Care Quality Commission

Inspection Report

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

Mental Health Unit, Lincoln County Hospital Site

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

Care and welfare of people who use services	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Lincolnshire Partnership NHS Foundation Trust
Overview of the service	This location consists of two in-patient units called Peter Hodgkinson Centre and Francis Willis Unit. It provides services to patients who experience mental health, learning disability, and substance misuse, some of whom may be detained under the Mental Health Act, 1983.
Type of service	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Regulated activities	Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury

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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 carried out a visit on 3 June 2013, observed how people were being cared for, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with staff.

What people told us and what we found

The Peter Hodgkinson Centre provided acute admission services and had one male and one female ward. Patients who were admitted were either detained under the Mental Health Act, 1983 or in agreement with their admission on an informal basis.

The Francis Willis Unit provided low secure forensic services for patients who were all detained under the Mental Health Act (MHA), 1983. The services were provided to male patients only.

We used a number of different ways to help us understand what patients experienced. This was because some patients had complex needs which meant they were not able to tell us about their experiences. We looked at records, including patient's care files. We spoke to a number of patients in both units, the managers and staff who were supporting them and we observed how support was provided.

Patients told us they were generally satisfied and involved with the care, treatment and support they received. They said there were plenty of activities to do but in one unit there was limited access to outside space. Managers within the centre informed us they had taken steps to address this.

We found there were some issues with staffing levels in one unit. However, unit managers informed us they had taken steps to address this.

We saw each unit was using the provider's systems to regularly assess and monitor the quality of service that patients received. Patients told us they were encouraged to express their views and they felt they were listened to.

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

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

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We spoke with a number of patients in both units. They made comments about the caring nature of nursing staff and leadership within both units.

They told us things like, "Overall it's the best hospital I've been in", "Since the new manager has been here it feels like things are running better", "The nurses are fantastic, they cater for needs" and "Majority of staff will be involved with you as much as you like, they are pretty good. There is no rush here."

Patients in Francis Will Unit told us since the new manager started work they had better quality food and more access to services such as psychology.

All of the patients we spoke with told us they were aware of their rights and had access to advocacy services. One patient told us, "I have been given paperwork, I've not read it but I have the information."

Patients also told us they were involved in planning their care and treatment and we saw they had signed their care plans where they were able to. When we asked one patient about being involved in their care and treatment they said, "Oh yes, and if you need to have a chat they [nursing staff] are always there."

Patient's personal records were held in paper files and computer files.The records we looked at contained clear contact information for people like GPs and family members. They also recorded the patient's wishes about sharing information with other people.

Care plans were in place for identified needs such as emotional support and medication. There was a system in place to show where there had been any variation from the patient's care pathway and why the variation had occurred. We saw care plans were updated regularly by patients and staff. Up to date risk assessments were also in place for issues such as moving and handling and nutrition to ensure the patient's individual safety.

There was reference in care plans to providing choice and maintaining privacy and independence for the patient. For example, one care plan for cookery sessions showed the patient should choose their own meal and collect the ingredients they wanted.

We saw patients in Peter Hodgkinson Centre had access to a telephone which they could use in private. One patient in Francis Willis Unit told us, "Because the phone is on the ward everyone can hear what you are saying." This telephone was located in a hallway near to the lounge area. We saw a patient using the telephone during our visit was disturbed by other patients and staff walking past to access other areas of the unit. The provider should consider other ways to enable patients to have privacy when making phone calls.

Care plans referred to "least restrictive practice" to ensure patients who were detained under the Mental Health Act (MHA), 1983 had as much freedom of movement as they were allowed. A patient in Francis Willis Unit told us, "There are no restrictions on the ward…." In Peter Hodgkinson Centre the main ward doors were locked. We saw signs on the doors explaining that although there was an open door policy current risk levels meant the doors needed to be locked and these arrangements were reviewed daily. The signs also told informal patients and visitors how they could get in and out of the wards when they wished.

Daily notes about patient's progress were clear and detailed. They showed what activities they had joined in with, their progress with treatment plans and if there were any physical health issues. For example, one patient's daily notes showed when they had been unwell, what treatment they had received and how they had been supported with infection control issues.

A patient in Francis Willis Unit described their care plan for discharge. They told us staff had recognised the issues they had with certain locations and they [staff] were supporting them to move to a new location. For example, the patient described pre-admission visits to their new home. Records we saw supported this information. A patient in Peter Hodgkinson Centre told us staff had directed them to the right agency to deal with their housing needs.

Peter Hodgkinson Centre had a nurse dedicated to discharge planning and support. We saw an audit of discharge planning carried out in December 2012. The audit showed that in the majority of cases patients were actively involved in their discharge planning.

We saw up to date records of special leave arrangements for patients who were detained under the MHA, 1983 and consent forms regarding the administration of medication.

Patients in Francis Willis Unit told us they received their special leave as arranged and we saw patients being taken out to access community facilities as part of their leave arrangements. They said there were plenty of activities to join in with. One patient said, "We do groups and stuff like arts and crafts. We have a Play Station and a Wii and TV. They do encourage people to take part. We requested Bingo and we've had a bingo game. People listen to views." Records confirmed what we were told.

Patients in Peter Hodgkinson Centre who were detained under the MHA, 1983 told us access to outside space and fresh air was limited. Wards were located on the first floor of the centre and some patients needed staff to escort them whilst off the ward. Patients reported some special leave was cancelled due to a lack of staff to support those who

needed escorts. They also said they had to wait a long time to be escorted to the outside areas to smoke.

We spoke to the unit manager about these issues. They told us one ward in the centre was due to be relocated to the ground floor so as to provide patients with access to a secure garden area. The unit manager acknowledged there had been shortages of staff numbers recently and that plans were in place to manage this. They said these plans would ensure there were enough staff to provide patients on the other ward with more access to outside space and meet their special leave arrangements.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Overall there were enough qualified, skilled and experienced staff to meet patient needs. There were on occasion times when this was not the case. However, the provider had taken appropriate steps to address the shortfalls.

Reasons for our judgement

We looked at staff rotas in both units. We saw there were a mixture of qualified nurses and healthcare assistants allocated to each unit. We saw the mix of staff was dependent on the needs of the patients in each unit.

Francis Willis Unit rotas showed they had been fully staffed in the two weeks before our visit. Staff told us they can access staff from the trust wide bank nurse system if they needed extra cover, for example if a patient needed increased observations. The bank nurse system provides contact numbers for staff who are willing to work to help cover staff shortages. Patients and staff told us there were enough staff on duty to meet patient needs.

We saw two senior nurses had allocated management days so they could complete things like audits and staff supervisions. Other staff were allocated each day to specific roles such as named nurse in charge, named nurse for medication administration and named nurse for security. We saw patients and staff were also supported by a team of other healthcare professionals such as a social worker, occupational therapists, medical staff and housekeepers.

In Peter Hodgkinson Centre we looked at the previous two months rotas. We found the rotas difficult to understand due to the amount of crossing out and amendments. For example, we saw four days where one ward was short of healthcare assistant cover. Due to the amendments we could not see how, or if, the shifts had been covered. The provider may wish to note if rotas are not clear and legible they would not be able to effectively monitor how shifts were being covered.

The manager from one ward in Peter Hodgkinson Centre told us there had been one shift in the previous month where they could not fully staff the ward from their rota. They said another service within the trust had provided staff cover to support them. The manager told us they were able to respond to patients needs and alter staffing levels accordingly. For example, they told us they had a lot of patients requiring specific observations last month and they had increased the night staff from three to five nurses.

Staff on another ward in Peter Hodgkinson Centre told us it was often difficult to ensure they had enough staff on each shift and they had struggled in recent times to cover shifts from the bank nurse or agency systems. One staff member said, "It's a bit of a juggling act." Another staff member told us the bank nurse system was not always effective due to out of date staff contact information or bank staff not having enough experience of their type of care and treatment.

Staff said nurse agencies were often unable to provide staff at short notice. One staff member said, "They [managers] told us if the bank was exhausted we could go to an agency but the last time the agency couldn't help either."

We saw there were staff vacancies across Peter Hodgkinson Centre for healthcare assistants and one permanent psychiatrist. However patients and staff were also supported by other healthcare professionals such as a discharge nurse, a practice development nurse and occupational therapy staff.

Staff we spoke with in the centre acknowledged managers were taking action to address the issue of staffing levels. One staff member said, "Everything is in a bit of a flux and sometimes people struggle with that. I don't think it's for want of trying to fill the posts."

We spoke to senior nurses and managers within Peter Hodgkinson Centre. They told us about the work force plan which was now in place. We saw managers were in the process of recruiting to vacant posts and had already sent offers of employment to a number of applicants. We knew interviews were taking place to recruit into the vacant psychiatrist post. Three extra staff posts had also been created to provide responsive staff cover within the centre. Managers told us the trust had carried out a review of the bank nurse system and was making changes so that it was more responsive to need.

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 provider had an effective system to regularly assess and monitor the quality of service that patients receive and to identify, assess and manage risks to the health, safety and welfare of patients using the service.

Reasons for our judgement

Records showed the trust had a programme of quality assurance in place to monitor the effectiveness of the services it provides. Both of the units we visited were included in the programme of audits.

The assurance programme included audits of areas such as security, ligature points, controlled medications, physical health, Mental Health Act, 1983 documentation, cleanliness and health and safety. We saw examples of these audits and the actions plans which were in place to address any shortfalls identified.

We know that both units carried out an on-going trust wide programme called 'The Productive Ward'. This process regularly measured things like the frequency of individual patient meetings and therapeutic input.

In Francis Willis Unit we saw a notice board which contained information about progress with 'The Productive Ward' programme. The provider may wish to note the information we saw was dated 2011 and not relevant to the patients who currently lived in the unit. Therefore patients did not have access to up to date information and it did not demonstrate that work continued on the programme.

Patients we spoke with in both units told us they had regular meetings with staff in which they could express their views about subjects such as menus and activities. Records from both units confirmed this and showed where staff had responded to any issues. The records also showed patients were given information about things like quality assurance projects. In Peter Hodgkinson Centre we saw there was a notice on the wall asking patients if they had got anything they would like to say and who they could talk to.

We know from records the trust sent us current and previous patients are involved in hospital based and regional groups. For example, we saw how patients had been involved in a regional forum to discuss recovery pathways. We also saw they had been involved in developing their own standards for the use of the Care Programme Approach (CPA) within

the trust.

We spoke to a practice development nurse in Peter Hodgkinson Centre. They told us they were responsible for things like weekly clinical records audits. They said good practice and shortfalls were fed back to individual staff members and any issues were addressed through staff supervision.

In Peter Hodgkinson Centre we saw regular meetings had recently been introduced to monitor admission and discharge issues. This was to ensure the effective use of the beds available in the unit. For example, if a patient could not be safely discharged due to social care issues the unit social worker would address the issues.

Patients in both units told us they knew how to make a complaint and said generally staff listened and helped to resolve them. We saw the complaints policy was displayed in both units for patients and visitors to refer to.

The trust regularly monitored any complaints they received. We saw the monitoring reports for January and February 2013. The reports showed how individual complaints had been managed in line with the trust policy.

The same reports contained feedback from friends and family of patients. For example, comments were made about Peter Hodgkinson Centre such as, "Excellent support, kind caring staff" and "Housekeeping is excellent." Other comments were made about patients not liking dormitory style accommodation and the amount of noise on wards at night.

The trust regularly monitored incidents and accidents. Reporting of incidents and accidents, including episodes of physical restraint was completed through a computer based system. This meant the trust could monitor any trends across all of its locations and take action to reduce risks.

The trust sent us information about serious incidents in a timely manner. The information showed investigations were carried out and action plans were developed to address any shortfalls or risks identified.

About CQC inspections

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.

Glossary of terms we use in this report

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.

Contact us

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