**Inspection Report**

**Lincoln County Hospital**

Greetwell Road, Lincoln, LN2 5QY  
Tel: 01522573982

Date of Inspections: 05 July 2013  
04 July 2013  
02 July 2013  
26 June 2013  
22 June 2013  

Date of Publication: September 2013

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

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 22 June 2013, 26 June 2013, 2 July 2013, 4 July 2013 and 5 July 2013, 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 reviewed information given to us by the provider. We were accompanied by a pharmacist and were accompanied by a specialist advisor.

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.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

The Care Quality Commission was contacted by the Bruce Keogh Rapid Response Team as they had concerns about the staffing levels at the hospital, particularly at night and weekends. We undertook three unannounced inspections to the hospital, one on a Friday night. In addition, we visited the hospital to speak to specific members of staff including specialist nurses, matrons and senior managers. We spoke with staff side union representatives and we contacted the Occupational Health Department to gain an understanding of sickness levels and the nature of referrals and the Chaplaincy Department.

We looked at staffing levels and care practices across a number of wards and clinical areas. We were assisted by a number of professionals including professional advisors experienced in Trust Board Governance and workforce planning; a medical professional and a practicing professional who works in a care of the elderly service. We had received concerning information about how the trust was dealing with controlled drugs (controlled drugs are medicines which are subject to special storage and recording requirements). Therefore, a pharmacy inspector undertook a focussed inspection of the trust's arrangements for managing controlled drugs. We also contacted Health Education East Midlands to obtain information on post-graduate medical education in the hospital.

We spoke with patients, their families and representatives. We were assisted by an Expert by Experience (a person who has received services or has cared for someone in receipt of
services). We contacted Lincolnshire's Local Healthwatch to see if members of the public had raised any concerns or given feedback on services relevant to this inspection. We also looked at information given to the Bruce Keogh Rapid Response Review about the views of members of the public about services at the hospital.

Overall, we found a mixed picture. We found staffing levels were low and this impacted on a range of activities across the hospital including care and treatment of patients, communication between clinical staff, the maintenance of patient records and staff access to training and appraisal. This meant the hospital staff were not always responsive to patients' needs, at times due to inconsistent care and recording practices so patients were not always kept safe. Not all staff had attended the necessary training to ensure they had up to date knowledge and skills to perform their duties appropriately.

We found staff to be caring and dedicated across all staff groups. When we asked patients about their care we received positive feedback. A patient told us, "The staff are good I don't know how they keep going when they are busy." When we asked patients about being consulted about their treatment patients reported they were informed about what was happening. One patient said, "My treatment was explained to me." Another said, "I understand what they are going to do." However, patients noticed staff were rushed and that this impacted on their care. We found that some care practices were poor, one patient told us, "I am not pleased about just being given a booklet to read. I want someone to sit with me."

We found staff could not always respond to the needs of patients. We found not all care needs were assessed, planned for or delivered in a timely manner. We found that some care records were not updated appropriately such as care plans, risk assessments and hourly observation charts. This meant patients were at risk of not receiving consistent or appropriate care.

We found a confusing picture when we looked at how patients, their families and representatives were involved in the decision whether to resuscitate a patient or not. When we looked in the documents used for 'do not attempt cardio pulmonary resuscitation' we found some poor recording practices, not all records were clear who had been involved in the decision and why, and there were some medical records without details of discussions held.

Staff reported they could not give the care they would wish to do and also keep up with the necessary paperwork. This was causing increased levels of stress, particularly when registered nurses had to undertake additional duties and procedures to cover for newly registered nurses and agency staff.

We found communication at times ineffective between different staff groups including medical and nursing as well as between clinical staff and senior managers at Trust Board level. We found leadership was variable across wards and between ward/department level and senior management. We found some very positive practice taking place, but this was not necessarily shared across the hospital. Staff were not confident in the reporting system and told us that feedback was inconsistent between managers. One doctor said, "I do complete incident forms but what's the point I don't get any feedback."

The trust had introduced some quality monitoring systems and these were indicating that improvements across care and practice were improving. However, we found some poor performance and high levels of risk had been identified over several months and action taken was ineffective. It was not clear for some performance information that any action
had been taken to address issues or drive improvement or that timescales were appropriate. The Trust Board had recently agreed a revised board assurance framework, which contained robust reporting and management systems. However, this was not yet fully introduced and embedded in the trust. There was a drive to improve staff morale and relationships with clinicians. New strategies had been introduced to improve communication and consultation, including 'Listening Events', whereby senior managers including the Chief Executive were meeting with staff groups.

Staff reported over the last few months, there had been improvements in staffing in some areas. The trust had initiated recruitment strategies, with some success. There had been an increase in the number of consultants and newly registered nurses. There had been advertising campaigns taking place, including internationally and the trust was working with local universities. However, recruitment was proving a challenge.

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 02 October 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

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

### Respecting and involving people who use services  
Action needed

**People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run**

### Our judgement

The provider was not meeting this standard.

Patients did not always have their dignity and independence respected. Patients were not always enabled to make, or participate in making decisions relating to their care or treatment. Patients were not always assessed in accordance with the Mental Capacity Act 2005 when appropriate to their needs.

We have judged that this has a moderate 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 inspected a range of wards and clinical areas and spoke with staff, patients, their families and their representatives. We were supported by a practicing professional who worked in a care of the elderly service and an expert by experience. We had advice and support from a medical professional when we looked at how the hospital staff managed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) decisions. There was a mixed picture on how patients were cared for and involved, with some very kind and caring practices observed and reported, but also some poor practice as well. How patients, their families or representatives were involved in decisions made about whether resuscitation was appropriate was unclear and at times confusing.

The expert by experience spoke with nine people, all but one person giving positive feedback. The expert by experience observed patients were generally treated with dignity and respect. For example patients were given choices in having a blood transfusion or medication. One person said, "I was told the choice is mine at the end of the day."

When asked about being consulted about their treatment patients reported they were always informed about what was happening. They said their treatment was explained well to them. However patients told us they would like more involvement in their treatment and not just be presented with a decision. One patient told us she was concerned about her treatment and had been given a booklet to read. She told us she felt her concerns had been brushed away and she had not been listened to.

The expert by experience observed staff attending to the needs of patients. Privacy was respected by curtains being pulled around beds. The doctors and nurses kept their voices low when in discussion with patients. Staff spoke to patients in a kind and caring manner.
On one ward a patient told us the doctor had explained the treatment they were going to have. They said, "I know who is looking after me, I'm getting all the information I need, my dressings are done and I'm getting pain relief."

We found information about the hospital for patients and visitors at ward entrances, in the majority of wards visited. However, we did not see any information leaflets for patients or families on the end of life decision making. We did not see any information notices or leaflets related to DNACPR orders in any of the clinical areas visited.

We looked at how decisions about whether to resuscitate a patient or not was made and whether patients, their families or representatives such as Lasting Power of Attorneys were involved. We examined 16 DNACPR orders across three wards. We looked at both the DNACPR order form (which had a tick box structure) and whether there was a corresponding entry in the medical records about the conversations that had taken place and with whom.

We had concerns about the completion of the documentation, the lack of clarity over reviewing decisions and the lack of consistency in how forms were completed across a range of wards. For example, in one case the only evidence of family involvement was a ticked box to indicate they were involved, but the reason for the decision was not ticked. In one case both boxes were ticked stating discussed with patient and not discussed with patient as it would be too distressing. In another case the box was ticked which stated not discussed with patient and box ticked as discussed with wife but this was not dated. We also found that there was inconsistency with reviewing DNACPR decisions.

We found the approach to MCA was inconsistent in all areas. On one ward we looked at the notes of two patients and in each case staff had been given information about their mental capacity on admission. No assessment forms had been completed to see the patients' current level of understanding. However on one case a referral had been made to the mental health team.

We found overall there was inconsistency in how clinicians involved patients, their families or any Lasting Power of Attorneys in decisions about resuscitation. We saw a lack of referrals to the IMCA services. We found a lack of mental capacity assessments or 'Best Interest' meetings taking place. We found only certain staff were trained in undertaking MCA assessments and patients would be referred to these for assessment, which could lead to delays.

The provider was not compliant with this standard.
Our judgement

The provider was not meeting this standard.

In the past three years, the Care Quality Commission has continued to raise its concerns about the quality of care provided by this trust. Improvements have not been sustained. We are aware that the trust has recently been placed in special measures by The NHS Trust Development Authority due to the poor quality of care that has been identified.

After careful consideration, we have concluded that further enforcement action regarding breaches of regulations 9 and 10 and 22 would not lead to further improvement and may instead have a significant impact on the local health and social care economy. In the circumstances it would not be appropriate to take further enforcement action.

The trust has already developed an action plan in response to the Sir Bruce Keogh’s rapid responsive review and this will be monitored by NHS England. The NHS TDA will have the responsibility to support the trust to improve and to take the necessary action to ensure that the issues raised in the Keogh Review are addressed.

In response to the findings in this report, we will also require the trust to show us how it will become safe, effective, caring, responsive and well lead. We will continue to closely monitor the trust, inspecting as required and working with NHS England to review progress.

We have judged that this has a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

We inspected this outcome as we had concerns that low staffing levels might be impacting on patient care. At this inspection we undertook three unannounced visits to the hospital, one of which was on a Friday night. We inspected a range of wards and clinical areas and spoke with staff, patients, their families and their representatives. We were supported by a practicing professional who worked in a care of the elderly service and an expert by experience. We had advice and support from a medical professional when we looked at how the hospital staff managed the ‘do not attempt cardio pulmonary resuscitation’ (DNACPR) decisions. We found both good and poor practice was reported and observed.

As part of this inspection we asked the Lincolnshire local Healthwatch if they had any information about issues raised by the public to be considered as part of this review. They told us problems with care planning were raised as people had found they were not always...
appropriate for the person following discharge and would like to see improvements made.

The expert by experience saw some kind and caring practices by nurses and carers and patients told them their care and experience had been good or better. One patient said, "Care is spot on." Another patient told us, "I've been well looked after. It's all been very civilised."

Everyone was able to receive the personal care they needed. They were able to use the showers and were given an option of being helped. All had call bells within easy reach and reported call bells were answered quickly.

None of the patients we spoke with had to call a doctor out at night, but most reported seeing a doctor each day. During the week all patients saw a doctor every day and often saw a doctor more than once a day. Most felt they understood the doctor, if they didn't they told us they just needed to ask and someone else explained what the doctor was saying. Or the doctor explained it in a different way.

Patients told us they were treated as individuals. Staff seemed to know about their preferences. One patient commented. "I don't know how they do it, but they do."

On the second unannounced visit, we examined a number of care plans and found these were core plans and had been personalised to the individual. Where a patient required wound management treatment this had not been fully completed within the documentation. However we observed treatment taking place. The named nurse completed the plan when it was highlighted to her. When advice was required from other departments such as tissue viability or a dietician the records showed when referrals had been made. One patient confirmed she had received treatment which had been outlined in her care plan. The patient told us staff, "Were absolutely great."

In another care plan it was recorded that a patient required to be observed but there was no frequency indicated. Some of the time sections of the charts were blank and staff did not confirm when observations should take place. The patient could not tell us due to poor memory problems. We could not ascertain whether the person had received the care they required.

Omissions in recording and planning put patients at risk of not receiving care in a consistent and timely manner or even their care needs not being met. It would be difficult for staff to consistently monitor any deterioration in a patient's condition. We were particularly concerned because we were aware that staff taking care of patients on the wards were not always based there, some were bank and agency. Therefore it was important for continuity of care that care records were completed correctly and kept up to date.

Staff told us there was a system in place to identify when a patient had complex needs and required close monitoring. This was called the track and trigger system. We reviewed one track and trigger system on one ward and found the documentation had been completed for someone requiring tissue viability assessment. This was a good use of the system to identify risk to the patient.

We asked about the handover of patient information from the medical team and at shift change for the nursing and support staff. It was reported this was variable. Many staff felt there was not enough time to do a proper handover, and it often made them late off duty. One doctor told us, "For me it takes as long as it takes, I will not release or take on
patients where I don't understand or feel there is more work to be completed." A nurse told us, "When you have bank and agency staff you have to make sure they understand about the patients at handover as there is often little time to explain later in the shift."

Communication between nurses and doctors was also reported as variable. Some felt the relationship was excellent, while others felt there was a problem. In the interviews with staff from different disciplines a common theme was time to hand over and for those who worked in different areas of the hospital, knowing how different ward staff communicated with each other. One nurse told us, "There is good rapport with doctors (on their ward)." However, when one staff member tried to discuss communication difficulties on their ward they were told, "It's always been like that. Get on with it."

We looked at how the DNACPR decisions were managed and responded to on the wards and clinical areas we visited. We found some staff were unclear about the policy. We found different wards operated different methods to indicate if a patient was not to be resuscitated, some used a printed handover sheet; others used the white board with symbols as well as handover notes. On each of the wards we visited staff knew exactly who had a DNACPR form in place. The details given to us correlated with information in the patients' notes. Staff told us the resuscitation status patients were discussed at handover. We observed this practice on two wards.

We were informed the resuscitation team had arrived at a cardiac arrest on some occasions where the DNACPR policy was unclear as to whether it applied to the patient or not. There was considerable variance between the information from consultant staff and ward staff about applying the DNACPR policy and timely review of decisions.

We found the DNACPR policy was not up to date and was not universally applied in all cases where it might improve end of life care or dying with dignity. We found the critical care outreach teams were making decisions about resuscitation without reference to the patient's admission consultant.

The provider was not compliant with this standard
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 not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the management of medicines.

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 had received information which raised concerns about the management of controlled drugs in the trust. Controlled drugs are medicines which are subject to special storage and recording requirements. Quarterly checks on these by the trust had picked up that several wards and departments were not recording or accounting for these medicines properly. Quarterly checks are a set of auditing tools looking at different aspects of controlled drugs management and completed every three months. Therefore we inspected this regulation to check specifically on how the trust and the hospital dealt with and managed controlled drugs. We visited a range of wards and departments including the Pharmacy Department. We specifically looked at the storage facilities, recording of the storage and use of controlled drugs, any auditing processes in place and staff practice. We were supported by a specialist pharmacist. We did not speak with anyone who used the service about the way their medicines were managed, although we did examine individual patient controlled drug registers. There was one register in each ward and unit.

We looked at the storage and recording arrangements on seven wards and departments. We found the recorded stock balances of controlled drugs were the same as the amount of stock held. But we found some omissions in the records made when these medicines were received onto the wards and when they were disposed of. For example, if an amount of liquid was drawn up from an ampoule was less than that needed for the injection, the amount left was recorded as "wasted". There was no record made of what method of disposal was used. Staff we spoke with also told us the practice was to dispose of this in a "Pharmaceutical waste bin." (A bin specifically designed for the disposal of medicines) This meant that the amount disposed of was not stored correctly, the medicine was not properly accounted for, and it was not disposed of safely to prevent unauthorised access. We found that ward staff were checking the stock balances of controlled drugs against the records every day. This meant any discrepancies could be identified and investigated promptly.

Staff we spoke with described the procedure in place if any errors occurred with
medication. We were provided with evidence of analysis of these reported incidents but there was no reporting procedure in place to ensure any trends identified were reported to ward level.

There was a trust wide standard operating procedure for the safe management of controlled drugs. However, this was not dated to show it was current and we were told this had not been ratified by the Trust board. Staff we spoke with were not aware that this procedure was in place.

During our inspection we saw evidence that the quarterly checks, (the three monthly auditing checks to ensure safe management of controlled drugs) were being carried out by the trust's pharmacy department. We saw a number of ward areas had improved in their management and record keeping of controlled drugs, but there were still some areas which were not compliant with the trust's own procedures. After the inspection we were provided with action plans for each ward area so they would become compliant but not all these action plans carried a clear timescale for the action to be completed. We were not therefore assured that procedures for the management of controlled drugs would be effective and protect people from the risk of unsafe use of these medicines.

The provider was not compliant with this standard.
**Staffing**  
**Action needed**

**There should be enough members of staff to keep people safe and meet their health and welfare needs**

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**Our judgement**

The provider was not meeting this standard.

In the past three years, the Care Quality Commission has continued to raise its concerns about the quality of care provided by this trust. Improvements have not been sustained. We are aware that the trust has recently been placed in special measures by The NHS Trust Development Authority due to the poor quality of care that has been identified.

After careful consideration, we have concluded that further enforcement action regarding breaches of regulations 9 and 10 and 22 would not lead to further improvement and may instead have a significant impact on the local health and social care economy. In the circumstances it would not be appropriate to take further enforcement action.

The trust has already developed an action plan in response to the Sir Bruce Keogh’s rapid responsive review and this will be monitored by NHS England. The NHS TDA will have the responsibility to support the trust to improve and to take the necessary action to ensure that the issues raised in the Keogh Review are addressed.

In response to the findings in this report, we will also require the trust to show us how it will become safe, effective, caring, responsive and well lead. We will continue to closely monitor the trust, inspecting as required and working with NHS England to review progress.

We have judged that this has a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete.

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**Reasons for our judgement**

The Bruce Keogh Rapid Response Review team contacted the Care Quality Commission with serious concerns about staffing levels in the hospital, particularly out of hours and at weekends following an unannounced inspection. We had previously inspected the hospital in December 2012 and found a breach of Regulation 22 (this regulation deals with sufficient numbers of suitably skilled and qualified staff) resulting in a compliance action.

We undertook an unannounced inspection on a Friday night and also two further unannounced inspections the following week. To assess compliance with this outcome we were assisted by a practicing professional experienced with NHS workforce planning and Trust Board Governance. We spoke with a range of clinical and support staff including senior managers and directors in the trust. In addition we had a meeting with the staff side unions and contacted the Occupational Health Department. We spoke with staff from the
Hospital Chaplaincy Team. We also spoke with patients, their families and representatives.

We visited the operations centre where staffing levels were reviewed three times a day. We saw matrons and site managers were juggling the needs of one ward against the needs of another. We saw cover was generally found when staff shortages could be predicted, for instance if they had sufficient notice a member of staff was off sick. In the first instance the ward's own staff were asked if they could cover by doing longer shifts or overtime. When this was not possible they looked to see who could be moved from one ward to another. If a shift could still not be covered, bank (a pool of people employed by the trust) or agencies were approached. We found that although matrons and site managers worked hard to plan for and cover staffing short falls in advance not all staff shortages were covered. We found all staff spoken with whether medical, nursing or support agreed there were staff shortages. Staff said there were many staff vacancies and high levels of sickness. Staff reported low staffing levels meant they could not care for their patients as they would wish to do and this caused them considerable stress. When we looked at referrals to the Occupational Health Department we found the main reported reason for sickness was work related stress at 22.86%. Of this group the highest number reported off sick was nursing staff, with 47.86%. Of this 23.88% of referrals were due to depression and 19.4% were referred for stress and work related stress. One nurse told us, "You just walk through the door, you feel you have failed. So much work."

We were told more staff, at all levels, were increasingly accessing departments such as chaplaincy and their Trade Unions to discuss work related concerns, including staffing levels. The staff side representatives reported to us that staff were stressed, there was a lack of engagement with the senior management team and staff did not receive feedback from incident reports (known as IR1). Staff raised concerns that low numbers of staff including housekeeping were reported which could cause problems with cleanliness and infection. The staff said representatives linked this to a recent infection outbreak on one ward which had to be closed for deep cleaning. They also felt staff were stressed that investigations into staff conduct were taking too long. Staff representatives told us the maternity unit had improved but was still not there yet with staff levels. Sickness in the unit was causing a lot of stress with co-ordinators. At night two qualified staff can have 40 patients to oversee and the added burden of patients' partners to liaise with. Community midwives can be pulled into help but there is a time delay and they can only do four hours, including travelling time, as they come from all over the County. On a positive note, they said the staffing levels in the stroke unit had improved considerably.

It was acknowledged there had been improvements in staffing levels and recruitment had and was continuing to take place to address the problem. All staff spoken with said they were able to request staff cover and they reported staff shortages on the incident/event reporting form known as an IR1. We found a high level of reporting for staff shortages. When we asked the trust management about this, they reported that staff had been encouraged to report shortages as an incident/event. We were informed the incident reports had been reviewed and the number of reports did not equate to harm being done to patients. However, they were continuing to follow up on some of the reports. One staff member told us they were, "Frustrated in sending IRIs' as I have been part of this Trust for a long time and staffing problems never go away."

Many staff reported they were working longer hours, going off duty late and undertaking overtime by doing extra shifts. Trade Union representatives also raised the same problems when they fed back what staff reported to them. During our visit to one ward area no cover could be found for short notice sickness on a shift. The ward manager was pulled from her
normal duties to help with patient care. One nurse told us, "A good shift is where I have all my own staff and I am able to supervise and support as well as undertake my paperwork." On a positive note for doctor cover a member of the medical staff told us, "The doctor who does the organising of duties gets cover whenever it is needed." Another staff member told us, "We have had an overhaul of staffing and we now work up to the template as a minimum." The template is a scale used to determine how many staff are required each day, in each unit.

We were told because staff were rushing all the time sometimes they could not give total care to patients. This included patients not being given enough time when needing a toilet, giving regular fluids and pressure area care. Nursing and medical staff felt it was impossible to always keep up with paperwork and also support the needs of the patients. This had the risk of plans of care not always being up to date and putting patients at risk of their current needs not being assessed and being met.

We were told how difficult it was when staff cover included bank or agency staff who did not have necessary and in some cases extended skills. Extended skills are where staff have been trained in particular aspects of patient care. A staff member told us, "Bank and agency staff can do very little. No IVs, BMs or documentation. There are lots of them. every shift we have at least one."

Registered nurses told us how they had additional stress as they had to undertake the extended skills newly registered nurses and agency nurses could not do (skills gained following training to perform specific procedures). These were used for diagnostic purposes to aid patient care. Newly registered nurses were on a programme known as `preceptorship' for the first six months. This meant they were unable to perform the extended skills aspects of their role until trained. In addition, they would need supervising for six months whilst they became experienced.

It was reported that agency staff were frequently used for one to one supervision of patients and this was helpful. However, extra staff were not always provided for one to one supervision, even though each patient had been risk assessed and agreed by the matron or ward manager. This meant patients were at risk of not having the close monitoring to meet their needs and staff had the additional anxiety of ensuring the patient's safety without additional support.

There had been some improvement in the recruitment of medical staff recently with increases in the numbers of consultants. However, medical staff also reported problems due to shortages of doctors. One doctor said, "Locums do their best but they don't know the running of the hospital, so it is often quicker and safer to do jobs yourself." Another doctor said, "I wish more nurses had extended skills, but it is patchy. Those that can do an excellent job and help us obtain a quicker diagnosis for a patient."

Recruitment of specialist medical and nursing staff was a particular challenge especially for areas such as accident and emergency and neonatal. Neonatal refers to babies with their first month of life. The Board was advised the majority of ear, nose and throat (ENT) workforce was older than 55 years and there was an urgent need for succession planning (Private Trust Board 07 May 2013). The Lincolnshire local Healthwatch informed us the general public had reported concerns over the lack of paediatricians in Lincolnshire and that it was hard to get a referral. (A paediatrician is a doctor who specialises in the care of children)

We had previously been informed of in-depth reviews of the nursing workforce across
medical and surgical wards which took place in November 2012 and again in May 2013. A recruitment plan had been developed to ensure staff vacancies were recruited to, with some success but the trust was still finding it difficult to recruit. The trust was working with local universities to advertise posts for nursing staff about to qualify, for example there had been a recent drive to engage third year students who qualify this summer. We were told that 60 students had expressed an interest. The trust was also advertising internationally. We were informed regular interview dates had been arranged.

We were aware a paper with the outcomes to the nursing reviews went before the Trust Board in May 2012. It was agreed for £3 million to be invested in additional nursing across the trust in 2013-2014 with a further investment in 2014/15. This was later increased to £7 million over the next two years.

Since the Bruce Keogh Rapid Response Review team identified concerns over staffing levels and escalated these to the Care Quality Commission we have been informed of a number of actions taken by the trust to address staffing shortfalls. These included increasing staffing levels at night, senior executive review of staffing on a daily basis, an extra bank support worker and qualified nurse to cover for last minute sickness and one to one supervision of patients. Additional senior nurses have been made available to support the site manager. We had also been informed that if shortfalls persist then a risk assessment will be undertaken to decide whether to close beds. We were told during the information gathering stage of this inspection, 26 beds had been closed as an interim measure.

The provider was not compliant with this standard.
Supporting workers

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

Our judgement

The provider was not meeting this standard.

Patients were not protected from risk of unsafe or inappropriate treatment as not all staff were completing mandatory training or receiving appraisals.

We have judged that this has a major 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 inspected this outcome as staff were reporting a mixed picture about access to training. We were particularly concerned about the levels of attendance at mandatory training and the completion of appraisals. Training was provided through e-learning (computer generated) and face to face courses. Some staff reported they had completed their mandatory training and had in addition taken other courses to support their work. At trust level, five members of staff and teams had been nominated for an NHS Heroes award, which is given to teams or individuals who it was felt went the extra mile to improve lives for patients in the NHS.

The hospital had recently been visited by the quality management team from Health Education East Midlands, who were very positive about the improvements in postgraduate training. The quality team found considerable progress in leadership and governance, and they confirmed the trust now had a comprehensive training and education strategy. There was a champion on the executive senior management board, with a structured management system in place to support the medical director. The trainee doctors had given highly positive feedback on their experience of training and support at the hospital. It was reported that postgraduate students were gaining excellent opportunities for direct patient treatment experience. It was also reported that the Local Education and Training Board (LETB) were managing low level risks through a programme of visits with no high level risks reported. It was reported trainee doctors were working alongside the Matrons in different units such as accident and emergency and the orthopaedic units to ensure they received a wide breath of experience.

However, some staff told us how they could have their training cancelled at short notice should they be needed to cover for staff shortages. Clinical educators were often asked to work on wards rather than in their education roles to cover staff. It was reported staff were experiencing considerable amounts of stress due to staff shortages and were working longer shifts, some went without breaks and many were doing overtime. This was impacting on other areas of their working life, including access to training and appraisals. We looked at the staff survey which reported from a 46% response rate there were four
areas concerning staff; these were communication, staff engagement, staff wellbeing and appraisals.

When we asked for information on compliance with mandatory training, it was reported that historically training figures for this were not collected together but this was under review. We found not all staff had completed their mandatory training and this had been discussed at various trust committees and brought to the attention of the Trust Board. At the Private Trust Board meeting (07 May 2013) it was reported the trust had achieved only 56% completion of an annual mandatory training programme against a target of 85%. It was reported there were, "Fundamental issues with training generally."

We were particularly concerned about the low levels of attendance at safeguarding adult and children's training courses. A Board Safeguarding Position Paper (25 April 2013) reported the current position for safeguarding training was 75% across domains and this presented a significant risk to the organisation. The paper stated, "The shortfall relates to an initial lack of uptake, or when places had been booked and allocated, failure to attend." It also reported there was significant risk as the trust did not have sufficient capacity to undertake more than two Individual Management Reviews concurrently when dealing with serious case reviews. It was reported that the percentage of compliance for safeguarding children level one was 36%, level two 21%. For compliance with adult safeguarding training this stood at 30% for level one, 16% for level two with only 14% compliance with Mental Capacity Act 2005 training for each domain. Adult safeguarding training completion for FY1 doctors (foundation year one) stood at 48%, FY2 (foundation year two) stood at 65%. We were informed that lectures on safeguarding children would be included in the induction programme for trainees in August 2013.

Mandatory training completion had shortfalls areas such as infection, prevention and control. At the Quality and Safety Committee 13 December 2013 it had been identified the trust was off trajectory for compliance with meeting the Clostridium difficile target. A key area for improvement had been identified as hand hygiene with only 50% of staff having taken mandatory training, 22% of doctors and 66% of nurses. An action group was established with an action plan to improve the situation. At the Private Trust Board meeting 04 June 2013, it was reported there had been an increase in cases of Clostridium difficile across the trust. A root cause analysis of each case had been undertaken. One of the recurring themes was hand hygiene.

We had identified concerns around the awareness and application of the resuscitation policy. We found staff were made aware of the policy through basic life support training at induction. Resuscitation training for new starters took place every two weeks, medical staff received a briefing. We were told by staff there was no provision for basic life support training for healthcare support workers on induction, only an e-learning package. This was highlighted as a risk at the Quality and Safety Committee meeting 17 May 2013. It was not clear what the levels of training were for some staff groups. We were told training for consultants working in intensive care units was not always recorded.

Some staff reported they had had an appraisal or had one planned. However, some staff had not received an appraisal this year. When we looked at the trust's performance information on appraisals we found it had been reported at the Private Trust Board meeting 07 May 2013 that it was committed to investing in the right number of staff to support the levels the Trust operated as an organisation. Increased appraisal rates was one of the conditional key performance indicators' to be looked at to test whether the staffing levels were working.
From speaking with staff and observing performance information we found although there had been awareness of issues over attendance at training and a lack of appraisal activity; insufficient action had been taken by the trust to drive improvements. We found actions to mitigate risk of poor uptake of mandatory training had no time scales. There was a risk to patients if staff caring for them were not up to date with the necessary knowledge and skills to perform their roles. The trust would not be in a position to judge the individual performance of staff and need for training, support or further development without an effective appraisal system.

The provider was not meeting this standard.
Assessing and monitoring the quality of service provision

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 not meeting this standard.

In the past three years, the Care Quality Commission has continued to raise its concerns about the quality of care provided by this trust. Improvements have not been sustained. We are aware that the trust has recently been placed in special measures by The NHS Trust Development Authority due to the poor quality of care that has been identified.

After careful consideration, we have concluded that further enforcement action regarding breaches of regulations 9 and 10 and 22 would not lead to further improvement and may instead have a significant impact on the local health and social care economy. In the circumstances it would not be appropriate to take further enforcement action.

The trust has already developed an action plan in response to the Sir Bruce Keogh’s rapid responsive review and this will be monitored by NHS England. The NHS TDA will have the responsibility to support the trust to improve and to take the necessary action to ensure that the issues raised in the Keogh Review are addressed.

In response to the findings in this report, we will also require the trust to show us how it will become safe, effective, caring, responsive and well lead. We will continue to closely monitor the trust, inspecting as required and working with NHS England to review progress.

We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

We looked at this outcome to understand how the Trust Board (the Board) and management team monitored the care and welfare of people who use services at the hospital and how effective their governance systems were at identifying and addressing any risks and shortfalls. We looked at the governance framework to see whether this provided assurance to the Board. We also looked at what this meant at the ward and department level from the staff and patient perspective. We were assisted by a professional with board governance experience.

We particularly concentrated on how the Board assured itself about staffing levels, the care and welfare of patients and training. We considered whether the Board committees provided assurance to the Board that any risks to the delivery of the trust's strategic
objectives were appropriately managed.

To assess whether there was an effective system of internal control in relation to the management of risk at Board and sub Board level we spoke with a range of staff across the hospital. We also looked at key documentation to gain a picture of the governance arrangements in place including the Board Committee Structure, the Board Assurance Framework and the Corporate Risk Register. We also looked at a range of minutes from various meetings including the Trust Board (private and public) meetings, the Quality and Safety Committee meetings; the Governance Committee meetings and a range of ward meetings.

When we visited in December 2012 we found the assurance framework and monitoring processes were becoming embedded in the ward and department areas. New initiatives had been introduced following from the recommendations of the Care Quality Commission’s NHS Section 48 Investigation in 2011 (an assessment across the trust and its interaction with the Strategic Health Authority and the Primary Care Trust). New systems were in place to improve on incident reporting, complaint management and the recruitment of staff.

At this inspection, we were informed following an external review and internal self-assessments, the quality governance framework had recently been revised and agreed following a Trust Board development session on 22 May 2013. We saw this had robust systems in place to assess and monitor quality and safety with monthly reporting to the Board of risks and emerging risks that may compromise the achievement of the trust’s strategic objectives. However, this system was not yet fully in place and from speaking to staff and examining performance data as well as incident/event reports we had concerns that the present systems in operation were not effective. We found risk and poor practice was being identified but actions taken to address these were not always sufficient or timely.

General performance and clinical practice issues were dealt with at a range of Committees which then reported to the Quality and Safety Committee, then through the Governance Committee to the Trust Board. We found reference to outstanding risks discussed at various committees but it was not clear what action was taken to address issues identified or timescales for actions. It is acknowledged that the Howvre are action logs for each committee meeting with timescales for actions. However, we found that some issues such as safeguarding and mandatory training were raised at committee meetings over a period of months, yet no remedial action was evident to address the concerns.

We were particularly concerned about the fitness of the Operational Risk Register (dated July 2013). We found there were 719 risks identified in total, 388 had been on the risk register for over six months, with 217 rated as red risks (highest risk, with green as lowest). We found that 265 risks did not have a risk rating (red, amber or green) and 509 risks did not have any action summaries, 163 of these were red rated. Many risks had missed their review date, some by six months or more. A high proportion had blank or incorrectly completed entries. This meant that the Board could not be assured that once a risk had been identified that the appropriate actions were taken in a time appropriate manner and that problems with addressing any risks would be appropriately alerted to the Board.

At ward level the trust had adopted a quality and safety monitoring process, known as the Quality Safety Dashboard (QSD). This audits and measures a range of indicators, such as the commencement of repositioning charts and the weekly updating of falls risk
assessments. This was also risk rated, red, amber and green. Information on how the ward or department was performing was displayed on most wards and accessible to patients and the public.

On the whole staff were able to tell us about their ward's dashboard performance and that this was discussed at ward meetings. We saw from a range of ward minutes that performance with the QSD was discussed. We found by looking at the QSD data for three wards over 20 months, generally there had been a steady improvement.

The minutes of the Private Trust Board meeting dated 04 June 2013 recorded that, "Evidence from the introduction of the nursing safety and quality dashboard stimulated an improvement in core process reliability from an average of 50% to 80%." However, of the three wards we looked at we found on one ward it had been in red and amber for 12 months and of those 12 months three months had been in red against the section entitled nutrition. However the indicator stated nutrition was a section which had to be completed on admission. On another ward four sections had been in red or amber for 20 months, two of those being red for two months, covering areas of pressure area care and bed rail assessment. On a third ward six areas had been red or amber for 20 months and three had been red for either 19 or 20 months. Areas covered included falls assessments (which the indicator stated should be completed weekly), bed rails assessment and pressure area care risk assessment (again which the indicator stated should be completed weekly).

Staff told us the indicators were not all relevant to their ward's work and some of the data was not always correct. We found performance data did not always capture important aspects of clinical activity. There was no evidence to demonstrate the Board was aware of the inconsistencies in applying the 'do not attempt resuscitation' policy or the poor quality of some associated records. We did not see any evidence to show the Trust Board was aware that some patients were not being assessed in accordance with the Mental Capacity Act 2005.

When we asked the trust about the QSD results we were informed they had taken a range of actions in response including additional training, involved nursing staff in root cause analysis investigations (a deeper look to find out what was the cause of the incident), added issues to specific committee agendas and commenced daily reviews of patient documentation. We were informed some of the issues raised in the data were a recording problem, for which teaching was provided. We were also informed that some deterioration particularly on one ward was due to vacancies, sickness and increased usage of bank and agency staff. Actions taken were positive to support staff, but did not explain why ward performance for certain care practices remained red or amber rated for so many months without improvement therefore putting patients at risk.

We found a confusing picture when we looked at how staff reported concerns such as staff shortages. Communication between different levels of staff was reported as inconsistent. Incident reports were completed by any staff member; it was done on an electronic form known as an IR1. It was not clear how all reports were closed or how lessons were learnt from them. Many staff had no confidence in the reporting system. We were told by staff including medical, nursing and support workers that there was no or little feedback on IR1 reporting, unless it led to a complaint, or a serious incident. This view was not shared by the trust management team, matrons and some medical staff. One consultant reported there was good communication between consultants and the Board. We were informed that IR1 forms were discussed at ward meetings and each matron and ward manager would share the information in different ways, including by email and through printed copies on wards and units.
However, staff felt matrons and some ward managers received feedback and doctors thought consultants may get this, but other staff below these levels stated they did not receive feedback. One doctor said, "I've completed IRIs' but never get any feedback, so what is the point."

When the Quality and Safety Committee looked at the committee's terms of reference, which included governance it noted that clinical director representatives had never attended the meeting. More clinical representation was required. (Quality and Safety Committee 13 December 2012).

A lack of engagement with clinical staff did not promote an environment where lessons learnt were always shared effectively. The trust management team told us they were aware of issues with engaging with clinicians and they were taking steps to engage better with clinical staff for example through the new `Listening Events' had already taken place and would continue. A new medical director was due to start shortly and it was anticipated this would have a positive impact on relationships going forward. The trust was also developing a medical safety and quality dashboard, which would give more detail on what is working well and what needs improving. An action plan had been agreed at the mortality reduction committee. It was anticipated this would produce improved performance data and allow for better engagement with clinical staff.

We found that uptake on mandatory training was poor with only a 56% completion against a target of 85%. We were particularly concerned that safeguarding issues may not be identified and action taken due to the low attendance at safeguarding training putting patients at risk. We were also concerned the low numbers of staff completing Mental Capacity Act 2005 training meant a reliance on referrals to specific personnel and to another trust which could lead to unnecessary delays. Achievement against a target of 95% for staff appraisal was only 39%. It is acknowledged that there had been improvements in the numbers of medical staff being appraised. However, with poor uptake of mandatory training combined with a lack of appraisal, it would be difficult for the Board to be assured that the staff workforce where performing effectively.

The provider was not compliant with this standard.
Records

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

Patients were not always protected from the risks of unsafe or inappropriate treatment and care because accurate and appropriate records were not maintained. Patients' personal confidential information was not always safeguarded.

We have judged that this has a major 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 looked at a range of patient records on the wards and units we visited. We found the quality of recording was variable across all areas. We found that not all records were kept up to date with the changing needs of the patient and their treatments. We also found examples of when patient confidentiality was potentially put at risk.

Of the 16 'do not attempt cardio pulmonary resuscitation' (DNACPR) orders across three wards we found there were inconsistencies in the quality of recording. We expected to see DNACPR order forms, which has a tick box structure to be completed recording whether the patient, their family or representative such as Lasting Power of Attorney had been involved and if not why. With each DNACPR order, we checked the corresponding medical records to see if there was a record of any discussions and with whom. We found that not all forms were correctly completed, with some sections omitted. We found there were not corresponding records in the medical notes detailing the conversations about decisions when the DNACPR order indicated that the patient, their family or representative had been involved or the reason for the decision.

Some records were confusing, for example we found one DNACPR order with both the box ticked indicating the decision was not discussed with the patient as this would cause distress, and the box ticked to indicate they had been part of the decision. There was no corresponding record in the medical notes to explain or identify which was correct. This meant patients could be at risk of receiving inappropriate treatment, or there could be a delay in urgent treatment.

We checked on hourly observation charts at each bed to see if patients were being monitored according to their care plan. We checked on four wards and found on one ward out of eight days hourly observation charts, there were gaps in recording. This meant it would be difficult to establish whether a patient had received the necessary care planned for or identify if their needs were changing. Staff reported they were giving the necessary care but had not had time to update the records. This meant patients were exposed to the
risk of receiving unsafe or inappropriate care and treatment due to the lack of proper information about them.

We examined a number of care plans and found all had the patients' identity written on them. However, we found important information was missing, for example a patient with a diagnosis of dementia had no forms completed to assess their mental capacity since admission. Another care plan stated a patient required a risk assessment for tissue (skin) viability. This was called a Waterlow score. Other parts of the care plan stated a pressure relieving mattress was in place and bedrails, yet, the section on the Waterlow score stating equipment used was blank.

Without appropriate information in records, it would be difficult to ensure continuity of care, particularly monitoring whether a condition was improving or deteriorating. We found care being given but no documentation to support the care, for example we found a patient on a high dose of pain relief but no care plan in place on how to support and care for the patient with this.

We found some poor practice over safeguarding patient confidential information. On seven wards we visited patient information was on desks where other patients and visitors could clearly see notes and other information. The desk surrounds made it easy for people to look over the top and read information. We observed doctors walking away from open sets of notes and not closing the front cover over. On one ward we observed a nurse shouting the name of a patient and what they required for their meal. As soon as this was observed by the ward manager the issue was dealt with. However we did observe a handover between nursing staff, which took place at the end of each bay of patients to be quiet and when visitors or other patients were near by the nurses stopped talking.

The provider was not compliant with this standard.
### 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>
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<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td><strong>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010</strong></td>
</tr>
<tr>
<td></td>
<td>Respecting and involving people who use services</td>
</tr>
<tr>
<td></td>
<td><strong>How the regulation was not being met:</strong></td>
</tr>
<tr>
<td></td>
<td>Patients did not always have their dignity and independence respected. Patients were not always enabled to make, or participate in making decisions relating to their care or treatment. Patients were not always assessed in accordance with the Mental Capacity Act 2005 when appropriate to their needs.</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td><strong>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</strong></td>
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<tr>
<td></td>
<td>Management of medicines</td>
</tr>
<tr>
<td></td>
<td><strong>How the regulation was not being met:</strong></td>
</tr>
<tr>
<td></td>
<td>People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the management of medicines.</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td><strong>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010</strong></td>
</tr>
<tr>
<td></td>
<td>Supporting workers</td>
</tr>
<tr>
<td></td>
<td><strong>How the regulation was not being met:</strong></td>
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</tbody>
</table>
Patients were not protected from risk of unsafe or inappropriate treatment as not all staff were completing mandatory training or receiving appraisals.

<table>
<thead>
<tr>
<th>Regulated activity</th>
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<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010</td>
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</table>

**How the regulation was not being met:**

Patients were not always protected from the risks of unsafe or inappropriate treatment and care because accurate and appropriate records were not maintained. Patients' personal confidential information was not always safeguarded.

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 02 October 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 other services less often. 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.

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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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:

- Respecting and involving people who use services - Outcome 1 (Regulation 17)
- Consent to care and treatment - Outcome 2 (Regulation 18)
- Care and welfare of people who use services - Outcome 4 (Regulation 9)
- Meeting Nutritional Needs - Outcome 5 (Regulation 14)
- Cooperating with other providers - Outcome 6 (Regulation 24)
- Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
- Cleanliness and infection control - Outcome 8 (Regulation 12)
- Management of medicines - Outcome 9 (Regulation 13)
- Safety and suitability of premises - Outcome 10 (Regulation 15)
- Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
- Requirements relating to workers - Outcome 12 (Regulation 21)
- Staffing - Outcome 13 (Regulation 22)
- Supporting Staff - Outcome 14 (Regulation 23)
- Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
- Complaints - Outcome 17 (Regulation 19)
- Records - Outcome 21 (Regulation 20)

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.
Glossary of terms we use in this report (continued)

(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.