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

Urgent and emergency services	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The United Lincolnshire Hospitals NHS Trust has three main hospitals and provides a range of hospital-based medical, surgical, paediatric, obstetric and gynaecological services to the 700,000 people of Lincolnshire. The trust employs 7,500 staff

We inspected Grantham Hospital between the 18 and 19 October 2016. We did not carry out an unannounced inspection to this hospital.

We inspected Urgent and Emergency care at Grantham Hospital; we did not inspect any of the other core services that were offered at this hospital.

We rated the urgent and Emergency Care service overall as Good, with safety requiring improvement.

Our key findings were as follows:

Safe

- There was not a robust system in place for checking availability of life saving equipment.
- We found staff had not checked resuscitation equipment in line with trust policy. Several single-use items in the paediatric resuscitation trolley were out of date.
- There were not sufficient numbers of children's nurses in the department and four out a possible 20 (20%) adult nurses had completed paediatric competencies
- The environment in the department was visibly aged; we saw exposed plaster in a number of areas for example in the children's cubicle and dirty utility room.
- Nurses and doctors told us the department was not big enough for the number of patients now accessing the department, one nurse said they had "outgrown" the department. We saw doctors bringing patients into the department to cubicles, which were already in use. There was no dedicated receiving area for patients arriving by ambulance. Staff allocated ambulance stretchers to the corridor until a cubicle was available. There was a risk to safety as it would be difficult to evacuate the area in an emergency or to assess and treat a patient who became unwell.
- There were insufficient numbers of nurses and doctors trained in paediatric resuscitation.
- We saw effective and reliable systems and processes in place for medicines management, patient records and assessing and responding to patient risk.
- We saw an effective system in place to ensure patients received appropriate initial assessment by appropriately qualified clinical staff within 15 minutes of arrival to the emergency department (ED) in line with best practice.
- Emergency preparedness plans were in place and staff knew of these.
- Openness and transparency about safety was encouraged.
- When staff reported incidents, these were investigated and learning was shared.
- Staff gave sufficient priority to safeguarding vulnerable adults and children.
- The environment posed a risk to patients' privacy and dignity. There were no "in use" signs on treatment room doors, the surgical procedures room was not closed off from a storage area and adjacent resuscitation room and staff did not always seek permission to enter closed cubicle curtains.
- It was not always possible to maintain patients' confidentiality due to the position of the waiting room and the glass partition at the reception desk.

Effective

- Care and treatment was mostly planned in line with current evidence based guidance, standards and best practice. Patient needs were mostly assessed throughout their care pathway in line with National Institute of Health and Care Excellence (NICE) quality standards and Royal College of Emergency Medicine (RCEM) guidelines.

Summary of findings

- Information about patients' care and treatment, and their outcomes was routinely collected and monitored. This information was used to improve patient care.
- Staff could access information they needed to assess, plan and deliver care to people in a timely way.
- Staff were supported to deliver effective care and treatment through meaningful and timely supervision and appraisal.
- Staff demonstrated understanding of the issues around consent and capacity for adults and children attending the department.
- The department did not audit the number of patients who were recalled to the department with a missed fracture.

Caring

- Patients were treated with dignity, respect and kindness during all interactions with staff.
- Staff helped people and those close to them cope emotionally with their care and treatment.
- Staff respected patients' rights to make choices about their care.
- We saw staff providing specialist support to patients and those close to them in relation to their psychological needs.
- The results of the CQC A&E Survey (2014) showed the trust scored 'about the same' as other trusts for most questions.
- The environment posed a risk to patients' privacy and dignity. There were no "in use" signs on treatment room doors, the surgical procedures room was not closed off from a storage area and adjacent resuscitation room. Staff did not always seek permission to enter closed cubicle curtains.
- It was not always possible to maintain patients' confidentiality due to the position of the waiting room and the glass partition at the reception desk.

Responsive

- Waiting times and delays were minimal and managed appropriately.
- Care and treatment was coordinated with other services and providers.
- There were systems in place to support vulnerable patients.
- There were arrangements in place to avoid unnecessary admissions to the hospital.
- Complaints about the service were shared with staff to aid learning.
- Patients could not always access the right care at the right time especially those with urgent care needs.

Well led

- There was an effective governance framework in place. Quality, risks and performance issues for the department were monitored through monthly clinical governance meetings and there was a good feedback loop.
- Department leaders had the experience and capability to lead the services and were committed. They prioritised safe, high quality and compassionate care.
- Nursing and medical staff said the department manager, matron, interim head of nursing and consultants were approachable, visible and provided them with good support.
- We saw effective team working across the department and an obvious mutual respect amongst staff.
- Morale in the department was mixed; some staff described the overnight closure as worrying and wondered if the department would ever re-open overnight. However, some said they liked it as there were more staff on duty in the day. Consultants said morale was low; they felt that they were unable to provide the service they wanted to the local population of Grantham.
- The risks and issues described by some leaders did not correspond to those that were currently on the department risk register.

We saw several areas of outstanding practice including:

Summary of findings

- The department inputted hourly data into an ED specific risk tool. The tool gave an "at a glance" look at the number of patients in ED, time to triage and first assessment, number of patients in resuscitation room, number of ambulance crews waiting and the longest ambulance crew wait. This gave a focus across the trust on where pressure was building and there were local actions for easing pressure.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- The trust must take action to ensure that the environment in the emergency department is fit for purpose
- The trust must take action to ensure staff have the appropriate qualifications, competence, skills and experience, in excess of paediatric life support, to care for and treat children safely in the emergency department.
- The trust must ensure there are sufficient numbers of medical and nursing staff working in the emergency department who have up to date and appropriate adult and children resuscitation qualifications.

The trust should:

- The trust should take action to ensure there are effective and consistent systems for learning from deaths to be shared across the emergency department.
- The trust should ensure there is a robust system in place for checking safety and suitability of life saving equipment in the emergency department.
- The trust should ensure ligature cutters are immediately available in the emergency department.
- The trust should ensure there is a protocol in place for management and manipulation of fractures.
- The trust should review the process for patients presenting to the ED reception at Grantham to maintain patient's privacy and dignity.
- The trust should ensure the emergency department risk register is reflective of the risks identified by senior leaders.
- The trust should ensure there is a hearing loop system in the emergency department at Grantham.
- The trust should ensure there are adequate processes in place to ensure handovers between the ambulance and the emergency department take place within 15 minutes with no patients waiting more than 30 minutes.
- The trust should consider the process in place for children awaiting triage in order to meet the 2012 Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings.
- The trust should consider how the emergency department can comply with the accessible standard for information.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good 	Overall, we rated urgent and emergency services as good. We rated safe as requires improvement, effective, caring, responsive and well-led as good because: Care and treatment provided by the department was in line with current evidence based guidance, standards and best practice. The department assessed patients throughout their care pathway in line with 'National Institute of Health and Care Excellence' (NICE) quality standards and College of Emergency Medicine (CEM) guidelines. The department collected information about patients' care, treatment and outcomes; the department used these to improve patient care. Staff treated patients with dignity, respect and kindness during all interactions we observed. Staff helped people and those close to them cope emotionally with their care and treatment. Staff respected patients' rights to make choices about their care. Waiting times and delays were minimal and managed appropriately. Care and treatment was coordinated with other services and providers. There were systems in place to support vulnerable patients. There was an effective governance framework in place. The department monitored quality, risks and performance issues through monthly clinical governance meetings and there was a good feedback loop. We saw an effective system in place to ensure patients received appropriate initial assessment by appropriately qualified clinical staff within 15 minutes of arrival to ED in line with best practice. Emergency preparedness plans were in place and staff knew of these. Staff gave sufficient priority to safeguarding vulnerable adults and children. However; There was not a robust system in place for checking availability of life saving equipment.

Summary of findings

We found staff had not checked resuscitation equipment in line with trust policy. Several single-use items in the paediatric resuscitation trolley were out of date.
There were not sufficient numbers of children's nurses in the department and four out a possible 20 (20%) adult nurses had completed paediatric competencies.
There were insufficient numbers of nurses and doctors trained in paediatric resuscitation.
Nurses and doctors told us the department was not big enough for the number of patients now accessing the department. We saw doctors bringing patients into the department to cubicles, which were already in use.
There was no dedicated receiving area for patients arriving by ambulance.
Staff allocated ambulance stretchers to the corridor until a cubicle was available. There was a risk to safety as it would be difficult to evacuate the area in an emergency or to assess and treat a patient who became unwell.
Patients could not always access the right care at the right time due to the department's overnight closure, especially those with urgent care needs.
There was a mixed morale amongst staff in the department, some staff described the overnight closure as worrying and wondered if the department would ever re-open overnight. Some said they liked it as staffing levels had improved during the day. Consultants said morale was low; they felt they were unable to provide the service they wanted to the local population of Grantham.

Grantham and District Hospital

Detailed findings

Services we looked at:
Urgent and emergency services.

Detailed findings

Contents

Background to Grantham and District Hospital

The United Lincolnshire Hospitals NHS Trust was formed in April 2000 by the merger of the three former acute hospital trusts in Lincolnshire, creating one of the largest trusts in the country. Through three main hospitals and four sites, the trust provides a range of hospital-based medical, surgical, paediatric, obstetric and gynaecological services to the 700,000 people of Lincolnshire. The trust employs 7,500 staff.

Grantham and District Hospital has 110 beds.

Lincolnshire is a largely rural area with only 27 miles of dual carriageway in the county. This makes travel times lengthy and road injuries/deaths are common. In Lincolnshire, traffic-related injuries/deaths are significantly worse than the average for these types of injuries in England.

The county's average of Black, Asian and minority ethnic residents is lower than the English average – with the largest ethnic group being Asian (1.2%). There are medium levels of deprivation, but these levels have increased since 2007. The county has an ageing population, with a higher than average number of older residents.

Our inspection team

Our inspection team was led by:

Chair: Judy Gillow,

Head of Hospital Inspections: Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a consultant surgeon, a medical consultant, registered nurses, allied health professionals, midwives and junior doctors.

We were also supported by two experts by experience that had personal experience of using, or caring for someone who used the type of service we were inspecting.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?

Detailed findings

- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before our inspection, we reviewed a wide range of information about United Lincolnshire Hospitals NHS Trust and asked other organisations to share the information they held. We sought the views of the clinical commissioning group (CCG), NHS England, National Health Service Intelligence (NHSI), Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team. We also spoke with patients and members of the public as part of our inspection.

The announced inspection to the trust took place between the 18 and 19 October 2016. We held focus groups with a range of staff throughout the trust, including, nurses, midwives, junior and middle grade doctors, consultants, administrative and clerical staff, physiotherapists and occupational therapists, porters and ancillary staff. We also spoke with staff individually.

We did not carry out an unannounced inspection to this hospital.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Urgent and emergency services

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

Information about the service

United Lincolnshire Hospitals NHS Trust provides urgent and emergency services at three hospital sites, Lincoln County, Pilgrim Hospital, Boston and Grantham and District Hospital.

The emergency department (ED) based as Grantham provides consultant-led emergency care and treatment and is usually open 24 hours a day, seven days a week serving a population of approximately 50,000. At the time of our inspection due to the shortage of medical staff in the ED at Lincoln and Pilgrim hospitals, Grantham ED was open to accept patients from 9 am to 6.30 pm, seven days a week; the trust expected these arrangements to last for three months.

The department has four "major" and four "minor" cubicles, a two -bedded resuscitation room, an eye treatment room, plaster room and a surgical procedures room. There is a designated triage cubicle and paediatric cubicle, a paediatric treatment room and paediatric waiting area. A relatives/quiet room are available in the department.

From September 2015 to August 2016 Grantham ED had 29,328 attendances, 6257 (21%) of these were children aged of 0-16. For 2015/16 there has been a 4.3% growth in attendances to ULHT emergency departments [National growth 2.3% and Midlands and East 6.5%] compared with 2014/15.

Grantham ED accepts unwell adults with medical conditions. There is no emergency surgery provision, and they do not accept trauma, cardiac, stroke, or paediatric admissions; these are diverted to the other two main sites (Lincoln and Boston) and a policy of exclusion was agreed with the local ambulance service. Cardiology emergency admissions from across Lincolnshire go direct to the heart centre at Lincoln. The department cannot receive patients by air ambulance.

During our inspection, we visited all areas of the emergency department. We spoke with 12 patients, four relatives and 21 staff, including junior and senior nurses, health care assistants, junior and senior doctors, allied health professionals, administrative and housekeeping staff. We also spoke with four ambulance service staff who were not employed by the trust. We observed interactions between patients, relatives and staff and considered the environment.

We looked at 18 records of care and treatment including medication prescription charts, observation and sepsis screening charts and care bundles. Eight of the records were those of children.

Before our inspection, we reviewed performance information from and about the hospital.

Urgent and emergency services

Summary of findings

Overall, we rated urgent and emergency services as good.

We rated safe as requires improvement, effective, caring, responsive and well-led as good because:

- Care and treatment provided by the department was in line with current evidence based guidance, standards and best practice. The department assessed patients throughout their care pathway in line with 'National Institute of Health and Care Excellence' (NICE) quality standards and College of Emergency Medicine (CEM) guidelines.
- The department collected information about patients' care, treatment and outcomes; the department used these to improve patient care.
- Staff could access information they needed to assess, plan and deliver care to people in a timely way.
- Staff treated patients with dignity, respect and kindness during all interactions we observed.
- Staff helped people and those close to them cope emotionally with their care and treatment.
- Staff respected patients' rights to make choices about their care.
- Waiting times and delays were minimal and managed appropriately.
- Care and treatment was coordinated with other services and providers.
- There were systems in place to support vulnerable patients.
- There were arrangements in place to avoid unnecessary admissions to the hospital.
- There was an effective governance framework in place. The department monitored quality, risks and performance issues through monthly clinical governance meetings and there was a good feedback loop.
- Department leaders had the experience and capability to lead the services, were committed to, and prioritised safe, high quality, compassionate care.
- Nursing and medical staff said the department manager, matron, interim head of nursing and consultants were approachable, visible and provided them with good support.
- We saw effective and reliable systems and processes in place for medicines management, patient records and assessing and responding to patient risk.
- We saw an effective system in place to ensure patients received appropriate initial assessment by appropriately qualified clinical staff within 15 minutes of arrival to ED in line with best practice.
- Emergency preparedness plans were in place and staff knew of these.
- Openness and transparency about safety was encouraged.
- Staff gave sufficient priority to safeguarding vulnerable adults and children.

However;

- There was not a robust system in place for checking availability of life saving equipment.
- We found staff had not checked resuscitation equipment in line with trust policy. Several single-use items in the paediatric resuscitation trolley were out of date.
- There were not sufficient numbers of children's nurses in the department and four out a possible 20 (20%) adult nurses had completed paediatric competencies.
- There were insufficient numbers of nurses and doctors trained in paediatric resuscitation.
- The environment in the department was visibly aged; we saw exposed plaster in a number of areas for example in the children's cubicle and dirty utility room.
- Nurses and doctors told us the department was not big enough for the number of patients now accessing the department, one nurse said they had "outgrown" the department. We saw doctors bringing patients into the department to cubicles, which were already in use. There was no dedicated receiving area for patients arriving by ambulance. Staff allocated ambulance stretchers to the corridor until a cubicle was available. There was a risk to safety as it would be difficult to evacuate the area in an emergency or to assess and treat a patient who became unwell.
- Patients could not always access the right care at the right time due to the department's overnight closure, especially those with urgent care needs.

Urgent and emergency services

- There was a mixed morale amongst staff in the department, some staff described the overnight closure as worrying and wondered if the department would ever re-open overnight. Some said they liked it as staffing levels had improved during the day. Consultants said morale was low; they felt they were unable to provide the service they wanted to the local population of Grantham.
- The risks and issues described by some leaders did not correspond to those that were currently on the department's risk register.

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement because:

- There was not a robust system in place for checking availability of life saving equipment.
- We found staff had not checked resuscitation equipment in line with trust policy. Several single-use items in the paediatric resuscitation trolley were out of date.
- There were not sufficient numbers of children's nurses in the department and four out a possible 20 (20%) adult nurses had completed paediatric competencies
- The environment in the department was visibly aged; we saw exposed plaster in a number of areas for example in the children's cubicle and dirty utility room.
- Nurses and doctors told us the department was not big enough for the number of patients now accessing the department, one nurse said they had "outgrown" the department. We saw doctors bringing patients into the department to cubicles, which were already in use. There was no dedicated receiving area for patients arriving by ambulance. Staff allocated ambulance stretchers to the corridor until a cubicle was available. There was a risk to safety as it would be difficult to evacuate the area in an emergency or to assess and treat a patient who became unwell.
- There were insufficient numbers of nurses doctors trained in paediatric resuscitation.

However;

- We saw effective and reliable systems and processes in place for medicines management, patient records and assessing and responding to patient risk.
- We saw an effective system in place to ensure patients received appropriate initial assessment by appropriately qualified clinical staff within 15 minutes of arrival to the emergency department (ED) in line with best practice.
- Emergency preparedness plans were in place and staff knew of these.
- Openness and transparency about safety was encouraged.
- When staff reported incidents, these were investigated and learning was shared.

- Staff gave sufficient priority to safeguarding vulnerable adults and children.
- The environment posed a risk to patients' privacy and dignity. There were no "in use" signs on treatment room doors, the surgical procedures room was not closed off from a storage area and adjacent resuscitation room and staff did not always seek permission to enter closed cubicle curtains.
- It was not always possible to maintain patients' confidentiality due to the position of the waiting room and the glass partition at the reception desk.

Incidents

- There were no never events in Grantham emergency department (ED) between August 2015 and July 2016. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- There were 156 incidents relating to Grantham ED reported to the National Reporting and Learning System (NRLS) between October 2015 and September 2016 of these 131 (83.9%) resulted in no harm, 13 (8.3%) low harm, nine (5.7%) moderate harm, two (1.2%) severe harm and one (0.6%) resulted in a death. The NRLS is a central database the trust submits patient safety incidents too.
- Incidents were investigated and closed once any lessons learned had been shared. Data provided by the trust prior to our inspection showed as of 12 October 2016 11 incidents remained open.
- Between March 2016 and June 2016, the trust reported seven serious incidents in urgent and emergency services. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Of these, one occurred in the emergency department (ED) at Grantham and resulted in the death of a patient. We saw that the department following this incident had carried out a comprehensive investigation and lessons learned shared, for example the department now obtained a National Early Warning Score (NEWS) from the ambulance crew for each patient who arrived by ambulance, so that they could assess how sick the patient was.
- Staff were aware of and appeared knowledgeable and confident about reporting incidents. All trust staff had access to the online reporting system. Staff told us they received acknowledgement they had submitted an incident report, and could request individual feedback about the incident when they reported it, if they wanted to. Staff who requested feedback said they did not always receive it.
- Staff gave us examples of when they might report incidents such as patients presenting to the department with a pressure ulcer or falls occurring in the department. Staff told us they were recording any concerns regarding patient safety as an incident. Staff said there was a non-blame culture in the department and they felt empowered to report incidents without fear of reprisal.
- Incidents giving cause for concern, or following a specific trend were discussed in the department meetings; minutes of these meeting we looked at confirmed this. Staff also discussed incidents at the daily "Time 2 Talk" meeting. This was a staff brief that occurred each morning.
- There were no formal mortality and morbidity meetings; however, we saw mortality and morbidity was an agenda item at the ED clinical governance meetings. Trusts use mortality and morbidity meetings to review deaths and learn from them.
- We reviewed the minutes of the governance meeting in June 2016 and noted that mortality reviews had fallen behind. The minutes stated, "This has fallen behind of late. January being done". We discussed the current backlog with the department leaders, who informed us, whilst formal mortality and morbidity meetings had not been held by the department, there was a process in place to review all patient deaths, and agree lessons learned. We did not see any evidence of this process. Department leaders were working to address the backlog, but did not confirm when this was likely to be cleared. There was a risk learning from deaths in the department might not be shared appropriately.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Staff had not followed the duty of candour regulations for a serious incident dated April 2016. We discussed this with department leaders who confirmed

that they had since received training in duty of candour to prevent this happening again. During our inspection, we saw an incident, which had occurred in the department, resulting in harm to a patient. Patient records and the patient's relatives confirmed that staff had followed the duty of candour requirements. Department leaders said this would be followed up with a letter.

- All staff were aware and able to explain their understanding of the requirements of duty of candour, staff said they would inform the patient of any error regardless if harm had occurred or not. We asked the trust to provide us with training figures for duty of candour for the department staff but we did not receive this.

Cleanliness, infection control and hygiene

- The department appeared visibly clean and staff were aware of the current infection prevention and control guidelines.
- We saw completed daily and weekly cleaning schedules and these were up to date.
- The environment in the department was visibly aged; we saw exposed plaster in a number of areas in the department for example in the children's cubicle and dirty utility room. We could not be assured that staff were able to effectively clean these areas so the risk of infection was increased.
- The Care Quality Commission (CQC) use national surveys to find out about the experiences of people who use NHS services. The CQC sent a questionnaire to 850 people who had attended the accident and emergency department (A&E) during January, February or March 2014. The CQC received 294 responses from patients at this trust. The trust scored 'about the same' as other trusts for describing the A&E department as clean.
- Staff received training in infection control. Data provided by the trust showed that as of 31 August 2016, 71% of medical staff and 63% of nursing staff were up to date with this training. The trust target was for 95% compliance.
- There were no reported cases of MRSA bacteraemia or clostridium difficile (C. difficile) infections between January 2016 and September 2016. C.Difficile is a bacterium affecting the digestive system; it often affects people who are given antibiotics and has the capability of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. The Department of Health adopted a zero tolerance approach to avoidable MRSA bacteraemia cases in April 2013.
- We saw the emergency department had not had a trust infection control audit between January 2016 and August 2016, therefore, we could not be assured the trust was monitoring cleanliness in the department. We discussed this with department leaders who told us this was due to a restructure in the infection prevention and control nurse team resulting in the hospital sharing a nurse across two sites.
- The trust carried out monthly environmental cleaning audits. The trust target was for a score of 95% compliance. Between August 2015 and July 2016, the department met this target on three out of the possible 12 months. Compliance during this period varied between 82% and 96%.
- Following two external inspections we saw an action plan in place to address the shortfalls in cleanliness. We reviewed the action plan and saw this was robust, the department had completed most of the required actions, for example, we saw a cleaning manual was now in place in ED.
- Cleansing gel was available at the entrances to the department and in each treatment area; patients and visitors were encouraged to use it by staff. Posters were prominently displayed encouraging staff and visitors to cleanse their hands and the process to follow to do this effectively.
- Staff were 'bare below the elbow' to allow effective hand washing.
- The trust required all areas to submit hand hygiene compliance data monthly. The department did not submit data for six out of the 12 months between September 15 and August 16. We discussed this with department leaders who told us the reason for no submission was due to the data being sent to the wrong internal email address and therefore not recorded.For the six months where data was submitted hand hygiene compliance was consistently at 100%.
- Patients with vascular access devices such as cannulas (a plastic tube inserted in the vein for administration of medicines) had a nationally recognised assessment tool completed which indicated specific interventions had been performed during insertion. We observed a nurse

inserting a cannula and found them to be adhering to this guidance. We also observed nursing staff removing cannulas when they were no longer required so as to avoid infection risks.
- Protective equipment, such as gloves and aprons, were available and we observed staff using these appropriately. We also observed staff washing their hands between patients.
- Staff used green 'I am clean' signed and dated stickers to show they had cleaned equipment and it was ready for use. We observed all patient-care equipment to be clean and ready for use.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste including the disposal of sharps such as needles and environmental waste.

Environment and equipment

- The department was over 30 years old and as such was not compliant with all of the standards specified in Health Building Note 15-01: accident & emergency departments. There was not a canopied drop-off zone to offer protection from adverse weather conditions for patients who self-presented to the department. Nurses and doctors told us the department was not big enough for the number of patients now accessing the department, one nurse said they had "outgrown" the department. During our inspection, at times, we saw doctors bringing patients into the department to cubicles, which were already in use; this meant there was not always sufficient space to treat patients. There was a risk to safety as it would be difficult to evacuate the area in an emergency or to assess and treat a patient who became unwell. The trust had recognised the environment was not fit for purpose and this was on the risk register.
- There was no dedicated receiving area for patients arriving by ambulance. Staff allocated ambulance stretchers to the corridor until a cubicle was available. During our inspection we saw that no patients who arrived by ambulance waited longer than five minutes for a cubicle. Nursing staff said they prioritised patients on stretchers for cubicles where possible. We spoke with four ambulance staff who confirmed they rarely had to wait longer than ten minutes on the corridor awaiting allocation to a cubicle.
- There was no patient kitchen. There was a dedicated patient fridge in the staff room. Drink and snacks were prepared in the staff kitchen.
- There was access to a designated children's waiting room adjacent to the main department. This was not visible from the main adult waiting area; however, the policy was that children and parents could only access this room following triage. Prior to triage children remained in the main adult waiting area. This was not compliant with Intercollegiate Children and Young People in Emergency Care settings standards.
- There was only one toilet available inside the treatment areas of the main department. Toilets were available in the waiting room.
- Reception staff did not have access to an emergency alarm to summon immediate help if there was an emergency in the waiting area. Reception staff would have to leave reception and shout for assistance in the department.
- We saw there was a specially designed sink in the eye treatment room used for irrigation of the eyes. The water supply in the room was filtered to ensure water could be used directly from the tap.
- The surgical procedures room resembled a storeroom, there were intravenous infusion pumps and various other pieces of equipment stored in this room such as a patient hoist and procedure trolleys. Department leaders told us they would try to avoid putting patients in this room wherever possible. During our inspection, we saw staff use the room on three occasions.
- Patients said, and we noticed the environment in the department and the waiting room was cold. The surgical procedures room and resuscitation room was also cold and staff were monitoring the temperatures of these areas. Three patients who we spoke with in these areas confirmed they were cold, and we asked staff to provide them with additional blankets. Accurate temperature control is very important for many resuscitation patients.
- Due to the cold temperature in the surgical procedure room, an electric heater inside a large metal cage was in place in the room on the first day of our inspection. There was a potential fire risk of this heater being close to curtains within the room. We escalated this to department staff and a porter. Staff had removed the heater when we returned the following day.

- Resuscitation and emergency equipment for adults and children was available in the department. Staff were aware of its location in the event of an emergency.
- There was not a robust system in place for checking availability of life saving equipment. There was no checklist for contents in the arterial and central line trolley, airway trolley and the paediatric transfer bag. The paediatric transfer bag had not been locked by staff; the department leader told us staff should have locked this. There was a risk that equipment may be removed from the bag and not be available when required. We escalated our concerns to the department leader, who said that they would address this. This had not been addressed at the end of our inspection.
- Staff had not checked resuscitation equipment in line with trust policy and we could not be assured it was safe and ready for use in an emergency. Several single-use items in the paediatric resuscitation trolley were out of date. We informed the department leader of this immediately. We returned later that day and found that one piece of equipment on the resuscitation trolley had not been replaced. It is unacceptable for life saving equipment to not be ready for use. We escalated this to the nurse in charge of the shift who replaced this immediately.
- We found out of date equipment in the emergency tracheostomy box. We escalated this immediately to the department leader who said they would get it replaced. This was not replaced at the end of day one of our inspection; we escalated this to the nurse in charge who said they would look to address this. We returned the following morning and this still had not been replaced. We discussed this with the department leader, who informed us they were unable to locate the item across the trust and were in the process of ordering them. We asked how often the department had used the equipment and two members of senior staff said they had never had to use this box. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help patients breathe.
- In the arterial and central line trolley, a pack of gauze was open. The pack said do not use if the pack is damaged or open. This meant the gauze was not ready to be used in the event of an emergency. We escalated this to staff who replaced it.
- A logbook for an anaesthetic machine in the resuscitation room showed this had been checked daily. Nursing staff said an operating department practitioner (ODP) from theatres did this for them.
- There was a safe and effective system for the repair, servicing and maintenance of medical equipment. We checked 12 different pieces of medical equipment, which included cardiac monitors, thermometers, vital sign machines and bladder scanners and found them to be in date with routine servicing.
- The location of the ED was within a suitable distance of supporting services. For example, x-ray and computed tomography (CT) scan.

Medicines

- Medicines were stored securely and appropriate emergency medicines were available. Medicines were all stored in locked cupboards or fridges and the nurse in charge took responsibility for the keys.
- There were specific containers for the disposal of medications, and we observed staff using these.
- Intravenous (IV) fluids were kept on shelves, secure in a locked cupboard.
- We observed staff checking and administering medicines in line with trust policy and the Nursing and Midwifery Council (NMC) guidance.
- Blank prescription pads and computer paper were held securely and tracked to avoid misuse.
- Medicines requiring storage at temperatures below eight degrees celsius were appropriately stored in medicine fridges .Records confirmed fridge temperatures were monitored daily to check medicines were stored at the correct temperatures. Information was clearly visible to all staff on what to do if a temperature was out of range
- Staff carried out checks on controlled drugs (CDs) in line with trust policy. Checklists we reviewed confirmed this.
- A designated member of the nursing team in conjunction with pharmacy staff was responsible for maintaining minimum stock levels and checking medication expiry dates. We checked seven different medicines and found them to be in date.
- Medical gases were stored in designated cylinder trollies, this meant the risk of them falling over and causing injury to someone was minimised.
- Qualified staff used patient group direction (PGD) for the prescription of three simple pain relief medicines to adults only. Patient group directions provide a legal

framework, which allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor.

- We reviewed the three PGDs for adults and found they were all correctly completed, authorised and in date. PGDs included good criteria under which a patient may or may not be eligible for treatment with certain medicines. A very small number of staff had signed the PGDs to confirm they had read these and would adhere to them. We did not observe the use of PGDs during our inspection. Nursing staff said they rarely used PGDs, as there was always a doctor in the department.
- Staff kept supplies of some medicines labelled for patients to take home, so they could start their treatment quickly when pharmacy was not open. We saw records of the use of these medicines, as required by the Trust's policy. We checked the stock records of four medicines and found the recorded stock balances were correct.
- Doctors dispensed take home medicines and provided patients with advice regarding the medication. Nurses acted as second checkers to the doctor for all medication dispensed from the department.
- The results of the CQC A&E Survey (2014) showed the trust scored 'about the same' as other trusts for having the purpose of new medications explained before they left A&E, for being told about possible side effects of medication and for those prescribed new medication while in A&E.
- There were eight medicine errors in ED between November 2015 and April 2016. The department manager had investigated these and no themes were identified. Lessons learned had been shared. There had been no further medicine errors between April 2016 and September 2016. We saw staff professionally challenge doctors in relation to prescribing for example asking the doctor to prescribe using the generic rather than brand names of medication, this minimised the risk of drug errors. Every medicine has an approved generic name. If several companies make it, each will also give the medicine a brand (trade) name. So one medicine may have a generic name and have one or more brand names. This can sometimes lead to confusion
- We looked at the prescription and medicine administration records on the treatment cards for 10 adults and eight children .We saw appropriate arrangements were in place for recording the administration of medicines. The records were clear and fully completed The records showed patients were getting medicines in a timely way, when they needed them. Staff recorded patients' allergies on all treatment cards.
- We observed medical staff accessing the online trust specific microbiology protocols when prescribing antibiotics. Records showed staff were prescribing in line with the protocols for example antibiotics used for the treatment of sepsis. Sepsis is a severe infection, which spreads in the bloodstream. The trust did not carry out any specific audits in relation to antibiotic prescribing in the ED.

Records

- Staff used paper patient records and these were securely stored in the emergency department.
- Patient records were written and managed in a way that kept patients safe. All records we reviewed were accurate, complete, legible and up to date.
- Records were stored in the department for up to a year before moving them to an offsite secure storage; this meant patients' records were easily accessible if required.
- Computers were locked when not in use. This meant there was no unauthorised access to patient information.
- Nursing staff confirmed that when required, patient records would include risk assessments. For example for falls, pressure care and nutrition and they would be reviewed and updated on a regular basis. There were no risk assessments present in the notes we reviewed during our inspections as the patients were in the department for short periods (not above four hours) and as such did not require these. We saw risk assessment booklets were readily available in the department.

Safeguarding

- The executive lead for safeguarding was the director of nursing who was supported by the deputy chief nurse. There was also a named safeguarding professional for adults and children supported by safeguarding practitioners.
- The department had a safeguarding link champion, and their name was displayed on a notice board, so staff knew who to approach for further support and guidance.

- Policies outlined the processes for the safeguarding of vulnerable adults and children. Staff followed specific guidelines and care pathways where concerns around safeguarding of children, young people and adults were identified, such as instances of domestic violence. There were processes in place to escalate concerns and staff showed us a list of safeguarding contacts. Staff also had access to the safeguarding team based in the ED at Lincoln and said they were very helpful and supportive.
- Staff followed a robust risk assessment process in order to refer patients, where appropriate to a Multi-Agency Risk Assessment Conference (MARAC). A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between a variety of professionals such as local police, health and child protection agencies.
- All staff described utilising "professional curiosity" when triaging children. Being professionally curious means looking to identify indicators of neglect and not being reliant on legal thresholds.
- Data for the emergency department at the end of August 2016 showed 81% of medical and nursing staff were up to date with level two adult safeguarding training. Safeguarding level two for children compliance was 82% and safeguarding level three (a) was 81%. The trust set a mandatory target of 95% for completion of safeguarding training.
- Nursing and medical staff used a 'SAFER' communication tool, based on Department of Health guidelines, for all paediatric patients admitted to the emergency department and for the identification and management of children at risk of abuse. SAFER communication guidelines are guidelines for communications between staff in the department, health visitors, school nurses and local authority children's social care teams and are used when a child may be suffering or is likely to suffer significant harm. The use of SAFER ensured a uniform approach to communicating the level of risk to a child. Six out of eight records we reviewed had this sticker completed. The safeguarding team audited completion of this sticker three monthly.
- We saw a trust wide policy for to female genital mutilation (FGM). Staff were aware of their responsibilities in relation to FGM. FGM is defined as all procedures (not operations) which involve partial or total removal of the external female genitalia or injury to the female genital organs whether for cultural or other non-therapeutic reasons.
- FGM training was provided as part of safeguarding level three (a) training and updated three yearly.
- There was a system in place for sharing information in relation to child protection, this involved the safeguarding team, health visitors and other professionals such as GPs.
- Staff told us the safeguarding team regular visited the department to offer safeguarding supervision and provide opportunities for staff to ask questions. These meetings were not minuted.
- Doctors in the department confirmed they were aware of the guidelines for detection of child exploitation, but stated they had never had to use these. Doctors said if they had any concerns they would access the guidelines directly through the internet.

Mandatory training

- Mandatory training for all groups included fire safety, health and safety, information governance and infection control amongst other subjects.
- Mandatory training data for nursing staff showed a completion rate of 83% and for medical staff 74% against the trust target of 95%.
- Staff said they had received sepsis training and confirmed they knew there was sepsis guidance included in the observation policy. We observed staff screening patients for sepsis during our inspection; they appeared confident and familiar with the requirements of the adult and children sepsis screening forms. Data provided by the trust following our inspection showed that eight out of 23 (34%) of nurses had completed the trust e- learning package for sepsis.
- There were low numbers of staff trained in paediatric resuscitation. Staff within the emergency department were expected to complete children's resuscitation training such as immediate life support and advanced paediatric life support. Data given to us by the department manager showed that nine out of 23 (39%) had completed paediatric life support (PILS) and three out of 23 nurses held the European advanced paediatric life support (EPLS) qualification. The department

manager confirmed and rotas we reviewed showed there was a PILS trained member of staff on each shift. The department manager was actively working to ensure that all staff attended the appropriate courses.

- Doctors in the department received a variety of resuscitation training based on their grades. Seven out of 15 doctors (46%) held a valid and in date advanced life support qualification (ALS) one doctor had a place booked for February 2017. Five out of 15 (33%) held an advanced paediatric life support qualification (APLS), two out of 15 (13%) held a European paediatric life support qualification (EPLS). Nine out of 15 (60%) held an immediate life support qualification. There were insufficient numbers of doctors with a valid paediatric resuscitation qualification. A total of seven out of a possible 15 (46%) of doctor held a paediatric resuscitation qualification.

Assessing and responding to patient risk

- An escalation policy was in place to escalate risks that could affect patient safety, such as low staffing and bed capacity issues.
- There was a specific ED admissions and exclusions protocol for adults and children. This had been communicated to local GPs and ambulance services to ensure that patients could be safely cared for in the department. Ambulance staff we spoke with confirmed they were aware of this protocol. We saw arrangements made during our inspection to transfer a self-presenting patient who did not meet the admission criteria to another ED.
- During our inspection an ambulance crew, presented to the department with a patient following a nearby incident. The crew checked with the nurse in charge if they would accept this patient. The nurse in charge referred to the admission and exclusion protocol, which was displayed in the department, before agreeing to take the patient in into the department.
- The department inputted hourly data into an ED specific risk tool. The tool gave an “at a glance” look at the number of patients in ED, time to triage and first assessment, number of patients in resuscitation room, number of ambulance crews waiting and the longest ambulance crew wait. This gave a focus across the trust on where pressure was building and there were local actions for easing pressure.
- Reception staff told us if a patient presented with symptoms suggesting serious illness, such as chest pain, or serious injury, such as heavy bleeding, they would escort the patient immediately to the treatment area and summon the registered nurse. We saw this to be the case during out inspection, although we did not see that there was a standard operating procedure in place to support staff.
- There was an effective system in place to ensure patients received appropriate initial assessment by appropriately qualified clinical staff within 15 minutes of presentation to the department in line with best practice. During our inspection, 14 out of 18 (77%) patients whose records we reviewed were seen within 15 minutes. Triage times varied between two and 22 minutes. None of the patient records we reviewed had waited longer than 22 minutes.
- Data provided by the trust showed between September 2015 and August 2016 on average 40% of patients were seen within the standard of 15 minutes. Compliance for this period varied between 32% (February 2016) and 60% (August 2016).
- Patients were allocated a colour category at triage. The colours were red, yellow and green. Red was immediate priority and green was not immediately in danger and safe to wait. The colours were recorded on the treatment card so all staff could see patient priority. We saw examples of care being escalated promptly when patients presented to the units scoring red. All staff appeared familiar with the categories and said they would upgrade patients to the next priority category should their condition deteriorate.
- The department did not operate a rapid assessment and treat (RAT) processes due to the small numbers of patients who presented to the department by ambulance. Ambulance patients were prioritised for cubicles where possible. RAT typically involves the early assessment of ‘majors’ patients in emergency departments, by a team led by a senior doctor, with the initiation of investigations and or treatment. Evidence has shown outcomes and the patient experiences are greatly improved when a RAT process is used.
- The Department of Health target is handovers between ambulance and emergency departments must take place within 15 minutes with no patients waiting more than 30 minutes.
- The trust was not meeting this target. Between August 2015 and July 2016, there were 3,071 black breaches at

this trust. Black breaches are those cases where it has taken over one hour from the time the ambulance arrives at a hospital, until the clinical and patient handovers have taken place.

- Between September 2015 and August 2016, compliance figures for ambulance handover times showed 19% of handovers took between 30 and 59 minutes. Five percent of handovers took between one and two hours and 0.3% took greater than two hours. However, figures provided were taken from a report produced by the local NHS ambulance trust and included all ambulances presenting to this hospital, not just those that arrived at the emergency department (ED). The trust was unable to separate out those relevant to the ED.
- During our inspection we observed four patients arrive by ambulance, no ambulances waited over 30 minutes to handover their patients.
- There was a trust wide policy for resuscitation and deteriorating patient and staff were familiar with their responsibilities in relation to this policy.
- Observation charts included the national early warning score (NEWS) for adults and paediatric early waring score (PEWS) for children. Early warning scores (EWS) have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points. EWS's were not always recorded during triage and therefore the severity of a patient's condition was not established at the earliest opportunity, however once a specific observation chart was commenced EWS were recorded.
- Compliance with NEWS/PEWS scoring and escalation of patients who triggered or were deteriorating was monitored monthly. We reviewed the data for urgent and emergency services (trust wide). Data for 10 months, data for March and April 2016 was not included, between July 2015 and June 2016 showed an overall average compliance score of 72% for correct patient details, 90% for patient observations on time and complete, 93% for PEWS/NEWS score added correctly and 63% for evidence of escalation for NEWS if required. The trust target for all four elements was 90%.
- During the inspection, we reviewed the observation charts for 10 adult patients and 8 children. All of the charts we reviewed showed that observations were performed in line with the NEW/PEWS protocol and appropriate interventions put in place when required. We observed nurses escalating deteriorating patients to the doctors in a timely manner and doctors responding to patients in a timely way.
- Ambulance crews were expected to give the patient NEWS/PEWS score to nursing staff prior to handover in the department or when calling the department to pre alert them to an incoming sick patient. This ensured that care could be prioritised appropriately. We saw this happening during our inspection.
- The performing and responding to observations in adult patients policy included information on the detection and response to a patient who may present with signs and symptoms of sepsis including the trust sepsis screening form and "sepsis six" care bundle. The trust also had a specific "sepsis six" proforma for children. The "sepsis six" is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis if given within an appropriate period. There is strong evidence that swift delivery of 'basic' aspects of care prevents treatment that is much more extensive.
- One of the fundamental aspects of the 'sepsis six bundle' is to administer antibiotics within one hour of suspecting sepsis. Data for Grantham ED between October 2015 and September 2016 showed that on average 47% of patients diagnosed with sepsis received the antibiotic within one hour, however compliance varied month to month with the lowest compliance at 16.6% (December 2015) and highest 75% (September 2016).
- A trust wide action plan was in place to address the variation in treatment times and we saw that actions included updating the sepsis bundle proforma, developing an e-learning package and the purchases of sepsis boxes to be placed in clinical areas. A sepsis box includes everything a medical professional may require to treat sepsis, such as medication to avoid delay in administration of time critical interventions. A sepsis box was not present in the department at the time of our inspection; the trust told us these would be rolled out once all staff had completed sepsis training.
- Departmental leaders told us that they had identified staff within the department who would undergo additional training to administer antibiotics using a Patient Group Directive (PGD) to patients who screened positive for sepsis. This would minimise the delay in treatment of patients with sepsis. The PGD was being ratified at the time of our inspection. A Patient group

directive provide a legal framework allow some registered health professionals to supply and/or administer specified medicines, such as painkillers and antibiotics, to a predefined group of patients without them having to see a doctor.

- Patients with a NEWS of five or more were required to be screened for sepsis in line with the trust sepsis screening proforma.
- During our review of observation charts and records, we found five adult patients had met the criteria, which would indicate a sepsis-screening tool should have been completed. Two patients had not had a sepsis screening form completed. Of the three patients who had the sepsis screen completed only two had received the full "sepsis six" within the recommended hour. According to the treatment record the third patient had received antibiotics within the recommended hour, however the sepsis screening form had not been completed in full and we were not assured they had received the full "sepsis six".
- There was a specific proforma for the management of paediatric sepsis. Children with suspected or proven infection who had two specific vital signs out of range for their age, for example, faster heart rate were treated as possible sepsis.
- We found two children who had met the criteria, which would indicate a sepsis-screening tool should have been completed. One had been completed fully although did not require any further interventions. A sepsis screening form should have been completed for the second child but we did not see this had been done. We reviewed the records in more detail and found not all of the criteria were met to proceed to treat the child as possible sepsis; therefore, although the form had not been completed the child was treated appropriately.
- We saw from the records we reviewed that seven out of 10 (70%) of adult patients and six out of eight (75%) of children were seen and reviewed by a doctor within one hour of presenting to the department.
- There was no paediatric team on site, however we saw there were clear protocols in place to transfer sick children to the nearest paediatric emergency department. We saw the protocol worked effectively when a child was transferred from the department to the Lincoln ED at the time of our inspection.
- The paediatric rota was displayed in the department so it was easily accessible to all staff.
- We saw staff at triage complete a screening tool to assess risk of physical abuse in children.
- Sudden, unexpected deaths of children in the department were investigated and lead by the paediatric team.
- We saw emergency pathways in place for example a major haemorrhage protocol and resuscitation guidelines. Staff gave us examples of when they may be used.
- The department had undertaken an environmental risk assessment to identify potential ligature anchor points that might endanger people at risk of suicide The Care Quality Commission defines a ligature point as anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The department had either put a plan in place to remove these or to manage them safely. We saw ligature risk assessments had been carried out in the department, in 2014, 2015 and again in April 2016 following replacement of the nurse call bell system. We saw there was a coat hook in the patient toilet, which was a ligature risk, we raised this with the department leader at the time, and when we returned, the following day it had been removed.
- Staff did not carry nor did the department have ligature cutters in the event of a patient attempting to hang themselves. Ligature cutters are specially designed to offer an effective and safe method of cutting a ligature attached to a person.
- Staff assessed the risk to patients who were leaving the department to go for x-ray or being admitted to the ward, this determined if the patient had a nurse or health care assistant escort. We saw on a number of occasions that nurses and health care assistants transferring patients to the ward and x-ray. We reviewed the records and found the escort was appropriate for patient needs.
- When the department was closed between 6.30pm and 9am a yellow phone was available outside of the department for patients to call 111 or 999 for emergency assistance.

Nursing staffing

- Urgent and emergency services used the 'Baseline Emergency Staffing Tool' (BEST) to plan nursing staffing requirements to ensure there was adequate cover of all areas including triage, minors, majors and resuscitation across the full 24 hour period. The BEST has been

designed to estimate emergency department (ED) nursing staffing requirements based on a combination of the number of patients attending the department, and a measure of the patients' nursing dependency. The department underwent a staffing review in August 2016 prior to the overnight closure.

- There were approximately five nurse vacancies within the department at the time of our inspection (26.4% of the total nursing establishment). There were plans in place to recruit into these posts. These posts were required to cover the department when open 24 hours a day. At the time of inspection due to the overnight closure the establishment was full.
- At the time of our inspection, we found there were sufficient numbers of trained nursing and support staff with an appropriate skills mix to ensure patients were safe and received the right level of care. Staff confirmed since the overnight closure staffing levels had been increased during the opening period to deal with the increased attendances.
- The trust monitored the planned versus the actual nursing staffing levels. Between March and June 2016, the actual daytime registered nurse levels versus the planned registered nurse levels were on average 91%. Overnight actual nursing staffing levels were on average 92%. Planned staffing levels are the number of nursing hours planned for a shift, based on numbers of staff agreed with the department in advance. Actual staffing levels are the number of nursing hours actually worked on a shift.
- Bank and agency nurses were used to maintain staffing levels in ED. Information received before our inspection showed an average bank / agency use of just over 14% between April 2015 and March 2016. Agency staff had not been used since the overnight closure.
- The Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings 2012 and Royal College of Nursing Standards 2013 state that a minimum of one paediatric trained nurse should work on each shift. The department employed 2.8 whole time equivalent dual trained nurses. Dual trained nurses are trained to care for adults and children. At the time of our inspection due to the overnight closure, the department was able to staff each shift with a children's nurse. There were not sufficient numbers of children's nurses to meet this standard when the department was open for the full 24/7 period. This was on the department risk register.
- The Royal College of Nursing guidance recommends emergency departments, urgent care centres and minor injuries units maximise existing resources and at the same time invest carefully into the existing nursing workforce to enhance their paediatric skills. The guidance recommends a number of competencies staff should be trained in. The Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings also provide clear guidance. Paediatric competency documents were available in the department. Four out of a possible 20 (20%) adult nurses had completed paediatric competencies. We asked department leaders why this was the case and they informed us that it was difficult to get staff "signed off" due to the low numbers of paediatric attendances in the department and therefore not all competencies could be achieved. Department leaders also said that staff undertook the Paediatric Life Support (PILS) course and felt this was sufficient to meet the needs of the patients. We discussed this with the head of nursing who told us that PILS was not sufficient to deem adult nurses competent to care for children.
- Nursing staff handovers occurred at each shift change and included discussions about patient needs and any staffing or capacity issues.
- We saw there was a process in place for induction of new and agency staff to the department. Whilst we did not observe agency nurses being inducted at the time of our inspection, we saw completed induction checklists.

Medical staffing

- The proportion of junior doctors reported to be working at the trust was higher than the England average. The proportion of consultant cover was lower than the England average.
- Two consultants between 9am and 5pm seven days per week covered the department. When the department was open 24 hours per day seven days per week there was on call consultant cover from 5pm to 9am.
- Middle grade and junior doctors covered the full 24-hour period from Monday to Sunday. There was increased numbers of doctors during peak times, for example late evening. A middle grade doctor is a junior doctor who has more experience than a senior house officer (SHO, now FY2), but less than a consultant. Middle grade

doctors include staff grade, clinical fellows and specialist registrars (ST1, ST2, ST3 and ST4). There was always a minimum of one ST4 doctor in the department at all times.
- The department was funded for six middle grade doctors specialising in emergency care. There was one middle grade vacancy at the time of our inspection.
- Medical locum agency staff were used to maintain staffing levels in ED. Information received before our inspection showed an average medical locum usage of 31.5% between April 2015 to March 2016. We discussed the reason for high locum usage with the service leads, who informed us this was due to gaps in the rotating medical staff rota.
- There were no paediatric emergency medicine trained consultants working the department at the time of our inspection, however this was not a requirement as the department treated less than 16,000 children per year.
- We saw a structured clinical standardised approach to handover.
- Nurses and junior doctors in the units told us advice and support from consultants was readily available, including out of hours.
- We saw there was a process in place for induction of new medical staff and locums to the department. We did not observe any inductions at the time of our inspection.

Major incident awareness and training

- Major incident and business continuity policies and protocols were in place and readily available. Action cards were included in the major incident policy for use by the emergency department medical and nursing staff in charge. Action cards were also displayed on a board near the department training room as quick reference for staff.
- The Emergo programme forms part of the Public Health England (PHE) funded programme directed by the emergency preparedness, resilience and response (EPRR) partnership board chaired by the Department of Health. PHE works with national and local government, industry and the NHS to protect and improve the nation's health and support healthier choices. The Emergo Train System (ETS) is a mass casualty simulated system for teaching, demonstrating and testing a whole system medical response to major incidents. It can be used by hospitals as a cost effective way to exercise, test and evaluate the medical response to a large scale incident, provided that a clear aim, objectives and measurable performance indicators are agreed in advance of the exercise.
- The United Lincolnshire Hospital Trust (ULHT) emergo exercise took place on 17 June 2015 at the same time across all three Trust sites, Lincoln, Boston and Grantham. Results of this exercise were largely positive and showed overall the trust managed the response to the incident well with very few patients being put at risk of a preventable death or preventable complication. Hospital sites were noted to have communicated and worked well together, good leadership was shown in all departments and the trust achieved all of the objectives set for the exercise.
- Staff appeared familiar with their responsibilities in the event of a major incident. Although department training records did not reflect it, staff had received training in major incidents. The department leader and all staff we spoke with confirmed they had received this, and confirmed they were part of a major incident exercise in June 2015.
- A porter told us they were aware of the major incident process for the department and had been involved in a major incident simulation, which involved putting up the decontamination tent. A decontamination tent is a tent where patients are showered prior to entering the emergency department following a serious incident such as a chemical exposure.
- We saw the decontamination tent had been checked and deemed fit for purpose in the year preceding our inspection.
- Radiation meters had been checked in June 2016.
- The department manager told us the next major incident /decontamination incident training was planned for spring 2017.
- There was no onsite security provision; nurses told us if they felt at risk they would call the police.
- Staff had received conflict resolution training so told us they were able to manage most situations themselves. Training records confirmed 27 out of 33 (82%) staff were up to date with conflict resolution training. Of the six out of date, three were new starters. Out of date staff were booked to attend this. We saw one member of the reception staff attended this during our inspection, and said the training was very useful.

Urgent and emergency services

- We saw personal attack alarms were available in the department should staff wish to carry them for their own safety. We saw they worked effectively when one was accidentally activated during our inspection.
- There was a trust wide 'winter plan' that set out the organisations arrangements for the winter period. This plan recognised increases in pressure, around winter, due to an increase in the clinical acuity of patients, capacity demands on resources within the trust and untoward events such as widespread infectious diseases including norovirus (sometimes known as winter vomiting bug) and the risk of the onset of pandemic flu. An influenza, or flu, pandemic happens when a new strain of flu virus spreads easily and quickly across the world.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated effective as good because;

- Care and treatment was mostly planned in line with current evidence based guidance, standards and best practice. Patient needs were mostly assessed throughout their care pathway in line with National Institute of Health and Care Excellence (NICE) quality standards and Royal College of Emergency Medicine (RCEM) guidelines.
- Information about patients' care and treatment, and their outcomes was routinely collected and monitored. This information was used to improve patient care.
- Staff could access information they needed to assess, plan and deliver care to people in a timely way.
- Staff were supported to deliver effective care and treatment through meaningful and timely supervision and appraisal.
- Staff demonstrated understanding of the issues around consent and capacity for adults and children attending the department.

However;

- The department did not audit the number of patients who were recalled to the department with a missed fracture.

Evidence-based care and treatment

- Staff provided care to people based on national guidance, such as National Institute for Health and Care Excellence (NICE) guidelines. Clinical guidelines were available in line with National Institute for Health and Care Excellence (NICE) Guidance and Royal College of Emergency Medicine (RCEM) guidelines, such as cervical spine injuries.
- We looked at four policies and procedures and two clinical guidelines on the trust's intranet and saw these were up to date.
- Staff in the emergency department used a range of care pathways for adult and children, in line with national guidance, such as patients presenting to the department who may be having a heart attack and children with a head injury.
- We saw specific pathways for the 'fast tracking' of patients presenting with a heart attack. This ensured they would receive timely treatment in the local heart attack centre.
- We reviewed several aspects of care being delivered from both a nursing and medical perspective. Many aspects of nursing care were based and aligned to best practice guidance. For example, use of the sepsis proforma.
- We saw a number of care bundles in place for example acute pulmonary odema (fluid on the lungs) and community acquired pneumonia. There were no patients on care bundles at the time of our inspection. A care bundle is a set of interventions that, when used together, significantly improve patient outcomes
- We saw protocols for the emergency treatment of children included specific paediatric parameters. We saw there was specific guidance in relation to recognising the sick infant.
- We saw written information given to patients regarding their conditions and treatment for example following application of a plaster cast. Information leaflets were consistent and in-line with national guidance, for example British Orthopaedic Association.
- There was no protocol in place for management and manipulation of fractures. The department consultants had recognised the problem and were looking to address this. There was a risk that patients requiring manipulation of fractures may be mismanaged.
- The department used an evidence based tool for assessing the suicide risk of mental health patients.

- The department was about to commence the E-Audit System. The E-Audit sytem would allow staff to produce reports on all open audits, and include progress reports, outcomes and actions outstanding.
- Consultants in the department regularly discussed management of patients that frequently attended ED with other professionals such as GPs and mental health teams to ensure appropriate care and treatment could be given to prevent further attendances and sign post patients to appropriate services.

Pain relief

- Patients we spoke with had been asked about their pain and given pain relief where appropriate and at regular intervals.
- Staff used recognised pain assessment tools to assess levels of pain and documented pain scores on the patient's record. Pain tools used were appropriate for all ages and cognitive abilities. This ensured patients' pain was assessed effectively.
- In all of the records and observations charts, we reviewed (adult and children) pain scores were recorded as part of triage and pain relief administered where required.
- We saw that where required children where offered and or given pain relief within 20 minutes of arrival to the department. The department did not audit this.
- The results of the CQC A&E Survey (2014) showed the trust scored 'about the same' as other trusts for not having a long wait to receive pain relief if requested and for feeling that hospital staff did all they could to help control their pain, if they were ever in pain while in A&E. This was trust wide data and therefore we were unable to specifically break this down for Grantham ED.

Nutrition and hydration

- The department had facilities for staff to make drinks and snacks for patients and we observed patients being offered snacks and drinks.
- The results of the CQC A&E Survey (2014) showed the trust scored 'about the same' as other trusts for being able to access suitable food and drink while in A&E, if they wanted to.
- Water fountains and vending machines were available in the department.

Patient outcomes

- The trust had one open mortality outlier alert. This is when there have been a higher number of deaths than expected for a defined condition. The trust received notification from Dr Foster Intelligence that they had shown a higher than expected hospital standardised mortality ratio (HSMR) in the area of sepsis. Dr Foster Intelligence is a provider of healthcare information in the United Kingdom, monitoring the performance of the National Health Service and providing information to the public.
- There was a consultant lead for audit in the emergency department. The department participated in national Royal College of Emergency Medicine (RCEM) audits so they could assess their practice and performance against best practice standards.
- In the 2014/15 Royal College of Emergency Medicine (RECM) audit for assessing cognitive impairment in older people, Grantham & District Hospital was between the upper and lower quartiles for three out of six measures and in the lower England quartile for three measures. The upper quartile means that the trust is in the top 25% of trusts. Being in the lower quartile means the trust is in the bottom 25% of trusts. It did not meet the fundamental standard of having an Early Warning Score (EWS) documented. This was to be re audited as part of the local department audit in 2016/2017.
- In the 2014/15 RECM audit for mental health in the ED, Grantham and District hospital was in the lower quartile compared to other trusts for four of the six measures. Being in the lower quartile means the trust is in the bottom 25% of trusts. It did not meet the fundamental standards of 'documented risk assessment taken' or the fundamental standard of 'dedicated assessment room for mental health patients'. This was to be re audited as part of the local department audit in 2016/2017
- The department did not take part in the RCEM audit 2014/2015 initial management of fitting children due to the low numbers of paediatric presentations with fitting.
- We saw there were action plans in place to address the shortfall in the RCEM audits; most of the actions had been completed.
- The effectiveness of care and treatment was regularly reviewed through local and national audits. We saw a local audit plan for 2016/2017 which included local re auditing of the RCEM national audits for example paracetamol overdose and local consent audits.

- Regular audit meetings took place to learn and feedback on audit findings. These were shared with the wider team as part of clinical governance and "Time 2 Talk" meetings.
- The rate of unplanned re-attendance to the emergency department within seven days was 8.8% between September 2015 and August 2016. This was not meeting the national standard of 5% but was in line with the England average during this period.
- The department did not audit the number of patients who were recalled to the department with a missed fracture. This meant there was no way of monitoring the effectiveness of diagnosing fractures and learning from missed fractures.

Competent staff

- Nursing and medical staff received an annual appraisal. The figures to July 2016 showed 78 % of nursing staff and 82% of medical staff had received an appraisal in the last 12 months. There has been a deterioration of the number of staff receiving an appraisal at this site compared to the same period in 2015.
- Nursing staff said they found their appraisals useful. Where learning needs were identified, staff were encouraged to access additional training to support their development.
- We saw there were core competencies for staff to work towards in line with national competencies for example specific skills in the triaging of patients.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council (NMC); this was carried out by the trust.
- A revalidation process was in place with good training opportunities for medical and nursing staff. The department leader was a "sign off" for nurses' revalidation with the NMC.

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place. We saw good teamwork between the orthopaedic team and the emergency department. We also saw effective working across site when a child was transferred to Lincoln ED.
- Staff told us and we saw there was effective working between bed managers and ED staff and between ED staff and the external mental health and admissions avoidance teams.
- We saw patients were referred appropriately to other health professionals for follow up, for example the fracture clinic.
- There were good links with other departments in the hospital for example the wards, imaging and pathology.
- Staff completed a handover checklist, which was used to communicate to the ward-receiving patients. This ensured continuity of care.
- We observed good MDT working between the local ambulance service and the department when transporting patients between sites.
- Letters were created for and sent to GPs following patient attendances at the department. For children an additional letter was sent to children's services.

Seven-day services

- The emergency department was consultant led offering a service seven days per week, however at the time of our inspection was not open 24 hours per day.
- X-ray and CT scanning diagnostic services were available to the emergency department seven days per week. Staff said they did not have problems accessing these when required.
- Support services for example the mental health and admission avoidance teams worked in the department seven-days per week.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results.
- There were sufficient numbers of computers available in the department for staff to access patient and trust information. For example policies and procedures. This meant staff had the most up to date information at all times.
- We saw doctors had access to a digital x-ray system to enable timely review of patient x-rays.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Urgent and emergency services

- Staff demonstrated understanding of the issues around consent and capacity for adults and children attending the department. Staff told us if they were unsure in any circumstances, they would seek guidance from senior staff or from the safeguarding lead.
- Staff were aware of Gillick and Fraser competence in children, although did not use Fraser competence as they did not offer contraceptive advice. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Children under 16 who are considered to be of sufficient age and understanding to be competent to receive contraceptive advice without parental knowledge or consent are defined as Fraser competent. We asked the trust to provide us with training figures for staff in relation to Frasier and Gillick competence. We did not receive this.
- We observed a member of the nursing team carrying out a test of capacity on a patient who was living with dementia.
- Staff told us if a patient was considered to lack capacity to make decisions they would seek support of appropriate professionals so decisions could be made in the best interests of the patient. We saw contact numbers for professionals to support staff doing this.
- The trust monthly ED health check score card for August 2016 showed that 69% of staff were up to date with Mental Capacity Act training.

Are urgent and emergency services caring?

Good

We rated caring as good because:

- Patients were treated with dignity, respect and kindness during all interactions with staff.
- Staff helped people and those close to them cope emotionally with their care and treatment.
- Staff respected patients' rights to make choices about their care.
- We saw staff providing specialist support to patients and those close to them in relation to their psychological needs.
- The results of the CQC A&E Survey (2014) showed the trust scored 'about the same' as other trusts for most questions.

However;

- The environment posed a risk to patients' privacy and dignity. There were no "in use" signs on treatment room doors, the surgical procedures room was not closed off from a storage area and adjacent resuscitation room. Staff did not always seek permission to enter closed cubicle curtains.
- It was not always possible to maintain patients' confidentiality due to the position of the waiting room and the glass partition at the reception desk.

Compassionate care

- Following our inspection, we reviewed information from 12 comment cards completed by patients and relatives before our inspection. Responses were mixed with 50% reporting a negative experience whilst in an emergency department at this trust. We were unable to determine from the comments cards which hospital the patient or relative had attended.
- We spoke with 12 patients and four relatives at this emergency department. They were all positive regarding the care provided, they told us they or their relative were cared for in a kind and compassionate manner by staff. Our own observations supported this.
- Patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner.
- Staff carried out regular comfort rounds if a patient was in the department for long periods, we saw these documented in the records we reviewed and saw staff carrying these out during our inspection. Comfort rounds are conducted by staff who visit every patient at set intervals and ask them if they'd like something to drink, or if they'd like to be repositioned or use the bathroom and enquire about their pain.
- We saw patient cubicle curtains were drawn and treatment room doors closed when care was ongoing, however we did observe staff enter treatment rooms and cubicles without checking it was alright to enter and this may compromise a patient's privacy and dignity. We saw a doctor bring a patient from the waiting room to a triage cubicle that was in use by another patient.

- The surgical procedures room was not closed off from a storage area and adjacent resuscitation room, on two occasions we were in the resuscitation room and could hear conversations in the surgical procedures room. Staff accessed the storage area to access a specific machine for analysing blood and could see into the procedure room from the storage area. There were curtains available in this room to pull around the treatment trolley but did not see these used.
- There were no "in use" signs on treatment room doors, and there was a risk that people could walk into the room which was being used and compromise patients' privacy and dignity.
- The large waiting area was adjacent to the main reception area, which had been moved recently. The reception was screened with glass and patients were expected to talk through a specific screen in the glass. The screen-distorted patients view of the reception staff and therefore they would lean to the side and have to speak up louder. The position of the waiting room and the glass partition meant that patients' confidentiality was not maintained. We sat in the waiting area on a number of occasions in various locations and were privy to sensitive information being asked for and given to reception staff. The interim head of nursing informed us that they were aware of this issue and were looking to source funding to address the issue. The environment not being fit for purpose was on the trust risk register.
- A completed sample form and sample that had been taken from a patient during treatment was left in an area where unauthorised people could see this. There was a risk to the patient's confidentiality. We escalated this immediately to nursing staff who turned the sample form over so the details could not be read. The sample remained in the same place for over four hours. We escalated our concerns again to a nurse who arranged for a porter to take the sample to the laboratory.
- There was a private room available for staff to take patients away from the clinical areas to have private conversations.
- The department was part of the 'counting compliments' project. The department had commenced auditing the number of compliments and positive patient stories they received each month. In July 2016 the department received 17 compliments and in August 2016, 45. There were four positive patient stories in July 2016 and six in August 2016. The 'counting compliments' project is reliant on teams counting their thank you cards and gifts.
- We reviewed the NHS Friends and Family Test (FFT) results in the ED from September 2016 to August 2016. The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care. Results showed the average response rate to be 24%. This was better than the England average of 13% for the same reporting period. Results from this reporting period showed 83% of respondents would recommend the service they had received in ED to friends and family who may need similar treatment or care.
- The Friends and Family Test (FFT) results for children attending the department showed that between January 2016 and September 2016 on average 66% of respondents would recommend the service they had received in ED to friends and family who may need similar treatment or care. Scores varied month on month with the highest score of 80% (August 2016) and lowest score of 37% (June 2016).
- The results of the CQC A&E Survey (2014) showed the trust scored 'about the same' as other trusts for:

- Being treated with respect and dignity.
- Being given enough privacy during examinations and treatment.
- Having enough privacy when discussing their health problem with the receptionist.
- Patient describing their A&E experience as good in relation to the way they were treated and cared for.

Understanding and involvement of patients and those close to them

- Patients and relatives told us they were involved and kept up to date with the care and treatment of the patient. They said the staff took time to make sure the patients and relatives understood the care and treatment and the options available.
- We saw good interaction between children and the medical and nursing teams.
- Staff respected patients' rights to make choices about their care.
- We saw staff sensitively manage a situation when a young patient presented to the department with mental

health support. The staff member communicated in a sensitive manner and appeared to put the patient and accompanying relative at ease. Further support and guidance was offered to the patient as appropriate.
- Observations of staff behaviours and attitudes confirmed that staff recognised patients' personal, cultural, social and religious needs. Staff told us that this was an important part of the triage process.
- We observed staff explain to a patient how to administer injections at home. The nurse checked the patient had understood the instructions and involved their relative in the discussion; this was done in a way the patient could understand.
- The results of the CQC A&E Survey (2014) showed the trust scored 'about the same' as other trusts for

- Being told how they would wait to be examined.
- Feeling they had enough time to discuss their health or medical problem with a doctor or nurse.
- Feeling the doctor or nurse explained their condition and treatment in a way they could understand.
- Feeling the doctor or nurse listened to what they had to say.
- Being given the right amount of information about their condition or treatment.
- Being involved as much as they wanted to be in decisions about their care and treatment.
- Family, or someone else close to them, having enough opportunity to talk to a doctor if they wanted to.

Emotional support

- Patients could access a range of specialist nurses, for example cardiac nurses and mental health liaison nurses. We saw these staff providing specialist support to patients and those close to them in relation to their psychological needs
- The results of the CQC A&E Survey (2014) showed the trust scored 'about the same' as other trusts for; feeling reassured by staff if distressed whilst in A&E and for feeling the doctor or nurse discussed any anxieties or fears they had about their condition or treatment.
  - Staff were able to direct patients to counselling services when required.

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

Good

We rated responsive as good because:

- Waiting times and delays were minimal and managed appropriately.
- Care and treatment was coordinated with other services and providers.
- There were systems in place to support vulnerable patients.
- There were arrangements in place to avoid unnecessary admissions to the hospital.
- Complaints about the service were shared with staff to aid learning.

However;

- Patients could not always access the right care at the right time especially those with urgent care needs.

Service planning and delivery to meet the needs of local people

- Arrangements were in place for those patients presenting to the department with specific conditions requiring time critical interventions. For example, where a patient was showing signs and symptoms of a heart attack the department would arrange for immediate transfer to the Lincoln heart centre, we observed this work effectively during our inspection
- The local ambulance service was able to pre alert the department of any sick patient who they were bringing to the department. This ensured that staff were able to prioritise the patient on arrival and arrange for the necessary professionals to be ready.
- There were clear admission criteria followed by the local ambulance service and the ED to ensure the department could adequately meet the needs of patients. For example the department did not accept trauma, cardiac, stroke, or paediatric admissions; these were diverted to the other two main sites (Lincoln and Boston).
- There was no secure room available to assess patients with mental health needs, although the department had access to a "quiet" room.

- There was adequate seating available within the reception and waiting area so patients did not have to routinely stand whilst waiting to speak to reception staff or for their consultation.
- Due to the lack of medical staff in the emergency departments (ED) at Pilgrim and Lincoln hospital the trust had made a decision to close the ED at Grantham overnight for a proposed period of three months. This happened in August 2016. There had been no consultation with local people.
- At the time of our inspection, the department was open from 9am to 6.30pm seven days per week. Although this was displayed on the trust website, on the ED main doors and on the main sign to the hospital, patients were still presenting to the department prior to and after the closure. Staff were auditing this. Between 30 September 2016 and 21 October 2016 on average six patients were waiting outside the department prior to the 9am opening. In the same period on average five patients presented to the department at 6.30pm.
- There were two protected in-patient beds at Grantham for patients needing transfer from ED to another hospital after ED closed and staff were not present.

Meeting people's individual needs

- There was a learning disability specialist nurse (LDSN) employed by the Mental Health NHS Trust covering Grantham hospital. There was an open referral system with mobile phone contact for any clinician, carers, patients, GPs and community staff to alert pre-admission. Staff in the department said they would contact the LDSN for patients with a learning disability who required support in the department, or if staff needed advice. We saw the contact details for the LDSN were displayed.
- A confusion assessment pathway was used to assess elderly patients with an existing dementia diagnosis or to assess delirium or for new / recent issues with memory and confusion. We saw this completed for patients during our inspection.
- The department had a resource box, which could be used by patients living with dementia. The box included distraction therapy such as coins and reminisce pictures. There were other items in the box for reminiscence. Staff said they would use the resource for patients if they became distressed. Staff told us and we saw during our inspection that relatives were encouraged to stay with patients living with dementia.
- The department had access to Child and Adolescent Mental Health Services (CAHMS) for children and young people who had difficulties with their emotional or behavioural wellbeing. CAHMS was provided by a local NHS mental health trust and would see children in the department or arrange a telephone call with the child and/or responsible adult. We saw staff accessing this service during our inspection.
- In January 2016, the Royal College of Emergency Medicine (RCEM) launched the CLEAR Campaign. CLEAR is a five-point plan to improve emergency mental health care. As part of this plan, RCEM recommends a patient who is experiencing mental distress should be seen within one hour of referral to mental health services. The department had access to a mental health liaison team provided by a local NHS trust. We saw the team responding to a request to review patients in the department at the time of our inspection. Nursing and medical staff said this was a great resources and that the team were always prompt to attend the department following referral. We saw the team visit two patients during our inspection; both visits took place within one hour of referral.
- Outside of the mental health liaison team working hours, staff had access to the local crisis team, and they told us they were quick to respond, however they did not audit response times.
- The reception area did not have a hearing loop system for those patients with hearing aids. A loop system is a type of sound system that boosts the signal in someone's hearing aids. They help those with hearing loss to focus on particular sounds, like a person talking, near the loop's internal microphone. In conditions without a hearing loop, all sounds including background noise are amplified making it sometimes difficult to focus on one sound.
- Staff told us and we saw there was a religion, spirituality and multi-faith care folder in the department. Staff said they would utilise the resources in the folder when required in order to meet individual specific needs.
- We saw language identification sheets were present in the department. The sheets allowed patients to read their native language, which assisted staff to find the correct interpretation service.
- The emergency department (ED) had access to a language translation service agency that provided a range of interpreting and translation services.

- Patient information leaflets were available for a wide range of injuries and illness most of these were only available in English. Staff told us and we saw a range of contact information such as an email address on the front of the leaflets on how the publication could be requested in different languages or other formats, such as braille, if required. Staff also informed us that they had access to specific applications on mobile phones to support patients.
- We saw the department was wheelchair user friendly. The reception desk had a lower counter, and the waiting area had sufficient areas where wheelchairs could be positioned, amongst fixed seating. A disabled toilet was available adjacent to the waiting room.
- Ample wheelchairs were available for use by patients and were easily positioned at the entrance to the department.
- Staff had access to the services of a drug and alcohol treatment charity, to support them care for patients with a drug and or alcohol problems.
- The hospital had a chaplaincy service and staff told us they could request support from the chaplaincy team if this was necessary.
- From 31 July 2016, all organisations that provide NHS care or adult social care are legally required to follow the accessible information standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support so they can communicate effectively with health and social care services. The service had not taken steps to address this

Access and flow

- An escalation process provided guidance for staff when dealing with periods of significant demand for services and staff demonstrated an awareness of what to do in these circumstances for example escalating to the site bed management team.
- There was a specific ED trust (escalation) holding protocol which had been agreed with the local ambulance service. This was for times when there was significant numbers of ambulances waiting to enter the department.
- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. The department achieved this target for 71.5% of the patients who attended the department between September 2015 and August 2016.
- The average total time per patient spent in the department between September 2015 and August 2016 was two hours and 48 minutes (168 minutes), slightly higher than the England average.
- Between September 2015 and August 2016 2.9% of patients remained in the department for six hours or more.
- The percentage of emergency admissions through the emergency department who waited between four and 12 hours from the decision to admit until being admitted was less than 1% this equated to 20 patients between September 2015 and August 2016 better than the England average.
- Between September 2015 and August 2016, no patients waited more than 12 hours on a trolley this met the current Department of Health guidelines relating to trolley waits.
- Between September 2015 and August 2016, 3.1% of patients attending the department left before being seen for treatment, this was better than the England average.
- The ED had an action plan in place, as part of an emergency care recovery programme, to address the shortfalls in the ED performance.
- The results of the CQC A&E Survey (2014) showed the trust scored 'about the same' as other trusts for patients not having to wait long with the ambulance crew before care was handed over to A&E and not spending too long in A&E.
- There were arrangements in place to avoid unnecessary admissions to the hospital. Older people admitted to the department who were medically fit for discharge were referred to and reviewed by the assertive in-reach team (AIR) provided by a local NHS trust. The team helped patients return home safely and with support where necessary. The AIR was available in the department 9am to 5pm seven days a week.

Learning from complaints and concerns

- Complaints relating to the emergency department (ED) were raised through the trust Patient Advice and Liaison Service (PALS).
- We saw 'See it my way' leaflets were readily available in the department and described the patient-centred

approach to resolving concerns or complaints. Key contact numbers and explanation of the complaints process was included in the leaflet along with sign posting to advocacy services if required.
- Staff were aware of and appeared confident in their roles and responsibilities in relation to patient complaints. Staff said they would wherever possible aim to resolve the complaint at the time it was raised
- The department leader said they received very few complaints.
- Between June 2015 and May 2016 the trust received 789 complaints, 28 (3.5%) were received by Grantham ED. The top five themes for complaints in ED at Grantham related to clinical treatment, communication, admission and discharge, patient care and waiting times.
- Complaints were discussed in team meetings, at the "Time 2 Talk" brief and during governance meetings. Minutes we reviewed confirmed this.
- We were given an example of how staff had changed the way they recorded ambulance arrivals into the department following a patient complaint.

Are urgent and emergency services well-led?

Good

We rated well-led as good because;

- There was an effective governance framework in place. Quality, risks and performance issues for the department were monitored through monthly clinical governance meetings and there was a good feedback loop.
- Department leaders had the experience and capability to lead the services and were committed. They prioritised safe, high quality and compassionate care.
- Nursing and medical staff said the department manager, matron, interim head of nursing and consultants were approachable, visible and provided them with good support.
- We saw effective team working across the department and an obvious mutual respect amongst staff

However;

- Morale in the department was mixed; some staff described the overnight closure as worrying and wondered if the department would ever re-open overnight. However, some said they liked it as there were more staff on duty in the day. Consultants said morale was low; they felt that they were unable to provide the service they wanted to the local population of Grantham.
- The risks and issues described by some leaders did not correspond to those that were currently on the department risk register.

Vision and strategy for this service

- The Trust had a five-year strategy for all clinical services for 2014 to 2019 to support the delivery of good quality patient care. The vision and strategy for urgent and emergency care was to provide a consultant-led service 24 hours a day, seven days a week in order to improve medical care and facilitate timely treatment across Lincolnshire. This was in line with recommendations from the 2013 Keogh urgent and emergency care review (a comprehensive review of the NHS urgent and emergency care system in England). Particular emphasis was to be placed on services that were time critical ensuring patients had rapid access to urgent care in the right place when they needed it.
- During our meeting with the senior leadership team, we asked if there was a specific strategy for the emergency department at Grantham. They told us there was not a specific vision created as they were waiting for the decision to be made by the trust board as to when / if the department would re-open 24/7. Once this decision had been agreed they planned to create a strategy incorporating the Sustainability and Transformation Plan (STP). An STP is a new approach to help ensure that health and care services are built around the needs of local populations.
- The senior leadership team felt it was important for the department to reopen 24/7 and were striving to achieve this. We asked the senior leadership team what they felt about the trust strategy for urgent and emergency care. They said that Grantham did not fit in to this strategy at present as the trust had made the decision to close the department overnight and therefore could not provide the service they wanted to.

Governance, risk management and quality measurement

- There was an effective governance framework in place. Quality, risks and performance issues for the

department were monitored through monthly clinical governance meetings. Agenda items included the departmental risk register, urgent patient safety issues, incidents, audit, and feedback on good practice. Meeting minutes we reviewed showed there was good representation from all disciplines in the department. Department leaders told us any staff member was welcome to attend governance meetings if they chose to. We did not see from the meeting minutes that junior staff attended.

- There was a good feedback loop from governance meetings for example at the daily "Time 2 Talk" meeting and during staff meetings.
- Records confirmed routine audit and monitoring of key processes took place across the units to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored by the trust. These were cascaded to staff through performance dashboards displayed in the department.
- A weekly operational meeting was held between the department manager, consultant, head of nursing and business manager.
- A poster was displayed in the staff room with key information for staff. The board included current quality and safety issues, last near miss, last complaint and serious incident, last never event, what was on the risk register and what was being done about the risks. The board was up to date at the time of our inspection.
- We reviewed the department risk register prior to our inspection and found there were three risks in relation to Grantham ED. These were around poor environment, lack of administration and clerical staff and insufficient paediatric trained nurses to cover the 24-hour period. Two of the risks had been in place since 2014 and did not have recorded suitable actions in place to mitigate the risk. The department leader told us that they were worried about the impact to patients of the overnight closure, for example they had seen an increase in patients waiting for the department to open each morning, some of whom had been sick, and also people presenting after the department had been closed. Although the overnight closure was on the risk register we were not assured that the true impact had been considered by the trust for example the number of patients presenting to the department prior to opening and following closure. We raised this with the deputy chief nurse at the end of our inspection.
- The interim head of nursing told us that they worried about patients self-presenting to the department or brought by ambulance who did not fit the strict admission criteria for the department and delays in the response time for an ambulance to transfer patients out of the department. Although department leaders said this was rare, we did not see that this risk had been considered as part of the department risk register, although there were transfer protocols in place with the local ambulance service, so the risk had been mitigated.
- In July 2016 the department leaders attended a newly formed 'cross site' meeting chaired by a consultant nurse. The meeting was a forum for discussing incidents or concerns that may have been raised in the emergency departments across the three hospital sites, with the aim to share learning and best practice. Prior to July 2016 there had been no forum to discuss issues across the three EDs. Further meetings were planned to take place every three months.

Leadership of service

- The senior leadership team consisted of the clinical director, business manager, interim head of nursing, matron for medicine and two consultants.
- There was a senior shift coordinator on each shift, they managed the day-to-day running of the department and kept an overview of patient priority and flow within the department as well as being a resource for other staff.
- Nursing and medical staff said the department manager, matron and interim head of nursing were visible. Staff told us who they would approach them if they had any concerns and would not hesitate to do so. Staff said managers were supportive.
- Nursing and medical staff told us they felt the consultants were approachable, visible and provided them with good support.
- Department leaders had the experience and capability to lead the services and were committed and prioritised safe, high quality compassionate care.
- Staff told us and minutes confirmed regular staff meetings took place so they were up to date.
- All staff attended a daily meeting in the department known as "Time 2 Talk". This provided staff with information on department staffing, operational issues, safety issues and weekly plans. Actions were agreed and

owned in relation to any issues that were raised in order to gain a timely resolution. Pertinent trust wide information was also provided at this meeting to keep the team updated.
- The senior leadership were aware of their responsibilities in relation to duty of candour and had received specific training. They were responsible for cascading training to other staff within the department and this had commenced at the time of our inspection. We asked the trust for the training figures for the department but we did not receive these.

Culture within the service

- Many staff had been in post for long periods and described the department as a good place to work.
- We saw effective team working across the department and an obvious mutual respect amongst staff. All the staff told us they felt proud of working in the department and we observed staff working well together and could see staff supporting each other.
- Staff told us there was a friendly and open culture and they were most proud of the teamwork within the department and the willingness to help and support each other.
- Following the trust decision to close the department overnight, staff were given a short period of notice of this change, they were consulted with on a one to one basis by the matron. Staff were given options to move to other emergency departments if they chose, however most staff chose to stay in the department at Grantham. Staff said this was because of the teamwork. A few staff chose to leave and go to other jobs within the hospital, some were temporary and others were permanent.
- Morale in the department was mixed; some staff described the overnight closure as worrying and wondered if the department would ever re-open overnight, some said they liked it as there were more staff on duty in the day. Consultants said morale was low; they felt that they were unable to provide the service they wanted to the local population of Grantham.
- Despite the challenges staff faced due the overnight closure senior leaders said staff had "stepped up to the plate" to deliver good triage and ED performance.
- We saw a student nurse in the department given support and provided with good learning opportunities to support their development. For example, we saw the student nurse was working with one nurse on a shift, and another nurse asked the student if she would like to participate in a task she was undertaking, as it was something she may not see again.

Public engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them. Patients were sent text messages to provide feedback on their care and treatment. Feedback forms were also available for patients to complete.
- There was a specific friends and family test for children who attended the department.
- Staff described how they engaged with local groups such as schools and children's clubs to raise awareness of keeping safe. We did not see any evidence of these events.
- The trust made a decision to close the department overnight from August 2016, prior to this there had not been any public consultation. Following the overnight closure key members of the trust were meeting with the public.
- Healthwatch Lincolnshire completed 33 'mystery shopper' visits to the Lincoln, Boston and Grantham ED sites, during the period 11 to 29 July 2016. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care. Findings by Healthwatch were consistent with our findings during this inspection.
- During our inspection, we saw that patients were gathering outside of the department prior to the opening at 9am. Some patients entered the hospital through other entrances and accessed the department waiting room until the department opened. We saw a patient with a life threatening condition was waiting for the department to open. A doctor noticed the patient on arrival to work and took the patient to into the department. Nursing staff told us that a similar incident had occurred one evening when the parent of a child with severe breathing problems was banging on the ambulance entrance door to be let in. Department staff said they had a duty of care to the patient and therefore let them in and treated them accordingly. The department were auditing the numbers. Between 30 September 2016 and 21 October 2016 on average five

patients were waiting to enter the department prior to the opening time at 9am. This suggests that the public were unaware of the department closure or chose to wait for the department to open.

Staff engagement

- The trust recognised staff contributions to patient care through the United Lincolnshire Hospitals NHS Trust (ULHT) staff awards. Each year, the awards provided a chance to recognise the work, dedication and care given by staff members and teams at the trust.
- We saw the use of a happy board in the department staff room. This displayed thank you letters and cards from patients to staff. Staff said they were grateful for this board, as they felt appreciated.
- We observed "post it notes" displayed on a notice board in a staff area. The "post it notes" had words of encouragement for staff on them from the senior leadership team.
- A staff pulse check was carried out on a quarterly basis. The pulse check asked 47 questions which were based around different areas that help and hinder staff engagement and the feelings and behaviours of staff that are associated with staff engagement level. Staff in the department were aware of this, however most said they hadn't completed it. Pulse check data could not be broken down at department level so gave a sense check of the hospital as a whole and therefore it was not possible to report the engagement scores for the emergency department.
- Staff said they felt able to raise concerns and that they would be listened to and actions taken as a result of them. Staff were unable to give us examples of when they had raised concerns resulting in a change.
- Following the decision to close the department overnight, matron consulted with all staff on a one to one basis, offered support, guidance and reassurance. Staff said they appreciated this. Staff who worked permanent nights, who would suffer financial loss because of the overnight closure, had been compensated.
- There were weekly meetings held on the Grantham site following the overnight closure, a member of the trust's executive team chaired these. Staff were invited to attend these meetings and the executive team kept staff aware of any changes

Innovation, improvement and sustainability

- The assertive in-reach team (AIR) worked with the emergency department to prevent avoidable admissions.
- The trust had an emergency department risk assessment tool. This was an electronic tool that calculated the risk of the department and rated it as either red amber or green.
- By working jointly with local commissioners and the health and care community in Lincolnshire the trust had planned a number of schemes and new ways of working that would improve capacity over the winter period for example focus on admission avoidance schemes, ambulatory care pathways and creating the capacity to meet increased demand of patient attendances.
- The department used a discharge tool 'TRACKS' (T-transport, R-relatives/ residential home, A-attire, C-cannula, K-keys, S-safe) to facilitate the safe discharge of older and/or vulnerable patients.

Outstanding practice and areas for improvement

Outstanding practice

- The department inputted hourly data into an ED specific risk tool. The tool gave an "at a glance" look at the number of patients in ED, time to triage and first assessment, number of patients in resuscitation room, number of ambulance crews waiting and the longest ambulance crew wait. This gave a focus across the trust on where pressure was building and there were local actions for easing pressure.

Areas for improvement

Action the hospital MUST take to improve

- The trust must take action to ensure that the environment in the emergency department is fit for purpose
- The trust must take action to ensure staff have the appropriate qualifications, competence, skills and experience, in excess of paediatric life support, to care for and treat children safely in the emergency department.
- The trust must ensure there are sufficient numbers of medical and nursing staff working in the emergency department who have up to date and appropriate adult and children resuscitation qualifications.

Action the hospital SHOULD take to improve

- The trust should take action to ensure there are effective and consistent systems for learning from deaths to be shared across the emergency department.
- The trust should ensure there is a robust system in place for checking safety and suitability of life saving equipment in the emergency department.
- The trust should ensure ligature cutters are immediately available in the emergency department.
- The trust should ensure there is a protocol in place for management and manipulation of fractures.
- The trust should review the process for patients presenting to the ED reception at Grantham to maintain patient's privacy and dignity.
- The trust should ensure the emergency department risk register is reflective of the risks identified by senior leaders.
- The trust should ensure there is a hearing loop system in the emergency department at Grantham.
- The trust should ensure there are adequate processes in place to ensure handovers between the ambulance and the emergency department take place within 15 minutes with no patients waiting more than 30 minutes.
- The trust should consider the process in place for children awaiting triage in order to meet the 2012 Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings.
- The trust should consider how the emergency department can comply with the accessible standard for information.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(c)** Care and treatment must be provided in a safe way for service users by ensuring the persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. **How the regulation was not being met:** • There were not sufficient numbers of nursing staff with the appropriate qualifications, competence, skills and experience, in excess of paediatric life support, to care for and treat children safely in the emergency department. This did not meet Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings 2012 and Royal College of Nursing Standards 2013. • There were insufficient numbers of medical and nursing staff working in the emergency department who held up to date and appropriate adult and or children resuscitation qualifications

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 (1)(c)** All premises and equipment used by the service provider must be suitable for the purpose for which they are being used **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

- The department was not big enough for the number of patients now accessing the department. During our inspection, at times, we saw doctors bringing patients into the department to cubicles, which were already in use.
- There was no dedicated receiving area for patients arriving by ambulance.
- There was no patient kitchen.
- There was no designated children's waiting room for children prior to triage. This was not compliant with Intercollegiate Children and Young People in Emergency Care settings standards.
- There was only one toilet available inside the treatment areas of the main department.
- Patients said, and we noticed the environment in the department and the waiting room was cold.

Regulation 15 (1)(d)
All premises and equipment used by the service provider must be properly maintained

How the regulation was not being met:

We saw exposed plaster in a number of areas in the department for example in the children's cubicle and dirty utility room.