

# Review of compliance

United Lincolnshire Hospitals NHS Trust Lincoln County Hospital	
<b>Region:</b>	East Midlands
<b>Location address:</b>	Greetwell Road Lincoln Lincolnshire LN2 5QY
<b>Type of service:</b>	Acute services with overnight beds Community healthcare service
<b>Date of Publication:</b>	July 2012
<b>Overview of the service:</b>	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

	midwifery services, termination of pregnancies, assessment or medical treatment for persons detained under the Mental Health Act.
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# Summary of our findings for the essential standards of quality and safety

## Our current overall judgement

**Lincoln County Hospital was not meeting one or more essential standards. Action is needed.**

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

### Why we carried out this review

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

### How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 25 April 2012, talked to staff and talked to people who use services.

### What people told us

We carried out this review to see if people were given information about the medicines prescribed for them, and received these medicines safely at the right times

We visited three wards, including one ward caring for elderly people. We talked to doctors, nurses and patients. We also went to the lounge where some patients wait for their medicines or for transport before leaving the hospital. We visited the pharmacy and met the trust's chief pharmacist and other pharmacy staff.

One person said "The doctors and nurses were fantastic." Another person told us "The drug rounds are usually on time. Staff check my wristband, name and date of birth and that I have taken the tablets."

However, several people told us that no-one had discussed their 'take home' medicines with them. One person said, "I was just handed the bag (of medicines)." We found that one of this person's medicines was incorrectly labelled and there was also a mistake in the discharge letter to their GP.

We found that people on one elderly care ward received their medicines at the right times. On the other two wards we visited medicines were sometimes 'out of stock'. Also, nurses had not always signed medicine charts to show whether the medicine had been given or not.

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

**Outcome 09: People should be given the medicines they need when they need them, and in a safe way**

The provider is not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Medicines were not always prescribed and given to people appropriately.

### **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. We will check to make sure that this action has been taken.

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

### **Other information**

In a previous review, we found that action was 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 06: People should get safe and coordinated care when they move between different services
- Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare
- 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.

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

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

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

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

## Outcome 09: 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

#### Our judgement

The provider is non-compliant with Outcome 09: Management of medicines. We have judged that this has a moderate impact on people who use the service.

#### Our findings

##### What people who use the service experienced and told us

During our visit most patients we spoke with said they had been given some information about their medicines while in hospital. Two patients said that they were not told about the possible side effects of their medicines. One patient said, "I think the reason why staff didn't explain about my tablets was because I was a medical patient on a surgical ward. Staff always checked my wristband, name and date of birth." This meant that nurses checked that they were giving medicines to the right patients.

On one ward we visited a nurse told us they thought the opportunity for self-medication could be offered to more patients.

We met one patient who was self-administering their tablets with help from a nurse. The patient showed us a list of their medicines, with times and doses, written by the nurse. They told us the nurse handed them the medicines in labelled bottles for them to choose which to take. However, the nurse gave them the bottles during the medicine round after tea, and one tablet needed to be taken 30 – 60 minutes before food. The patient told us that their general practitioner (GP), who had first prescribed the medicine, told them to take it before food, and 'before food' was written on their list of medicines. This meant that the patient was getting slightly less benefit from the medicine by taking it after food, and was confused by the different things they had been told.

The trust had a self – medication policy which described how patients could take full or

partial responsibility for taking their medicines while in hospital if they wanted to. This meant that a patient (and the nurses caring for them) could decide whether they would need help to take their medicines after leaving hospital. We found that doctors and nurses knew about this policy, and we were told that the nurse looking after a patient would decide if it was safe for them to self-administer.

We looked at medicine charts on each of the three wards that we visited. We noticed staff signatures were missing from the administration record on a third of the medicine charts on one ward, and on a significant number of charts on another ward. If the nurse administering a medicine did not sign the chart, doctors and other staff did not know whether the patient they were caring for had taken the medicine.

We found medicines were sometimes 'out of stock', which meant there was a delay in the patient getting the medicine they needed. One patient missed doses of an antibiotic three days in a row which meant that their infection was not treated properly. On another ward we found that the medicine charts were all signed and medicines were very rarely out of stock. The matron responsible for this ward told us, "Out of stock recorded on a chart should mean the medicine is not available anywhere in the hospital."

During the afternoon we visited the discharge lounge, where some patients were waiting for their medicines to take home and others for hospital transport or for a relative to collect them.

The area was full of patients, which meant the two members of staff on duty were very busy. We talked to four patients in the discharge lounge. One patient had been waiting for their medicines for five hours as the doctor could not be contacted. This patient had not taken their lunchtime dose of one medicine. We were told that 'take home' medicines could be handed to patients by nurses on the ward they had come from or by the nurse in the discharge lounge. This meant that 'take home' medicines were not always checked properly by a member of the pharmacy team, which may increase the chance of a mistake.

Two patients told us that no-one had discussed their medicines with them. One patient said, "I was just handed the bag". This patient had checked their bag themselves and found a mistake in the discharge letter to their GP. They told us they had informed the staff nurse in the lounge and she had corrected the letter after making a phone call. We found one of the medicines in this patient's bag was labelled with the wrong dose. This patient knew what their medicines were for, and the correct doses, but similar mistakes could result in another person taking a dangerously high dose of medicine.

After our visit, we were told by the trust they were putting a "helpline" in place for patients to access information about their medicines. They told us they were also going to give patients a leaflet to help them.

### **Other evidence**

The consultant and junior doctors we met were generally happy with the service provided by the hospital's pharmacy. Pharmacists visit all wards, apart from the maternity wards, every week day and spend more time on the busiest wards. Three doctors we spoke with felt there was a need for pharmacy to provide more than an emergency 'on call' service at the weekends. One doctor told us, "If I want to discharge

a patient after noon on Saturday I have to write an FP10 (the type of prescription form used by GPs) and the patient has to collect their medicines from a community pharmacy, which is not always convenient for them." The trust had informed us they are consulting with the pharmacists and should hopefully soon be able to provide pharmacy staff seven days a week.

Medicines were stored safely and the use of controlled drugs was accurately recorded on the ward where we looked at these issues. Controlled drugs are those medicines which may cause harm or addiction if used wrongly. The pharmacy had recently audited the use of controlled drugs in the hospital. The audit found that controlled drugs were used safely but record-keeping needed improving on one ward; the pharmacy had produced guidance called "Reducing Harm from Omitted and Delayed Medicines in Hospitals." This guidance was to ensure nurses knew what may happen if patients did not receive their medicines at the right times.

Following our visit, the trust informed us they were developing a way to provide on-going monitoring of safe medicine management.

**Our judgement**

The provider is not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Medicines were not always prescribed and given to people appropriately.

## Action we have asked the provider to take

### Compliance actions

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

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	<p><b>How the regulation is not being met:</b> The provider is not meeting this standard.</p> <p>People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Medicines were not always prescribed and given to people appropriately.</p>	

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.

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

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

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

## Information for the reader

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