Review of compliance

Lincolnshire Partnership NHS Foundation Trust Mental Health Unit, Lincoln County Hospital Site	
Region:	East Midlands
Location address:	Greetwell Road Lincoln Lincolnshire LN2 5QY
Type of service:	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Date of Publication:	August 2012
Overview of the service:	This location consists of two in-patient units called Peter Hodgkinson Centre, and Francis Willis Unit. It provides service to patients who experience mental health, learning disability, and substance misuse needs, some of whom may be detained under the Mental Health Act, 1983.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Mental Health Unit, Lincoln County Hospital Site was not meeting one or more essential standards. Action is needed.

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

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider and carried out a visit on 24 July 2012.

What people told us

We carried out this inspection over two separate days because each unit provided different care and treatment services.

The Peter Hodgkinson Centre provided acute admission services, and had one male and one female ward. Patients who were admitted to the unit 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, 1983. The services were provided to male patients only.

We reviewed all the information we hold about this provider and carried out visits on 24 and 31 July 2012. We reviewed information from other agencies, the provider's records, nationally held records and other people who wanted to share information about the service, for example relatives. Other agencies who gave us information included Monitor, and the Local Authority. Monitor is the independent body who authorise and regulate NHS foundation trusts.

We spoke to a number of patients in both units, and we used a range of different ways to help us understand the experiences of other patients who used the service. This was because some patients had complex needs which meant that they were not able to tell us about their experiences. We looked at records, including personal care plans. We spoke to the managers and staff who were supporting patients, and we observed how they provided that support.

What we found about the standards we reviewed and how well Mental Health Unit, Lincoln County Hospital Site was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

The provider was not fully meeting this standard.
Patients were supported to make choices and decisions about their lifestyles, and they were treated with dignity and respect. However, in Peter Hodgkinson Centre their privacy was compromised by the lack of appropriate patient telephone facilities.

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

The provider was meeting this standard.
In general patients received the care and support they wanted and needed, by way of clear assessment and care planning, and a knowledgeable staff team.

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

The provider was not meeting this standard.
The nutritional needs of patients may be compromised by the arrangements for the provision of meals.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The provider was meeting this standard.
Patients were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The provider was meeting this standard.
There were enough qualified, skilled and experienced staff to meet people's needs.

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

The provider was not fully meeting this standard.
The provider had a system to regularly assess and monitor the quality of service that people receive. However, at times, patients may be put at risk due to the lack of risk assessment and contingency planning for the times when there is a lack of acute admission beds.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has

been taken.

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

Other information

Please see previous reports for more information about previous reviews.

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

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

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

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

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that 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.

A moderate impact means that 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.

A major impact means that 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.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is non-compliant with Outcome 01: Respecting and involving people who use services. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke to a number of patients within both units. They told us that staff respected them and upheld their rights whether they were or were not detained under the Mental Health Act, 1983.

They said things like, "They (staff) tell me about my rights and I know I've got a care plan but I don't want to get involved", "They (staff) give you space when you need it and respect your privacy", "I do my own religion and staff respect that", "(I) feel listened to and respected by staff" and "They (staff) respect your views and are really on the ball."

We did not receive any negative comments from patients about this outcome area.

In both units we saw that staff spoke with patients in a respectful manner, using their preferred names and offering them choices for things like activities and meals. Staff made time to listen to patients who had issues to discuss and offered them private space for discussions. We saw staff supporting patients to make decisions about their care and daily lives, and to be involved in regular meetings with their doctors and other professionals.

Other evidence
We looked at a range of patient records across both units. In both units, staff had recorded when they had reminded patients of their rights. We saw that this was done on a regular basis, and in line with the requirements of the Mental Health Act, 1983.

In Francis Willis Unit paper records were still in use and we saw that patients had signed their care plans where they were able and wished to, to show that they had been involved.

In Peter Hodgkinson Centre we saw that records had been transferred to a secure, computerised system. Some information such as records to show patients had been informed of their rights, were still in a paper format. Care plans however, were all within the computerised system. Staff told us that patients were given a printed copy of the care plans. However there was no clear record to show that patients had been involved in the planning and development of those plans, or that they had received a copy.

In both units we saw records to show that patients who were detained under a section of the Mental Health Act, 1983 had signed consent to treatment forms.

The provider may find it useful to note that where computer records are being used, there should be a system in place to demonstrate the involvement of patients in their care planning.

We saw that staff respected privacy by, for example, knocking on doors before entering. Staff told us how they ensured patients privacy and dignity was respected, especially when the patient was receiving a high level of observation. For example, one staff member told us about how they risk assessed for privacy when a patient was bathing.

There was lots of information around in both units to help patients understand their rights and know where to get help. For example we saw there were leaflets about advocacy services, how to make a complaint, where to get support with housing issues, and how to contact independent mental health advocates. The manager of Peter Hodgkinson Centre told us that she had organised a regular group on the wards for patients to get help with housing issues.

We saw that the staff had taken appropriate action to try to engage with a patient whose first language was not English. Records showed that interpreting services had been used to enable the patient's views and decisions to be heard. Staff also told us how they used the internet to interpret some words when interpreter staff were not present, and how they used basic signs and pictures to convey information.

In Peter Hodgkinson Centre we saw that patients had use of public telephones. However the telephones were located near to the entrance to one ward, and in a busy corridor of another. There was no privacy screening on either telephone, and patients conversations could be clearly heard by anyone passing. Staff told us, and we saw, that they offered patients the use of the wards portable telephone when they wanted to make personal and private calls. However this had an impact on staff being able to make and receive calls in relation to the daily management of the unit. We had spoken to the provider about this issue when we last visited in December 2010, and they said then that they would take action to address the issue.

Our judgement
The provider was not fully meeting this standard.
Patients were supported to make choices and decisions about their lifestyles, and they were treated with dignity and respect. However, in Peter Hodgkinson Centre their privacy was compromised by the lack of appropriate patient telephone facilities.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We spoke to a number of patients within both units. They made comments such as "Everything is really good here", "Really good activity co-ordinator", "This lot here (staff) are great, those out there (community) don't communicate with me properly" and "I get involved with care planning with staff."

A patient in Francis Willis Unit told us that they were not getting an activity session that had been planned for them. The manager took immediate action to rectify this.

Other evidence
We looked at a range of patient records across both units. There were comprehensive admission assessments record, which covered needs such as moving and handling, culture, nutrition and discharge requirements. The records showed that the assessments were updated when needs changed.

Care plans were in place for things like medication, physical health, orientation to the units, managing finances and anxiety management. We saw that care plans had been regularly reviewed with patients in Francis Willis Unit. However a few plans in Peter Hodgkinson Centre needed to be reviewed. The manager told us that these plans were being reviewed with patients during our visit. A patient confirmed this had been done later in the day.

Care planning followed a standard format in both units, and core care plans were being used. However these had been personalised and were in line with assessment

information.

Where patients required extra services we saw that staff had made appropriate referrals. For example, we saw referral records to services such as housing, alcohol and drug support, and advocacy. There were also treatment and management plans in place from other professionals such as Occupational Therapists and Psychologists.

Daily records showed that patients were offered individual sessions with staff to discuss their progress. We knew that these sessions were usually provided on a daily basis. Audit outcomes showed that, for example on one ward in Peter Hodgkinson Centre they fulfilled the targets for these sessions 90% of the time.

Since we last visited the trust they had employed activity co-ordinators in both units. We saw general and personalised activity plans in both units, and saw patients taking part in activities in and outside of the units. For example, some patients were taking part in a golf experience and some went out on a countryside walk. Other patients were doing art and crafts activities. Patients activity preferences were recorded in their care files.

We saw staff providing care and treatment in line with patients care plans, for example offering anxiety management sessions. We also saw staff responding quickly to needs highlighted by patients, for example making referrals to opticians and chiropodists. In both units staff demonstrated a clear understanding of individual needs, and how to address them effectively.

Our judgement
The provider was meeting this standard.
In general patients received the care and support they wanted and needed, by way of clear assessment and care planning, and a knowledgeable staff team.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is non-compliant with Outcome 05: Meeting nutritional needs. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
In both units patients told us that they were not happy with the standards of catering. They made comments like "The food is abysmal, why can't we cook our own meals" "Food is rubbish and we've told them" and "The food's inedible sometimes so staff get us other things to eat, we can make our own sandwiches."

Staff in both units told us that some patients regularly refuse to eat the meals provided, and there is a lot of waste. Minutes of patient meetings showed that the issue had been raised.

Other evidence
We saw that a patient survey about meals had recently been carried out in Peter Hodgkinson Centre and the results were being analysed. We also saw how staff were supporting patients to have food that was to their liking, for example by taking orders for lunch to be delivered from the on site café, and providing foods within the unit to make sandwiches and light snacks. This issue was raised when we last visited the trust in December 2010 and the provider took action to change the catering contract.

Our judgement
The provider was not meeting this standard.
The nutritional needs of patients may be compromised by the arrangements for the provision of meals.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We spoke with a number of patients in both units. They made comments such as "(I) trust this lot, safer than home at the moment" and "I feel as safe as I can be with my problems."

We saw a patient satisfaction survey in Peter Hodgkinson Centre, which showed that 80% of patients felt safe within the unit.

Other evidence
We spoke to a number of staff in both units. They demonstrated that they knew what abuse was and how to report it in the right way. We know from our records that staff did this whenever they had concerns for patient safety. Staff also told us and records showed that they were given training about how to keep patients safe.

Records showed that staff underwent Criminal Record Bureau (CRB) checks before they started work in an unsupervised capacity. We saw that the trust were also completing checks for all staff who had been employed before 2003 as this had not been a standard practice before then.

Francis Willis Unit was a secure environment and we saw that they had complied with national guidance and requirements for this type of provision. For example, they had an air lock entrance system and secure fencing which enclosed the unit. We saw that some exit doors had recently been replaced following an incident in which they proved to be ineffective.

We spoke to staff on the unit about evacuation procedures in the event of a fire. They demonstrated a clear understanding of the procedure, including evacuation points.

Peter Hodgkinson Centre was an open unit however wards have a key pad entry system for use when required. We saw a situation whereby one ward door needed to be locked with the key pad system due the needs of a patient who was detained under the Mental Health Act, 1983. Notices where placed on both sides of the door telling other patients and visitors how to enter or exit the ward. The notice also showed what time the door had been secured and when the situation was to be reviewed. We also saw that staff had completed a risk assessment of the patients needs, including securing the ward door.

Our judgement
The provider was meeting this standard.
Patients were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We spoke with a number of patients in both units. They made comments such as "There's plenty of staff around", "I get my 1:1 when I want it" and "Staff are always available for me."

Other evidence
We looked at the staff working rotas on both units for the previous two weeks. They showed us that there were a mixture of qualified nurses and health care support workers on each shift. There was also an activity co-ordinator and some occupation therapy staff available during the day times, including weekends. Rotas showed that ward managers were available during office hours. However we saw that they worked shifts when there was a shortage of qualified staff.

Staff told us that the numbers of staff employed on each ward were sufficient to meet patient needs. They said that sickness levels were the only thing that impacted on staff numbers, but they had a 'bank' nurse system to use when they needed extra cover. They told us that they rarely had to use agency staff which meant that patients had access to experienced staff who knew them. Staff in both units said that they had not worked with insufficient staffing levels for a long time.

During a shift handover period in Peter Hodgkinson Centre we saw that whilst qualified nurses carried out the handover process and medication rounds, healthcare support workers and activity co-ordinators were supporting patients with general activities and individual support sessions. We saw that patients in Peter Hodgkinson Centre were

supported to leave the ward for cigarette breaks whenever they requested.

Throughout the visit staff demonstrated a clear understanding of patients needs. For example, we saw staff using different methods to reduce patients anxieties such as diversion or talking therapies, dependent upon their known needs. We also saw staff at shift handover discussing potential outcomes of specific actions for individual patients, based on knowledge of their needs. We were told that patients were now included in interviews for new staff in Peter Hodgkinson Centre, so that they were able to give their opinions on the quality of the staff being employed.

Staff in both units told us that they had a good induction to the units they worked in. They said that there was a good on-going training programme that kept them up to date with good practice.

Our judgement
The provider was meeting this standard.
There were enough qualified, skilled and experienced staff to meet people's needs.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is non-compliant with Outcome 16: Assessing and monitoring the quality of service provision. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke to a number of patients within both units about this outcome. They told us that staff listened to them and helped to sort out any problems they had. A patient satisfaction survey carried out in Peter Hodgkinson Centre showed that 80% of patients said that staff were willing to listen to their views.

In Peter Hodgkinson Centre one patient told us that they had made a complaint and said "I know they (staff) will sort it out." In Francis Willis Unit a patient said they had experienced problems with trying to make a complaint as not all staff were familiar with the procedure. They and the manager told us that the issue had been resolved and staff had been retrained about how to manage complaints.

Other evidence
We know from our records, and records that we saw in both units, that the trust had a quality assurance programme. The programme included regular audits of things like health and safety arrangements, ligature points, the environment, infection control and staff training.

We saw that both units carried out a trust wide programme called 'The Productive Ward' which regularly measures things like the frequency of individual patient meetings and therapeutic input. Outcomes of the productive ward programme were clearly displayed for patients and visitors to see. Records also showed that things like care plans, activity plans and risk assessments were audited on each unit.

Records showed that patients were encouraged to be involved in planning and improving services in both units. We saw minutes of in-patient meetings in which they discussed things like activities and catering. We also minutes of a service user involvement group which included in-patients and ex-patients. Issues discussed ranged from providing pet therapy, reviewing policies and developing a day ward booklet.

The productive ward surveys and minutes of patients meetings also highlighted the issue of the number of available beds for admission into Peter Hodgkinson Centre. During our visit one ward in the unit had 22 available beds and 29 in-patients listed, and another ward had 20 beds available and 22 in-patients listed. Staff told us that when they were fully occupied, any newly admitted patients were admitted into beds of patients that were on leave from the ward. They said that there was a particular pressure on male beds. We did not find any evidence of risk assessments or contingency arrangements in place to deal with these situations.

We saw one patient who had returned from leave during our visit, and their bed had been allocated to a newly admitted patient. This situation was resolved through other patients being discharged on the same day. However, staff told us that at times they needed to make risk assessments of patients who were on leave, with a view to extending their leave, so that they could accommodate more acutely ill patients.

Information was available to patients and visitors about how to make a complaint. Staff we spoke to described how they would deal with a complaint in the right way. During the visit we saw how staff in Peter Hodgkinson Centre responded calmly and appropriately to a patient who wanted to make a complaint.

Our records showed that the trust investigated any untoward incidents, and completed a report with recommendations for improvements. We saw minutes of staff meetings which showed that the reports and recommendations were used within the units to help staff learn lessons for the future.

Our judgement
The provider was not fully meeting this standard.
The provider had a system to regularly assess and monitor the quality of service that people receive. However, at times, patients may be put at risk due to the lack of risk assessment and contingency planning for the times when there is a lack of acute admission beds.

Action
we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: The provider was not fully meeting this standard. Patients were supported to make choices and decisions about their lifestyles, and they were treated with dignity and respect. However, in Peter Hodgkinson Centre their privacy was compromised by the lack of appropriate patient telephone facilities.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: The provider was not meeting this standard. The nutritional needs of patients may be compromised by the arrangements for the provision of meals.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The provider was not fully meeting this standard.	

	The provider had a system to regularly assess and monitor the quality of service that people receive. However, at times, patients may be put at risk due to the lack of risk assessment and contingency planning for the times when there is a lack of acute admission beds.	
Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The provider was not fully meeting this standard. The provider had a system to regularly assess and monitor the quality of service that people receive. However, at times, patients may be put at risk due to the lack of risk assessment and contingency planning for the times when there is a lack of acute admission beds.	
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The provider was not fully meeting this standard. The provider had a system to regularly assess and monitor the quality of service that people receive. However, at times, patients may be put at risk due to the lack of risk assessment and contingency planning for the times when there is a lack of acute admission beds.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

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

The provider's report should be sent to us within 28 days of the date that the final review of

compliance report is sent to them.

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

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

What is a review of compliance?

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

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

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

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

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

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
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