# Review of compliance

## United Lincolnshire Hospital NHS Trust
Lincoln County Hospital

<table>
<thead>
<tr>
<th>Region:</th>
<th>East Midlands</th>
</tr>
</thead>
</table>
| Location address: | Lincoln County Hospital  
Greetwell Road  
Lincoln  
LN2 5QY |
| Type of service: | Acute Hospital |
| Publication date: | April 2011 |
| Overview of the service: | United Lincolnshire Hospitals NHS Trust provides services to people across the county of Lincolnshire. The trust has three main hospitals as well as four other hospitals where it provides some services. Lincoln County Hospital serves the city of Lincoln and the North Lincolnshire area. It provides all major specialties such as maternity care, cancer services, intensive care and a 24-hour major accident and emergency service. |
Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Lincoln County Hospital was not meeting one or more essential standards. Improvements were needed.

The summary below describes why we carried out the 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, surveyed people who use services, carried out a visit on 8 February 2011, observed how people were being cared for, and talked with people who use services, talked with staff, checked the provider’s records, and looked at records of people who use services.

What people told us

During our visit to the hospital, we observed interactions between patients and staff that demonstrated people were being treated with dignity and respect. Adults who had undergone surgery told us they had received clear explanations, including the risks and benefits of the intervention before being asked to sign a consent form. One person said, “it was very helpful to have everything explained because I was very apprehensive about the operation.” A child told us that they had seen several doctors during their stay in hospital and said “all the doctors have been nice and they have explained things to me so I understand them.”

Not all people were happy with the level of care they had received and we received positive and negative comments. For example, some people did not think they received enough information about what was happening whilst others felt their care
had been good. All the patients’ that we talked to said that they felt safe whilst in hospital.

We observed lunch being served on two wards and found that all patients were given the appropriate assistance to eat their meals. People told us “the food is good and there is plenty of choice.” We observed that people appeared to enjoy their meals.

Some people did not feel that there was good communication between their GP and the hospital. Other agencies, such as the local doctors and some care home managers agreed with this and would like the hospital to improve.

People told us the hospital was clean. One patient said, “It is a nice hospital and it always looks clean.” With the exception of the women’s unit, we observed most areas of the hospital to be in a good state of repair and were clean and uncluttered. Some people had told us before our review that the facilities in the women’s unit needed upgrading. People in the other areas of the hospital said that they thought their ward was suitable for their needs and there was enough equipment for staff.

During our observations we found staff were competent in their role. One person told us “the staff appear very knowledgeable and suitably trained.” On the children’s ward, parents/guardians told us that the staff were too busy and they wanted to help them.

We found that not all people using the service were aware of how to make a complaint and during our observations we did not find it easy to locate information about how to raise a concern or a compliment about care and treatment. Some people also told us that the hospital did not always investigate their complaints thoroughly enough and in a timely way.
What we found about the standards we reviewed and how well Lincoln County Hospital was meeting them

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run
People using the service have their privacy, dignity and independence respected but they are not always involved in their care planning. There are occasions when people are not given sufficient information about their care and treatment.

- Overall, we found that Lincoln County Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Outcome 2: Before people are given any examination, care, treatment or support, they should be asked if they agree to it
There are arrangements in place for obtaining consent and people are able to give informed consent and have their rights respected and taken into account.

- Overall, we found that Lincoln County Hospital was meeting this essential standard.

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights
People are safe in the hospital and the risks of people receiving unsafe or inappropriate treatment are being reduced however, not all people who use the service benefit from having care that is clearly planned.

- Overall, we found that Lincoln County Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Outcome 5: Food and drink should meet people’s individual dietary needs
People are supported to have adequate nutrition and hydration and are given choices of food and drink that meet their needs.

- Overall, we found that Lincoln County Hospital was meeting this essential standard.

Outcome 6: People should get safe and coordinated care when they move between different services
People are not always receiving safe and coordinated care, treatment and support when more than one provider of care is involved, or they are moved between services.

- Overall, we found that improvements were needed for this essential standard.
Outcome 7: People should be protected from abuse and staff should respect their human rights

People are protected from abuse or the risk of abuse and staff respond to concerns appropriately.

- Overall, we found that Lincoln County Hospital was meeting this essential standard.

Outcome 8: People should be cared for in a clean environment and protected from the risk of infection

There are systems in place to protect people from the risks of acquiring an infection. The hospital carries out a regular audit of its cleanliness standards throughout all its areas and is aware that it does not meet internal targets.

- Overall, we found that Lincoln County Hospital was meeting this essential standard.

Outcome 9: People should be given the medicines they need when they need them, and in a safe way

People receive their medication at the times they need them and in a safe way. People are given information about their medicine and where possible the medication prescribed takes into account individual needs.

- Overall, we found that Lincoln County Hospital was meeting this essential standard.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

The hospital has taken steps to ensure people are protected against the risks of unsafe premises. The women’s unit requires further refurbishment work so that it provides suitable accommodation.

- Overall, we found that improvements were needed for this essential standard.

Outcome 11: People should be safe from harm from unsafe or unsuitable equipment

People who use services are not at risk of harm from unsafe or unsuitable equipment. Equipment is maintained and there are arrangements in place to ensure that it is used correctly.
Overall, we found that Lincoln County Hospital was meeting this essential standard.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

People who use services are safe and their health and welfare needs are met by staff that are fit, appropriately qualified, and are able to do their job.

Overall, we found that Lincoln County Hospital was meeting this essential standard.

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

There are a sufficient number of staff with the skills and experience required to support people using the service.

Overall, we found that Lincoln County Hospital was meeting this essential standard.

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

Staff are supported and properly trained to provide care and treatment to people who use the service.

Overall, we found that Lincoln County Hospital was meeting this essential standard.

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

The systems to monitor the quality of services are not sufficiently able to ensure that risks to people are managed. The trust does not always fully investigate incidents, complaints and near misses to enable the service to improve.

Overall, we found that improvements were needed for this essential standard.

Outcome 17: People should have their complaints listened to and acted on properly

The trust has systems in place to deal with complaints but not all people using the service are aware of how to use it. People do not always receive a response to their complaint within the set timescales and investigations are not always sufficiently thorough.

Overall, we found that improvements were needed for this essential standard.
Outcome 21: People’s personal records, including medical records, should be accurate and kept safe and confidential

Records are stored in a secure and accessible way that allows them to be located quickly, but some records are not accurate or fit for purpose. Other bodies have told us that they had concerns about the reliability of the clinical coding of records.

- Overall, we found that improvements were needed for this essential standard.

Action we have asked the service to take

We have asked the provider to send us a report by 12 June 2011 setting out the action they will take to improve. We will check to make sure that the improvements have been made.
What we found
for each essential standard of quality
and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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

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

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

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

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety.*
Outcome 1: 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

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider is compliant with outcome 1: Respecting and involving people who use services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>What people who use the service experienced and told us</td>
</tr>
</tbody>
</table>

We observed interactions between patients' and staff that demonstrated people were being treated with dignity and respect. For example, staff made sure bed area curtains were closed properly before carrying out a procedure. Staff spoke to people in a respectful and courteous manner and we found that staff made sure people had their call bell close to hand. Some of the people we spoke to were dependent on staff to provide personal care and they said that this was delivered in a respectful manner. We found entries in the nursing and medical records that demonstrated people had been treated with dignity and respect. For example, an entry by a doctor stated "the patient was upset so taken into a private room to talk further." In the areas we visited, we did not see any mixed sex accommodation.

One person told us that they found it difficult to get information about what was happening to their relative and they said their relative was not being treated with dignity and respect.

A report carried out by the Lincolnshire Local Involvement Network (LINk) in 2010
identified peoples best and worst experiences when accessing health services. LINk’s are a way for local people to have a stronger voice and greater influence over their local health and social care services. Positive comments that related to people feeling respected and involved included, “staff were great their smiles made my day. I cannot thank them enough;” another person said “I was not allowed or able to bath or shower and she (the nurse) washed my hair for me sitting upright using a bowl and jug - this made me feel presentable clean and human again and I thank her for this kindness from the bottom of my heart.” The report also described people’s negative experiences which included, “no one seemed to care;” and “they (the staff) did not listen to me.” Another comment in the report reads, “no assistance given with washing or dressing following a head injury and both arms in casts; my wife had to provide all personal care.”

We carried out a responsive review of the hospital in June 2010 and asked them to ensure that all in patient areas had somewhere private for staff to talk with people. Staff on Fillingham ward told us their ward had recently relocated to another part of the hospital and they lacked a private area to talk with people and their families. We raised the comments made by staff on Fillingham ward with the trust’s senior management team and they assured us that it would be addressed.

We did not find evidence that told us people had been involved in their care planning but some people told us they had been informed about their treatment. The arrangements for planning care across the trust were about to change with the implementation of a revised clinical record. A senior manager told us the new system would ensure care plans were more person centred.

Other evidence
We carried out a responsive review at the hospital in June 2010 and had minor concerns with this essential standard. The trust had been working to address the concerns we raised and the evidence that we have received demonstrated that significant action had been taken to improve compliance.

The trust provided us with evidence of how they involve people when they were developing services. For example, the trust had recently held a public consultation event for people to comment on plans to introduce a revised clinical record. The trust had a readers’ panel in place to help make information for people easy to understand. The panel is made up of volunteers who comment on new and revised information leaflets. The trust also had a patient council which is made up of members of the public. The members told us that they have a good working relationship with the trust and they were provided with administrative support. The council members carried out visits to the hospital and raised any concerns with the staff. They told us that although the staff were receptive to them, they do not always get feedback as to the outcomes of the issues they raised. In addition to the patient council, a maternity service and liaison committee (MSLC) had been established.

Our judgement
People using the service have their privacy, dignity and independence respected but they are not always involved in their care planning. There are occasions when
people are not given sufficient information about their care and treatment.
Outcome 2: Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:
- Where they are able, give valid consent to the examination, care, treatment and support they receive.
- Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
- Can be confident that their human rights are respected and taken into account.

What we found

Our judgement

The provider is compliant
with outcome 2: Consent to care and treatment

Our findings

What people who use the service experienced and told us

A child told us that they had seen several doctors during their stay in hospital and said “all the doctors have been nice and they have explained things to me so I could understand them.”

We talked to adults who had undergone surgery and said they had received clear explanations, including the risks and benefits of the intervention before being asked to sign a consent form. One person said, “it was very helpful to have everything explained because I was very apprehensive about the operation.” A person commented in the LINks report, “the consultant involved me fully in proceedings and encouraged me to give feedback,” however another person said “I felt that no one really wanted to answer my questions so I have had to rely on leaflets and voluntary sector bodies.” We found evidence in care records of completed consent forms that were signed by the person obtaining consent as well as the person undergoing the intervention.

We found examples in care records of people’s preferences being taken into account. For example, we noted an entry in some nursing notes that stated “refused
a wash at present."

During our observations in the children’s ward we saw staff obtained verbal consent before carrying out an intervention. Staff were aware of the Gillick principle, which is a legal term used to decide if a child under the age of 16 has sufficient understanding of what is involved in their treatment.

**Other evidence**

We asked the trust to complete an assessment of their compliance for this outcome area and they said their risk management arrangements had not identified any significant problems with regard to consent in terms of clinical incidents, complaints or negligence claims. There were plans in place to seek the views of people about the quality of information provided. Real time patient experience surveys were being rolled out across the trust and included questions about information provision. We were told that the trust would use the findings to improve the experiences of people using the service.

All staff that we spoke said they had received training on obtaining consent which included the Mental Capacity Act (2005). Medical staff demonstrated a good understanding of the issues relating to assessing the capacity of a person to consent. The Mental Capacity Act (2005) helps to support and protect people who lack, or may lack, the ability to make certain decisions for themselves. The trust’s consent policy takes into account department of health guidance on consent, including the issues relating to peoples capacity to consent.

A junior doctor described to us how they take into account if people might need help to make decisions. We found that medical staff were aware of the need to obtain best interest assessments and independent mental capacity advocates (IMCA’s) for people if they had concerns about a persons capacity to consent. NHS trust’s are required to appoint an IMCA to represent the individual if there is no-one else to support them and there are important decisions about serious medical treatment to be made. Medical staff were aware of the trust’s advanced decisions policy and were aware of the circumstances when an advanced decision could be lawfully over-ruled. Advanced Decisions are made by people who are concerned that they might not have the ability to make decisions in the future, so they make a statement explaining what medical treatment they do not want in the future.

Nursing and therapy staff were aware of the trust’s consent policy and when consent should be sought from people. Staff also demonstrated an understanding that consent may be expressed verbally or non-verbally. One member of staff said “I would explain to the person that I needed to take a blood sample and if they hold their arm out for me then I take this as them giving me non verbal consent.” We also found that these staff were aware of the need to assess whether a person has the capacity to consent but they were less clear about how to obtain a best interest assessment and the role of the IMCA. One member of staff told us, “we try to explain to the patient what we need to do but sometimes they do not have the capacity to understand so we would do what is in the best interest of the patient: we never force anyone.” The trust confirmed that they have three staff who were trained to carry out best interest assessments but they were aware of the need for further
staff training. The trust employed a consultant psychiatrist, mental health liaison nurses and a learning disability nurse specialist who provided support to staff and patients’ on issues around consent. In addition, the trust was in the process of appointing a lead role for safeguarding vulnerable adults and it is envisaged that this person will help further enhance staffs understanding of the Mental Capacity Act.

We found information leaflets were in place for many procedures and treatments and these highlight the benefits and risks for treatment. The trust’s senior management team told us that they are currently part way through achieving compliance for a nationally recognised information standard and this demonstrates their commitment to providing effective information for people who use the service.

Our judgement
There are arrangements are in place for obtaining consent and people are able to give informed consent and have their rights respected and taken into account.
Outcome 4:
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 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People being cared for on the Emergency Assessment Unit described differing experiences. One person said they were happy with the care they had received but another person told us they had not received the level of care they needed. The LINKs report highlighted a mixture of positive and negative experiences. For example, one person said “the triage staff and minor injuries nurses were caring, professional friendly and informative. I felt I received a high standard of care.”

We observed in people’s care records that risk assessments were completed most of the time for moving and handling, nutrition, falls, pressure area care, infection prevention and control, and blood clot formation. We did not always find that care plans were in place as a result of the identified risks. For example, we found entries in one set of notes that stated, “eating small amounts, and has no real appetite.” This person did not have a nutritional risk assessment or care plan in place. We pointed this out to the ward sister and it was addressed immediately. Patients’ told us staff had discussed how they could help reduce some of the risks associated with being in hospital such as the prevention of blood clots and pressure sores. We observed that nationally designed posters were displayed in ward areas to raise awareness of the importance of preventing blood clots forming. Staff were aware of the importance of risk assessment to identify people at risk of developing pressure ulcers and they were able to describe the risk factors and the actions they took to
reduce the risks. Staff told us they could always obtain specialised equipment to help prevent pressure ulcers and we observed that there were sufficient stocks of the equipment on the day of our visit.

On the children’s ward we found that care plans were clear and it was easy to identify the child’s needs. In the adult inpatient areas we observed documented assessments of people’s activities of daily living in order to identify their needs. It was particularly evident that assessments completed by Occupational Therapists (OT’s) were very detailed and clear. Occupational Therapists help people of all ages who have physical, mental or social problems to improve their independence.

Staff told us that they used the “track and trigger” system to help identify when a person who uses the service becomes seriously ill. All of the clinical staff we talked to were aware of how to use it and were able to demonstrate an understanding of it. In addition, staff told us they had received recent life support training at various levels. Medical staff told us they received sufficient training and support to enable them to respond to people if they were becoming seriously ill.

We talked to staff about their understanding of end of life care. Staff on the children’s ward told us how they support children and their families to have a dignified death. There is a county wide approach to end of life care and the trust used the Liverpool Care Pathway which is a plan of care that a person can expect to receive in the final days of life or as they approach death. During our pathway tracking we found evidence of this being put into practice. The 2010 national review of Stroke Care carried out by the Care Quality Commission identified that end of life care was a weak area for the whole of the Lincolnshire health community. The trust told us that they recognise they have further developments to make regarding end of life care and they have action plans in place.

Medical staff told us that treatment is delivered to people in accordance with best practice and in line with relevant national guidance such as that issued by the National Institute of Clinical Excellence (NICE). NICE is an independent organisation that provides guidance on treating people’s ill health. Medical staff told us that they had protected learning time in place which allows them to keep up to date with new developments in medicine and surgery. We saw evidence of clinical policies and procedures that were based on national guidance, for example, pressure ulcer prevention is based on NICE guidance.

Other evidence

Cancer services were provided by the hospital. In July 2010 the trust underwent a review of their cancer services by the National Cancer Peer Review Programme. This programme aimed to improve cancer care for people and their families and involves the trust completing a self assessment and then they receive a targeted visit to the hospital. The panel of reviewers concluded that the trust has a good cancer services strategy but they face the ongoing problem of serving a geographically diverse population. The peer review team found that some specialised cancer services were being delivered to less people than is recommended by NICE. These recommendations exist because doctors need to
see enough people to maintain their skills. The trust was working with the PCT to address this concern whilst balancing the needs of people living in Lincolnshire. The review team also found that there were not enough nurse specialist resources for people receiving urological (bladder) cancer services. The trust reacted quickly to this concern and recruited a further nurse specialist.

Our judgement
People are safe in the hospital and the risks of people receiving unsafe or inappropriate treatment are being reduced however, not all people who use the service benefit from having care that is clearly planned.
Outcome 5:  
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

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider is compliant with outcome 5: Meeting nutritional needs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
</tr>
<tr>
<td>We observed lunch being served on two wards and found that all people were given the appropriate support to eat their meals. People who use the service were served the meal that they had chosen and we observed menu cards that had photographs of the food as well as nutritional information about the meal. People have a wide choice of menu and their religious and cultural requirements were provided for. People told us “the food is good and there is plenty of choice.” We observed that people seemed to enjoy their meals and in most cases the food was served at the right temperature.</td>
</tr>
<tr>
<td>Children were also offered a range of meal choices. A parent told us that some of the food for the children was poor quality and a child said “I don’t like the chips and there are chips with everything.”</td>
</tr>
<tr>
<td>People were served hot drinks on the wards from a teapot/coffeepot and in a cup and saucer as opposed to from a drinks machine with plastic cups. A milky drink is also available. People value having their drinks served in this way and one person said “it is nice that some of the old fashioned ways are still going and we get a proper cup of tea.” People also have access to drinking water which is changed during the day, however, one person told us that the water needed to be cooler. People who had undergone an operation told us that they were given something to eat and drink as soon as they were able to tolerate this. People who had been</td>
</tr>
</tbody>
</table>
admitted outside of normal mealtimes were offered drinks and snacks and the staff told us they could always get something to eat for a person if they needed to. We saw evidence that a range of snacks are stored in the ward kitchens.

A new mother in the maternity unit told us that she had requested more support to help her breast feed her baby and staff had quickly arranged for a specialist advisor to see her.

**Other evidence**
The trust had a protected meal time policy in place which is where unnecessary and avoidable interruptions were stopped during meal times. We observed this policy being put into practice on the wards we visited. Nursing staff told us that other professionals, such as doctors, respect the protected meal time policy, unless there is an emergency.

We found entries in one set of nursing notes that stated, “eating small amounts, and has no real appetite.” This person did not have a nutritional risk assessment or care plan in place. We pointed this out to the ward sister and it was addressed immediately. We did however find evidence of nutritional risk assessments and care planning in other care records we reviewed. We also observed completed food and fluid balance charts to enable staff to monitor people’s intake but we did not always find that there were care plans in place that stated food and or fluid should be monitored.

**Our judgement**
People are supported to have adequate nutrition and hydration and are given choices of food and drink that meet their needs.
Outcome 6: Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:
- Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

There are moderate concerns
with outcome 6: Cooperating with other providers

Our findings

What people who use the service experienced and told us
A parent of a child told us there had been delays transporting children from Lincolnshire to the high dependency units in Nottingham and Sheffield. As a result of this a charity was in the process of being set up by parents to transport these children by helicopter. We discussed this with the trust’s senior management team who stated they were working to address this issue.

The Local Involvement Network (LINk) carried out a review of patients experiences of health services in Lincolnshire. One person said in the report, “I was admitted for a hernia operation but the anaesthetist said they were unable to carry out the operation and that an explanatory letter would be sent to my GP.” No letter was received by the GP or the person using the service.

On the children’s ward we found clear evidence of multi agency working. In the adult in patient areas we observed that people receive support from a multi disciplinary team and saw an example of a discharge plan which showed that a joint assessment with social services had taken place.
Other evidence

The Health Scrutiny Committee for Lincolnshire told us that they have “strong working relationships with the senior management team at the trust.” A new Chief Executive was appointed at the trust in August 2010 and he had met with the committee to outline some of the key issues facing the trust and the proposals to address these. The lead commissioning Primary Care Trust (PCT) also report strong working relationships with the trust’s senior management team.

The Head of Safeguarding Adults for Lincolnshire County Council told us there were good relationships in place and the Chief Nurse is represented on the multi agency safeguarding and dignity board.

The safeguarding adults team at Lincolnshire County Council had observed a trend in the number of referrals that go to them which related to concerns about discharge from hospital. For example, there had been cases where assumptions had been made by hospital staff that people using the service were being discharged to care homes that provide nursing care. On occasions this had been inaccurate and people were returning to residential placements without the appropriate medical follow up being arranged. Several care home managers within Lincolnshire had expressed recent concerns to us that communication between ward staff and care home staff is inadequate and care home staff find it difficult to obtain information about the condition of the person and the plans for the future. For example, one manager of a care home said, “person X has lived in this care home for six years and it is their home, we have a good relationship with this persons family and we really understand the needs of the people who live here. Recently this person was admitted to Lincoln County Hospital and we sent in information with them about their care needs. We found that the hospital had not taken this into account even though we took the time to give them this information. This was very distressing for the person their family and our staff.”

Local General Practitioners (GP’s) had raised concerns to the PCT about delays in the receipt of clinic outpatient letters and discharge documentation. Following an internal review, concerns were identified relating to the timely dispatch of out patient letters in some areas. The trust addressed this and provided additional administrative capacity to manage the back log and performance had improved. Performance relating to electronic discharge documentation had also significantly improved but there was a backlog of historical discharge documents. The PCT had worked closely with the trust to agree an acceptable and manageable approach to addressing the backlog and performance was monitored through the PCT’s GP incident reporting systems. In addition assurance was also sought through the PCT patient safety and contract quality review meetings.

Our judgement

People are not always receiving safe and coordinated care, treatment and support when more than one provider of care is involved, or they are moved between services.
Outcome 7: 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 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People told us they felt safe whilst they were in hospital. We observed wards had controlled entry systems in place but people could leave the ward as and when they wanted to. We did not find any evidence of people who lacked the capacity to make decisions were being deprived of their liberty.

Other evidence
There are trust wide multi agency policies for safeguarding children and vulnerable adults in place that reflect best practice. On the children’s ward, we saw information about safeguarding children on display. Staff had a good understanding of safeguarding and we found evidence of multi agency working to safeguard children. The Office for Standards in Education, Children’s Services and Skills (Ofsted) and the Care Quality Commission carried out a review of safeguarding children’s services in May 2010 and found that safeguarding children’s services across Lincolnshire were excellent. Ofsted inspect the social care of children and young people. It was noted in the report that the trust had a dedicated serious case review investigation and implementation committee, which is ensuring that actions are fully embedded into practice.

In the adult in patient areas of the hospital we found one ward had information displayed about safeguarding vulnerable adults. Staff were able to tell us what they
would do if they suspected someone had been abused and they understood the different types of abuse and how they often present in people. Staff also said they had received training in safeguarding adults and that there was an electronic learning package they could access from the trust intranet. Medical staff gave us examples of how they had raised safeguarding concerns and demonstrated awareness about the signs of abuse.

The head of safeguarding for Lincolnshire County Council told us that when a safeguarding alert is made involving the hospital, the chief nurse is the identified single point of contact into the trust. This arrangement is in line with national guidance. The trust responded quickly to safeguarding alerts and there were good working relationships in place. The numbers of safeguarding alerts made by hospital staff had increased during the past seven months and the trust manage safeguarding concerns in line with the safeguarding policy. The safeguarding strategic board stated, “the trust demonstrates openness, honesty and is willing to acknowledge where problems are and then how they are trying to tackle problem areas.”

During our responsive review of the hospital in June 2010, we identified a moderate concern in relation to this outcome. The trust developed an action plan in order to achieve compliance and we saw evidence of this action plan being implemented. For example, training had taken place and the staff we talked to had a greater level of understanding about the process for making referrals than they did in June 2010.

**Our judgement**
People are protected from abuse or the risk of abuse and staff respond to concerns appropriately.
Outcome 8: Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

The provider is compliant

with outcome 8: Cleanliness and infection control

Our findings

What people who use the service experienced and told us

People told us that the hospital was clean and we did not receive any concerns from the people we talked to about this outcome area. Staff also said the hospital was clean. We observed staff washing their hands between contact with patients and they also wore protective equipment appropriately such as gloves and aprons. We observed that medical staff were following the trust’s uniform policy and were bare below the elbow. We saw a hospital porter entering a ward and observed that he used hand gel before he went onto the ward. We also observed information for visitors at the entrance to wards, reminding them to wash their hands.

Staff told us they had training on infection control, hand hygiene and some wards had received additional training sessions on specific areas such as isolation. We observed many clinical areas during our visit and did not find any evidence that the hospital was not clean. Sluice rooms on the wards we visited were clean and tidy. We checked that the equipment labelled as clean and ready for use was actually clean.

Other evidence

There was an infection prevention and control team in place at the hospital. The hospital has a zero tolerance stance to healthcare infection and there had been a considerable reduction in healthcare acquired infection such as methicillin resistant staphylococcus aureus (MRSA) and Clostridium difficile (sometimes known as C. diff). MRSA is a common skin bacteria that is resistant to a range of antibiotics. If it...
gets into the body through wounds or through inserting drips it can cause serious infection. *Clostridium difficile* are bacteria that are present in the gut but some antibiotics can alter the balance of bacteria which can cause diarrhoea and fever. MRSA cases in the trust had reduced by 28% in the last year and *Clostridium difficile* cases reduced by 23%. Infection prevention and control training was mandatory and all staff had their responsibilities for infection prevention and control outlined in their job description. Training is given on induction and then it is provided regularly as part of the trust’s mandatory training programme. Infection control is a standing agenda item for clinical meetings which helps to make this a high priority for all staff.

The trust has an infection prevention and control development plan which takes account of the requirements laid out in the Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control of infections and related guidance. We saw evidence that progress with this plan was being made.

The hospital told us that there are regular audits to check standards of cleanliness. High risk areas such as operating theatres were subject to weekly audits. Other areas such as out patients were audited monthly. We saw the results of the audits which revealed that many areas did not always achieve the pass rate set for the area. For example, the emergency care directorate results from January 2010 to October 2010 demonstrate that the majority of wards did not achieve the pass rate, with many of these wards consistently scoring well below the pass rate. Out patient clinic areas generally met the pass rate set for them. The trust told us that they were aware of some areas not achieving the pass rate, however, the reasons for this were often due to issues such as the outside of the windows required cleaning. Other cleanliness audits that the trust carry out reveal that areas are meeting cleanliness standards.

There are deep clean teams who support the wards and departments particularly during outbreaks of infection. Although this is positive, it had resulted in the ongoing rota for deep cleaning being reduced to once every 10-11 weeks, rather than the original plan of once every six weeks. A proposal for additional resources had been put forward and the issue was identified within the hospital's risk register.

The trust had a dedicated part of their intranet for infection prevention and control where staff could access information and policies. The infection control team provided support to ward areas if there was a suspected outbreak of infection. The infection prevention and control team also provided ad hoc training to clinical teams and we saw evidence of this taking place. In addition, all clinical areas had identified link nurses for infection prevention and control.

Some ward areas on the Lincoln site do not have doors to the bays to allow for cohort nursing of patients in line with Department of Health recommendations. Cohort nursing is where people using the service with the same infection are cared for in the same part of the ward. This issue was highlighted on the trust’s risk register however the single room capacity had increased at the hospital so there were more facilities to care for people who were being nursed in isolation. The
The hospital had two negative pressure rooms located on Navenby ward which were used for highly infectious respiratory cases such as tuberculosis.

The hospital was taking steps to reduce the amount of unnecessary antibiotic prescribing. For example, they have trialled a separate prescription sheet for antibiotics to ensure that each antibiotic has a stop date. Audits take place to monitor the appropriateness of antibiotic prescribing. The trust acknowledges that there are further improvements to make with regard to reducing the amount of unnecessary antibiotics that are used; this is a health community issue and involves GP’s working in the community.

Preadmission screening for MRSA was undertaken and performance was monitored. The MRSA care pathway reinforces the need to inform other providers of the infection status of the person. For example, if a positive MRSA result was obtained after a person is discharged from hospital, there were mechanisms in place to inform the person’s GP. The trust audited the movement of identified people with infections such as MRSA or *Clostridium difficile* in September 2010. The audit highlighted that people were being moved between wards appropriately and for clinical reasons only.

**Our judgement**

There are systems in place to protect people from the risks of acquiring an infection.
Outcome 9:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider is compliant with outcome 9: Management of medicines</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
</tr>
<tr>
<td>Patients’ told us that they usually got their medication on time and if they asked for something outside of the usual times such as pain relief, they received it quickly. Staff told us they had sufficient staffing levels in place to allow them to respond to people’s needs for medication such as pain relief. The LINks report into patient’s experiences of healthcare in Lincolnshire stated a patient had said they had received “inadequate pain relief” and were “unhappy with clinical assessment and treatment.” Medical staff told us they considered the patient they were prescribing medication for and tried to take into account their preferences. Staff told us they would always try to explain to the patient all about the drugs they had been prescribed. Patients we talked to confirmed this and one person said “the doctors and the pharmacists have gone through what my tablets are for with me.”</td>
</tr>
</tbody>
</table>
| During our observations in the ward areas we did not see any medication being left with people to take unsupervised but one patient told us, “the staff give me the tablets, some of them stand and watch me and some don’t.” A healthcare support worker told us that they sometimes support the registered nurses that were administering medication by watching the person take their tablets. The Nursing and Midwifery Council who are the regulator for nursing and midwifery state in the Standards for Medicines Management (2007) that “a registered nurse may delegate
an unregistered practitioner to assist the patient in the ingestion or application of the medicinal product."

**Other evidence**

We carried out a responsive review of compliance at this hospital in June 2010 and had a minor concern with the management of medicines. The trust implemented an action plan to improve the way that medication is administered. Clinical practice audits have demonstrated that performance in the administration of medication has improved and, where required, improvement plans have been drawn up. Further audits were scheduled to take place in the near future to reassess performance. The trust has provided us with evidence to demonstrate they have taken action to address the areas of non compliance that were identified in 2010.

**Our judgement**

People got their medication at the times they need them and in a safe way. People were given information about their medicine and where possible the medication prescribed takes into account the persons individual needs.
Outcome 10: Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
- Are in safe, accessible surroundings that promote their wellbeing.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are moderate concerns with outcome 10: Safety and suitability of premises</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>What people who use the service experienced and told us</td>
</tr>
<tr>
<td>The premises at Lincoln County Hospital vary, some wards and departments were located in modern buildings and some were located in premises that were constructed in the 1960’s. The women’s unit, located in the grounds of the hospital consists of a six floor tower block. The unit had undergone a programme of refurbishment, including window replacement but this programme had not been fully progressed due to financial constraints. Some of the floors required replacement and not all of the windows had been replaced. Staff told us that the state of the building provided them with significant challenges and routine repairs were made more complicated because of the presence of asbestos in the unit. We observed some of the window sills were in a poor state of repair and the facilities are generally dated. Despite this none of the people we spoke to on the day of our visit to the maternity wards told us they were concerned about the state of repair of the premises. Prior to our visit, we had received comments from people about the poor state of repair of the women’s unit as well as the unsightly derelict buildings located in the hospital grounds. However the demolition of these buildings commenced the week of our visit to the hospital and plans to redevelop this area were in place.</td>
</tr>
<tr>
<td>All of the people we spoke to said they thought their ward was suitable for their needs. People on Fillingham ward commented that they liked the layout of the ward because they could always see a nurse through the glass panel. The staff also said they liked the ward layout as they could look down both sides of the ward at any one</td>
</tr>
</tbody>
</table>

Page 30 of 54
time and see the patients’ in the bays. Staff on several of the wards we visited told us they did not have enough storage space and they found this frustrating. We also observed this in some areas, for example we saw a hoist stored in a bathroom. The maintenance staff told us that when wards are relocated or refurbished there was an opportunity to review issues such as the heating system and the capacity for storage. For example, we saw evidence of a ward being refurbished and a waste storage area had been incorporated into the design so that it was in line with best practice and national guidance.

People told us the hospital was clean. One person said, “it is a nice hospital and it always looks clean.” With the exception of the women’s unit, we observed most areas of the hospital to be in a good state of repair and were clean and uncluttered.

Staff told us that they knew what to do in the event of a fire and they needed to evacuate the area. They told us they had received fire, health and safety and Control of Substances Hazardous to Health (COSHH) training on an annual basis and the training records we observed supported this.

**Other evidence**

The women’s unit contained asbestos, and although regular air testing provided assurance that the building was safe, the trust had a plan for its removal. The presence of asbestos has meant that routine maintenance of the building had been challenging. For example, there have been instances where drains have become blocked and in order to fix the problem the maintenance team had to consider the requirements of the Control of Asbestos Regulations 2006. Repeated drainage problems led to an enforcement notice being issued to the trust by the Health and Safety Executive in 2010. The maintenance staff told us that following the purchase of a new paper mulching machines (used to dispose paper bedpans) and increasing staff awareness of the problems with the drains in the women’s unit, the number of occurrences where the drains have blocked has significantly reduced. We saw records to support this. The trust was working with the Health and Safety Executive to develop an acceptable plan for the safe removal of the asbestos in the women’s unit but this has not yet been carried out.

The East Midlands Healthcare Workforce Deanery (EMHWD) carries out visits to all Trust’s within the region to check they are suitable to train post graduate medical staff. Both the EMHWD and the General Medical Council (GMC) had raised concerns about the location of the Children’s Ward and the Neonatal Unit at Lincoln County Hospital. The wards are located 10-12 minutes apart and are on different levels of the hospital. Medical staff provide cover for both of these locations and they raised concerns that if there was an emergency situation, the distance between the units could have a negative effect as the doctor would not be able to reach the child/baby in a timely way. This issue was first raised with the trust in 2004 and had only recently been addressed. There was a plan in place to relocate the children’s ward to another area of the hospital that is much nearer to the neonatal unit. Until this is completed a separate neonatal rota is in place to provide dedicated support to the unit and reduce the risk to babies and children being cared for at the hospital.
We asked the trust to provide us evidence that the move had taken place. We were concerned about the time taken for the trust to address the concerns raised by staff and the risk this presented to peoples safety.

The trust had a water chlorination process in place to prevent the growth of the bacteria that cause Legionnaires’ disease which is a type of pneumonia. Outbreaks of the illness occur from exposure to bacteria growing in water such as hot water systems.

The trust had a contract in place with an external company to provide waste management services. The arrangements for this are in line with current legislation. We observed waste being segregated and stored appropriately and both clinical and non clinical staff were able to demonstrate to us that they understood the trust’s waste handling arrangements.

The maintenance team told us that there was a hospital maintenance schedule but there are significant challenges for the team to access the operating theatres in order to carry out routine maintenance. The theatres are in constant use during the week so the team have to plan work to take place out of hours.

**Our judgement**

The hospital has taken steps to ensure people are protected against the risks of unsafe premises. The women’s unit requires further refurbishment work so that it provides suitable accommodation.
Outcome 11:
Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
- Benefit from equipment that is comfortable and meets their needs.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider is compliant with outcome 11: Safety, availability and suitability of equipment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>What people who use the service experienced and told us</td>
</tr>
</tbody>
</table>
People told us that staff had the equipment they needed to do their job and that they were comfortable and felt safe. We observed people who were at risk of developing pressure ulcers being nursed on specialist pressure relieving equipment and staff told us that they can always obtain pressure relieving equipment at any time of day or night.

<table>
<thead>
<tr>
<th>Other evidence</th>
</tr>
</thead>
</table>
The clinical engineering team were responsible for the maintenance of medical equipment such as blood pressure monitors and ventilator machines. The trust had an equipment inventory where all the equipment in use is logged and is given a classification score based on risk. For example, equipment such as a defibrillator had a high risk score because of its impact on the person needing it. Targets had been set to monitor the performance of equipment maintenance and we saw evidence that demonstrated the trust was exceeding the targets. The Head of Clinical Engineering told us that the team had the capacity to deliver the maintenance requirements across the trust and where possible they carried out in house maintenance rather than using external contractors.
There was a process in place for the purchasing of new equipment and all medical devices are configured the same across the trust. For example, all infusion pumps used to deliver medication are the same and operate in the same way. This helps to ensure that equipment is used correctly and safely.

**Our judgement**

People who use services are not at risk of harm from unsafe or unsuitable equipment. Equipment is maintained and there are arrangements in place to ensure that it is used correctly.
Outcome 12: Requirements relating to workers

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 staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider is compliant</td>
</tr>
<tr>
<td>with outcome 12: Requirements relating to workers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>What people who use the service experienced and told us</td>
</tr>
<tr>
<td>During our observations we found that staff were competent in their role. Staff told us they felt appropriately trained to carry out their role and received training and updating to develop their practice. One person told us “the staff seem to know what they are doing.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>The trust had a recruitment policy and associated procedures. We looked at five sets of staff records and checked if the recruitment procedures had been followed. We found that the records were very clear and there was evidence that criminal record bureau (CRB) checks had been completed prior to the staff member commencing employment, qualifications had been checked, two references had been sought, pre employment health assessments had been carried out and the identity of the person and entitlement to work in the United Kingdom had been ratified. Each file we reviewed contained a contract as well as information about the terms and condition of employment. Where required, professional registration checks are carried out with the relevant bodies such as the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who use services are safe and their health and welfare needs are met by</td>
</tr>
</tbody>
</table>
staff that are fit, appropriately qualified, and are able to do their job.
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

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider is compliant with outcome 13: Staffing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
</tr>
<tr>
<td>Some people using the service that we talked to felt the staff were very busy. One parent on the children’s ward said “I feel sorry for the staff and want to get up and help them because they are so busy.” The Head of Children’s services told us that although the ward had a full complement of staff, the establishment does not meet current guidance from the Royal College of Nursing. In addition, the dependency of the children being care for on the ward has significantly increased over recent years and they care for more children who have higher dependency needs. The trust had supported the need to increase the staffing levels on the children’s ward at the hospital. The head of children’s services told us that he received support from the chief nurse. For example, it was necessary for the trust to retain student children’s nurses because recruitment can be a challenge for the trust due to the rural location of its hospitals. The chief nurse had recently approved a request for the current students to be employed by the trust upon registering with the Nursing and Midwifery Council (NMC), even though this exceeded the staff budget allocated for the department.</td>
</tr>
</tbody>
</table>
| Staff told us that there are times when the hospital is short of staff, but we did not see evidence that there were not enough staff with the right competencies to meet people’s needs. People using the service told us they thought there were enough staff to care for them, although one person said “there would be enough staff if no
one was off sick.” In the recent LINks report into people’s experience of healthcare in Lincolnshire, one person commented that “the staff in the A&E department at Lincoln County Hospital were really busy but they were still polite and comforting.” Staff did not raise concerns with us about staffing levels, but some staff did comment that it was a challenge to meet the needs of all people during evenings, weekends and bank holidays. We have no evidence that outcomes for people were being affected during these times.

Other evidence
The East Midlands Healthcare Workforce Deanery (EMHWD) (described in outcome 10), and the General Medical Council (GMC) had raised concerns in 2010 about medical foundation training in general surgery. The trust developed an action plan to address the concerns and the EMHWD and the GMC are monitoring the current position.

Our judgement
There are a sufficient number of staff with the skills and experience required to support people using the service.
Outcome 14: Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:
- Are safe and their health and welfare needs are met by competent staff.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider is compliant with outcome 14: Supporting workers</td>
</tr>
</tbody>
</table>

Our findings

What people who use the service experienced and told us
One person told us that “the staff appear very knowledgeable and suitably trained.” Staff said they were appropriately skilled to care for people in the hospital. Junior medical staff told us they were never pressurised to carry out procedures or treatments they were not competent to do. Consultant medical staff said they would not ask junior staff to carry out procedures they were not competent to perform. All staff said that they felt able to raise any concerns about clinical practice and knew how they would do this. No one told us that they had been subject to any bullying or harassment whilst working at the hospital.

There were a range of training opportunities to allow staff to develop their skills. Many staff had opportunities for internal promotions and the retention of staff was high. Staff told us they worked in good teams and received support from each other. Morale amongst most staff was high. A junior doctor said “I've had an appraisal and I get to meet regularly with my clinical and educational supervisors.” Doctors also told us that their training at the hospital had been good.

Other evidence

We carried out a responsive review of the hospital in June 2010 and we had minor concerns relating to this outcome. The trust developed an action plan in response to our concerns and whilst not all of the actions had been fully implemented, we saw
evidence that they were making satisfactory progress.

The trust told us that they had an induction programme for new members of staff. Three days of general induction were given as well as orientation into the work area. In addition, newly qualified nurses had a preceptorship programme. Temporary staff are required to complete an electronic induction via the trust’s intranet.

Information received from the NHS counter fraud and security management service (NHS CFSMS) demonstrates that the trust is in the lowest 10% of trust’s nationally for staff being trained in conflict resolution. The NHS CFSMS aim to reduce fraud within the NHS such as people falsely making claims about prescription charges or staff making fake claims for expenses. The trust had received some funding to implement a training programme but the CFSMS had concerns about the length of time it would take to train all staff (seven years). The trust had prioritised the staff who required this training more urgently, such as staff working in the emergency department.

Our judgement
Staff are supported and properly trained to provide care and treatment to people who use the service.
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

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are minor concerns with outcome 16: Assessing and monitoring the quality of service provision</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
</tr>
<tr>
<td>We did not ask people specific questions relating to this outcome area during our visit to the hospital. The trust told us that they are in the process of purchasing a system to obtain feedback from people about their experiences in hospital. During our discussions with staff, staff were not always able to give us examples of how they had learnt from incidents, complaints or near misses.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are systems within the hospital for assessing the quality and safety of care treatment and support. As highlighted in other parts of this report, we saw examples of assessment and monitoring of quality such as infection prevention and control.</td>
</tr>
</tbody>
</table>

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The local primary care trust who commission (buy) services from the hospital told us the hospital did not have robust mechanisms in place to investigate serious incidents in a timely way and the quality of investigations was not always good. The Strategic Health Authority had also reported these concerns. The trust was taking steps to improve performance in this area and had recently recruited additional resources for the patient safety team. Despite the concerns, the trust’s performance on reporting serious incidents to the National Patient Safety Agency (NPSA) is</td>
</tr>
</tbody>
</table>
good. The NPSA run a National Reporting and Learning Service that enables patient safety incident reports to be submitted to a national database. Evidence from this database from April to September 2010 demonstrates that 0.75% of the trust's incidents are deaths and severe harm compared to 0.90% nationally.

The trust had two mortality outlier alerts in 2010. Mortality outliers look at the number of people within an organisation that have died after being admitted to hospital for a particular condition or procedure. We use the term 'outlier' to describe a service that lies outside the expected range of performance. One of these alerts required the trust to complete an investigation into the cases concerned but this did not raise concerns about the care and treatment that was delivered to these people.

The trust told us that they had a Quality Governance Committee (QGC) in place which is the primary committee for all quality and patient safety matters and was responsible for overseeing the trust’s activities to provide high quality and safe care. The trust also had a clinical audit programme in place which covered both national and local audits to address trust priorities. There was also a published quality plan for 2009-11 which set out the vision, purpose and a number of quality goals the trust wanted to achieve. Performance against these goals was monitored by the trust board.

To address and monitor serious incidents the trust told us that they had an established incident review group chaired by the Medical Director. They acknowledge that there was a delay with the completion of Serious Untoward Incident investigations and this is a priority for 2011/2012. We found that there was an improvement plan in place to achieve this. In addition, there was a forum where lessons from incidents are discussed and shared and then information is cascaded through directorates and local teams. Some staff said that they would get information about complaints from the ward sister at their ward meetings but they were not able to give us examples of how they had changed practice as a result of learning from a complaint, incident, error or near miss. We saw an example of the trust providing maternity staff with information about lessons learnt from incidents and complaints through the publication of a maternity newsletter.

The trust told us they were about to launch “Safety Express Plus” across the trust. This is a nationally recognised quality improvement programme in the NHS which aims to reduce harm for people using the service. The trust had set a number of priorities for their safety express programme which included, prevention of venous thromboembolism (blood clots), pressure ulcers, catheter acquired infections, falls and the deteriorating patient.

The trust told us that there was a Quality Review Group in place with the commissioning PCT which meets quarterly to review the trust’s performance based on the requirements in the contract.

Our judgement
The systems to monitor the quality of services are not sufficiently able to ensure that risks to people are managed. The trust does not always fully investigate incidents,
complaints and near misses to enable the service to improve
Outcome 17: Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:

- Are sure that their comments and complaints are listened to and acted on effectively.
- Know that they will not be discriminated against for making a complaint.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are moderate concerns</td>
</tr>
<tr>
<td>with outcome 17: Complaints</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>What people who use the service experienced and told us</td>
</tr>
</tbody>
</table>

Some people using the service were not aware of how to make a complaint but some said they would talk to the nurse looking after them. A relative of a person said “I don’t know who I would speak to but I suppose I would ask one of the nurses what to do.”

During our observations of the hospital we did not find it easy to locate information about how people could raise a concern, make a complaint or a compliment about their care and treatment. In the maternity unit we observed a rack of information leaflets and whilst this did include information about the Patient Advice and Liaison Service (PALS), it was not prominent and required some looking through the leaflets to find it. PALS are a confidential service that helps patients, their families and carers to find answers to questions or concerns regarding the care or treatment received from NHS Trust’s. The hospital had a customer care team who deal with complaints, concerns and compliments from people who use the service but we did not see any information about them in the hospital’s main reception. Despite our observations, the trust told us that they had produced information for people in a variety of languages and there was information on the trust’s web site, the staff intranet as well as leaflets located in and around the hospital. The trusts senior
management team told us that they would address this lack of information on display as soon as possible.

Other evidence
The trust had a complaints procedure. They told us that this procedure underpins their commitment to manage complaints effectively and achieve local resolution. Training in complaint handling and investigation was provided to those involved in this process and in addition, customer care training is provided to all staff which sets out the expectations of staff as well as developing staff's skills. We asked staff if they knew what to do if a person wanted to make a complaint and found the knowledge of staff was variable. For example, some staff told us they would give the person a telephone number to ring and some would tell the person to contact the Patient Advice and Liaison Service (PALS). We found that medical staff were aware of what to do if a person wanted to raise a complaint. Nursing staff told us that they could recall receiving feedback about previous complaints from their ward sister or charge nurse. The customer care team told us that all of the clinical management teams within the hospital received a monthly report on the numbers and types of complaints that have been received.

The trust had told us how complaints are managed and they recognised that further improvements were required. For example, the timeliness of their responses to people making a complaint is not in line with national requirements. Performance on this area was monitored monthly and an improvement project is currently being undertaken to determine the root cause for the delays and then a solution will be piloted, tested and once proven as successful will be rolled out across the organisation. Where delays occur, contact is made with the complainant to ensure they are kept up to date.

The customer care team told us that they were starting to offer people the opportunity to have face to face meetings with people who have made a complaint as opposed to just a written response. They told us that they find this is an effective way of dealing with complaints as people often want the opportunity to talk about their experience with someone who will listen to their concerns. The customer care team would support people and put them in touch with an advocate. This demonstrated that people were dealt with in a sensitive way and their individual circumstances were taken into account. There were arrangements in place to ensure that people making a complaint are not discriminated against, for example, copies of complaints are not stored in the person’s medical record.

We found an example of a change in practice that came about from a trend in complaints because some people received an outpatient appointment letter after the date that the appointment was due to take place. A courtesy call was made to people prior to the appointment to ensure people have received the details of their appointment. This has had a positive impact on people using the service and as a result the number of complaints has reduced.

The trust does not formally monitor the number of compliments that they receive so they are unable to recognise areas in the hospital that are performing well.
Our judgement
The trust has systems in place to deal with complaints but not all people using the service are aware of how to use it. People do not always receive a response to their complaint within the set timescales and investigations are not always sufficiently thorough.
Outcome 21: Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

There are minor concerns with outcome 21: Records

Our findings

What people who use the service experienced and told us

One person using the service told us that their surgery had been delayed by three months because the hospital could not locate his medical records. People using the service had not seen their records or their plans of care, but some people did tell us that the staff had told them what was happening to them.

Other evidence

The trust told us that they there was a Clinical Records Committee that provided the strategic governance for the management of health record activities and there are a number of up to date policies and procedures for the management of records in place. The trust were aware that records management is an area that requires improvement and have a comprehensive health records improvement programme in place. We saw evidence of this improvement programme being implemented.

We spoke to the medical records team and found that they were very aware that they provided a vital role in the care of people at the hospital. The medical records team had a slot on the trust’s corporate induction programme which all new starters have to attend. They told us that since they have been doing this they had seen an
improvement in the quality of the filing of the records. However the records team also told us that they did frequently receive records back for filing that contained loose papers. This presented a risk that records became separated and the notes of people’s care and treatment were not accurate. The records team did not report all of these instances through the trust’s risk management reporting system therefore an accurate assessment of the extent of the risk can not be determined.

We asked staff if they had difficulty in obtaining records for people, particularly when their admission was unplanned. Staff did not report any concerns and told us there was a good system in place to get hold of records out of hours. We observed the process to obtain records and found that records were securely stored and there were systems in place to retrieve notes when required. The trust had a patient document tracking system in place and were introducing a new filing system called “random filing,” which requires each record to be bar coded. The new system provides a more efficient way of filing and significantly reduces manual handling. Medical records that have not been used for one year are stored securely off site. There were arrangements in place to obtain these as required and these included arrangements for obtaining records in an emergency situation.

The medical records team log all records that can not be located onto a spreadsheet. When and if the records are located, the name of the person is removed from the data. There was some monitoring of this within the records department, but we were told that as part of the health records improvement programme, performance would be reported and monitored by the Clinical Records Committee. This would then provide more formal opportunities to identify trends, as well as where practice could be changed and improved.

We looked at a selection of care records of patients’ and found that generally these were legible, signed and dated. We noted that records made by occupational therapists were very detailed and were used to plan care for people. The trust was currently implementing a comprehensive health records improvement program which includes a project called “take note.” The objective of this project is to implement a revised clinical record for all adult in-patients during their stay within the trust. Staff we talked to knew about this programme and training had commenced. Some staff told us they looked forward to its full implementation as they felt it would be a better system.

Record keeping audits took place across the trust and areas for improvement are identified and then monitored within the directorates. We saw an example of a recent records audit which also provided evidence that action had been taken to improve performance.

The Audit Commission raised concerns with the trust about the quality of data and incorrect use of clinical coding. The Audit Commission is an independent watchdog which looks at the efficiency and effectiveness of public services. Clinical coding is the changing of medical terminology into a nationally recognised coded format. Codes are given for the reasons why people have been in hospital, for example, a hip replacement operation has a specific clinical code. The Audit Commission also
told us that as part of a review of the trust's clinical coding, they found that the trust's rate for unfit to audit records was 20.8%. The average rate in England for this is just 3% demonstrating that the trust's performance is poor. The Audit Commission found that records were unfit because they could not be located or there was no clear record about the coded inpatient activity in the notes. The trust told us that they have recently appointed a new Director who is responsible for data quality and they aim to improve performance in this area.

The trust had a policy in place for the handling of requests to access health records.

**Our judgement**
Records were stored in a secure and accessible way that allows them to be located quickly, but there were occasions when people's records are not accurate or fit for purpose. Other bodies have told us that they had concerns about the reliability of the clinical coding of records.
Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider maintains compliance with the essential standards of quality and safety.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| Treatment of disease, disorder or injury, Assessment or medical treatment of persons detained under the Mental Health Act 1983, Surgical procedures, Diagnostic or screening procedures, Maternity and midwifery services, Termination of pregnancy. | 17         | 1
|                                                                                   |            | Respecting and involving people who use services.                       |
| Why we have concerns:                                                            |            | People using the service have their privacy, dignity and independence respected but they are not always involved in their care planning. There are occasions when people are not given sufficient information about their care and treatment. |
| Treatment of disease, disorder or injury, Assessment or medical treatment of persons detained under the Mental Health Act 1983, Surgical procedures, Diagnostic or screening procedures, Maternity and midwifery services, Termination of pregnancy. | 9          | 4
|                                                                                   |            | Care and welfare of people who use services.                            |
| Why we have concerns:                                                            |            | People are safe in the hospital and the risks of people receiving unsafe or inappropriate treatment are being reduced however, not all people who use the service benefit from having care that is clearly planned. |

The provider must send CQC a report about how they are going to maintain 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 by 12 June 2011.

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

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury, Assessment or medical treatment of persons detained under the Mental Health Act 1983, Surgical procedures, Diagnostic or screening procedures, Maternity and midwifery services, Termination of pregnancy.</td>
<td>24</td>
<td>Outcome 6 Cooperating with other providers</td>
</tr>
<tr>
<td><strong>How the regulation is not being met:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People are not always receiving safe and coordinated care, treatment and support when more than one provider of care is involved, or they are moved between services.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Treatment of disease, disorder or injury, Assessment or medical treatment of persons detained under the Mental Health Act 1983, Surgical procedures, Diagnostic or screening procedures, Maternity and midwifery services, Termination of pregnancy. | 15 | 10 Safety and suitability of premises |
| **How the regulation is not being met:** | | |
| The hospital has taken steps to ensure people are protected against the risks of unsafe or unsuitable premises and generally we found that the hospital was well maintained. The women’s unit requires further refurbishment work as well as the removal of the asbestos. |

<p>| Treatment of disease, disorder or injury, Assessment or medical treatment of persons detained under the Mental Health Act 1983, Surgical procedures, Diagnostic or screening procedures, Maternity and midwifery services, Termination of pregnancy. | 10 | Outcome 16 Assessing and monitoring the quality of service provision |
| <strong>How the regulation is not being met:</strong> | | |
| Although there are systems in the trust to monitor the quality of service, the trust des not always fully investigate incidents, complaints and near misses to enable the service to improve within nationally recognised timescales. Not all staff were able to tell us how they learnt from incidents, complaints and near misses. |</p>
<table>
<thead>
<tr>
<th>Treatment of disease, disorder or injury, Assessment or medical treatment of persons detained under the Mental Health Act 1983, Surgical procedures, Diagnostic or screening procedures, Maternity and midwifery services, Termination of pregnancy.</th>
<th>19</th>
<th>Outcome 17 Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How the regulation is not being met:</strong> The trust has systems in place to deal with complaints but not all people using the service are aware of how to use it. People do not always receive a response to their complaint within the set timescales and investigations are not always sufficiently thorough.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment of disease, disorder or injury, Assessment or medical treatment of persons detained under the Mental Health Act 1983, Surgical procedures, Diagnostic or screening procedures, Maternity and midwifery services, Termination of pregnancy.</th>
<th>20</th>
<th>Outcome 21 Records</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How the regulation is not being met:</strong> Records are stored in a secure and accessible way that allows them to be located quickly, but there are occasions when people’s records are not accurate or fit for purpose. Other bodies have told us that they have concerns about the reliability of the clinical coding of records.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 by 12 June 2011.

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

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>Audience</td>
<td>The general public</td>
</tr>
<tr>
<td>Further copies from</td>
<td>03000 616161 / <a href="http://www.cqc.org.uk">www.cqc.org.uk</a></td>
</tr>
<tr>
<td>Copyright</td>
<td>Copyright © (2011) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.</td>
</tr>
</tbody>
</table>

Care Quality Commission

<table>
<thead>
<tr>
<th>Website</th>
<th><a href="http://www.cqc.org.uk">www.cqc.org.uk</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>03000 616161</td>
</tr>
<tr>
<td>Email address</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
</tr>
<tr>
<td>Postal address</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td></td>
<td>Citygate</td>
</tr>
<tr>
<td></td>
<td>Gallowgate</td>
</tr>
<tr>
<td></td>
<td>Newcastle upon Tyne</td>
</tr>
<tr>
<td></td>
<td>NE1 4PA</td>
</tr>
</tbody>
</table>