- The provider had a robust complaint process and we saw evidence of learning from these. We saw complaints and learning were discussed at the clinical governance meeting and reported through to the business unit.

## Are maternity and family planning services well-led?

The head of midwifery post had been vacant for three months. We found no evidence to show us that a formalised system had been put into place to ensure the head of midwifery post was temporarily covered until a replacement head of midwifery employed.

The majority of staff told us they felt isolated from the trust and felt decisions were made without consultation. An example of this was that, although staff were aware of a consultation being undertaken to discuss the future of the birthing facilities at Grantham and District Hospital, they heard on the radio that the birthing unit was to close on the actual day it closed. They did not receive any formal communication from the board prior to the closing of the unit.

## Vision and strategy for this service

- During the staff interviews and focus groups, the vision and values of the trust were not clearly identified by staff. Some staff identified the element of being financially sustainable as a key aim of the trust.
- The majority of staff were very concerned about the future of the service at Grantham and District Hospital.

## Governance, risk management and quality measurement

- We saw a robust governance framework and reporting structure. Incidents, serious untoward incidents, complaints and audits were analysed and reported through the committee structure to the board.

# Maternity and family planning

- Risks to the delivery of high quality care were identified, analysed and controls put into place. Key risks and actions were reported through the governance structure and reported to the board.

## Leadership of service

- We asked midwifery staff and support workers how supported they felt. We received mixed responses. The staff in the antenatal clinic felt well supported from managers at the Lincoln Hospital. We were also told that the manager visited at least once a week. However, the community midwives in the antenatal clinic told us they very rarely saw the modern matron or anyone more senior.
- There had not been a head of midwifery in post for three months and as such, we were told by senior midwives this had had an impact on their availability to lead, manage and support staff. One modern matron explained to us they felt over-stretched at times and were not always able to be as visible as they would have liked to be. We found no evidence to show us that a formalised system had been put into place to ensure the head of midwifery post was temporarily covered until a

replacement head of midwifery could be employed. However, staff were able to confirm the head of midwifery post had been filled and had met the new appointee.

- We also asked staff if the executive team were visible. The majority of staff told us they were not.

## Culture within the service

- The majority of staff told us they felt isolated from the trust and felt decisions were made without consultation. An example of this was that, although staff were aware of a consultation being undertaken to discuss the future of the birthing facilities at Grantham and District Hospital, they heard on the radio that the birthing unit was to close on the actual day it closed. They did not receive any formal communication from the board prior to the closing of the unit.

## Public and staff engagement

- We saw evidence that women, families and staff were engaged and their views sought. Women and families comments were displayed in some areas and were included in the quality report. They were also reported through the governance reporting structure to the board. The majority of comments we saw were positive about the care and experience received.

# End of life care

Safe	Good	●
Effective	Good	●
Caring	Good	●
Responsive	Good	●
Well-led	Good	●
Overall	Good	●

## Information about the service

We went to ward 1 at Grantham and District Hospital and we also visited the Haematology Clinic in the Chemotherapy Suite. When we carried out our inspection of the service, we were informed there were currently no in patients receiving end of life care services.

We spoke to nine staff; these included medical staff, nurses, occupational therapists, care staff and domestic workers.

We spoke to fifteen patients to find out their views of the service. We also spoke to three relatives.

## Summary of findings

We found that end of life care services were planned in a way that ensured they would be safe and suitable to meet patients' needs.

Considerable effort was made by the services to ensure that patients received a holistic service, focused on their physical, emotional and spiritual needs. Support was also given to families and friends.

# End of life care

## Are end of life care services safe?

Good



The patients we met spoke highly of the staff and they told us they felt safe with them.

We saw that the staff provided care for people in a safe and suitable way. For example we saw that staff followed infection control procedures when barrier nursing patients. We also saw safe procedures when they assisted people with impaired mobility.

There were governance systems in place that helped to ensure that end of life care services were safe and met patients' needs. There was learning and analysis of incidents that could impact on patients who receive end of life care. This information was to improve the experience for patients as well as safety of the services they received.

Staff were committed to providing person-centred services for patients who receiving end of life care. There was an effective multidisciplinary team working to achieve this for patients at the hospital and when they were discharged.

### Incidents

- There were no serious incidents reported attributed to end of life care.
- All staff we spoke with told us that they were encouraged to report incidents and received direct feedback from their matron. Themes from incidents were discussed at weekly meetings and staff were able to give us examples of where practice had changed as a result of incident reporting. Information was also fed back to staff via email and notices on staff notice boards, where relevant.

### Environment and equipment

- Staff had access to suitable equipment to assist patients safely with their care and treatment.
- The design of the wards enabled staff to monitor and care for patients safely. There were enough single rooms where close observation was required. Rooms were available next to the nurse stations.

### Medicines

- When needed, anticipatory end of life care medication was appropriately prescribed. This was audited regularly by the palliative care team.

- Appropriate syringes were available when required to deliver subcutaneous medication.

### Records

- We found that DNA CPR forms checked had been signed by an appropriately senior member of staff. The trust audited their DNA CPR forms annually to ensure that they were always completed properly.
- Following the Keogh Mortality Review, the trust was told to redesign the form. The DNA CPR form in use at the time of the Keogh Mortality Review was a county-wide form developed across community, ambulance and GP services. Since the hospital has changed the format of the DNA CPR forms, the new form has not been recognised by the community services. This has led to confusion and patient safety issues.
- Risk assessments were completed and reviewed regularly. These set out how to provide patients with safe and effective care and treatment.
- Care records clearly set out the care pathway for each patient.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were systems in place to ensure that patients who did not have capacity to consent to end of life care were treated appropriately by staff. The staff told us they had staff receiving training around consent.
- There was a procedure for staff to follow to ensure that consent was appropriately obtained from patients.

### Safeguarding

- Staff received training to understand what safeguarding was. Staff were also able to explain to us about whistle blowing and they knew how to report concerns about the service.

### Mandatory training

- Staff told us they had received mandatory training in health and safety, safeguarding, and infection control.
- The staff told us there were designated training leads to provide on-the-job training for staff.

### Assessing and responding to patient risk

- Specialist support was available from end of life care trained specialist nursing staff when required.
- The specialist palliative care nurse worked across the hospital site.

# End of life care

## Nursing staffing

- Regular agency and bank staff were used where possible to ensure continuity of care for patients.
- Patients and staff told us that The Haematology Clinic at Grantham and District Hospital does not run when the two nurses who run it are not available. This is because there are no other staff on-site who are suitably trained to run the clinic in their absence. Patients are given the option to attend alternative clinics at Lincoln Hospital.
- The patients we spoke with told us this could be very inconvenient for them.

## Medical staffing

- Ward rounds were held daily and end of life care assessments were carried out when needed.
- On-call out-of-hours consultant cover operated at weekends and nights.
- There was out-of-hours medical cover at weekends and nights.

## Are end of life care services effective?

Good



Treatment and care was based on national guidance. Specialist nurses supported patients in the management of their symptoms and care. All grades of staff received appropriate training and supervision. Multidisciplinary working was evident and ensured a holistic approach to patient care and treatment.

## Evidence-based care and treatment

- The palliative care liaison nurse and the Macmillan nurses provide specialist guidance to staff on the wards about end of life care.
- Due to the high demand for their services, patients receiving end of life care services were referred to the palliative care liaison nurse.
- The Gold Standards Framework was in use on the ward we visited. The Gold Standards Framework for end of life care was used in care pathways to ensure that patients received appropriate evidence-based care.

## Pain relief

- The palliative care liaison nurse and the Macmillan nurses gave advice to the medical and nursing staff about appropriate pain relief when required.

- Appropriate pain relief was discussed and prescribed when needed at daily ward rounds by the medical staff and other members of the multidisciplinary team on the wards that we visited.

## Nutrition and hydration

- Patients we spoke with spoke positively to us about the quality of food and drink that they were provided with.
- Risk assessments and care records showed how to support people who were identified as being at nutritional risk. We saw that fluid and food charts had been commenced to enable staff to monitor intake and output effectively.
- Specialist dietician support was available across the wards.

## Patient outcomes

- The service participated in the National Care of the Dying Audit (NCDA) and were waiting for the report at the time of our inspection. This report shows that the hospital failed to meet five of the seven key performance indicators.
- Medical staff told us that there was effective multidisciplinary team working to ensure the most suitable outcomes for patients. The medical staff we met told us that families were fully involved in decisions about their care and treatment

## Competent staff

- Staff told us that they were provided with appraisals and supervision of their overall performance at work.
- There were learning facilitators providing training for staff.

## Multidisciplinary working

- Staff reported that there was effective multidisciplinary team-working and decision-making.
- The electronic palliative care coordination system meant that patients' records could be accessed when they were discharged from the hospital. This was to help ensure patients received 'joined up' package of care from the different providers who were involved with them.

## Seven-day services

- Although reduced, a physiotherapy service and occupational therapy support was available over seven days.
- A consultant was on-call out-of-hours if needed.

# End of life care

## Are end of life care services caring?

Good

We saw that patients received care from staff that were attentive and sensitive to their needs.

During our observations, we saw staff treated people in a way that showed them respect and that curtains were closed, to protect people's dignity, when personal care was being delivered.

People we spoke with told us they were given sufficient information to understanding their treatment choices.

End of life care pathways were implemented when needed and care was planned in a person-centred way to ensure that patients received a service-centred on their unique needs.

### Compassionate care

- Staff assisted people with their care and treatment in a caring and sensitive manner.
- NHS Friends and Family Test results are publicised on the wards. Generally, high satisfaction results being obtained for the wards that were visited. For ward 1, the stroke unit, the results were 88.
- The service had rooms available on-site for relatives of patients who were at the end of their life.
- Staff ensured that privacy was maintained by staff when they assisted patients with their needs.

### Patient understanding and involvement

- Patients told us they knew about the named nurses system. They told us they spoke to the nurses about their care and were kept informed by them.
- Patients told us that they talked to the staff about their care and what help they felt they needed. The patients who we spoke with were not aware of being formally involved in writing care plans for their needs.

### Emotional support

- Clinical nurse specialists provided support and guidance for staff to meet patients' needs.
- Patients records included guidance that set out how to support them when they were anxious or low in mood.

## Are end of life care services responsive?

Good

The service aimed to deliver care that was person-centred and flexible to the needs of the individual. Staff told us the patients' wishes were at the centre of any decisions made about their care.

A partnership had been formed with a local hospice to provide patients with a streamlined service when they are in the hospital and after discharge.

The specialist palliative care team provides a varied training programme to enable staff to effectively meet patients' needs. Training courses focused on a range of outcomes for patients including

physical needs, emotional needs and how to maintain dignity.

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

- An end of life care strategy has been produced by the hospital that aims to ensure that patients receive a service that is responsive to their needs when they are in hospital and when discharged.

### Access and flow

- The hospital does not keep records of bed occupancy for end of life care services. This could impact negatively on how patients who need end of life care services are supported as there is no forward plan how to provide a responsive service.

### Meeting people's individual needs

- Staff were able to tell us about the complex needs of patients on the ward and the clinic that we visited. Care records and treatment records provided detailed information that set out how to effectively meet those patients' needs.
- Translation services are available as well as a telephone translation service. We were also told that information could be given to people in different languages.
- The trust does not keep a record of how many patients die in their preferred location. If the trust did know this information, it could be beneficial to driving up service improvement in this area.

# End of life care

## Learning from complaints and concerns

- The staff were able to give us examples of how complaints and concerns had been acted upon on the wards that we visited.

## Are end of life care services well-led?

Good



End of life services were well-led at this service. We found that staff on the ground shared the visions and values that the leadership board were trying to promote namely that the patients were at the centre of decisions made about how the service was run.

## Vision and strategy for this service

- The trust has put in place a strategy for end of life care across the hospital. A key aim is to work with other providers to ensure a streamlined service for patients receiving end of life care. This strategy was not yet embedded.
- Staff told us that they felt well supported by senior staff at the service. Staff reported that sisters and matrons led by example and were 'hands on' with patients.
- We saw that the trust vision for the future of the hospital was on display on wards and along corridors. The staff we met told us about this vision at focus groups and during one-to-one conversations.

## Governance, risk management and quality measurement

- Governance systems were in place that ensured learning and improvements were shared across the service.
- Complaints were responded to in accordance with the trust policy. If someone wanted to make an informal complaint they were directed to a senior member of staff. If they were not able to deal with their concern satisfactorily, they would be directed to the Patient

Advice and Liaison Service. If they still had concerns, people were advised to make a formal complaint. This process was outlined in leaflets available throughout the department and was depicted on multiple posters in other languages, if required.

- The ward we visited displayed their quality dashboards so that all levels of staff understood what 'good looks like' for the service and what improvements they were aiming for.

## Leadership of service

- Staff were positive in their views of the leadership of the ward and at the clinic where they worked.
- We were told that sisters and matron took a 'hands on' approach to care and acted as role models for the staff they led.
- Staff spoke positively about the new direction of the trust leadership boards. They reported that the leadership team were more visible to staff.

## Culture within the service

- Staff reported that the culture of the service has become more open and transparent. Staff were encouraged to air their views and management responded positively to them.
- Staff reported positive working relationships and we saw that staff were respectful of each other, not only in their specialities but across disciplines.
- Staff were positive about the service they provided for patients. They told us that ensuring they provide a patient-centred experience is seen as a key priority for everyone who works for the service.

## Public and staff engagement

- There were systems in place that ensured staff were consulted by the leadership team about the way the service was being run.
- Staff were positive in their views of the way the leadership board was actively seeking their feedback.

# Outpatients

Safe	Good	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

## Information about the service

Grantham and District Hospital outpatients provides an service from Monday to Friday from 9am to 5 pm Outside of these hours patients requiring outpatients services go to Pilgrim Hospital or Lincoln Hospital.

Clinics run from the departments include Dermatology, Urology, and Orthopaedics services

## Summary of findings

The service was safe, with a culture of reporting incidents. Systems were in place to ensure action was taken as a result and learning disseminated to staff. Patients reported that staff were caring and compassionate in the outpatients departments and clinics. Patients' privacy and dignity were maintained.

The service was responsive to people's needs. Patients were sent text alerts to remind them of appointments. Any delays and waiting times in clinics were clearly identified. However, some staff reported a lack of car parking space when they came for afternoon clinics.

The service was well-led, with staff reporting that they felt supported by managers. Senior managers were said to be more visible within the hospital. Staff focus was on providing good care to patients.

# Outpatients

## Are outpatients services safe?

Good



There was a good culture of reporting incidents and systems were in place for action to be taken and learning disseminated. The department was clean and staff were observing the bare below the elbows policy in line with national guidance.

All of the patients who we spoke with told us they felt that they were safe and well cared for by staff at outpatients.

### Incidents

- The staff we spoke to told us that they would report incidents to a senior member of staff. They told us they would receive feedback from their department sister or matron. Incidents were also discussed at weekly meetings. The staff were able to give us examples of where practice had changed as a result of incident reporting. For example, the location of one clinic had been moved in the department.
- There have been no Never Events or serious incidents in the Radiology Department from between March 2013 to April 2014.

### Safety thermometer

- Health and safety audits were carried out and the results were displayed in the department.
- Where areas for improvement had been identified we saw that actions were put in place to ensure these were addressed promptly.

### Cleanliness, infection control and hygiene

- Clinical areas looked clean and we saw that the staff regularly washed their hands and use hand gel between appointments and contact with patients.
- We saw that staff followed the bare below the elbow policies in the outpatients clinical areas.
- Toilet facilities were clean and we saw records that showed that they were checked by staff regularly to ensure that cleanliness was maintained.

### Environment and equipment

- The environment in the outpatient areas that we viewed looked safe and satisfactorily maintained.
- Patients told us they felt safe with the staff they saw at the department.

- Staff told us that equipment was checked on a regular basis and was cleaned regularly and where needed between patients. We saw adequate equipment available in all of the outpatient areas.
- Resuscitation trolleys in the outpatients clinics were located in easy to access areas. Regular checks of the trolleys were undertaken.
- The environment was clean and care was delivered in an appropriate care setting for children and young people.
- The equipment we saw was appropriate for children and was in good working order.

### Records

- No issues were raised with us by staff about not having access to the full set of patients' notes in front of them. Staff we spoke with told us that patients records were available for clinic appointments.
- The staff told us that regular audits were carried out to monitor how records were stored and maintained.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The patients we spoke with told us they were asked for informed consent and were given the information they needed to understand the treatment options available to them.
- Staff were able to explain to us how they would support patients who did not have capacity to consent to their procedure. The Mental Capacity Act 2005 was adhered to appropriately.

### Safeguarding

- Staff told us that they had attended safeguarding training. The staff were also able to tell us what whistleblowing meant if they felt they need to raise concerns.

### Mandatory training

- Staff told us they had been on regular mandatory training, including health and safety. The staff we spoke with had also attended training that was relevant to their role at the department.

### Nursing staffing

- The staff told us there was no shortfall in the number of nurses employed to work in outpatients.
- We observed that there were nurses in each clinic who were attending to patients' needs.

# Outpatients

- The patients we met told us their appointment times were running on time or with only a short delay. They told us that staff made them aware of delays and kept them informed.

## Are outpatients services effective?

Not sufficient evidence to rate

The feedback from patients was very positive about the services at Grantham Hospital Outpatients. Examples of comments made included “the communication is fantastic and my consultant really listens”.

Patients told us that their doctors communicated with them about their health needs. They told us this was always done in a way that they understood.

Treatment records were informative and helped to show provider a clear pathway that set out what care and treatment patients were receiving

### Evidence-based care and treatment

- The outpatients department had a clinical nurse lead who provided staff with clinical guidance and support in their work.
- Staff told us that they worked to local policies that were reviewed regularly as part of the governance arrangements for the service.

### Patient outcomes

- Patient had positive feedback to share with us about the doctors who they saw at the department and in the clinics. Patients also had positive views to share with us about other staff who they saw.
- The average waiting time for a first outpatient appointment was audited as being between five to seven weeks over the 12 months prior to our inspection.
- From the trust’s quality account we were able to see that the paediatric service participated in a variety of national clinical audits. We saw in 2013 the service participated in the paediatric asthma audit, the national neonatal audit programme, paediatric diabetes audit and the monitoring of readmission rates.

### Competent staff

- Staff were able to explain to us what their role was and told us they were provided with support and supervision to ensure they were able to work effectively.
- Staff told us they were provided with regular appraisals of their overall performance.
- The service had a clinical educator who worked in the department providing on the job clinical training.
- Within the services for children and young people we found that data on training was poor. We saw that the paediatric services were in the process of developing a system for the collection of the data. We were able to see that this had commenced.

### Multidisciplinary working

- MDT clinics were held at the department. Specialists who worked there included Physiotherapists occupational therapists, medical staff and nurses. The head of the children and young people’s service explained to us that the specialty governance meetings were open to all and attended by midwives, obstetricians, human resources staff, anaesthetists, paediatricians and paediatric nurses.
- Staff were positive in their views about the positive multi-disciplinary team working in the department. Staff told us they felt there was an open culture and they were able to make their views known.
- We saw evidence that children’s speciality clinics were provided by other trusts. Examples of this included the monthly cardiology and neurology clinics, where care was provided by University Hospitals of Leicester.
- The service for children and young people’s governance meetings were held at the Boston Hospital. Staff told us they found it difficult to attend meetings off-site.

### Seven-day services

- Certain clinics were run on Saturday mornings and afternoons.
- Pharmacy services were available during the working week.

### Medicines

- We saw that medicines were stored correctly in locked cupboards or fridges. Records of fridge temperatures were maintained. We saw that checks were carried out on a daily basis.

## Are outpatients services caring?

# Outpatients

Good



We found that patients in outpatients were seen by staff who were polite and respectful to them.

Patients had positive views to share with us of medical staff and nurses they saw at outpatients. We observed staff interactions with patients were respectful and attentive to patients in the departments.

Staff knew how to maintain patients' privacy and dignity during their time in outpatients. We observed staff ensuring that patients' privacy and dignity was maintained during their time at the department.

Patient feedback was very positive about outpatients. Examples of comments made included, "They have a good approach when they see people," and, "They mostly talk me through things," and, "The nurses here are polite and efficient I can't knock them at all."

## Compassionate care

- Patient feedback to us was positive and complementary about the attitude and approach of the staff at outpatients.
- We saw that patients were treated in a caring and respectful way by the staff.
- Staff were able to give us examples of ways they ensured that privacy and dignity was maintained for patients.
- We saw that dignity curtains were always used when patients were seen for examinations.
- We viewed patient records and saw they had been completed sensitively and they showed that discussions had taken place with patients and their relatives, if relevant.
- Female staff told us that they were available to chaperone patients if this service was requested.
- Regular checks on the safety and well-being of patients who had not yet been seen for their appointment.
- A review of the way that staff communicate with patients has been carried out Listening into Action aims to improve communication between staff and patients.

## Patient understanding and involvement

- Patients told us that they felt that they had been consulted about decisions regarding their care.

- Advocacy Services were displayed on notice boards in the department. These were for a number of different health conditions.

## Emotional support

- Staff told us there was a plan in place that included the use of a private room if patients were going to be given bad news about their medical condition.
- Patients and relatives told us they had been treated in a respectful manner when they were given difficult diagnoses and had been given sufficient proper support.
- There was a chaplaincy service available, as well as bereavement counselling services.

## Are outpatients services responsive?

Good



We found that patients in outpatients were seen by staff who were polite and respectful to them.

Patients had positive views to share with us of medical staff and nurses they saw at outpatients. We observed staff interactions with patients were respectful and attentive to patients in the departments.

Staff knew how to maintain patients' privacy and dignity during their time in outpatients. We observed staff ensuring that patients privacy and dignity was maintained during their time at the department

Patient's feedback was very positive about outpatients. Examples of comments made included "they have a good approach when they see people, and "they mostly talk me through things and "the nurses here are polite and efficient I can't knock them at all".

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

- The staff told us that they supported patients through busy times by ensuring they communicated with them and told them what the waiting times were. Reasons for why clinics were running late were given where appropriate.
- A text service had been introduced to alert patients about their appointments.

# Outpatients

## Access and flow

- Patients told us they were sent out an initial letter with a map of the hospital. The patients we spoke with told us there was frequently a shortage of care parking spaces for afternoon clinics.
- A system of automatically booking in for appointments has been introduced. This can be done in six different languages.
- The average waiting times to be seen at the department or at one of the clinics was between five and seven weeks. Delays in clinics and waiting times were displayed.

## Meeting people's individual needs

- Patients gave us positive feedback about how doctors and other staff at the department and the clinics meet their individual needs. There was a visually and hearing impaired support service available and this was clearly advertised for patients.
- Patients could also access a translation telephone service, or interpreters.
- Written information was available in several languages and large print.
- Wheelchairs were available at the entrance to outpatients.

## Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Initial complaints would be dealt with by the senior's sister in charge of each clinic. If they were not able to resolve concerns people would be referred to the Patient Advice and Liaison Service. If Patient Advice and Liaison Service were not able to address their concerns, people were advised to make a formal complaint. This process was outlined in leaflets available throughout the department and was displayed on posters in the department.
- The senior sister produced a newsletter which was emailed to staff which detailed any recent concerns.

## Environment

- Car parking was available.
- There was a children's play area with toys.
- There was a coffee shop in reception with snacks and drinks.
- Seats were comfortable.

## Are outpatients services well-led?

Good



Staff reported that they felt well supported in their work by senior staff and managers.

Staff were aware of the visions and values for the department and for the trust. Staff told us they felt consulted about decision-making about the way the hospital was run.

There were systems in place to ensure the overall quality of the services at outpatients was effectively monitored.

The views of patients and staff were being sought by the managers of the department and by the trust leadership team.

Staff reported that they felt well supported in the department by sisters and matrons.

Staff also told us they felt there was a positive change in the culture in the hospitals. Staff felt more listened to and they told us that the executive team were more visible around the hospital.

There were systems in place to monitor the overall quality and effectiveness of the services at outpatients.

## Vision and strategy for this service

- The trust vision and plans for the future was visible throughout the wards and corridors.
- Staff were able to repeat the vision to us at focus groups and during individual conversations.

## Governance, risk management and quality measurement

- Texts were sent to patients, if this is their preferred method of communication, after they used the services at outpatients to seek their views as part of NHS Friends and Family Test feedback.
- Staff reported that regular governance meetings took place. Staff also told us that feedback was given to staff who did not attend via staff meetings and emails. Staff used these meetings to discuss complaints, incidents and quality improvement projects matters.
- A quality dashboard was on display for staff to what 'good looks like' for the service and what they were hoping to aim for in different areas of the service.

# Outpatients

## **Leadership of service**

- The staff were positive and felt supported by the leadership they received from the clinic and department sister.

## **Culture within the service**

- Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility.
- Openness and honesty was the expectation for the department and was encouraged at all levels.

- Staff told us that teams worked well together and there was respect between specialities.

## **Public and staff engagement**

- Notices were displayed in outpatients asking staff and patients to give feedback to the leadership team about the services they received.

## **Innovation, improvement and sustainability**

- The staff felt that their views and ideas were sought from senior staff across disciplines. Nurses were able to give us examples of practice that had changed as a result of their suggestions and innovation.

# Outstanding practice and areas for improvement

## Outstanding practice

- The A&E department had a robust system for reporting incidents, known as IR1s. These were discussed and staff had changed their practices as a result of them.
- There was a designated and suitably decorated cubicle for children in A&E.
- Patients stated that they were cared for with compassion, and were very supportive of staff.
- Staff were using an assessment tool for pain, specifically designed for patients with dementia, where this was applicable.

## Areas for improvement

### Action the hospital SHOULD take to improve

- Review arrangements for the provision of medications and transport on discharge.