We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

## Lincoln County Hospital

Greetwell Road, Lincoln, LN2 5QY

Tel: 01522573982

Date of Inspections: 01 November 2012
31 October 2012

Date of Publication: January 2013

We inspected the following standards as part of a routine inspection. This is what we found:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Met this standard</th>
<th>Action needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and welfare of people who use services</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Meeting nutritional needs</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Management of medicines</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Safety and suitability of premises</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Staffing</td>
<td>✗</td>
<td>Action needed</td>
</tr>
<tr>
<td>Supporting workers</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Complaints</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
## Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>United Lincolnshire Hospitals NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of the service</td>
<td>United Lincolnshire Hospitals NHS Trust has several hospitals. Lincoln County Hospital provides all major specialties such as surgery, medicine, orthopaedics, maternity, cancer and intensive care. It also has an accident and emergency department.</td>
</tr>
</tbody>
</table>
| Type of services | Acute services with overnight beds  
Community healthcare service |
| Regulated activities | Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Maternity and midwifery services  
Surgical procedures  
Termination of pregnancies  
Treatment of disease, disorder or injury |
When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

<table>
<thead>
<tr>
<th>Summary of this inspection:</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>How we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>What people told us and what we found</td>
<td>4</td>
</tr>
<tr>
<td>What we have told the provider to do</td>
<td>5</td>
</tr>
<tr>
<td>More information about the provider</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our judgements for each standard inspected:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and welfare of people who use service</td>
<td>6</td>
</tr>
<tr>
<td>Meeting nutritional needs</td>
<td>9</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>10</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>13</td>
</tr>
<tr>
<td>Safety and suitability of premises</td>
<td>16</td>
</tr>
<tr>
<td>Staffing</td>
<td>18</td>
</tr>
<tr>
<td>Supporting workers</td>
<td>20</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>22</td>
</tr>
<tr>
<td>Complaints</td>
<td>25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information primarily for the provider:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Action we have told the provider to take</td>
<td>27</td>
</tr>
</tbody>
</table>

| About CQC Inspections                                         | 28   |
| How we define our judgements                                  | 29   |
| Glossary of terms we use in this report                       | 31   |
| Contact us                                                    | 33   |
Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 31 October 2012 and 1 November 2012, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and talked with stakeholders.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

This report includes the evidence we gathered on our visits to the hospital. As well as inspectors from the Care Quality Commission we also took a pharmacy inspector, a theatre specialist and a person with professional experience of NHS clinical governance and risk management.

During the visits we went to ten wards, the theatre suites, the accident and emergency department, the pharmacy department, the trust headquarters and the women’s unit. We spoke with patients, members of staff and senior managers as well as relatives. We also looked at some hospital records and gathered information from Lincolnshire County Council social services department and their safeguarding team. In addition, we gathered information from NHS Lincolnshire who commissioned the treatment patients received at the hospital.

The majority of patients we spoke with said they were happy with the care they were getting and felt staff were kind. One patient told us, “The co-ordination between departments and staff is first class. I couldn’t have asked for more.” We did have concerns on one ward but these were being addressed by the trust as a matter of urgency.

Patients spoke highly of the food they ate and we saw patients being supported appropriately to eat and drink when it was necessary. One patient told us they could have something to eat in the middle of the night if they wanted it.

We saw improvements in some discharge practices and well structured planning to ensure discharges were safe. However, some patients informed us they experienced unacceptable delays in obtaining medication to take home, especially at weekends. Information was not always shared with their GP or other providers in a timely manner.

The women’s unit was still undergoing a programme of improvement including the removal
of asbestos: this was being monitored on a regular basis to ensure patients’ safety.

Patients across the hospital told us their care was good. Doctors and some patients informed us they did not think there was enough nursing staff on duty at times and this could impact morale. The staffing of wards and departments by nurses was managed by senior staff at regular intervals.

Staff at all levels told us they felt supported to do their job and we saw both mandatory and specialist training had been put in place, particularly on dementia, for both nurses and doctors.

The trust had continued to improve its systems and processes for monitoring the quality of care. Incident reporting was seen to be robust and the trust board took an active approach in investigating serious untoward incidents. As a result of this, risks to patients were reduced.

Patients we spoke with were aware they could make a complaint and knew who to approach. The trust had made improvements to the time they responded to complaints made in the hospital although there was still further work to be done. They also had plans to introduce a new complaints procedure which was more structured and robust than the one currently in place.

You can see our judgements on the front page of this report.

**What we have told the provider to do**

We have asked the provider to send us a report by 07 February 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

**More information about the provider**

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

<table>
<thead>
<tr>
<th>Care and welfare of people who use services</th>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>People should get safe and appropriate care that meets their needs and supports their rights</td>
<td></td>
</tr>
</tbody>
</table>

Our judgement

The provider was meeting this standard.

Patients experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

When we visited the hospital in November 2011 the hospital was not meeting this standard and they had to improve.

In preparation for this inspection we spoke with other key partners and organisations to gather their views of the hospital. We received information from NHS Lincolnshire about quality assurance visits they had carried out to the hospital during 2012. NHS Lincolnshire commissions (buys) care from the trust and is responsible for monitoring the quality of care that is delivered. They told us they had not found any concerns in relation to patient care on any of the wards we visited.

As part of the inspection we visited a number of wards, the operating theatre department and the accident and emergency department. During the visits to these areas we spoke with patients to obtain their views about their experience at the hospital. Apart from one ward area, patients from four different wards told us they had received good care and felt well looked after. One patient told us, “The care is excellent. Staff get to know you, they’re very understanding.” Another patient said, “I can’t thank them highly enough for how they have helped me. I couldn’t have wished for any better care.”

On two other wards, one patient told us, “I am included in the discussions about my treatment.” Another patient told us, “I’ve been looked after as if I’m in a five star hotel.”

Patients were able to describe how staff had told them they could read their notes and explained to us how other health care professionals were involved in their care.

Whilst visiting the different ward areas we examined a range of patient records and found these had been updated with identified patients’ needs to ensure any changes in their condition or treatment were recorded. They included a full assessment of patients’ needs such as personal care and nutrition. Risk assessments and details of any specialist involvement, for example speech and language therapists were incorporated into the records.
All staff wrote in the same patient record, which ensured continuity and a team approach to care delivery. Staff included doctors, nurses and other allied health care professionals. The records we saw were dated and signed and were easy to understand. They included daily history notes for each patient, which were highly detailed.

We found that patients on the surgical day unit had been given full information about their operation prior to their admission, during their stay and following their operation. Patients told us medical staff did not use words they did not understand. Patients on the Stroke Unit and Shuttleworth Ward described how all staff had given them clear instructions about their care, treatment and discharge.

We talked to senior ward staff about the arrangements in place for those patients who were “outliers.” An outlier is the term used where patients are admitted onto wards temporarily that are not the speciality they have been admitted for. For example, a patient with a chest infection may be admitted to a surgical ward until a bed is free on a medical ward. This is not uncommon practice in NHS acute hospitals.

The trust may wish to note that staff on all in-patient wards described the difficulties they experienced with ‘outliers’ on their wards. For example not knowing how long the ‘outlying’ patient would occupy the bed and not always knowing about the specialty of the patient. We were informed medical ‘outliers’ made up the biggest number.

Staff on the stroke unit informed us they had on average two ‘outlying’ patients a week but in the recent past they had experienced eleven in one day. When we spoke with the trust about this issue, they said there had recently been an unprecedented demand for beds in the hospital. They also told us they had needed to open additional wards (known as escalation wards) to cope with the demand. Arrangements had already been drawn up to cope with the added pressure for beds over the winter period which had gone to the Strategic Health Authority for approval.

We found on one ward, Marshall Ward there was a different patient experience. Prior to our visit some concerns had been raised regarding the new use of the ward. We were informed that Marshall Ward had merged with the Surgical Emergency Assessment Unit a few weeks earlier bringing together patients admitted as surgical emergencies and elective urology treatments. This had occurred after NHS Lincolnshire’s visit to the ward. Patients were disrupted in the night and as staff were busy, not all patients received the attention they required in a timely manner. A member of staff on the ward told us, “The current mix of patients doesn’t work. The noise level cannot be addressed.”

We raised our concerns during the visit and were given information that showed the trust had been looking at the problems raised by staff since the ward opened four weeks previously. After our visit we received confirmation from the trust that they had reacted positively to our concerns and were in the process of addressing issues raised. We have also received an action plan detailing how proposed changes were to be managed.

When we went to the operating theatres we saw patients were well cared for. In all the theatres we visited we saw the World Health Organisation (WHO) surgical safety checklist being used appropriately. The WHO surgical safety checklist is a procedure for use in any operating theatre and reduces risks to patients. Patient records looked at in theatres showed correct documentation was in place including completed WHO checklists.

However, when we spoke to three surgeons in theatres, they told us they were not pleased with the numbers of patients who had to have operations cancelled because of the lack of
beds. Some had been cancelled on the day of our visit. We also saw delays between operations because patients had not arrived in theatre on time.

When we visited the accident and emergency department we saw it was very busy. All the cubicles were full and patients were waiting on trolleys in the corridors. We found patients had been assessed on their admission to the department and where it was necessary pain relief had been given to them. They then had to wait for a vacant cubicle so a doctor could examine them.

We were able to speak with those patients, some of whom had been waiting for up to three hours. One patient told us they were, “Fed up of waiting,” but realised patients who were really ill had to be seen first.

We checked with NHS Lincolnshire who commissions services from the trust. They informed us the trust was meeting the four hour waiting target in the department. During our visit to the accident and emergency department we were shown plans to increase the number of cubicles in 2013.
Meeting nutritional needs

| Food and drink should meet people’s individual dietary needs |

Met this standard

**Our judgement**

The provider was meeting this standard.

Patients were protected from the risks of inadequate nutrition and dehydration. Patients were supported to be able to eat and drink sufficient amounts to meet their needs.

**Reasons for our judgement**

When we visited the hospital in March 2011 the hospital was not meeting this standard and they had to improve.

At this inspection we observed that food was delivered to each ward in a heated trolley and nursing staff served meals out from the trolley. This meant patients could have the right size portion dependent on their needs and wishes at the time. Nursing staff could also observe how much patients were eating.

The patients we spoke with across all the wards said they liked the food and the quality of it was good. One patient said, "I get plenty to eat, there is always a choice and I'm not hungry." Another patient told us, "The food isn't bad at all and I always have plenty to drink." This patient also told us the staff had taken note of their food preferences and the food they received was always hot when it was served.

One patient told us they had been hungry in the night and staff had prepared toast with tea for them. We saw patients on all wards had a menu card each day with a choice of food for each meal. If they didn't like any of the choices on the card an alternative list of foods was available. Special food was also available for those with a religious or cultural need.

We observed in detail a teatime service on a ward caring for mainly elderly patients, some of whom had complex needs. We saw the interaction between staff and patients was good. Choices for patients were explained and they were offered special cutlery and crockery if it was needed to help promote independence. Patients who needed support in order for them to eat and drink were helped into a position that was suitable and comfortable for them.

Nutritional risk assessments were seen in patients’ care plans on all wards we visited. These were updated on a regular basis if this was required and where necessary records were made of what people had eaten and drunk.

Patients on the two day wards we visited had access to hot and cold drinks as well as snacks. The patients we spoke with on these wards told us this was sufficient for their needs.
Cooperating with other providers

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

Patients receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

Reasons for our judgement

When we visited the hospital in February 2012 the hospital was not meeting this standard and they had to improve. The majority of the improvements needed had been about discharges for older people.

In preparation for this inspection we spoke with other key partners and organisations to gather their views of the hospital. Lincolnshire County Council has a special safeguarding team who investigate any incidents of alleged poor care for vulnerable adults. We received information from the team that over the last eight months there had been three cases which were related to poor discharge arrangements for patients. This was a reduction of seven cases compared to ten in the previous twelve months. Investigations had taken place or were ongoing to address concerns and make changes where needed.

We also had information that NHS Lincolnshire previously had concerns about the discharge arrangements in place for patients, due to delayed written communications between the hospital and GP’s. These are called electronic discharge records (eDDs). If the GP does not receive them quickly it may put the patient at risk.

Before we visited this time, we contacted NHS Lincolnshire and asked if there had been improvements to the number of electronic discharge records being sent out within twenty four hours. An audit on discharge delays in May 2012 was shared with us. This audit had been supported by the management of the trust and other partner agencies. The audit identified issues over planning, the completion of records, assessment and the need for a dedicated discharge planning team. An audit from September 2012 was also shared with us and demonstrated that the trust had achieved 65% for sending eDDs to GPs within 24 hours of discharge by the end of September; this was an improvement from 35%.

NHS Lincolnshire also informed us the trust was currently investigating the delay of letters from out patient clinics to GPs. At Lincoln County Hospital these were generally centred on nephrology and cardiology.

On visiting the accident and emergency department we spoke with a member of staff who told us of the arrangements in place for older people admitted to the department. Where necessary, patients were referred to a special team, the assertive in-reach team (AIR), which was nurse-led and had access to physiotherapists and occupational therapists. The
team was funded by NHS Lincolnshire and helped patients return home safely and with support where necessary. Where support could not be given immediately patients were admitted to a hospital ward overnight.

We found that the discharge document found in all patient records was usually started when a patient was admitted, although we did see evidence on one ward where this had not occurred in two of the patient records we looked at. When we asked ward staff about this they did not know why it had not been done.

On the stroke unit we spoke with a patient who described how staff had spoken with a social worker based in the community. They had arranged for the delivery of equipment to the patient's home ready for their discharge which would prevent any delays once they were medically fit to go home.

The unit was structured so patients moved from high dependency to supervision and on to rehabilitation. Patients we spoke with liked the system as it meant with each move they were going closer to home. Another patient told us how staff had helped them with new walking sticks to mobilise and become more independent.

On another ward we spoke with a patient who described how clear the instructions had been for their discharge and after-care following surgery. We also saw specially developed discharge sheets for patients who were going to care homes. This was because more information was required about these patients to enable a safe discharge.

When we visited one ward we saw senior nursing staff updating a white board with the expected date of discharge of patients. They told us that each patient's length of stay was monitored closely and they were discharged as soon as the doctors felt they were medically fit and could return home safely.

Staff told us about things that sometimes delayed patients being discharged in a timely way such as access to medicines to take home at weekends and waiting for senior medical staff to give permission because they were busy elsewhere, for example in theatre. We found that one patient had been sitting in their wheelchair waiting for their medicines since 10:30am. The doctor had written the discharge letter but this had been left unsigned. He was not available until 2pm.

After our visit we spoke by telephone to a social worker in the hospital. The social work team is employed by Lincolnshire County Council. Some of the information they gave us related to the reason for delays in discharging patients. In September 2012 the main reasons for delays included packages of care not being in place and waiting for the delivery of equipment to either care homes or patient's homes.

We also spoke to a discharge liaison nurse who worked in the hospital. They told us of the work they did to ensure people with complex needs or those requiring rehabilitation were discharged safely once they were medically fit. This included meetings with people like social workers and a representative from the mental health team if it was needed. They said some things caused discharge delays, for example transport issues and waiting for care home staff to undertake their own assessment of need for a patient before they were discharged to the care home. They added the transport issues were now a lot better.

It is clear that the trust had improved its arrangements regarding discharge planning and preparation to improve the patients’ experience when getting ready to leave the hospital.
Strategies had been introduced and where problems had been identified actions were being taken to address them.
Management of medicines

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

Our judgement

The provider was meeting this standard.

Patients were protected against the risks associated with medicines because the trust had appropriate arrangements in place to manage medicines.

Reasons for our judgement

When we visited the hospital in April 2012 the hospital was not meeting this standard and they had to improve.

At this inspection we visited three wards, the discharge lounge and the pharmacy department. We talked with doctors, nurses, members of the pharmacy team and patients and their relatives.

One person said, “Today they brought my medicine in and said they were antibiotics. I don’t know what the appropriate times are to give this to me. They gave me morphine when I said I had pain.”

One person told us they had the opportunity to self medicate (this is when a patient takes care of their own medication and when to take it), but they did not want to.

We looked at samples of people’s medicine charts and found that medicines were prescribed, and staff had signed the administration chart. However, one antibiotic dose had been due earlier in the morning. This was brought to the matron’s attention and the nurse on medicines duty immediately administered and signed the chart. We saw the nurse informed the patient that they were being given an antibiotic. We found other antibiotics and medicines were administered regularly and were signed at appropriate times.

A nurse said, “I always tell them what the tablets are in the pot and what they are taking. I habitually do it. Prior to discharge, I go through what they are and the side effects. I go through their discharge letter.”

During our visit most patients we spoke with said they had their views considered, medicines were given in the appropriate form and securely kept locked in their cupboards. However, there were some reported issues over delays and problems at discharge. A patient in the discharge lounge told us they were unaware of two newly prescribed ‘take home’ medicines and that one medicine was to be taken weekly and not daily. Another patient had received their dressings but was waiting for some ‘take home’ medicine and said, “As far as I know I will get antibiotics but I don’t know”. When we spoke with one of the doctors about any problems with medication they said, “The only time is when trying to discharge, it can take a while. The biggest problem is if the consultant said they can go,
the patient can be waiting for some time here”. The trust provided us with information to show that they had plans in place to address issues over access to take home medication at weekends.

The junior doctor, nurses and matrons we met were generally happy with the service provided by the hospital’s pharmacy. Pharmacists and pharmacy technicians visited all wards, apart from the maternity wards, every week day and spent more time on the busiest wards. The pharmacy team had made progress in the use of the mobile pharmacy computers. They felt they were now in a position to spend more time on the wards. They wore pharmacy team badges to enable patients to approach and ask any questions regarding their medicines. A ‘bleep’ in each ward was made available to contact the pharmacy team. The trust had informed us they were consulting with the pharmacists to provide pharmacy staff seven days a week. At present there is an additional pharmacy service on Saturday mornings.

All the ward managers had recently been provided with a Medicines Safety information pack. This included guidance for reducing harm from omitted or delayed medication. Details for obtaining medicines, a safety notice relating to the reporting of medicines errors and the first issue of a medicines newsletter were also provided.

One of the doctors said, “I know the ward pharmacist; I talk to her with regards to at least three or four patients. I call switchboard to access pharmacy advice. They have always been available when I have called.”

Staff we spoke with were aware of the procedure for reporting medicine related incidents. One doctor said, “I have not reported any. I know a doctor that has. The patient had an allergy to a medicine and was written up for this medicine; this was not given, but an incident report form was filled in. They learnt from it and now are very careful.” We were provided with a list of medicine related incidents. The ward matrons updated the reports monthly. However, we heard from one member of the pharmacy team who had not received feedback from an incident they reported. We were informed that the hospital had recently introduced a form for the management of drug incident/errors across the whole hospital and we saw this was used in practice. We saw some patients wearing red bands to alert staff that they were allergic to a certain type of medicine. However, there was one patient who we found was allergic to a medication and did not have a red band.

During the afternoon we visited the discharge lounge. We saw the two members of staff on duty were very busy. We talked to three patients in the discharge lounge. One person was not aware that their medicines were already in their bag with their belongings. The nurse confirmed the ‘take home’ medicines were checked with another member of staff on the ward. We saw the patient had all their medicines in the monitored ‘dosette’ system. However, we observed one box of medicine for epilepsy was missing. The nurse immediately obtained this from the ward and said this had been checked but had not been placed together with the ‘dosette’.

The trust may like to note some of the patients we met were not always given sufficient information about their medicines and the system of checking ‘take home’ medicines was not always robust.

After our visit, we were told by the trust they had a ‘helpline’ in place for patients to access information about their medicines. They also told us that ‘Ask your Pharmacy’ patient awareness leaflets will be distributed in early December.
We found that the trust is working to improve the way medicines were handled, for the benefit of patients. The trust had recently held a study day for all nurses and senior staff administering medicines. There was a plan in place for staff to undertake medicine management assessments and to re-educate nurses with regards to discharge medicines’ processes and counselling. We were also informed a plan was underway to review junior doctor’s competence for completing medicines reconciliation and history taking.
Our judgement

The provider was meeting this standard.

Patients who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

When we visited the hospital in February 2012 the hospital was not meeting this standard and they had to improve. The concerns we had related to the Women's Unit.

As well as looking at the Women's Unit we also looked at other wards, the operating theatres and the accident and emergency department.

The trust had given us an updated plan on actions they had taken in relation to the Women's Unit. We saw they had addressed the issues concerning poor drainage and we saw a policy displayed in case of any water leaks in the area where asbestos was present. Further removal of asbestos had taken place from some areas. We saw that regular monitoring by the trust was taking place to ensure that the building was safe.

When we visited one ward in the unit we saw a room that was used for bereaved parents. The room was dark and the window was draughty and did not close properly. Staff told us they had done their best with the room but they had limited resources to use. We told the trust about this after our visit and they said they would look at the issue as a matter of urgency.

Shower rooms were clean and we saw a system in place to review this every three months on one particular ward. Some flooring had been replaced on two of the wards and a programme of replacing window catches was in place.

On one ward we saw a shower had been out of use since the end of August 2012 although a request for its repair had been completed at the time. As a result of this there was only one shower and one bath for twenty seven patients. When we told the trust about this they said they would deal with the matter quickly and resolve it.

We also visited the newly opened surgical day unit: it had been opened for two months. We found the unit to be well equipped and thought had been given to the environment. For example, there were designated areas for male and female patients, bed spaces were wide and there was a large waiting room equipped with magazines. Staff told us they hoped to provide a television for patients very soon.

In another day area unit of the hospital we spoke to patients about the environment and
they told us they were happy with it. One patient told us, "I just wish there were more tables as I like to have my things around me. I have got one today so I'm lucky."
Staffing

<table>
<thead>
<tr>
<th>Action needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>There should be enough members of staff to keep people safe and meet their health and welfare needs</td>
</tr>
</tbody>
</table>

Our judgement

The provider was not meeting this standard.

There were times when there was not enough qualified, skilled and experienced staff to meet patients' needs.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We found the trust was aware of the need to increase some staffing levels across the hospital, and in particular to specialist roles. There were 189 vacancies across the trust's hospital sites including Pilgrim Hospital, Louth County Hospital and Grantham Hospital at the time of the inspection and workforce planning was in the process of completion for next year.

The trust was undertaking a staffing review of in-patient wards in the hospitals across the trust. There were plans to extend this to other departments. In addition, we were informed that a directive had been issued in regard to minimum acceptable staffing levels in advance of the findings.

The trust also provided information on the recruitment strategies in place across the trust such as a vacancy control process. The trust was also working with other local organisations on promoting the area as a place to live and work: the trust reported that the demographic challenges of the area made employment difficult for all public sectors. They also told us how electronic rostering was a more effective way of using staff.

The trust informed us that they had reduced the levels of sickness and absence although those levels differed on each ward and department. Sickness and absence for the trust as a whole was 4.8%, which was an improvement. We were informed that across the trust the average length of long-term absence had also reduced from 198 days to 99 days. They reported that it was starting to invest in technology in order to better manage staffing pressures.

During this inspection, patients we spoke with in all areas and departments were generally complimentary of the care they received from all the staff team including doctors, nurses and therapists.

We found a mixture of experience between patients on one ward. One patient told us, "The bell gets answered in five minutes." Another patient on the same ward told us, "Some people have to wait for up to half an hour for someone to answer the bell – the staff are
always busy." Then they added, "I think a lot of the time they're short staffed. Some days you see staff racing down the corridor to get things done." A doctor we spoke with on the ward told us, "There have been times when the nurses struggle."

When we spoke with nursing staff on the ward they told us they had been short-staffed and they had sometimes had to postpone admissions for specialist treatment because of either a lack of beds on the ward or specialist nurses to give the treatment. Staff were aware that the trust was undertaking a recruitment drive to increase the number of specialist nurses required.

However, in one of the day unit areas a patient we spoke with said, "I think there's enough staff, they're always about if you need someone to help you."

We spoke to a consultant in the accident and emergency department who told us, "We have consultant cover in the department until 10pm every day of the week. At times the number of senior doctors exceeds the junior doctors." In addition they told us the nursing staff received additional training to add to their skills, but they added there was sometimes a shortage of them.

On one of the wards we visited we spoke with a junior doctor who told us the consultant visited the ward twice a week and was always available by telephone if they were needed even at weekends. They said, "There's a strong senior presence on here."

We also spoke with a senior therapist who told us, "It would be better if we were staffed over and above our whole-time equivalents to deal with annual leave and sickness but that would be Utopia."

A member of nursing staff on one ward told us, "I enjoy coming to work." Another member of staff told us, "Morale is low; everyone is tired because they are trying to do their best."

When we visited the operating theatres staffing levels were appropriate. A member of staff described the procedure used for raising concerns if insufficient staff were on duty. However, a surgeon told us how frustrated they were that theatre staff were moved around specialist areas to fill gaps in the rota. When we spoke to theatre staff they confirmed that this happened to ensure the lists were safely staffed.

Staff on two wards described staff shortages and how sickness levels had a negative impact on the normal duty rotas as well as on their stress levels. Bank and agency staff were used sometimes but some staff told us this gave them more difficulties when those staff did not know the patients' needs or the layout of the particular ward they worked on. Bank staff are staff who work for the trust either on a regular or occasional basis. Agency staff are those staff who are recruited from an agency to work in the hospital on an occasional basis only.

During our visit we went to the 'operations centre' for the hospital where staffing levels on all wards was managed by a team of senior staff three times a day. The team ensured staff were relocated to the busier parts of the hospital when it was necessary. On one ward we visited, staff told us they very rarely had a full complement of staff on duty because they helped other areas out to cover sickness and absences.
Supporting workers

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

Met this standard

Our judgement

The provider was meeting this standard.

Patients were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

We spoke with staff on each of the wards and departments we visited. We found that staff were open, friendly and willing to answer any questions we asked.

Staff were able to demonstrate their job roles well, knew their speciality and could tell us the needs of their patients. On one unit a member of staff said, "All the staff have a really good relationship with each other. I love working here."

Staff we spoke with told us they were well supported by their line managers and told us about their appraisal sessions. 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. On one ward we saw a list of appraisal dates for staff in the office.

Staff told us their line managers were approachable and had an 'open door' policy if they needed to talk with them.

Although staff did not receive regular supervision sessions, we were told if a member of staff or their line manager felt it was needed a 'file note' would be made and put in their records.

Staff informed us they were prompted to undertake their mandatory training but also encouraged to do specialist training, for example bladder screening. Mandatory training is training that has to be done by everyone.

We found some nursing staff had received specialist training to support patients with swallowing difficulties. This had been an advantage to all wards and departments ensuring the team who deal with speech and language problems were kept up to date with the assessments of patients.

Earlier in the year a course had been held for 'Champions in Dementia Care'. This included training on end of life care for those with dementia and understanding the emotional changes people suffer when they have dementia. On one ward we asked if staff had received training for caring for patients with dementia. We were informed one member of senior nursing staff had received it, three others already had places on the training course confirmed and training for the rest of the staff would follow.
We were also informed by the trust that a course on dementia was going to take place for consultants: this had been arranged for the new year.

A member of staff on one ward described how they had been encouraged by the trust to undertake their nurse training. Prior to that they had been a part of the housekeeping staff in the hospital.
Assessing and monitoring the quality of service provision

Met this standard

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

Our judgement

The provider was meeting this standard.

The trust had systems in place to regularly assess and monitor the quality of service that patients received. It also had a system in place to identify, assess and manage risks to the health, safety and welfare of patients using the service and others.

Reasons for our judgement

We did not speak directly with patients for this outcome but have considered patients' comments on their experience throughout the inspection as part of the assessment.

In preparation for this inspection we spoke with other key partners and organisations to gather their views of the hospital and the trust as an organisation. This outcome looked at how the trust managed and oversaw quality of care at an organisational level as well as at the local level. This is because many of the policies, procedures and processes were designed to gather information and give guidance trust wide.

During the inspection we examined documents dealing with the assurance processes used by the trust to ensure that the appropriate information about the services and operation of the hospital was received by senior managers and the Trust Board. We also looked at the processes in place to ensure that staff providing services were kept informed about and guided on hospital policies and procedures and supported to do their roles.

We found that the trust had a governance committee in place, which was a sub committee of the Trust Board. This committee was responsible for receiving and monitoring reports and action plans from reviews and reporting progress to the Trust Board. The governance committee was supported by a sub-committee for quality and safety. Other committees supported the assurance mechanisms in the trust.

When we visited last time the hospital had introduced a system of 'safety quality dashboards' (SQD). The system was a way of looking at various aspects of care in the in-patient areas of the hospital and whether certain things were in place for patients. It included for example risk assessments and medication charts. However the system used was not easy for patients and members of the public to understand.

On this visit we found the system had been embedded into the culture of each ward. The results were given to the wards on a monthly basis which in most cases were placed on their notice boards for people to see, although on one ward a member of staff had to go and find the results. We found examples where the results had been discussed at ward meetings and staff on one ward told us it was used to actively encourage them to make
improvements.

We received information from the trust after our visit which detailed the plans in place to commence the SQD in other places, such as paediatrics (children), maternity and the accident and emergency department. This would be in place by the end of March 2013. Further thought had been given to adding theatres, outpatients and diagnostics, for example pathology in 2013/14. The theatre business manager told us they were keen to have one in place for their department in order to monitor quality standards.

Senior members of the trust had undertaken regular unannounced visits to the wards. We were informed that four of these visits a month were undertaken across all the hospitals in the trust.

We saw evidence on wards of 'IR1' forms: these are incident reporting forms and are completed by staff when incidents arise. For example after a patient fall, staff shortages or a clinical incident. The trust may wish to note that two members of staff told us that sometimes they didn't have time to fill in these forms if they were short staffed until they had officially finished their shift. As a result they sometimes did not get filled in at all.

We were told on one ward incident reports were discussed and lessons learned from them including making improvements that were needed. We saw evidence of 'IR1' forms being managed effectively by the patient services manager who allocates them to the most appropriate person.

Managers were supported by the risk manager or the quality and safety manager for all serious incidents. The trust had produced a Quality Governance Framework - `Becoming a learning organisation`. This document detailed the way in which incidents would be used for learning.

From looking at the minutes of meetings at the trust headquarters, they could demonstrate effective use of information and monitoring of services to inform their risk management processes. This included the reporting and learning from investigations of all serious untoward incidents (SUI's). SUI's are an unplanned occurrence or event where there is loss of life, injury, loss or damage to patients or property. It can include any event that may give rise to physical, emotional or psychological harm.

We saw two investigation reports from SUI's and saw a detailed analysis of the incidents. This demonstrated openness and a willingness to learn. Action plans clearly indicated who was responsible for any action to be taken and when it was expected they would be completed.

NHS Lincolnshire informed us they monitored the investigation process of any new SUI until it had been closed and any actions required had been completed.

We were informed by the trust a new appointment had been made of a deputy director with responsibility for patient experience. A patient experience committee had been established and a strategy had been developed. A patient experience report was presented at the Trust Board meetings containing patient stories.

The trust, particularly the governance team, had worked hard to improve systems to identify and manage risk and learn from incidents. Time is needed to embed these new ways of working, protocols and procedures into the organisation. Care needs to be taken
to ensure that staff stay engaged with the new systems and that the patient experience is integral to other quality initiatives. There is a need to expand the quality monitoring initiatives such as the SQD to other departments in the hospital.
Complaints

Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. The trust had made progress in responding appropriately to the comments and complaints people had made.

Reasons for our judgement

Patients we spoke with told us they felt they could raise concerns should the need arise and felt they would be listened to. One patient told us they knew about the complaint's process and would use it, if it was necessary. When we asked if they had any concerns they told us the only thing they could think of was the signposting around the hospital, for example directions to wards and departments. They felt it was inadequate and sometimes very confusing.

Two other patients we spoke with told us they felt they had not been given enough information during their stay in the hospital. We told the ward staff and the matron about this. The issues were dealt with before we left.

In the accident and emergency department we were informed by a senior member of staff they usually had one or two complaints a week. These were investigated, anonymised and the outcomes sent to all staff so the department could learn for the future and about actions put in place to avoid a repeat of the problem.

On one ward we visited we asked about complaints management and the member of staff we spoke with was aware of how to deal with dissatisfaction from patients or relatives and would refer a complaint to their ward leader. There was evidence in the ward minutes that complaints were discussed.

Before and after the inspection the trust sent us information about how they dealt with complaints. We saw they had produced a draft document entitled 'Complaints, Concerns & Compliments Procedure'. This was to be approved and implemented in the near future. This was a comprehensive document and had been written with reference to a number of well known documents including 'Listening, Responding, Improving – A guide to better customer care,' written by the Department of Health.

The trust informed us they had received 302 complaints for the hospital since January 2012. The minimum number received was 22 in January 2012 and maximum 44 in May 2012. They also said the increases tended to have occurred after external reports and media coverage around the trust's services.

The trust's timescales for concluding complaint investigations was based on 25, 35 or 50 days depending on the complexity and the number of teams who needed to be involved.
Timescales were agreed mutually with the complainant. Any delays in concluding complaint investigations were audited on a weekly basis to ensure that senior management in the trust had up to date information.

Further information they provided showed the average time for concluding complaint investigations was 42.3 days including bank holidays. Performance on achievement of the timescales indicated the trust had improved since May 2012 and by the end of September 2012 had achieved 80% for complaints related to Lincoln County Hospital. The information we saw showed this was an upward trend. The trust may like to note further work is needed to improve the timescales for concluding complaints.

We found the trust's quality and safety committee received reports on managing risks and this included complaints. An analysis of the complaints identified the need to focus on certain areas for improvement.
Action we have told the provider to take

Compliance actions

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

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td></td>
<td>Staffing</td>
</tr>
<tr>
<td>How the regulation was not being met:</td>
<td>There were times when there was insufficient numbers of suitably qualified, skilled and experienced staff to meet patients' needs.</td>
</tr>
</tbody>
</table>

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 by 18 February 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.
We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

- **✔ Met this standard**
  This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

- **✘ Action needed**
  This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

- **✘ Enforcement action taken**
  If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

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

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

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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
## Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>Regulation 17</td>
</tr>
<tr>
<td>Consent to care and treatment</td>
<td>Regulation 18</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>Regulation 9</td>
</tr>
<tr>
<td>Meeting Nutritional Needs</td>
<td>Regulation 14</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>Regulation 24</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>Regulation 11</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>Regulation 12</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>Regulation 13</td>
</tr>
<tr>
<td>Safety and suitability of premises</td>
<td>Regulation 15</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment</td>
<td>Regulation 16</td>
</tr>
<tr>
<td>Requirements relating to workers</td>
<td>Regulation 21</td>
</tr>
<tr>
<td>Staffing</td>
<td>Regulation 22</td>
</tr>
<tr>
<td>Supporting Staff</td>
<td>Regulation 23</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>Regulation 10</td>
</tr>
<tr>
<td>Complaints</td>
<td>Regulation 19</td>
</tr>
<tr>
<td>Records</td>
<td>Regulation 20</td>
</tr>
</tbody>
</table>

## Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.
<table>
<thead>
<tr>
<th>Contact us</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phone:</strong></td>
</tr>
<tr>
<td><strong>Email:</strong></td>
</tr>
</tbody>
</table>
| **Write to us at:** | Care Quality Commission  
Citygate  
Gallowgate  
Newcastle upon Tyne  
NE1 4PA |
| **Website:** | www.cqc.org.uk |

Copyright Copyright © (2011) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.