United Lincolnshire Hospitals NHS Trust

Lincoln County Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**

Our findings

Overall summary of services at Lincoln County Hospital

Inspected but not rated

United Lincolnshire Hospitals NHS Trust (ULHT), situated in the county of Lincolnshire, is one of the biggest acute hospital trusts in England serving a population of over 736,700 people. The trust provides acute and specialist services to people in Lincolnshire and neighbouring counties. The trust has an annual income of £447 million and employs 8,000 people.

In the last year, the trust had around 642,000 outpatient attendances, around 145,000 inpatient episodes and around 147,000 attendances at their emergency departments.

The trust provides acute hospital care for the people of Lincolnshire from their sites in Lincoln, Boston and Grantham and delivers services from community hospitals and centres in Louth, Gainsborough, Spalding, and Skegness.

We carried out a short notice unannounced focused inspection of the Children and Young People core service on 31 May 2023. We received information of concern about the safety and quality of the service.

During the inspection we focused on our safe questions relating to medicines and inspected Safari and Rainforest wards based at Lincoln County Hospital.

During the inspection we spoke with 1 relative and 12 staff including the ward manager, consultant, junior doctor, nurse in charge, band 4 and band 5 nurses. We also spoke with the Medicine Safety Officer and Associate Chief for Clinical Pharmacy.

We did not rate this service at this inspection. The previous rating of good remains:

We found:

The service had systems and processes to prescribe and administer medicines safely.

Staff learned from medicine incidents to improve practice. Action was taken and lessons were learnt.

The service had enough staff to care for children and young people and keep them safe.

However:

The service did not have specialist equipment to support children and young people to meet their individual needs.

Services for children and young people

Inspected but not rated

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We found:

- The service had systems and processes to prescribe and administer medicines safely.
- Staff learned from medicine incidents to improve practice. Action was taken and lessons were learnt.
- The service had enough staff to care for children and young people and keep them safe.

However:

- The service did not have bespoke equipment needed to meet the individualised needs of a child.

Is the service safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training.

Services for children and young people

After 2 incidents relating to children being administered too much medication had identified the need for further training, the trust had ensured all staff had received resuscitation training, in line with the action plan.

The department completed simulation training every week for staff to attend, this covered many different training sessions, and opened discussion for staff to ask questions and for the department to identify any lessons that can be learned.

Staff told us they had completed medication training and had their competency assessed, to ensure they were able to safely administer medications.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment generally kept people safe. Staff were trained to use them.

The service did have enough suitable equipment to help meet individual needs of children and young people.

During the inspection we were informed that the service had access to a mobile hoist to support children and young people for non-weight bearing patients, the service also had handrails in the en-suite bathrooms situated in the rooms.

However, in one instance the service did not have bespoke equipment needed to meet the individualised needs of a child. For example, there was no space to keep their wheelchair on the ward and they had no access to a specialised shower chair. We shared these concerns with the leadership team who planned for the wheelchair to be stored safely on the ward. They also took action to identify suitable specialist equipment required for showering and are in the process of purchasing this equipment.

Nurse staffing

The service had enough staff with the right qualifications, skills, training, and experience to keep children, young people, and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels.

The service had enough nursing and support staff to keep children and young people safe.

The ward manager could adjust staffing levels daily according to the needs of children and young people.

The number of nurses and healthcare assistants matched the planned numbers.

The service had staff vacancies for the 2 wards this was 11.98% of staffing.

Nursing sickness rates for the month of April 2023, the service had 8 staff absences due to sickness this equated to 3.27% for Rainforest and 7.12% for Safari.

The service had reducing rates of bank and agency nurses.

The service used bank and agency staff to ensure there were enough staff to cover the shifts.

Services for children and young people

The service ensured that where possible they would use agency staff that were familiar with the wards, to ensure consistency for the children and young people.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep children, young people, and their families safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep children and young people safe.

The medical staff matched the planned number.

The service had a 5.83% medical vacancy rate across the 2 wards.

There was 1 occurrence of medical staff absence in April 2023. This was the equivalent of 0.2% of the contracted medical staff full time equivalent, demonstrating the absence rate was low for the month.

The service used locum staff to cover vacancies within the service for the months of April and May 2023. During this time there had been 1 shift in May 2023 that was unfilled, however, this had been identified as unfilled sickness and was covered through a consultant on-call.

The service ensured that where possible that they used locums who were familiar to the service to ensure consistency for the child and young people.

The service always had a consultant on call during evenings and weekends.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

Information and policies for the administration of intravenous (IV) medicines were reviewed and kept up to date. These were accessible to staff in folders kept in medicine storage rooms and were also available electronically on the trust intranet. Although we were told that the electronic availability to these policies was not as easy as paper versions and was more time consuming for staff to quickly access.

Administration of IV medicines was undertaken by either a nurse and a doctor (not the prescriber) or 2 nursing staff who had undergone extra training and had been assessed as competent. This included an annual medicine management competency check. Staff we spoke with highlighted that there was a lot of training available which included simulation exercises in different scenarios, such as asthma, anaphylaxis, cardiac arrest, and seizures. A doctor commented that nurses double checked dose prescribing and calculations with a doctor if it was unusual.

Following a serious incident involving a high-risk medicine action was taken in the following areas:

Services for children and young people

- The trust guidance available on the prescribing and administration of the medicine was discussed at the Children and Young People Clinical Governance meeting. This involved reviewing all the available evidence on the most effective and safe form of administering the medicine. The British Thoracic Society guidelines were also reviewed for treating acute asthma. Following this further guidance, training and information was made available to staff. Staff said the updated information including calculations was helpful to ensure the correct dose was calculated.
- To take action to ensure staff have easy access to a paediatric emergency information card for the administration of adrenaline and infusion calculations. These were available on all the resuscitation trolleys.
- A flow chart for treating and assessing the severity of asthma was available in clinical treatment rooms including information on prescribing.
- A flow chart for treating anaphylaxis was available in clinical treatment rooms.

Staff completed medicines records accurately and kept them up to date.

Allergy statuses were routinely recorded on all medicine records seen. This meant that allergies were highlighted, and medicines could be prescribed safely.

Weights of patients were recorded on medicine administration records which was important for calculating weight-based medicines prescribing.

Staff stored and managed all medicines and prescribing documents safely.

High risk injectable medicines, which included adrenaline and magnesium sulphate, were stored on a separate shelf that was clearly marked as 'High Risk Medicines.'

Resuscitation trolleys were immediately available in the event of an emergency. These were sealed with tamper evident tags. This followed the guidance from the UK Resuscitation Council. Evidence of daily checks were recorded to ensure the medicines were available and safe to use.

Staff learned from safety alerts and incidents to improve practice.

The trust had systems in place for recording incidents and staff we spoke to were able to identify its use and how to access the system.

Staff told us they felt supported when there was a medicine incident with good de-briefing, as well as knowing where to go for advice if needed.

The trust has a Medicines Safety Officer (MSO) which was in line with NHS England directives. The MSO attended regional and national MSO networks to share and contribute to learning from safety incidents. They had shared the recent medicine safety incidents with the regional MSO network to ensure lessons learnt could be shared across other trusts. The MSO was involved and contributed to discussions concerning the recent investigations of medicines safety within the trust, however, they were not acknowledged on any of the investigation reports.

Services for children and young people

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents in line with trust policy.

Staff understood the duty of candour. They were open and transparent, and gave children, young people, and their families a full explanation when things went wrong.

The service held monthly governance meetings and duty of candour had been regularly discussed and monitored during these meetings.

Staff received feedback of incidents and when the senior leaders discussed patient journeys, they discussed the outcome and congratulated staff when the patient had received a good standard of care.

Managers investigated incidents thoroughly. Children, young people, and their families were involved in these investigations.

Managers investigated incidents and once completed findings were then shared with an independent panel within the senior leader's team, who held a discussion and agreed actions. An action plan would be implemented, and the department would work to address the actions in a timely manner and within agreed timescales. For example, for the 2 serious incidents we reviewed, the service had completed an action plan with set dates for completion. We found all actions had all been completed and staff were aware of any identified learning.

The senior leaders discussed risks monthly. These meetings identified the risks and any agreed actions implemented to mitigate future risk.

Staff told us that after a serious incident had occurred that they received support from local managers within the department.

Our inspection team

The team that inspected the service comprised of a CQC (Care Quality Commission) lead inspector, a CQC operations manager and CQC pharmacist inspector. The inspection team was overseen by a Deputy Director of Operations.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation