Review of compliance

The Ipswich Hospital NHS trust

<table>
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<th>Region:</th>
<th>East</th>
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| Location address: | The Ipswich Hospital NHS Trust  
                  Heath Road  
                  Ipswich  
                  Suffolk  
                  IP4 5PD |
| Type of service: | Acute Services        |
| Date the review was completed: | 08 and 09 December 2010 |
| Overview of the service: | The Ipswich Hospital NHS Trust is a general hospital located in Ipswich and serves the local community |
We found that The Ipswich Hospital NHS trust was meeting all the essential standards of quality and safety we reviewed but, to maintain this, we have suggested that some improvements are made.

The summary below describes why we carried out the review, what we found and any action required.

**Why we carried out this review**

We carried out this review because concerns were identified in relation to:

- Care and welfare of people who use services
- Management of medicines

**How we carried out this review**

We reviewed all the information we hold about this provider, carried out a visit on the 8 and 9 December 2010. We observed how people were being cared for, talked to staff and patients, checked the provider’s records, and looked at records of people who use services.

**What people told us**

We spoke with seven patients whilst visiting the hospital. People we spoke with confirmed that their medicines were checked when they first came to hospital and that they were generally informed about what their medicines were for, and about any changes. We were told that medicines were administered regularly and nursing staff asked about pain relief when carrying out observations and during the medicines rounds, to help ensure this is well managed. Patients told us that their medicines
were locked in personal bedside cabinets and those wishing to self-administer inhalers were supported to do so.

What we found about the standards we reviewed and how well The Ipswich Hospital NHS trust was meeting them

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights.

Patient falls
The Ipswich Hospital NHS Trust has systems and practices in place for the management of patients at risk of falling. Staffing levels have improved, however in some areas of the hospital there are still shortages and where bank/pool staff are used they are not always appropriately trained in the management of patients at risk of falling. There is a concern regarding the availability of appropriate equipment notably at the weekend.

Pressure Damage
The Ipswich Hospital NHS Trust has a trust wide pressure ulcer prevention programme and action plan with appropriate monitoring in place. There is a commitment from all the staff spoken with to reduce the incidence of pressure ulcers. Risk assessments are in place however ongoing monitoring is not clearly documented. There is a concern regarding the availability of appropriate pressure relieving equipment notably at the weekend.

Overall, we found that The Ipswich Hospital NHS trust was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 9: People should be given the medicines they need when they need them, and in a safe way.

The Ipswich Hospital NHS trust has appropriate systems and practices in place to manage all patients medication, which is supported by staff informing each individual patient what there medication is for. Pharmacists and pharmacy technicians are in place to ensure the correct management of medications.

Overall, we found that appropriate arrangements were in place for supporting the safe handling of patients medication.

Action we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.
**Other information**

In a previous review, we suggested that some improvements were made for the following essential standards:

*Outcome 4*
**People should get safe and appropriate care that meets their needs and supports their rights**

*Outcome 8*
**People should be cared for in a clean environment and protected from the risk of infection**

*Outcome 10*
**People should be cared for in safe and accessible surroundings that support their health and welfare**

*Outcome 14*
**Staff should be properly trained and supervised, and have the chance to develop and improve their skills**

Please see previous review reports for more information.
What we found
for each essential standard of quality
and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety.*
Outcome 4: Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

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<th>Our judgement</th>
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<td><strong>There are minor concerns</strong> with outcome 4: Care and welfare of people who use services</td>
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<tr>
<td>We did not speak to service users regarding this outcome</td>
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| **Other evidence** |
| Patient falls |

The Ipswich Hospital NHS trust has a falls prevention programme and an action plan in place. Confirmation has been given by the trust that all falls are carefully reviewed and where appropriate investigated. Trends in falls are recognised notably a slight increase in patient falls at night; as a result the location of the falls has been supported by an increase in staff. Following a staffing review in May 2010, active recruitment has taken place which has resulted in the appointments of 45 healthcare assistants and 99 registered nurses. Along side this central bank (pool staff), fill rates have increased to a monthly average of 68% in June 2010 to 76% in October 2010.

On some wards the staff confirmed that there is still a shortage of nursing staff. Pool staff, when available are allocated to these wards and at times the pool staff do not have the skills and knowledge regarding the management of patient falls to ensure safe practices for patients is maintained at all times.
The trust staff followed the policies and risk assessment practices for the management of patient falls. On one ward, staff confirmed that with the introduction of the Seven Simple Steps for Falls Prevention guidance, and the two hourly checks they had seen a reduction in patient falls. Throughout the hospital patients with a high risk of falling are moved to areas of the ward so that they can be easily observed by the staff.

A falls prevention training programme is in place; however some staff confirmed that they had not attended the training. Staff training attendance is at 84.5% with plans to achieve 90% by the end of January 2011. There are study sessions for registered nurses and healthcare assistants on learning from falls that require investigation.

The trust confirmed that a full business case for the purchase of equipment was presented to the Trust management team in November 2010 and to the Investment Scrutiny Committee in December 2010. The trust is currently performing a trial of alarmed seat cushions, and crash mats are not used. There is a limited availability of low beds, and access to equipment notably at weekend is seen by staff as a problem.

Pressure damage

The Ipswich Hospital NHS trust has a trust wide action plan for pressure ulcer prevention, led by the Director of Nursing and Quality. The action plan includes the review of documentation, risk assessment, pressure area care, pressure relieving equipment, use of dressings and prevention. Progress is being made, however the trust is not yet fully compliant.

The number of developed pressure ulcers is monitored via the trust's quality management system and presented to a number of governance and nursing committees and to the trust board at their monthly meetings.

Of all the hospital staff spoken with there is a commitment to the reduction of skin pressure damage to the all patients in the hospital. Generally, risk assessment practices are implemented; however the ongoing management of pressure damage is not always clearly documented. Underlying conditions of patient's nutritional needs are clearly taken into account when managing all incidence of pressure damage.

The Six Simple Steps to Pressure Ulcer Prevention are established within the wards visited and on one ward meal times have been altered to accommodate patient turns with a positive impact.

There is limited access to appropriate equipment notably at weekends. There is inconsistent staffing to provide appropriate care to patients at risk of pressure damage on some wards, and some staff have not received training on pressure damage prevention.

Our Judgement
Overall, we found that The Ipswich Hospital NHS trust was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.
Outcome 9: Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

The provider is compliant with outcome 9: Management of medicines

Our findings

What people who use the service experienced and told us

We spoke with seven patients whilst visiting the hospital. People we spoke with confirmed that their medicines were checked when they first came to hospital and that they were generally informed about what their medicines were for, and about any changes. We were told that medicines were administered regularly and nursing staff asked about pain relief when carrying out observations and during the medicines rounds, to help ensure this is well managed. Patients told us that their medicines were locked in personal bedside cabinets and those wishing to self-administer inhalers were supported to do so.

Other evidence

With the consent of each person we checked their prescription charts and found them to be generally clearly presented showing that medicines had been given as prescribed. Entries showed that people’s current medicine regimens had been checked when they were admitted and that any discrepancies were followed-up. Patients said that their medicines were administered at regular times, although sometimes later at night than at home. They also told us that nurses asked about pain relief when they were carrying out observations and administering medicines. One patient explained that they found it difficult to swallow large pain tablets and said the nurses had acted quickly in ensuring that a soluble tablet was prescribed.
Patients can be supported to look after and take their own medicines. Each bed has a ‘patients own drugs’ locker. Nurses explained that if someone was assessed as self-administering all their own medicines they would be given their own locker key; otherwise the key was held by nursing staff. None of the patients we spoke with self-administered all their own medicines but several managed their own inhalers. Nurses explained that they observed people wishing to manage their inhalers for the first 24 hours and recorded this in the nursing notes. Records were also made on the prescription chart to show the inhalers were self-administered, but a ‘wider’ assessment was not completed. One person we spoke to said they normally used a ‘spacer’ device with their inhaler, but although they were managing they didn’t have one in hospital. This may have been identified if a wider self-administration assessment was completed.

Most patients spoken with confirmed that they were informed when changes were made to their medicines and that they were told what their medicines were for. One person told us that they were happy with the information provided and support offered by a nurse when explaining how to use an enema. Another patient described how the doctor clearly explained why a new medicine was being given, what the possible side-effects could be and how this would be reviewed. A third patient commented that their General Practitioner knew about their medicine changes when they came out of hospital.

All wards at the hospital are supported by the clinical ward pharmacy team of pharmacists and technicians. Pharmacists do participate in some ward rounds and do meet with the ward matron to discuss people’s medicines. The presence of pharmacists on the wards is valued by nursing staff who felt that a good pharmacy service was provided.

We looked at how the hospital responded to national alerts or internal concerns about the handling of medication. Staff spoken with confirmed their use and understanding of the hospitals electronic error reporting system, and confirmed that feedback and support was given where appropriate. Senior managers explained the role of the trust-wide Medication Safety Link Practitioners in championing medicines safety and helping to communicate responses to incidents and NPSA alerts at ward level. For example, we saw that a new ‘Doctor’s Information Sheet’ was being rolled out for nurses to record any queries about peoples prescriptions, to help ensure any requests or concerns can be promptly addressed, whilst maintaining an audit trail.

Our judgement
Overall we found that appropriate arrangements were in place for supporting the safe handling of people’s medication.
**Improvement actions**

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

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<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
<th>Why we have concerns:</th>
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| Treatment for disease disorder or injury | 9 | Outcome 4 Care and Welfare of People who use services | **Patient falls**  
The Ipswich Hospital NHS Trust has systems and practices in place for the management of patients at risk of falling. Staffing levels have improved, however in some areas of the hospital there are still shortages and where bank/pool staff are used they are not always appropriately trained in the management of patients at risk of falling. There is a concern regarding the availability of appropriate equipment notably at the weekend. |
| Assessment or medical treatment for persons detained under the 1983 Act | 9 | Outcome 4 Care and Welfare of People who use services | **Pressure Damage**  
The Ipswich Hospital NHS Trust has a trust wide pressure ulcer prevention programme and action plan with appropriate monitoring in place. There is a commitment from all the staff spoken with to reduce the incidence of pressure ulcers. Risk assessments are in place however ongoing monitoring is not clearly documented. There is a concern regarding the availability of appropriate pressure relieving equipment notably at the weekend. |
| Diagnostic and screening procedures | | | |
| Maternity and midwifery services | | | |
| Termination of pregnancies | | | |
| Family planning services | | | |
The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider’s report should be sent within 28 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.
What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called Guidance about compliance: Essential standards of quality and safety.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions**: These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions**: These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action**: These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.
Information for the reader

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<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
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<tr>
<td>Author</td>
<td>Care Quality Commission</td>
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<td>Audience</td>
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</table>
| Postal address| Care Quality Commission  
Citygate  
Gallowgate  
Newcastle upon Tyne  
NE1 4PA |