United Lincolnshire Hospitals NHS Trust  
Lincoln County Hospital

<table>
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<th>Region:</th>
<th>East Midlands</th>
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<tr>
<td>Location address:</td>
<td>Greetwell Road Lincoln Lincolnshire LN2 5QY</td>
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<tr>
<td>Type of service:</td>
<td>Acute services with overnight beds Community healthcare service</td>
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<tr>
<td>Date of Publication:</td>
<td>May 2012</td>
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<td>Overview of the service:</td>
<td>United Lincolnshire Hospitals NHS Trust has several hospitals. Lincoln County Hospital provides all major specialties such as maternity, cancer, intensive care and an emergency department. The trust provides the following regulated activities: Treatment of disease, disorder or injury, surgical procedures, diagnostic and screening procedures, maternity and</td>
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<td>midwifery services, termination of pregnancies, assessment or medical treatment for persons detained under the Mental Health Act.</td>
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Our current overall judgement

Lincoln County Hospital was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review

We carried out this review to check whether Lincoln County Hospital had made improvements in relation to:

Outcome 06 - Cooperating with other providers
Outcome 10 - Safety and suitability of premises
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 8 January 2012, carried out a visit on 13 February 2012, carried out a visit on 14 February 2012, talked to staff and talked to people who use services.

What people told us

This report includes the evidence we gathered on two visits to the hospital in January and February 2012. During the visits we went to 6 wards, the social work department, the medical records department and the women’s unit. We spoke with people using the service, members of staff and senior managers as well as relatives. We also looked at some of the records the hospital keeps and gathered evidence from Lincolnshire County Council social services department and their safeguarding team.

We saw evidence of some good discharge planning although some patients experienced poor and uncoordinated care after leaving hospital.

Most of the areas in the hospital were clean and well decorated. However, the women’s unit was still undergoing a programme of improvement to the fabric of the building which included the removal of asbestos. Patients in that area had not raised any problems about the building and said that the environment did not have any effect on their care.

The trust had improved its systems and processes for monitoring the quality of care and any risks to patients were reduced. Ward staff were informed on a monthly basis of how they performed against some key indicators. This meant they were able to be more focussed on improving outcomes for their patients.
Patients were aware that the hospital kept records about them and these were kept securely.

What we found about the standards we reviewed and how well Lincoln County Hospital was meeting them

Outcome 06: People should get safe and coordinated care when they move between different services

Some patients were at risk from delays and uncoordinated care and support when they were discharged from the hospital.

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

Patients who used the service were generally protected against the risks associated with unsafe premises. However the environment for patients in the women’s unit posed a potential risk.

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

Systems and processes had been improved for the assessment and monitoring of the quality of care and staff had been able to learn from untoward incidents.

Outcome 21: People’s personal records, including medical records, should be accurate and kept safe and confidential

Records were accurate and fit for purpose and were stored in a secure and accessible way that allowed them to be located quickly. The trust had actions in place to replace old and worn files. Some records were not always completed.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

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

Other information

In a previous review, we found that improvements were needed for the following essential standards:

• Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights
• Outcome 05: Food and drink should meet people's individual dietary needs

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

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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 06: 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 06: Cooperating with other providers

Our findings

What people who use the service experienced and told us
When we looked at this outcome in April 2011 we had moderate concerns.

The social workers who worked at the hospital were employed by Lincolnshire County Council social services department and not by the trust.

On the wards we saw some evidence of good discharge planning but there were occasions when discharges were not planned appropriately or safely. For example, we had been made aware of a patient being discharged to a care home with no medication and no information about what medication had been given prior to their discharge. Nursing staff on the ward concerned acknowledged that not all the information about the patient's care had been passed on to the home.

We also saw evidence of patient's discharge plans in place in their notes and we saw requests for occupational therapist and physiotherapist input into the discharge process. However, staff we spoke to said that social workers did not always tell the ward when they had been allocated patients and this resulted in ward staff having to spend time "chasing up" the social work department to find out who the social worker was for a particular patient.

We had been told by relatives of an elderly patient that the discharge arrangements for their loved one had been poorly planned and that they had not been involved, which gave them great concerns. They felt it was unsafe. We have since been informed that the situation has still not been resolved satisfactorily.
Other evidence

We saw on the wards that any drugs that needed to be taken home with a patient were ordered from the hospital's pharmacy when the patient was medically fit to be discharged. These sometimes had to be re-ordered if there was a delay in the patient's discharge and their drugs were changed.

We had evidence that two patients with dementia had been moved from an elderly care ward to the discharge lounge in the hospital during the night so that new patients could be admitted. Both patients had been scheduled for discharge later that day. The discharge lounge had minimal staff on duty at night time. The hospital was informed about this and plans were put in place to prevent this happening again.

When we spoke with a general manager of the social services department, at Lincolnshire County Council after our visit they provided us with evidence of nine cases of poor discharges over the last six months. For example one person had been discharged home without the knowledge of the company who had been providing the person's personal care prior to their admission. This meant that the company had not been able to find out if the person's care had changed and may have put their health and safety at risk.

Lincolnshire County Council also have a special safeguarding team who investigate any incidents of alleged poor care for vulnerable adults. We received evidence from the team that over the last twelve months there had been ten cases which were related to the poor discharge arrangements for patients. For example, one patient had been discharged without being properly dressed and without the equipment required to keep them safe at home.

Since our visit we have had information from a care home that the electronic discharge record for a patient who went there from the hospital had not been completed properly. It did not contain all the details they needed to know about the patient's care which may have put the person at risk.

The information we received from ward staff and the social work department was different. Some patients who had been medically fit to be discharged remained in hospital for several reasons. It wasn't clear whether the delay related to the trust or other stakeholders. When we spoke with NHS Lincolnshire about this we were informed that they were aware of concerns around discharge arrangements and that an audit was taking place with regard to delayed discharge. This audit had been requested by the Chief Executives in Lincolnshire to look at the multi-agency involvement in planning discharge. The result of the audit is will be known in May 2012.

Our judgement

Some patients were at risk from delays and uncoordinated care and support when they were discharged from the hospital.
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

Our judgement

There are minor concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
When we looked at this outcome in April 2011 we had moderate concerns relating to the women’s unit.

As well as looking at the women’s unit we also looked at other wards. Some of the newer areas were bright, spacious and well decorated.

One ward had moved to its current location in July 2011. The staff on the ward felt it had been a negative move because they were not able to fully observe patients who were poorly from the nurses’ station and there wasn’t enough room in the bays for the proper storage of patient lockers. The ward had received a complaint from a patient relating to lack of storage facilities and cluttered bays. Staff told us, and we also saw that they were managing the situation appropriately.

On one of the maternity wards in the women’s unit we saw there were replacement windows in the majority of areas, although there were a further two areas and a bathroom still to be finished. We saw the estates manager arranging for scaffolding to be erected to commence the work the following day.

We saw one new window that had a closure catch missing and staff told us that more were missing from other windows, however the windows were safe. They also told us that some of the windows were very draughty and some window sills had been replaced but not all of them.

The midwives we spoke with told us they thought the environment they had to work in
was poor because of the draughty windows, the low ceilings and the dark environment. However, two patients we spoke with told us the environment in the unit did not have any effect on the good care and treatment they received.

We were told that some of the ward flooring was being replaced. The work was being carried out at different times and in consultation with the ward manager, so it did not affect the ward activity too much.

Some areas of the ward contained asbestos and there were warning signs in place to alert people. The estates manager told us that areas of this were going to be treated in the near future. Regular monitoring by the trust ensures the building is safe. Some of the ceilings, where asbestos was in place, had been painted. The colour was very patchy and staff told us that it had an effect on morale and was not good for patients either. The assessment bay on the ward had new ceilings and we saw that it was much brighter.

**Other evidence**

Previous drainage problems on the maternity ward had not been fully resolved although patients were able use the shower. Where work had been carried out regarding the drainage problems that part of the ward had been refurbished.

When we looked at the shower rooms on this ward we saw that they were small and staff said they could not easily accommodate a patient who wanted to take their baby with them. Tiles in one shower room were stained brown and looked dirty, although the cleaning schedule had been adhered to.

**Our judgement**

Patients who used the service were generally protected against the risks associated with unsafe premises. However the environment for patients in the women's unit posed a potential risk.
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>
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<tr>
<th>Our judgement</th>
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<tr>
<td>The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision</td>
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<th>Our findings</th>
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<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
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<tr>
<td>When we looked at this outcome in November 2011 we had major concerns.</td>
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<td>During our visit we saw evidence of increased activities and systems that had been put in place to manage and reduce risks to patients.</td>
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<td>On our arrival at the hospital we saw the &quot;duty log&quot; from the night site manager and were shown the &quot;operations centre&quot; for the hospital where staffing levels on all wards is managed by a team of senior staff three times a day. We found that there was increased senior nurse support &quot;out of hours&quot; because of increased activity in the hospital. The &quot;duty log&quot; showed where staff were required in order to ensure adequate care provision for patients. With the use of their own &quot;bank staff&quot; and if necessary the use of agency staff, the staffing issues had been resolved. The night site manager had visited all areas of the hospital during their shift except the maternity unit, where there had been very few reported problems.</td>
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<td>On the second day of our visit to the hospital we found that in the afternoon initially only four of the 21 wards had been fully staffed. The trust's monitoring systems had identified the problem and senior staff dealt with this.</td>
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<td>The hospital had also introduced a system of &quot;quality dashboards&quot;. This system is a way of looking at various aspects of care in the different areas of the hospital and whether certain things are in place for patients. It includes for example medication charts, risk assessments and patient identification bands.</td>
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During our visit we saw that the hospital had provided this information for each ward on a monthly basis. Each ward we went to displayed the most recent chart on a notice board. On one ward we saw the most up to date chart and discussed this with the junior sister. They told us they had had reservations about the system when it was first introduced but now felt it was a useful tool to share with staff and make improvements.

On all the wards we visited we saw that ward meetings had to include set agenda items. One of these items was to look at the number of incident reports that had been made on the ward. Incident reports included things like staff shortages, drug errors that had been made and patient falls.

On one ward we saw the ward meeting folder containing one set of minutes, although these were not dated and the ward name had not been filled in. One section informed the reader how many incident reports had been completed in a month. Thirteen of thirty six staff signatures were evident in the folder to say those staff had read the minutes. On this ward the staff we spoke with said they did not receive any feedback from completed incident reports, although they clearly described feedback on audits that had been carried out, for example risk assessments. The feedback had been given at their staff meetings. They demonstrated clear knowledge of any outcomes and the lessons they had learned.

We met with a junior sister on one acute medical ward who told us that the senior sister raised any issues and gave feedback to all the staff with regard to the completion of incident report forms and any action plans that were made. The ward had received a letter from the deputy director of nursing commending them for their high levels of compliance with standards on the ward.

We saw the ward meeting minutes and were told that staff received an email if they hadn't signed the minutes. The junior sister felt that any investigation of incidents that had occurred on the ward were comprehensive and that the staff group learned from the experiences.

When we spoke with staff on an elderly care ward, we were informed that the amount of time senior staff had for assessing quality of care had improved. We were also told that incidents reports were printed off and fed back at ward meetings, acknowledging any lessons that had been learned from them and actioning any improvements that had needed to be made.

**Other evidence**

We were able to see examples of letters received from patients on one ward complimenting medical and nursing staff for the care received. We also saw examples of food audits, undertaken every mealtime, monthly mattress audits and controlled drug audits. The senior sister audits patient's notes every month.

**Our judgement**

Systems and processes had been improved for the assessment and monitoring of the quality of care and staff had been able to learn from untoward incidents.
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
The provider is compliant with Outcome 21: Records

Our findings

What people who use the service experienced and told us
Patients we spoke with were aware that they could see their records if they wished and we saw that regular audits of the quality of patient's records were undertaken

We looked at patient notes on all the wards we visited and also spoke with staff in the medical records department.

On one ward we saw that of the five patient's notes we looked at, none of the hourly rounding charts were completed for a full twenty four hours in the previous week. "Hourly rounding" is a way of checking patients are comfortable every hour and their needs have been met. We also noted it was mainly in the afternoons where gaps occurred in the charts. However, patients we spoke with said they were comfortable and pain free and we saw they looked well cared for. A member of staff we spoke with said they didn't really have time to complete them.
On another ward we were informed that hourly rounding charts were not used on this ward and this had been approved by the director of nursing.

On all the wards we found that patient's notes were stored in two different places. The medical and nursing notes for the patient's current admission were stored in one folder, generally an A4 type binder. This made them easier to use by all the health care professionals involved in their care. Notes from previous admissions were stored in
beige files.
All the notes we saw were being stored appropriately and were available for health professionals to use when needed. They were easy to read.
On the wards we saw that some pages were falling out of the notes or files. One sister informed us they were "not fit for purpose" Staff informed us new binders had been ordered.

On another ward we looked at two sets of notes belonging to patients that had had a lot of previous admissions. Both sets of notes had been sent from the medical records department the night before. They were very full and were at great risk of falling apart as the binders were old and worn.
We were told by the ward clerk they generally had to send about six sets of records back to the medical records department each week for re-binding. If a set of records needed to be re-filed we were told that it could take up to four hours to do. We were informed that all notes were being transferred to new files when patients were discharged.

When we arrived in the medical records department we were shown the new files that had been purchased and were told the new record system had been put in place in August 2011. Many patients' records had already been put into the new system. Extra funding has been applied for to purchase additional files and staffing hours in order to speed the process up. We were informed that the request for the additional resources is going back to the trust's executive board in March 2012 for approval.

When we asked about requesting past medical records for a new admission we were told that it should only take a maximum of 24 hours to get them to the ward where the request came from and there was a special process in place to request notes urgently.

Other evidence
There is currently an e-learning module in place within the trust to show newly recruited administrative, security and medical staff what is expected of them in relation to the care and security of medical records.

Our judgement
Records were accurate and fit for purpose and were stored in a secure and accessible way that allowed them to be located quickly. The trust had actions in place to replace old and worn files. Some records were not always completed.
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.

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<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 24 HSCA 2008</td>
<td>Outcome 06: Cooperating with other providers</td>
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<td>(Regulated Activities) Regulations 2010</td>
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<td>How the regulation is not being met:</td>
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<td>Some patients were at risk from delays and</td>
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<td>uncoordinated care and support when they</td>
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<td>were discharged from the hospital.</td>
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<td>Treatment of disease, disorder or injury</td>
<td>Regulation 15 HSCA 2008</td>
<td>Outcome 10: Safety and suitability of</td>
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<td>Patients who used the service were generally</td>
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<td>protected against the risks associated with</td>
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<td>unsafe premises. However, the environment</td>
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<td>for patients in the women's' unit posed a</td>
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The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

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

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.
CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

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

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

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

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

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<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
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<tr>
<td>Author</td>
<td>Care Quality Commission</td>
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<td>Audience</td>
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## Care Quality Commission

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<td>Postal address</td>
<td>Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA</td>
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