Review of compliance

United Lincolnshire Hospitals NHS Trust Pilgrim Hospital	
Region:	East Midlands
Location address:	Sibsey Road Boston Lincolnshire PE21 9QS
Type of service:	Acute services with overnight beds Community healthcare service
Date of Publication:	July 2012
Overview of the service:	United Lincolnshire Hospitals NHS Trust has several hospitals. Pilgrim Hospital provides all major specialties such as maternity, cancer, intensive care and an emergency department. The trust is registered to provide the following regulated activities: Treatment of disease, disorder or injury, surgical procedures, diagnostic and screening procedures, maternity and

	midwifery services, termination of pregnancies, assessment or medical treatment for persons detained under the Mental Health Act.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Pilgrim Hospital was not meeting one or more essential standards. Action is needed.

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

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 21 May 2012, talked to staff and talked to people who use services.

What people told us

We carried out this review to see if people were given medicines safely and at the right times. We asked people whether staff explained why their medicines had been prescribed.

We visited six wards, where we talked to doctors, nurses, patients and the parents of a child. We also met three of the pharmacists who work in the hospital.

People told us they were very happy with the way doctors and nurses looked after them. One person said, "Everyone has been fantastic." Another said, "I would give it 10 out of 10 for care. Any questions I have asked have been answered."
One person was being given a continuous injection of fluid and did not know why they needed this.

We talked to a mum and dad on the children's ward: They said that the plan for treating their child's illness and the medicine prescribed had not been fully explained to them. The parents said that the ward was busy and noisy; this was difficult for them as their child was very poorly.

We met two people when we visited the discharge ward. Both people told us no-one had explained their 'take home' medicines to them. The nurses said that they had not talked to these people about their medicines as both of them were going to care homes where carers and other nurses would look after them.

What we found about the standards we reviewed and how well Pilgrim Hospital was meeting them

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Medicines were not always kept safely.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

In a previous review, we found that action was needed for the following essential standards:

- Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run
- Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights
- Outcome 06: People should get safe and coordinated care when they move between different services
- Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare
- Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs
- Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Please see previous reports for more information about previous reviews.

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 09:
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 non-compliant with Outcome 09: Management of medicines. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
People told us they were very happy with their care: One person said, "Everyone has been fantastic." Another person said, " I would give it 10 out of 10 for care. Any questions I have asked have been answered."
Another person we spoke with was being given a continuous injection of fluid but did not know why they needed this.

People usually received their medicines at the right times. We met one person who was continuing to look after and take some of their medicines, as they had done before coming into hospital.
A person on one ward who could have gone home in the morning had to stay until after lunch as their 'take home' medicines were not ready for them.

On the discharge ward, we met two people waiting for their 'take home' medicines and for hospital transport. Both told us that no-one had explained their 'take home' medicines to them.
The nurses on this ward said that they had not talked to these people about their medicines as both of them were going to care homes where carers and other nurses would look after them. This decision does not promote people's rights and choices, and the lack of a 'final check' with the patients meant that any errors with the medicines or the instructions supplied with them may not be found.

Other evidence

When we visited the children's ward a mum and dad told us that the medicine and plan for treating their child's illness had not been fully explained to them. They said that the ward was busy and noisy; this was difficult for them as their child was very poorly.
We noticed that one dose of medicine had not been signed as being given on the child's medicine chart. The nurse said that she had given the dose four hours late, but had not recorded this on the chart. According to the hospital's own guideline, giving a dose of this medicine more than 30 minutes late could reduce its effectiveness.
On a different ward we saw another example where we couldn't be sure medicines had been given due to lack of clear recording.

After our visit we were told by the trust they were putting a "helpline" in place for patients to access information about their medicines. In addition, patients were also going to be given a leaflet to help them. We were also told by the trust they were developing a competency framework. They are confident this will ensure each professional group is competent in regard to the safe management of medicines.

The doctors and nurses we met were satisfied with the service provided by the hospital's pharmacy, but said that delays in getting medicines sometimes happened because the pharmacy was always very busy.
Two senior nurses told us that wards borrowed medicines from each other until pharmacy could supply them, so that patients got their medicines on time.

Pharmacists visited most wards every week day. Two nurses spoke highly of the pharmacist who visited their ward saying, "He is brilliant, very helpful." This pharmacist told us, "We are a stressed department trying to do our best." Two pharmacists said that they did not have enough time to thoroughly check the medicines of all new patients, to make sure that the medicines they were taking at home were prescribed in hospital, unless deliberately stopped for the patient's good.
Following our visit, the trust informed us they were planning to commission a review of staffing levels and the skill mix in the pharmacy departments across all their hospitals. This will commence at Pilgrim Hospital

A junior doctor said, "I really like the pharmacy input. I would like them to be more involved." A consultant on the children's ward felt there was a need for pharmacy to provide more than an emergency 'on call' service at the weekends. He said, "If I want to discharge a child after noon on Saturday I have to write an FP10 (the type of prescription form used by GPs) and the parents have to collect the medicines from a community pharmacy. It can be hard to find a pharmacy that is open." The trust had informed us they are consulting with the pharmacists and should hopefully soon be able to provide pharmacy staff seven days a week.

On some wards the room in which medicines were stored could not be locked. This meant that if staff were in another part of the ward, staff could not be confident about the security of the medicines cupboard in that room.
The minimum and maximum temperatures of the medicines fridge, which should be checked every day, were not written down on some wards. This meant that staff could not be sure that the medicines in the fridge had been kept at the right temperature all the time and were safe to use.

Following our visit, the trust informed us they were developing a way to provide on-going monitoring of safe medicines management.

Our judgement
The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Medicines were not always kept safely.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The provider was not meeting this standard. People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Medicines were not always kept safely.	

The provider must send CQC a report that says what action they are going to take to achieve 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 to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance 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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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 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

Document purpose	Review of compliance report
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