

Review of compliance

United Lincolnshire Hospitals NHS Trust Lincoln County Hospital

Region:	East Midlands
Location address:	Greetwell Road Lincoln Lincolnshire LN2 5QY
Type of service:	Acute services with overnight beds Community healthcare service
Date of Publication:	January 2012
Overview of the service:	United Lincolnshire Hospitals NHS Trust has several hospitals. Lincoln County Hospital provides all major specialties such as maternity, cancer, intensive care and an emergency department. The trust provides the following regulated activities: Treatment of disease, disorder or injury, surgical procedures, diagnostic and screening procedures, maternity and

	midwifery services, termination of pregnancies, assessment or medical treatment for persons detained under the Mental Health Act.
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Summary of our findings for the essential standards of quality and safety

Our current overall judgement

Lincoln County Hospital was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review

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

Outcome 04 - Care and welfare of people who use services

Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 21 November 2011, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

When we undertook a visit to Lincoln County Hospital patients told us they were happy with the care and support that they received.

Of the five wards we visited the care and welfare of patients was met in all but one ward, Clayton ward.

During our visit we spoke with patients, members of staff and senior managers as well as relatives and another professional who worked for the trust.

On one ward a patient we spoke with told us, "They couldn't do enough for me when I came in".

Another patient we spoke with stated that they felt that they were being treated as an older person and "not as a person in my own right". They also added that they had been "treated very well" and had been included in their care and treatment.

A relative we spoke with stated that there were always "call bells going off" during evening visiting and felt there were insufficient staff to answer them. They told us that the bells were rung for attention to go to the toilet most of the time.

Another person who was visiting their relative told us, "Staffing has been good; they are always available when needed".

A patient on another ward told us "The care is fantastic" and that they had been treated very well.

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

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

Patients needs were not consistently met across the hospital. In one ward people were at risk as their records were poorly maintained.

Outcome 05: Food and drink should meet people's individual dietary needs

On one ward we found that patients were not always supported to have adequate nutrition and hydration and risks were not always being identified.

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

Not all staff were properly supported to provide care which includes having access to acceptable levels of training, supervision and appraisal.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The systems to monitor the quality of services were not sufficiently robust to ensure that risks to patients are managed. The trust does not have an effective system to learn from incidents.

Actions we have asked the service to take

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

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

Other information

Please see previous reports for more information about previous reviews.

**What we found
for each essential standard of quality
and safety we reviewed**

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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

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

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

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

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

Outcome 04: Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are major concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

On one ward a patient we spoke with told us, "They couldn't do enough for me when I came in". Another patient we spoke with stated that they felt that they were being treated as an older person and "not as a person in my own right". However they also added that they had been "treated very well" and had been included in their care and treatment.

A patient on another ward told us "The care is fantastic".

A person who was visiting a patient told us that the patient had been moved to another ward the day before and said that they had not been consulted about it. However the patient had been returned to the ward that morning. They also explained how the patient had been left lying in faeces for half an hour before being cleaned and changed. They felt that this resulted in a lack of dignity for the patient.

Other evidence

We saw staff communicating with patients in a way which showed they knew them well and were taking time to listen to what they were saying.

Staff worked to minimise the risk of infection for people. For example, we saw information on the walls at the entrances to wards about how to reduce the risk of infection. We also saw staff regularly using gloves, aprons and alcohol hand gel throughout our visit.

Patients were respected and their dignity was maintained by using privacy curtains

when providing personal care and when assisting patients with dressing. However, on one occasion we saw that staff hadn't considered how dignity could have been maintained for a patient and their care plan did not include a plan relating to dignity. This patient was clearly distressed and their dignity was not maintained on several occasions. Other patients said that this behaviour was evident "all of the time".

Overall, care plans regarding patient's needs were available and actively being used by the nursing teams. Most of the care plans were clear and enabled nurses to give personalised care. One person we spoke with told us the care plan contained enough information to ensure that their relative's needs were met and stated "They have been superb. Mum went straight in for surgery".

Most of the care plans also contained contact details of other professionals involved in the patient's care, as well as risk assessments and plans to minimise the risk of patients falling. However in one ward, risk assessments were not always completed and when they were, there were not always plans in place to minimise the risk.

In most cases care plans were written in a way that staff could understand and meet patient's needs. We also saw that information was kept near the patients' bed so that it could be looked at regularly and so that nurses knew what time people needed help with things like their mobility or with eating meals. On one ward care plans had been updated but there were some inaccuracies in how this had been completed. The updated care plans did not accurately reflect patient's needs. On some occasions this created a potential risk for the patient as staff would not know how to meet patient's assessed needs. Records were not all dated and signed by the nurses.

Standardised care plans are used on all wards; these are care plans that every patient will need and should be modified to ensure that they are person-centred. However on one ward they were not always amended to be person-centred. This meant that staff who were not familiar with the ward would not know how to properly care for their patients' needs. For example, one patient who was very poorly did not have a care plan to accurately reflect their care needs and another patient did not have a care plan for a pressure sore which had been identified on admission. The staff we spoke to about this were not able to identify whether or not the patient had a pressure sore.

One patient admitted two days before our visit did not have a care plan. We were informed by staff that they aim to have care plans completed within the first twenty-four hours of admission. Another newly admitted patient on the same ward had a fully completed care plan that gave comprehensive details on how to care for them. Bank and agency staff had regularly worked in that ward area, therefore it is essential that care plans are clear and accurately reflect patient's needs.

Relatives told us that they had been involved in the plan for discharge for their relative and that they had been given information about how to contact other professionals like social workers, to help set up care in advance of the patient returning home. We have also received information about discharge arrangements that have not been effective which has resulted in patient's needs not being met and of them being at risk. The trust recently responded to a complaint about discharge procedures and an apology was made.

The Lincolnshire Local Involvement Network (LInk) undertook a review of responses to the trust's discharge arrangements across all their sites including Lincoln County

Hospital. They concluded that the trust needed to improve the arrangements and the trust have stated that they will respond to the concerns raised. Link will be monitoring their response.

Some care is provided from Monday to Friday only, for example; patients on one ward were receiving physiotherapy and occupational therapy from qualified health professionals at the time of our visit. We were told by staff that they have their own therapists who work on the ward weekdays only. Since our visit we have been informed that the trust is in the process of expanding therapy services to provide a 7 day service. On the ward we spoke with nursing staff and were informed that thrombolysis (the break down of blood clots using special medication) can only be administered to patients between 8am and 6pm during the week and three weekends out of four. This is because of the need for specialist staff to undertake this procedure. This means that consistent care is not delivered throughout the week. We were informed by the trust after our visit that it had a stroke implementation plan which includes the expansion of the hours when thrombolysis is going to be available.

Our judgement

Patients needs were not consistently met across the hospital. In one ward people were at risk as their records were poorly maintained.

Outcome 05: Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:

* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

There are moderate concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us

A relative on one ward told us that the "food is amazing" whilst a patient told us that "the food is OK".

Another patient told us that the food was "OK" although they hadn't eaten a lot because they had had an operation that morning.

Other evidence

The majority of patient's nutritional needs were being met and they reported that the food was good and they were supported to eat.

A new system had been implemented to help nurses see at a glance what a patient's nutritional needs were and staff had received training on this.

However a patient on one ward who had been admitted to the hospital for investigations into weight loss did not have their needs met. We saw that the recorded weights of the patient could not have been accurate because of the large variation and the risk of malnutrition had therefore been amended, which did not reflect the needs of the patient. Records of food and drink taken by the patient had not been maintained since admission, and the malnutrition pathway had not been followed as they had not been referred to a dietician. We spoke to the nurses about our concerns on the ward and they took action to carry out an immediate review of the person's care needs.

Our judgement

On one ward we found that patients were not always supported to have adequate nutrition and hydration and risks were not always being identified.

Outcome 14: Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:

* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are major concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us

We did not speak with patients or relatives about their experiences of this outcome.

Other evidence

We spoke with staff on each of the wards we visited. Two nurses on one ward told us they had received some ongoing training to make sure patients' medical needs could be met. They told us about the outcome of their training, which included knowing about the action they would take to keep people safe from harm. However, they also told us that they did not always get time for much training and one nurse told us that, "Its okay. We know how to meet patient's needs safely. I just wish we had more time for our own learning and development needs".

One of the wards we visited provided support for patients who experienced memory loss and confusion. We saw staff talking with patients in a way that showed they knew them and understood their needs. They called them by their first name and sensitively encouraged them to eat and drink when needed.

The manager of the ward told us that the staff were meeting patients day to day needs and that they wanted to develop specialist skills further by providing training for staff on dementia. However, this had not yet taken place because staff had been needed to ensure the ward was run safely. The staff told us that they were concerned about this but often this was due to a shortage of staff and training was the lowest priority. We were told that a senior nurse is going to take the lead on this work in the near future.

In another ward we were informed by nursing staff that they were "generally well staffed and we can get help when it is needed".

When we spoke to staff on one ward they said the ward manager was supportive but that for some time they did not feel there had been enough staff available to ensure records and care plans could be kept fully updated to ensure that staff, not familiar with the patients, could meet their needs. We had been informed about this by a "whistle blower" before we visited the hospital, who told us that they had raised this but "nothing gets done".

The nurses we spoke with said they did not always have time to record what care they had given to patients. They told us that they had raised this with their managers and that that they had thought this had been taken forward to senior hospital managers to review, but they couldn't be sure.

Some staff were upset and said that they felt intimidated and not able to raise their concerns with either senior management or their own professional regulator. However, they were aware of the "voicing concerns" policy. Staff were not all aware of the agreed staffing arrangements for their wards and had been told that until recently that they could not book bank staff. This had impacted on their ability to appropriately and safely staff some of the wards and created many potential risks.

One nurse said, "It is better than it was, during the last two weeks we have been able to have access to more staff. I think we have been listened to". Another nurse said, "There have been serious issues in the past but staffing has been increased back to what it should be and we can now bring in cover when staff are off".

A relative on another ward we spoke with stated that there were "always call bells going off" during evening visiting and felt there were insufficient staff to answer them. They told us that the bells were rung for attention to go to the toilet most of the time.

We know that senior hospital managers had recently held a meeting with all the nursing staff to discuss the concerns raised by them about the running of the wards and staffing levels. There were no records available to show the outcome of the meeting or what had been agreed, however a letter had been written by a manager to their line manager to escalate the concerns raised.

We spoke to a nurse on another ward who also told us that the nurse team had raised concerns about staffing levels saying, "We are getting more staff cover. The care has never been in doubt, it's just the records that we didn't always get time to fully complete, I would say it's getting better".

Due to staffing levels, staff did not always have the opportunity to update their practice. A professional that we spoke with told us that they felt healthcare support workers were "not always equipped to give good or appropriate front-line care".

All staff said they were supported by their own line managers. However, staff said they had not all had formal supervision and there were no records of staff or supervision meetings available to show that the nurses concerns had been acted on.

Supervision sessions are meetings with the member of staff and their line manager to talk about the work they do and the sort of training they need to make sure patients are well cared for. Staff told us that sometimes it could be difficult to make time for more formal supervision meetings because the priority was meeting patient's needs.

We found that there was a variation in the amount of time between meetings held at ward level; some wards have weekly meetings and some are held less than monthly. The ward meetings did not have a standing agenda item for learning lessons from any

incidents that have occurred and were not always recorded.

Learning and development needs are not always identified for people on a formal basis and records for appraisals are not sufficiently detailed to demonstrate this. Appraisals are a way that managers look at how well their staff are doing their job and identifies any training and development needs; this normally happens once a year.

Our judgement

Not all staff were properly supported to provide care which includes having access to acceptable levels of training, supervision and appraisal.

Outcome 16: Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:

* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are major concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us

All the patients we met told us they were happy with the service they received and knew if they had any concerns they could raise them with the ward manager. They also said they knew how to make a complaint if they needed to. One patient said, "I would just tell the nurses if I had any worries". When asking people about the support provided by staff, one patient told us, "They are easy to talk to and they keep checking that I am okay".

Other evidence

At our last visit to the hospital in February 2011 we made a compliance action for this outcome as we had minor concerns.

We know that the County Hospital provides information about what is offered, how to make contact with the service to make any suggestions for improvement and how to raise any concerns. We know that the web site for the trust provides this information and we also saw this on one of the ward's notice boards during our visit.

We spoke to managers of two of the wards we visited who told us that they worked on the wards with staff and that they aimed to monitor the quality of the work being undertaken by looking at records and through "on the job" supervision. On another ward the manager reported that she was not able to monitor quality and care delivery as she had to work on the ward to ensure patient's needs were met.

A new system of monitoring care has been introduced which means that nurses are

required to check with patients every hour that they are comfortable and that their needs have been met. In most of the areas we inspected these records had not been maintained; on some occasions periods of up to 12 hours had not been recorded on the charts. We were informed by a visitor that the hourly charts were not always completed. They stated that one was not filled in for five hours and another day for two hours for the patient they were visiting. Staff said that they did not always have the time to complete the charts.

We were informed by a member of the management team that there had been a consultant's meeting the week before our visit to discuss staffing levels on one ward; we do not know the outcome of the meeting. We were also informed that a member of the medical team had written to a senior manager about the concerns of staffing levels on wards. We were told that staffing levels was generally a fixed number for each shift and we had no evidence that this was varied according to the needs of the patients. Ward meeting minutes that we saw did not include reference to the staff raising their concerns about staffing numbers on each shift.

We saw records of checks of staffing levels on wards which were undertaken by managers three times a day. In some areas the numbers and experience of staff had not been sufficient to meet the needs of patients. Staff said they have raised issues with their line managers through both formal (via incident reports) and informal routes but they expressed disappointment that they did not receive feedback or learn lessons from the incidents that had occurred.

We looked at information about one incident that had occurred recently where a patient had left the ward without the knowledge of the ward staff. We saw that the incident had not been properly investigated or taken forward to ensure that lessons could be learnt to minimise risk for other patients. There was no evidence that any actions had been taken to ensure that a similar incident could not re occur.

The quality of some investigations undertaken by the trust were not sufficiently robust and did not clearly identify recommendations, timescales for implementing the recommendations and who was responsible for monitoring the impact of them. The investigation reports that we saw were not always dated and signed. We did not see evidence that there was an effective system to ensure that lessons were learnt and practice changed as a result of incidents occurring.

A senior nurse stated that she had not been made aware of any staffing problems in the hospital until approximately two weeks ago. This was after we raised concerns with the medical director of the trust following staff "whistle blowing" to CQC. There was no evidence that serious issues relating to staffing levels in the hospital were being reported to the board. Following an investigation into the issues that were raised, the trust decided to close eight beds on one ward. We do know that when hospital managers became aware of the staff concerns they took action to meet with the nurse teams to check on things and to talk to staff about their concerns.

During the inspection the inspectors identified that there was a significantly high number of incidents that had occurred in one ward. Although there were systems to record and identify themes in incidents these are not effective as the trust had not identified any themes or risks prior to our inspection. The senior nurses were unable to clarify if the information we were given was accurate as when wards were moved and

the name of the ward changed this may have impacted on the management information they used.

Although there is day to day contact between the senior nursing staff there is no formal record of it and the support and direction that is provided. Some significant meetings are not recorded so that there is not an audit trail of decision making.

In one area, we were shown completed "patient experience" forms that covered the ward and the accident and emergency department. The majority of the responses were positive. The department manager was analysing the responses and plans to put an action plan in place for any of the negative trends that are highlighted and is going to repeat the questions in six months time to see if things have improved.

Our judgement

The systems to monitor the quality of services were not sufficiently robust to ensure that risks to patients are managed. The trust does not have an effective system to learn from incidents.

Action we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Patients needs were not consistently met across the hospital. In one ward people were at risk as their records were poorly maintained.	
Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: On one ward we found that people were not always supported to have adequate nutrition and hydration and risks were not always being identified.	
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Not all staff were properly supported to provide care which includes having access to acceptable levels of training, supervision and appraisal.	

The provider must send CQC a report that says what action they are going to take to

achieve compliance with these essential standards.

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

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

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

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

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

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

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

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

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

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

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

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

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
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