Peninsula Community Health C.I.C

1-247215513

Community health inpatient services

Quality Report

During this inspection we visited the follow registered locations:

CQC Registered Location
CQC Location ID

St Austell Community Hospital
1-303962531
Bodmin Hospital
1-303999240
Newquay Hospital
1-303947227
Liskeard Community Hospital
1-303946965
Launceston Community Hospital
1-303946863
St Barnabas Hospital
1-303984801
Fowey Hospital
1-303926348
Falmouth Hospital
1-303926236
Helston Community Hospital
1-303946611
Camborne and Redruth Community Hospital
1-303925581
Edward Hain Hospital
1-303998774

This core service is also provided at the following registered locations which were not visited during the inspection:

CQC Registered Location
CQC Location ID

St Mary's Hospital, Isles of Scilly

Summary of findings

1-303985084
Stratton Hospital
1-303985486
Tel:01726 627 930
Website:www.peninsulacommunityhealth.co.uk

Date of inspection visit: January 21,22,23,28,29,
Date of publication: 21/04/2015

This report describes our judgement of the quality of care provided within this core service by Peninsula Community Health C.I.C. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Peninsula Community Health C.I.C and these are brought together to inform our overall judgement of Peninsula Community Health C.I.C

Summary of findings

Ratings

Overall rating for Community health inpatient services	Good
Are Community health inpatient services safe?	Good
Are Community health inpatient services effective?	Good
Are Community health inpatient services caring?	Good
Are Community health inpatient services responsive?	Good
Are Community health inpatient services well-led?	Good

Summary of findings

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Overall summary

Overall rating for this core service Good

The service provided good care across all of their community hospitals. Multidisciplinary care was provided to help patients meet their potential and be discharged to the most appropriate setting. Patients and relatives told us that staff were helpful, kind, supportive and knowledgeable. Patients felt their dignity and privacy was maintained and they were involved in their care, including plans for discharge. Staff told us access to training was good, and they were able to develop their skills.

The service learnt from incident reports and complaints and was open with patients and relatives about how they intended to make improvements. Feedback from the friends and family test was overwhelmingly positive and the results were displayed on most wards.

Staff were well led at a local level. They knew who their locality managers, interim director of operations, the chair of the board and the chief executive officer were, and thought they were all approachable.

Staff told us about local innovations which included a memory café, work with the local Age UK team, as part of their 'living well' programme and a 'clinical skills week' which all staff participated into ensure they were skilled and competent to start work on the wards.

Pain assessment documentation was not always completed fully but most patients received pain relief medicines when they needed them.

A shortage of therapy staff at some of the smaller hospitals meant that important rehabilitation pathways, such as the management and prevention of falls, were not always being fully implemented and reviewed.

Summary of findings

Background to the service

Background to the service

The provider runs 13 community hospitals across the whole of Cornwall and the Isles of Scilly. The hospitals vary in size, ranging from nine beds at Fowey Hospital to 44 beds at St Austell Hospital. They provide general inpatient services with a focus on rehabilitation and specialist stroke services (Camborne and Redruth hospital). Edward Hain and Bodmin Hospitals, each had a bed allocated for patients who required alcohol detoxification, this was in conjunction with Addaction-Cornwall. We visited 11 hospitals during the inspection, some announced and others unannounced. Stratton Hospital was closed to inpatients at the time of our inspection due to major remedial work taking place. We did not visit St Mary's Hospital on the Isles of Scilly but we did speak with the hospital manager about a range of aspects of care and service provision.

Peninsula Community Health Services CIC (PCH) employs staff across the 13 hospitals. They are supported by local GPs who carry out ward rounds on a daily basis during the week. Some hospitals have consultant cover provided by the local acute trust. Medical cover overnight, at weekends and on bank holidays was provided by the out-of-hours GP service via the 111 system.

We spoke with five doctors, three locality managers, six matrons, eight ward managers, 24 registered nurses, 14 healthcare assistants, occupational therapists, assistant occupational therapists, physiotherapists, two discharge coordinators, five administrative staff and housekeeping staff.

We spoke with over 50 patients across all of the hospitals and 15 relatives, friends or neighbours.

Information about the Provider

Peninsula Community Health CIC provides NHS healthcare services to a population of almost three quartersof a million people in Cornwall and the Isles of Scilly. The demographics of Cornwall and the Isles of Scilly are broadly similar to England, although there is a slightly larger elderly population in Cornwall compared with England (6% higher in proportion). Deprivation in Cornwall and the Isles of Scilly is lower than the England average, although about 18.1% of Cornish children live in poverty. Life expectancy in Cornwall and the Isles of Scilly is slightly higher than the national average, standing at 79.5 for males and 83.5 for females compared with 79.2 and 83.0 nationally.

Our inspection team

Our inspection team was led by:

Chair: Dorian Williams, Assistant Director of Governance, Bridgewater Community Healthcare NHS Foundation Trust

Team Leader: Mary Cridge, Care Quality Commission

The team included CQC inspectors and a variety of specialists: district nurses, a community occupational therapist, a community physiotherapist, a community children's nurse, palliative care nurses, a director of nursing, a governance lead, registered nurses, a community matron and two experts by experience who had used services.

Why we carried out this inspection

We inspected Peninsula Community Health CIC as part of our comprehensive community health services inspection programme.

Peninsula Community Health CIC is an independent organisation providing NHS services and therefore we used our NHS methodology to undertake the inspection.

Summary of findings

How we carried out this inspection

During our inspection we reviewed services provided by Peninsula Community Health CIC across Cornwall and the Isles of Scilly. We visited community hospital wards, minor injuries units and outpatient clinics. We accompanied district nursing teams on visits to people in their homes where they were receiving treatment.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the core services and asked other organisations to share what they knew, this included Healthwatch. We carried out an announced visit on 21, 22 and23 January 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists. We talked with patients. We observed how patients were being cared for and talked with carers and/or family members and reviewed care or treatment records of patients. We carried out an unannounced visit on 29 January 2015.

What people who use the provider say

- Patients and their relatives spoke positively about staff, referring to them as kind, caring and knowledgeable. A relative told us that they thought the care and treatment on the stroke ward was excellent, with the family fully involved, they said "there is not a bad word to say".
- Patients we spoke with said "I have been given information to aid my choices, for example, about being discharged" and "I know my named nurse and she would tell me about my care".
- At Falmouth Hospital we were told "this is the only place I would choose to be, it's very clear that I am improving". Another patient told us they had made "considerable progress" since moving from the acute hospital. They said the information provided and discussion with the staff ensured they were well informed about their prognosis and discharge targets.
- Patients told us "staff work so hard, they're always on the go" and "I think they could do with a few more sometimes, but staff would come running to help me if I needed them". Relatives told us, "they're [the staff] run off their feet", "everyone's needs are entirely different, but from what I've seen, they cope with everything".

Good practice

- All staff we spoke with or observed showed commitment to good care, displaying caring and positive attitudes.
- Launceston Hospital staff told us about working with the local Age UK team as part of their 'Living Well programme' aimed at identifying areas of a person's life they may like support with once they had left the hospital. They told us this had enabled patients to revisit hobbies they had enjoyed before becoming ill and Age Uk had helped them to access transport to local clubs and provided staff to accompany them, for example.
- Newquay Hospital had recently established a memory café. It was open to patients and members of the public. There were cream teas, music from a male voice choir and a rabbit whisperer performing during the afternoon. Following its success we were told the hospital would be running a memory café once a month.
- Each morning the person in charge of each community hospital attended a teleconference, along with acute hospital discharge teams to discuss potential

Summary of findings

discharges from the community hospitals and review suitable admissions from the acute hospitals to the community hospitals. Staff reported these daily conversations were helpful when planning resources.

- Locality managers told us that on order to ensure newly appointed registered nurses and healthcare assistants were able to work effectively soon after they had started with the organisation, they were encouraged to attend a week of clinical skills training following their corporate induction. Topics covered included pressure ulcer care, continence awareness, venepuncture, A-Z of wound care and falls, frailty and Parkinson's awareness. Staff who had attended this week told us it was invaluable and "great to help me get started".

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST or SHOULD take to improve

The provider should

- Continue to review staffing levels across the community hospitals, including therapy staff.
- Ensure that there is a consistent multidisciplinary approach to the prevention and management of falls across the hospitals.
- Ensure pain assessment and review is always carried out and documented.
- Ensure care records are always completed in full.
- Ensure meals are served in a timely fashion so that all courses can be enjoyed at the pace of the patient and all course are hot (where appropriate).
- Ensure patient mealtimes are 'protected' in line with the organisation's policy.
- Ensure staff receive an annual appraisal in line with the organisation's policy.
- Ensure all pressure relieving equipment is checked to ensure it is fit to use and the checks documented.
- Ensure each inpatient service has a consistent and robust pharmacy service.

Peninsula Community Health C.I.C

Community health inpatient services

Detailed findings from this inspection

The five questions we ask about core services and what we found

Good

Are Community health inpatient services safe?

By safe, we mean that people are protected from abuse

Summary

Peninsula Community Health Services CIC (PCH) provided good services to community inpatients. The service learnt from incidents and changed/improved practice as a result.

Patient information and records were well managed in terms of confidentiality but not always fully completed.

The hospitals were clean and staff complied with PCH infection control policies. Equipment was clean and serviced as required.

The pharmacy service offered to the community hospitals was inconsistent due to low numbers of pharmacy staff.

Most hospitals reported low staffing levels (nursing and healthcare assistants) supported by bank and agency staff. The organisation was continuing to recruit staff at all levels. Nursing staff told us, despite staffing levels being a challenge, they were able to access training and the organisation provided a good training programme.

Detailed findings

Incident reporting, learning and improvement

- Staff reported incidents on the organisation-wide electronic reporting system. This was available in all ward and department areas via the organisation's intranet. Staff in all community hospitals told us this was easy to do, although time consuming. Many staff we spoke with had reported incidents. Some said they got feedback and others said they did not. Therapy staff on some sites reported not having time to make incident reports.
- There was learning from incidents. Staff described changes in practice arising from reported incidents. It was evident that learning took pace organisation-wide. At Falmouth Hospital we saw a bereavement information booklet that had been produced following a reported incident that identified a lack of clear

information about the facilities available at the hospital. The booklet provided clear information for patients and relatives about the arrangements for managing bereavement.

Duty of Candour

- A new statutory duty of candour regulation applicable to the provider will come into force in April 2015 (Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour explains what providers should do to make sure they are open and honest with patients when something goes wrong with their care and treatment. Staff we spoke with were aware of the duty of candour regulation and its introduction due in April 2015. They felt the organisation already dealt with complaints in an open and collaborative manner.

Safeguarding

- Staff we spoke with had a good understanding of safeguarding. They were able to identify what constituted abuse, and how to report suspicions. A member of staff told us, "we can approach the safeguarding team for advice and support".
- Most staff had completed safeguarding training although some community hospitals such as Bodmin had less than 50% of staff recorded as completing this. Range 45-100%
- In most hospitals we saw a flow chart displayed in staff rooms and/or nurses' stations which had information for staff about the safeguarding process.
- At Helston Community Hospital we saw that a safeguarding concern had been identified regarding a patient. A risk assessment had been completed and was being reviewed on a regular basis. There were records that showed a multidisciplinary approach was being coordinated.
- The provider had a named nurse for safeguarding for children and adults. Staff were aware of who these people were and how to contact them.

Medicines management

- We observed medicine rounds in several of the hospitals we visited. Some nursing staff administered medicines from a medicines trolley, while others administered patients' own medicines stored in a locked box at their bedside. We observed staff carrying out appropriate checks to confirm the patient's identity. They spent time giving medicines to people, explaining what they were for and remained with them while the medicine was swallowed. We saw one example of a nurse leaving medicines with a patient for them to take later. The patient had capacity to remember to take their medication and was aware of the importance of making sure the medicines were not left unattended at any time. The nurse signed the medicine administration record when she had checked the patient had taken their medication.
- We reviewed medicines administration records and noted they were correctly completed, including recording patient allergies. In the event that a medicine had not been given, the reason for this was correctly recorded using the coding system on the form.
- Any reported medication errors were dealt with appropriately. This included informing the patient what had happened and where necessary, the nurse involved being given support and extra training.
- Medical gases were stored appropriately in all of the hospitals we visited. Staff were trained in safe use and storage of medical gases.
- The ordering, receipt, storage, administration and disposal of controlled drugs were undertaken in accordance with the Misuse of drugs Act 1971 and its associated regulations. The Standard Operating Procedures for Controlled Drugs had been reviewed and updated in December 2014. An external audit of controlled drugs storage on inpatient units had taken place in September 2014 and action plans had been put into place in response to the findings. Incidents involving controlled drugs were reported via the incident reporting system and were investigated by the Accountable Officer for controlled drugs and records made of the actions taken.
- Three patients who were waiting to be discharged told us the sister had explained to them about the medicines they were taking home and they knew what they were taking and why.
- Staff had been trained to administer vaccines and there were anaphylaxis trays for use in the event allergic reactions, in place and ready for use if required.
- Records confirmed that drug fridge temperatures were checked daily.
- Patients received their medicines as prescribed by their doctor. Not all the inpatient units received a clinical pharmacist visit and therefore there was no oversight of prescribing by a pharmacist at these locations. Bodmin

Hospital, Newquay Hospital, Stratton Hospital and St Mary's Hospital did not have a clinical pharmacist visit. It was not clear if St Austell Community Hospital and Fowey Hospital had monthly visits by a clinical pharmacist as one document seen stated there had been a monthly visit to the sites and one document stated there had been no monthly visit. At the remaining hospitals a pharmacist visited once a week, which is considered good practice. Only three hospitals received a stock medicines top-up service. These arrangements had been identified as a risk by the organisation. We were told that the pharmaceutical advisors were available by telephone and that staff could also access medicines information and an out-of- hours service from the local NHS acute trust. The organisation was aware of the issue and had placed it on the risk register. It had been given a score of 20 which is the second highest score in the system the organisation used. One action planned was to employ a pharmacy technician to target areas that needed support.

- A pharmacy helpline was available to support ward staff when the pharmacist technician was not available.
- The provider had introduced a new prescription and administration record in 2013 for use on the inpatient units, so that all the relevant medicines information was available in one document. The CQC pharmacist looked at 14 records on the units visited. We found that the direction to administer medicines were correctly written by the doctor. In November 2013 an audit of the quality of prescribing was undertaken on the inpatient units following the introduction of the new prescription chart. This demonstrated that the quality of prescribing had improved since the previous audit, particularly for the prescribing of 'when required' medicines. An action plan was developed with timescales that indicated that the audit would be repeated in September 2014, however this had not taken place.
- The service had a comprehensive system for reporting incidents. Three hundred and sixty-eight incidents involving medicines had been reported from 1 April 2014 across the provider's services. Of these 222 had been reported by the inpatient units. Forty (18%) of these involved lack of documentation provided by the organisation from where the person was transferred, 73 (33%) related to delayed doses or the medicine not being administered and 45 (20%) resulted in delay to the patient. The four inpatient units which did not receive a clinical pharmacy service had reported 93 of these medicine incidents, which accounted for 42% of medicine incidents on inpatient units.
- The pharmaceutical advisors provided support to investigate medicine incidents, provided training for staff and produced a monthly newsletter which highlighted medicine issues and learning from the investigation of incidents. They also held regular meetings with ward nursing staff and matrons to discuss current medicine issues

Safety of equipment

- We looked at a range of equipment in all the hospitals we visited, including beds, hoists, wheelchairs, physiotherapy equipment and medical equipment. We found that all maintenance was up-to-date and recorded and annual safety checks had been carried out. However, we saw two pressure relieving cushions had 'bottomed out' meaning they were no longer able to give the required relief. This was pointed out to the matron and ward manager.
- Staff told us they were never asked to use any equipment they had not been trained to use and said they would refuse should they be asked.
- We had received concerns, from an anonymous source, that not all wheelchairs had footplates attached to them. During the inspection all of the wheelchairs we looked at had footplates attached. We saw some wheelchairs with 'out of use' labels attached as they were waiting for repair.
- Staff said equipment was repaired promptly, particularly when this related to a safety or hygiene issue.
- We reviewed the records which were kept to confirm emergency equipment, including resuscitation equipment, was checked every day. We saw the safety checks had taken place.
- Staff said they were able to obtain pressure relieving equipment such as mattresses and cushions from the equipment store if they were not already available on the ward. However, a member of staff said, "It's difficult to get equipment at weekends and after 4pm" and "there's no Bank Holiday cover for the equipment store".

Environment

- Issues that related to the buildings themselves often took longer to resolve as the organisation did not own any of the premises they provided services in. There was

a backlog of estates' maintenance that the organisation had placed on their risk register. Staff told us they knew the organisation was in negotiation with the owners of the buildings about the outstanding maintenance issues.

- The provider had taken the decision to close Stratton Hospital to inpatients, for a short period of time (which included the time we inspected the organisation). This was to ensure the safety of patients was not put at risk whilst some important remedial building work was taking place. Staff had been redeployed to work in other local community hospitals or in the community. We spoke with patients who would normally have been at Stratton Hospital as it was nearer to their home. They said their discharge did not appear to have been delayed by being further away from home.
- Most community hospitals had access to outside space, which was well maintained. This meant patients could get some fresh air which in some cases being able to go outside helped patients with their rehabilitation.
- Feedback from staff at Newquay Hospital described the 'ward office' as being too small with only three desks and up to seven people working in it at times. A member of staff said the "ward office is always full with staff, including occupational therapists and physiotherapists, making it difficult to manage important paperwork and phone calls".
- Patients had access to call bell system to summon staff assistance. We saw patients who preferred to sit in the dining/day room when it was quiet were given hand bells to use to gain staff attention as there were no call bells in the area.

Records and management

- All the patient records we looked at were securely stored and patient confidentiality was protected. Where patient information was written on white boards they were usually in an office accessible to staff who required the information but not to people visiting the ward or other patients. However, at St Barnabas Hospital we saw a white board displaying patients' names that was in a public thoroughfare. We pointed this out to the ward manager and the names were immediately removed.
- We reviewed 20 sets of care records and saw these contained detailed information on each patient, including risk assessments and daily evaluations. In some of the hospitals, Launceston Community Hospital, St Austell Community Hospital and Liskeard Community Hospital, risk assessments and pain assessment charts were not always up-to-date. Staff undertook recordkeeping audits at various intervals, but most records were subject to a monthly audit with findings reported back at ward level.
- We saw inconsistent practices in the completion of discharge planning records. Some discharge plans were developed soon after the patient had been admitted and contained clear information about future plans. However, some patients, who had a discharge date, did not have much documented information about the plans for their discharge.

Cleanliness, infection control and hygiene

- All areas visited were clean. Each ward area had a large board at the entrance, which displayed ward-specific information. We saw the results of cleanliness audits on these boards in some of the community hospitals visited.
- Cleanliness audits were undertaken by housekeeping staff, and hospitals had patient-led assessments of the care environment (PLACE) assessments undertaken. Overall, these assessments achieved a cleanliness score of 93.6% across all 13 locations inspected between January and June 2014. We saw how the findings of these audits improved performance. For example, at Newquay Hospital, additional training and local audits had resulted in ongoing improvements in infection control.
- Staff had access to personal protective equipment such as gloves and aprons. We observed staff and visitors applying gloves and aprons before entering, washing their hands and using hand sanitising gel following their time spent with patients. All hospitals had side rooms for nursing patients who had an infection. We saw this in practice in several of the hospitals visited. Signage indicating the infection control risk was clear on doors and there was a supply of gloves and aprons at the entrance to the room.
- The service had a specialist infection control team. Community hospitals had infection control link nurses who liaised with the organisation's infection control team.
- Clinical waste was safely managed. Different coloured bins were used for waste disposal and linen was also segregated and bagged, depending upon whether it was soiled or not.

- Equipment had 'I am clean' tapes affixed to them, which were easily visible. These showed the last date and time equipment, such as commodes, had been cleaned. We saw a commode being thoroughly cleaned and a tape applied.
- Hand hygiene was practiced in accordance with the organisation's policy. We saw staff, including medical staff, using good hand hygiene practices at all the hospitals we visited.
- At Helston Community Hospital we looked at the weekly infection control monitoring record for all the patients on the ward. The records showed that all new patients were screened for MRSA (meticillin-resistant staphylococcus aureus) within 24 hours of admission. A record was kept of patients with urinary catheters and those with long term antibiotics to monitor any incidences of infection.
- Relatives told us, "generally it's clean and infection control is good", "the ward is always clean, they go under the beds and all over", "as soon as people leave the chairs they're hand cleaned", "the place is always clean and tidy" and "we see staff washing their hands". Patients told us, "the ward is always clean", "they're always cleaning the floors" and "you could eat your dinner off this floor".

While all hospitals visited were clean, the environments in which patients were cared for varied. Some of them were in modern premises and others were in very old buildings. In the old buildings some areas looked tired but we saw they were being kept clean in line with the organisation's cleaning schedules.

Mandatory training

- Staff told us they had access to "excellent" training and there were "plenty of opportunities". Staff said although it was sometimes difficult to get to the new training centre in mid Cornwall, the facilities were good.
- Staff said "we do infection control, fire, information governance, basic life support and anaphylaxis training" and "we have an annual update day which covers everything." A member of staff added "its better now the training is done in one day". Staff also told us there were link staff on the wards who were able to provide additional support in areas such as such as infection control.
- We saw staff at some hospitals were not up-to-date with mandatory training, For example, at St Austell Hospital, 12 out of 33 staff were not up-to-date with their fire training. The matron at Newquay Hospital told us a number of staff were out-of-date for their fire training. She had arranged for a trainer to come to the hospital so staff, including community staff, could get up-to- date.
- The percentage of staff receiving mandatory training had improved over the last few months. It had been recognised that staff shortages had led to staff sometimes having to cancel mandatory training sessions to provide cover on the wards. Ward managers we spoke with told us they allocated their staff a day for their mandatory training. As it was now completed in one day it was easier for staff to arrange cover for their shifts.

Assessing and responding to patient risk

- The care records we reviewed contained risk assessments which included nutrition and falls. These were reviewed regularly (in many cases daily) and updated when care needs changed. Oak Ward at Liskeard Hospital had a system in place to ensure each part of the care plan, for example, personal cleansing and dressing, was reviewed and updated weekly and/or more often if things changed in between. This ensured each section of the care plan was reviewed at least weekly. We saw details of actions to be taken as a result of risk assessments.
- The National Early Warning Score (NEWS) documentation was used in all of the community hospitals (a standardised bedside chart that uses universally recognised terminology to make it easier for clinical staff to recognise and respond to a patient whose condition is deteriorating). We saw records that showed patients had been referred to the medical team appropriately based on changing scores.
- Staff we spoke with told us they usually received information about patients prior to admission. This meant they could access appropriate equipment prior to the patient arriving in the hospital.
- Nursing staff completed immediate life support (ILS) training every two years. In between they undertook basic life support (BLS) training, which was also completed by healthcare assistants. We saw records that showed this training was up-to-date. Healthcare assistants also undertook the 'recognition of deteriorating patients' course.
- We saw all of the hospitals we visited had isolation rooms or bays. These would be used in the event of any

infection control outbreak. Staff told us visiting would be restricted during any outbreak of infection where this was required, and advice given to relatives, should this be necessary.

- Each patient had a named nurse. Where necessary, occupational therapists and physiotherapists had been allocated to work with patients to aid their rehabilitation, reduce their risk of falls and help them to learn how to use mobility equipment.
- Care records we reviewed contained risk assessments. These provided guidance to staff on how to reduce or eliminate risks. For example, there was a falls risk assessment explaining what equipment a patient needed to use and how many staff were required to support them. Risk assessments were also completed for patients at risk of developing pressure ulcers and patients with vulnerable areas were checked regularly.

Staffing levels and caseloads

- Most hospitals had staff vacancies (nursing and healthcare assistant). The organisation continued to advertise for and recruit new staff. The clinical practice week, that trained nurses undertook following their induction, meant that they were able to work on the wards using the required skills quite soon after commencing employment. Staff told us the recruitment process for bank staff (including therapists) could be lengthy and had meant some people had found alternative employment due to the long wait.
- Most wards displayed information which showed the number of nursing staff that should be on duty and the number there actually were. The number of therapists was not highlighted in the same way to visitors or patients.
- Levels of staffing were assessed through use of a policy and matrix which stated the number of registered nurses and healthcare assistants that should be on duty for each shift at each community hospital. The policy also contained information on which hospital staff should be moved from if another hospital was short. This enabled a consistent approach and was coordinated by the matrons. If community hospitals were unable to help each other out as per the policy then agency or bank staff would be used.
- Staff, including therapists, at all sites we visited and including St Mary's Hospital on the Isles of Scilly, where we interviewed the matron by telephone, told us that staffing levels were a concern. We were told there was frequent use of agency and bank staff. The matron from St Mary's Hospital told us by the end of April 2015 they would be 80 hours short per week. They would continue to cover the vacant shifts with bank and agency staff until they could recruit more permanent staff. They said they were continuing to advertise nationally but as there was little affordable accommodation on the island this discouraged people from relocating. She added she had spoken with the chief executive and board members about the problem and was hoping for a solution.
- We identified some concerns over the staffing ratios on certain wards at certain times. For example, at Helston Hospital the ratio was one registered nurse to 12 patients during the day and at night it could be one registered nurse to 24 patients. At Camborne and Redruth Hospitals at night it could be two registered nurses to 44 patients, across two wards. This meant that staff were very busy but able to meet patients' needs. The Royal College of Nursing recommends a ratio of one trained nurse to eight patients for the care of older people.
- In the event of sudden staff sickness absence, staff told us they worked flexibly to provide cover.
- Staff carried out an induction with any new agency or bank nurse prior to them commencing a shift. The manager at St Barnabas Hospital told us there was occasionally a situation where two agency/bank staff were booked for a night shift. They said in these circumstances a Peninsula Community Health (PCH) staff member from Liskeard Hospital was asked to work a shift at St Barnabas Hospital This was to ensure there was a member of staff who was familiar with PCH working practices, and policies and protocols, to ensure patient safety.
- The organisation had a 'safer staffing' proforma. This stated the minimum staffing levels for community hospitals for trained nurses and healthcare assistants. The document detailed the actions to be followed when safe staffing levels could not be met and this included moving staff from other wards, requesting bank or agency staff and cancelling non-statutory training. We heard staff working through this proforma when staff had called in sick and when a patient was assessed as needing one-to-one care for a period of time.
- Locality managers we spoke with explained how the organisation was the reviewing the skill mix of registered nurses and healthcare assistants on the wards. We were told that there were plans to separate the staffing of the

minor injuries unit from the ward at Helston Community Hospital, and also that it had been identified that Edward Hain Hospital needed additional healthcare assistants.

- Medical staff cover varied across the hospitals. Most had regular ward rounds from GPs. For some this was Monday to Friday (for example Helston and Newquay Hospitals) and for others less frequently (for example Fowey and St Barnabas Hospitals, although the local GPs would make daily visits to see specific patients when requested to by staff). Some hospitals had ward rounds ranging from daily to once a week from visiting consultants. Each hospital we visited said the medical cover arrangements worked for their particular environment.
- All staff were aware of how to access medical support, both during the day and out of hours.
- Patients told us "staff work so hard, they're always on the go" and "I think they could do with a few more sometimes, but staff would come running to help me if I needed them". Relatives told us, "they're [the staff] run off their feet", "everyone's needs are entirely different, but from what I've seen, they cope with everything".
- At St Barnabas Hospital, due to the number of allocated occupational therapy (OT) hours, we saw that a home visit with a patient was carried out by an OT that had never met the patient.

Managing anticipated risks

- Where detailed discharge information was received in advance of admission from the acute hospitals, patient risks (such as the moving and handling of bariatric patients) was well managed and planned, and staff ensured required equipment was in place, ready for the patient's admission.
- Staff we spoke with were aware of contingency plans in terms of unplanned sickness or inclement weather. A member of staff said, "they [senior staff] do their best and phone everyone. I've come in when taking annual leave."
- Staff told us they were aware of the bed pressures faced by the acute hospitals and had developed a daily teleconference that involved reviewing possible discharges from the community hospitals and potential admissions from the acute hospitals.

Major incident awareness and training

- The organisation's major incident plan was available for staff on their intranet. Staff knew how to access the policy. Matrons and ward managers explained what would happen in the event of a major incident and were well informed.
- Some of the larger community hospitals had a major incident room where equipment and policies and procedures were kept. Ward managers at the smaller hospitals said they did not have a permanent major incident room, but had a room that would be allocated in the event of a major incident and a major incident pack to use as required.

Good

Are Community health inpatient services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

The services provided care and support in line with evidence based and good practice guidance.

We saw many examples of good multidisciplinary work to ensure patients were seen by the most relevant specialists during their stay in hospital. This included dieticians or speech and language therapists. Appropriate correct care and support was arranged for people once they were discharged.

Most staff had had an annual appraisal and had regular one to one meetings with their immediate managers to discuss their training needs and ongoing performance.

We found patients were routinely asked for their consent before staff provided care. Staff recognised the need to ensure mental capacity assessments were carried out when appropriate. They ensured that where patients lacked capacity to take valid informed decisions about their care and support, these were made on their behalf in their best interests.

Falls prevention and management programmes were not always in line with best practice. This may have been a result of the limited number of occupational therapy hours at the smaller hospitals.

Patients generally had pain control medicines when required but not all pain assessment charts were completed to show that patients had been asked about their pain levels.

Detailed findings

Evidence based care and treatment

- Policies and procedures were developed in line with national guidance and were available for staff on the organisation's intranet. We saw evidence that policies, such as the policy for the prevention and control of infection, and prevention of pressure sores, were being followed.
- Staff carried out regular observation and personal care rounds (comfort rounds) which included observation of at risk pressure areas. Staff promoted skin integrity through the use of SSKIN, a five step model for pressure ulcer prevention (surface (of the bed/chair) – make sure your patients have the right support, skin inspection – early inspection means early detection (show patients and carers what to look for), keep patients moving, incontinence/moisture – your patients need to be clean and dry and nutrition/hydration – help patients have the right diet and plenty of fluids).
- Staff undertook risk assessments for patients who might fall and completed post-fall checklists following patient falls. Most of the hospitals provided some degree of rehabilitation for patients to help them to become more mobile or independent. However, the limited availability of physiotherapists and occupational therapists (OTs) in some of the smaller hospitals meant that falls management programmes, as part of a patient's rehabilitation, were not being carried out in line with accepted best practice.
- Evidence based care requires rehabilitation to be over 24 hours, seven days a week. However, as there was no physiotherapy or OT support at weekends rehabilitation often stalled at this point. We saw care records which included rehabilitation plans that detailed the support and equipment a person would need overnight. Ward staff confirmed they were generally able to follow these instructions overnight.

Pain relief

- Patients were prescribed pain relief, as appropriate. Most hospitals received daily visits (Monday to Friday) from GPs, who were able to adjust prescriptions for pain relief as required. The out of hours service was able to alter or prescribe pain relief medication at weekends, evenings and bank holidays.
- We saw patients had been prescribed regular analgesia, which had been given to prevent pain developing.
- At Liskeard Hospital in two sets of care records we reviewed pain assessment records had not been regularly completed. However in one case we heard a patient being asked if they were in pain and given some

analgesia. In another case the medication administration sheet showed the patient had been given pain relief but the assessment had not been completed.
- At St Austell Hospital we saw pain assessment records did not always show measurement of pain levels or include the effects of strong analgesia, for example, during a wound dressing change.

Nutrition and hydration

- Staff had access to speech and language therapists and dieticians. Staff told us specialist staff were accessible and would provide advice and also review patients, as required.
- The hospital used a nationally recognised tool for monitoring people's risk of malnutrition. We saw patients had been referred to a dietician where appropriate if their score recommended this.
- Protected meal times were in operation at the time of the inspection, meaning patients were not supposed to be interrupted during their meals for investigations, therapy sessions or by doctors' rounds. Visitors were asked not to visit at mealtimes, unless helping their relative. Staff were available to help patients and should not be engaged in any other activity, unless urgent, during the mealtime. We saw this regime was observed in most hospital sites we visited. At Launceston Hospital we saw a lunchtime where domestic staff continued to clean the ward and some patients were left with their meals for 15 minutes before a staff member was able to help them. At Launceston Hospital we also saw patients were given a hot dessert at the same time as their main course. We noted that by the time some patients had finished their main course their dessert was cold. One patient told us they had left some of their main course so they could eat their dessert whilst it was still warm. We fed this back to the matron during the visit. We made an unannounced visit to the same hospital to observe teatime. We found this was a better experience as protected mealtime principles were being applied. Information about protected mealtimes was displayed on most wards we visited. Patients, who were well enough, were given the option of eating in a communal area.
- Patients in some hospitals had their food and fluid intake monitored, using a food and fluid chart, on admission for a period of 36 to 48 hours. This was used to identify how well they were able to eat and drink and what assistance they might need during their stay. One hospital used a 'red tray' system to identify to all staff which patients required support to eat and drink. Healthcare assistants told us this was a good system as it reminded them they needed to complete the food and fluid charts.
- At Falmouth Hospital a new system was being trialled to monitor patients' food and fluid intake. This involved using cups that showed how much had been drunk, monitoring charts that were completed, and prompts to remind staff which patients needed more assistance. The system included colour coded place mats which indicated how much support a patient needed with their meals
- Patients admitted late in the day were offered soup and sandwiches. Staff told us extra trays were prepared when they knew an admission was expected and extra sandwiches made up.

Use of technology and telemedicine

- The services used telemedicine technology (a home monitoring system, individually tailored to support patients living with long term conditions) in some areas. The company the organisation used were registered as a provider in their own right with CQC.
- The matron from St Mary's Hospital on the Isles of Scilly said they had a working group established to identify how the system could be best used on the Islands and to encourage consultants from the acute NHS trust to use it. She gave an example where it was used successfully with a patient on one of the other islands in the group and it had significantly reduced their hospital admissions.

Approach to monitoring quality and people's outcomes

- The hospitals used the 'SSKIN bundle' approach to prevent pressure ulcers. This identified people who were at risk of developing pressure ulcers and included monitoring their nutrition and mobility. Most wound assessment charts were well completed. However, we saw one which was only completed once, although the document stated it should be completed weekly. We saw one patient had a repositioning regime for four hourly turns, although a tissue viability nurse had requested two hourly turns.
- Each ward had to complete a number of local audits, which included ensuring food and fluid charts and

medication administration records were completed and the number of falls were monitored. Any themes that emerged were bought to the attention of the staff to ensure quality and consistency of care was being maintained.

Outcomes of care and treatment

- Information required to meet CQUIN (Commissioning for Quality and Innovation payment framework) targets set by the local clinical commissioning group (CCG) were monitored. These included the number of patients assessed as being at risk of pressure damage and nutritional screening needs. This meant patients at risk were being assessed and reviewed regularly to ensure they were getting the care relevant to their condition.
- The service told us the average length of stay (ALOS) of patients had reduced across the community hospitals. Staff told us this was due to improved communication with acute trusts, local social service teams, and the introduction of a discharge coordinator. They had been particularly helpful in organising complex packages of care.
  - In the north of the county the ALOS had reduced from 24.1 days in September 2014 to 22.6 days in October 2014.
  - In the mid region it had reduced from 24.1 days in September 2014 to 23.6 days in October 2014.
  - In the west it had reduced from 23.9 days in September 2014 to 23.1 days in October 2014. The organisation had set a 23 day length of stay target across the county.
- At Falmouth Hospital we were told “this is the only place I would choose to be, it’s very clear that I am improving”. Another patient told us they had made “considerable progress” since moving from the acute hospital. They said the information provided and discussion with the staff ensured they were well informed about their prognosis and discharge targets.

Competent staff

- Most staff received annual appraisals, six monthly reviews and regular supervision sessions. While most staff we spoke with told us they had received appraisals, a review of the data provided by the organisation showed a compliance rate of 75% against a target of 95%. This had been recorded on the risk register with a score of 16 (8 being the lowest score and 25 representing the highest score). At Camborne and Redruth Community Hospital we found that inpatient staff were up-to-date with reviews, having had appraisals and six monthly reviews. At Falmouth Hospital and Helston Community Hospital we found that while the majority of staff had had annual appraisals, the six monthly reviews were not being completed.
- Staff we spoke with told us developmental training was readily available and they were encouraged to attend. While some was delivered online, other training was delivered face to face at a variety of locations across the locality but more recently at a central training base in mid Cornwall. Most of the staff we spoke with liked the new training venue and found they could attend more than one training session in a day.
- Staff told us specialist training was available, such as for caring for patients with Parkinson’s disease and epilepsy. Staff had links with the tissue viability nurses, the stroke teams, and infection control specialist staff who were able to provide support.
- The organisation did not employ most of the GPs who provided medical cover for the hospital wards and was therefore not responsible for their overall training. We were told the organisation ensured appropriate employment checks had been carried out by a GP’s employer before they could work on the wards.
- Nurses and allied health professionals (physiotherapists and occupational therapists) belonged to their relevant professional bodies to whom they had to provide assurances that they remained clinically competent to remain registered.
- An occupational therapy assistant (OTA) involved with the care of the patients at St Barnabas Hospital told us they followed the care plan set out by the occupational therapist (OT). They called an OT working at another hospital for advice or to request a review of a patient when necessary. This showed the OTA’s understood the limits of their role. The OTAs we spoke with were experienced and competent, writing good evaluation notes and building good relationships with patients.

Multidisciplinary working and coordination of care pathways

- We attended several multidisciplinary meetings where the care of all patients on a wards was discussed. They were well organised, involving both health and social care professionals.

Good

Are Community health inpatient services effective?

- Daily multidisciplinary teleconferences took place, which in some cases included the local acute trust, to identify patients who were fit and ready for discharge and therefore could be transferred from the acute trust.
- In most hospitals, ward handovers between trained nurses, were conducted using handover sheets. These provided staff with brief details of the patients and their needs which were then disseminated to the wider staff team. Ward rounds, which included medial staff, nurses, allied health professionals and, on occasions, social workers, occurred at the bedside with a safety briefing.
- Where community nursing teams and/or domiciliary care agencies were being used to provide complex home care packages, staff from the teams/agencies attended the wards prior to the patient's discharge. This was in order to meet the patient and review their individual needs, such as moving and handling.
- Consultant cover was provided to some of the hospitals by the local acute trust. Staff reported they had access to advice from consultants when required and felt supported by them.
- We saw good multidisciplinary working with the end of life team, community psychiatric nurses, district nurses and allied health professionals to ensure care while in hospital and at home was tailored to meet individual needs.
- Work between the wards that offered specialist stroke care and the community stroke teams was coordinated and well informed. This ensured the care pathways were followed and patients got the right care to help them recover as much as possible.
- We saw physiotherapists and other healthcare professionals involved in discussions regarding the most effective treatment. For example, when people had pressure ulcers, dynamic mattresses appropriate to the level of risk for the patient were used.
- Some of the hospitals had district nurse teams based on site and staff told us this helped to support the discharge process. Staff reported excellent communication which made for a well-planned discharge.

Referral, transfer, discharge and transition

- When a patient's discharge date was agreed staff arranged appropriate equipment (if necessary), medicines to take home, and transport if required. Discharges back to the Isles of Scilly depended on the transport links available but patients were kept informed and understood the challenges for staff.
- We observed some patients arrive and some being transferred or discharged to other facilities or home. We saw patients were greeted appropriately on admission and escorted to their bed space which had already been prepared for them. We saw staff checking that when a patient was discharged or transferred they had all their belongings with them, and a completed discharge or transfer form.
- On one occasion at Liskeard Hospital a patient was ready for discharge before their medicine to take home was ready. In order that the patient did not have to wait, they were able to go home and a nurse said she would arrange for the volunteer motorcycle service to collect the medicine and deliver it to them at home as soon as it was were ready.
- We saw expected patient admissions were usually written on white boards so staff knew who was expected and where there bed was. We were told that, although the acute trust was aware the community hospitals did not like to accept admissions after 8pm it was quite common for them to arrive after that time. We were told this was due to late doctors' rounds in the acute hospital. This may have meant patient discharges were organised late in the day. This had an effect on transport, especially if transport had been ordered at short notice. The timing of doctors' rounds and late booking of transport were not, however, in the control of PCH.
- Patients sometimes remained in hospital after they had been assessed as 'medically fit for discharge'. This was usually due to delays in the local social services being able to arrange suitable packages of care, particularly when they were complex. The discharge plans for these patients were discussed at multidisciplinary meetings and daily teleconferences to ensure that their discharges remained a priority and their rehabilitation and support was maintained whilst they remained in hospital. The provision of social service care and support was out of the control of the organisation but discussion about future provision and flow through the hospitals remained on the agendas of meetings held with the local clinical commissioning group, the local acute trusts and social services.

Good

Are Community health inpatient services effective?

- There was ongoing discussion between the Peninsula Community Health community nursing teams, specialist community teams such as Urgent Care at Home teams and therapy teams about how best to meet patients' needs when they were ready for discharge. Community team members were able to visit patients in hospital prior to discharge if necessary to ensure they knew how to carry out a particular procedure or learn about a new piece of equipment.

Availability of information

- Patient information was available to all relevant staff in the form of medical records, care records and therapy care plans.
- We were told that information about the results of blood tests or imaging such as X-rays were available as expected. They were seen by doctors if necessary as soon as possible. We saw doctors reviewing test information and making changes to medicine regimes as soon as the information had arrived.
- The electronic recording system in use by community staff did not link in to the system used in the hospital settings so paper information was used to pass information between the two settings as required. This was not reported as a problem within the community hospitals.

Consent

- There was evidence of mental capacity assessments being completed in some of the records we reviewed. One had been completed by a speech and language therapist. This was due to concerns about the patient's capacity, once discharged, to eat the correct consistency of food to prevent choking. Another had been reviewed due to a patient's fluctuating capacity.
- We observed a best interests' meeting and found it to be informative to the relatives that attended, discussed the issues of the patient's capacity sensitively; and came to a multidisciplinary conclusion based on how the patient's needs would be best met.
- We saw in written notes and during observations that care, nursing and therapy staff asked for consent from the patient before, for example, using manual handling equipment, repositioning them or providing mouth care.
- Medical staff were heard asking patients' permission to examine them prior to doing so.
- At Bodmin Hospital a member of staff told us, "we always assume someone has got capacity unless it is proved otherwise". Where necessary, capacity assessments were completed by staff nurses or the rehabilitation team. A member of staff told us "we always ask if patients agree to us giving them a wash" and "we'll go back later if necessary, but we make the staff nurse aware of this". We saw staff recognised patients' capacity to consent could fluctuate. Staff gave us an example of one patient whose capacity to make decisions improved with time. Staff explained that when best interest meetings were held they invited multidisciplinary teams, families and social workers. Best interest meetings were held to make decisions for people who were unable to make decisions for themselves. Staff were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and those we spoke with had received training.

Good

Are Community health inpatient services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

Patients and their relatives spoke very highly of the staff who provided care and support to them. They described them as kind, caring and knowledgeable. We saw some very caring, compassionate and discreet interactions between patients, relatives and staff during our visits to the hospitals. In the 'friends and family test' the overwhelming number of patients responded that they would be 'extremely likely' or likely' to recommend the service to friends and family.

Patients (and relatives where appropriate) were involved in decisions about their care. Patients we were able to speak with knew why they were in hospital and were aware of their discharge plans.

Staff provided emotional support in a range of ways, for example, taking time to sit and have a cup of tea with a patient when distressed or by putting them and their family in touch with local support networks that may be useful once discharged home.

Promotion of self-care and increased independence was evident when reading care records and included therapy plans designed to help patients regain skills and gain confidence.

Detailed findings

Dignity, respect and compassionate care

- Staff responded to patients in a kind and compassionate manner. Staff had a good rapport with patients, particularly those who had been inpatients for a period of time.
- Staff spoke kindly to people and were very caring and compassionate. Staff said, "I wouldn't like to treat a patient any way I wouldn't want to be treated" and "we'll sit with any distressed patients and have a chat with them over a cup of tea. We'll ring the family or an advocate if appropriate". One relative told us "I don't think there's anything they could do better".
- The 'friends and family test' was undertaken in all areas. The overwhelming number of patients responded that they would be 'extremely likely' or likely' to recommend the service to friends and family.
- Care was provided in a range of accommodation, including side rooms, two and four-bed bays and open plan 'Nightingale' wards. Staff closed curtains and doors during episodes of care and knocked on doors before entering rooms.
- We observed mealtimes at most hospitals we visited. In some areas patients were encouraged and able to have their meal in the day room and were able to enjoy socialising. For those patients who wanted to stay at their bedside their meal were served to them. We saw staff interacted well with the patients, took their time, held conversations with the patient explained about the food they were being offered.
- Staff gave examples of how they promoted people's dignity and one person told us "if someone doesn't want to be changed I explore the reasons and explain what the risks are, such as skin integrity".
- At Falmouth Hospital a patient and their partner explained how the nursing staff and healthcare assistants always ensured the curtains were drawn around the bed before they started any care. They described the atmosphere on the ward as "caring and respectful".
- The England 2014 Patient Led Assessment of the Care Environment (January 2014 to June 2014) found the scores in the 'privacy, dignity and wellbeing' category fell below the national average of 85%, with an organisation average of 75%, across nine community hospitals reviewed. Where there was a low score reported action plans were in place. We saw the action plans and current progress displayed on some of the wards we visited. In one hospital this included plans to make better use of communal space to give patients some privacy away from their bed space.
- Results of the staff feedback on the 'friends and family test' (FFT) showed that 46.2% of staff would be likely to recommend the organisation to friends and family if they needed care or treatment and 35.4% would be extremely likely to recommend the organisation.

Patient understanding and involvement

Good

Are Community health inpatient services caring?

- We heard medical and nursing staff discussing patients' care and plans for discharge with them and their relatives. Patients said they knew why they were in hospital and the expected outcomes.
- Staff told us "patients' decisions are respected, we record them in their multidisciplinary file" and "patients' decisions are recorded at multidisciplinary meetings and are written in their medical notes".
- Staff introduced themselves to new patients and explained the different colours of the uniforms and what they meant. We saw 'named nurses' were displayed on the wall behind patients' beds; however patients lying in bed were not always able to see this.
- Patients told us "I have been given information to aid my choices, for example, about being discharged" and "I know my named nurse and she would tell me about my care".
- The friends and family test (FFT) had a ward target response rate of 25% - this had been exceeded each month from April 2014 to September 2014, with the latest one being a 38.9% response rate. This meant the opinions of many people who had used the service were being captured.

Emotional support

- Visiting hours were limited in most hospitals but visiting was permitted at any time for patients approaching the end of their life. Newquay Hospital was trialling open visiting for all patients. This was reported as being successful so far and enhancing the experience of being in hospital for the patients.
- Chaplaincy services could be arranged when required. Staff told us they were able to access support for patients who belonged to a variety of religious denominations.
- One patient had become upset by an emergency situation and told us that a member of staff had come and sat with them for 10 to15 minutes, chatting until they felt better. The patient was very grateful for this.
- Staff told us about the local support networks they could contact for patients, such as bereavement counselling, advocacy services and Age UK, who could provide emotional support to patients when they were discharged home.
- We saw a 'Pets as Therapy' (PAT) dog visiting one hospital which provided comfort for a number of patients.
- Some staff told us they undertook psychological support training. We were told that group supervision/ support sessions were held for staff if they had experienced a distressing or difficult situation to "provide support and comfort for each other".
- Most of the hospitals had small private rooms to use if staff needed to deliver bad news or have difficult conversations.

Promotion of self-care

- In a number of the community hospitals there were occupational therapy assessment kitchens to help and support patients regain or learn new skills in the kitchen to help their independence when they returned home. We saw staff taking a patient home for a home assessment as part of the discharge planning process.
- We asked about self medication and were told there was a PCH policy for guidance. We saw that in some of the hospitals there were small locked cupboards attached to patients' lockers for storage of their own medication. Patients who could manage and were assessed as being able to manage their own medicines were supported to do so during their inpatient care.
- One of the wards at Bodmin Hospital was dedicated to the care of stroke patients. We saw they held a 'stroke arm activity' to help people who were having difficulties using their affected arm.
- A relative, whose mother had been admitted to one of the hospitals three days previously, told us the physiotherapist had already met with them and explained how they were planning to develop the patient's confidence and mobility skills in preparation for their return home.

Good

Are Community health inpatient services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

Services were planned in accordance with people's needs. Most patients were being looked after in community hospitals near to where they lived. During the temporary closure of inpatient wards at Stratton Hospital some patients were being looked after further away from home. The patients understood why and felt their discharge plans had not been affected by it.

Most hospitals had or were developing 'dementia friendly' areas and making signage to bathrooms and toilets more obvious. There were link nurses and information that provided ward staff with help and support to meet the needs of people with a learning disability.

Some of the hospitals provided an alcohol detoxification service in conjunction with a local organisation. Some staff had specialist training to help look after these patients and those who were not trained were booked onto training in February 2015.

There were a variety of arrangements for medical cover across the community hospitals. The staff we spoke with told us the arrangements were suitable for their needs and their patients were seen and assessed very regularly. Staff reported there were sometimes long waits for the out of hours service to contact them back if they had requested a doctor.

Detailed findings

Planning and delivering services which meet people's needs

- Daily multidisciplinary teleconferences and strict admission criteria to the community hospitals meant that patients were admitted without having to wait too long either at the local acute hospital or their own home when needing admission for example for a urinary tract infection that did not need an acute hospital admission.
- During the course of our inspection inpatient beds at Stratton Hospital in Bude, North Cornwall were closed while building repairs took place. This meant patients who lived near Bude were admitted to hospitals in other parts of the county, for example Saltash and Launceston. Patients understood this was a short term measure and were happy with the hospital they were currently staying in. They did not feel it had hampered preparations for their discharge home. Most hospitals we visited had all beds full and where patients had been discharged the beds were filled the same day.

Equality and diversity

- The organisation had access to translation services via a telephone system. Staff told us they had used it occasionally and it was easy to access.
- Staff had equality and diversity training during their induction which was updated every three years.
- Access to the community hospitals was good. There was disabled parking available at all sites. There were lifts available in the hospitals that provided services on more than one level. All sites we visited were accessible for people who used a wheelchair or other mobility aids.
- Patients were cared for in accordance with national same-sex accommodation guidelines. There had been no reported mixed sex breaches prior to or during our inspection.

Meeting the needs of people in vulnerable services

- The hospitals had link nurses and healthcare assistants with an interest in dementia care. Some of these staff were studying on courses to learn more about dementia and how to look after people living with the condition. They showed us how they had made a difference to their hospital environment, making them more 'dementia friendly', with reminiscence memorabilia available that helped patients engage in conversation.
- A memory café in Newquay Hospital had held its first meeting and had proved successful. The café invited people, both inpatients and people from the local community, who were living with dementia and their relatives or friends. It provided an opportunity for people to socialise and share information about what it was like for people living with and looking after people with a form of dementia. It was hoped this type of service could be duplicated at some of the other community hospitals as a result.
- The 'Weekly Sparkle' was a newsletter that provided reminiscence and current information for all patients but particularly aimed at people living with a form of

dementia. **It included "old news" listings to encourage reminiscence, brain games for mind fitness, such as puzzles, quizzes, stimulating questions and gossip and entertainment from the era the newsletter focussed on for that week.**

- There were a number of staff who took on a link role around care and support for patients with a learning disability. These staff provided help and support to ward staff, when necessary, enabling them to provide effective services to patients. Wards also worked with family or care staff of people with a learning disability to understand their care and support needs. We saw information was accessible regarding managing people with a learning disability and contact numbers for relevant staff were displayed on a number of the wards we visited.
- Some of the hospitals had provision for access to an alcohol detoxification service which provided one inpatient bed that was funded by a local organisation. The nurse on duty at Edward Hain Hospital had attended detoxification training, although three new nurses on the ward had not yet attended the training. However this was booked for February 2015. Healthcare assistants had no detoxification training but provided personal care and support, including talking to patients on the programme when they were upset.
- Meals were delivered pre-cooked and frozen to all community hospitals. Some desserts and sandwiches were made in the hospital kitchens. Housekeeping staff heated meals and served them according to patients' choice.
- Feedback from patients we spoke with and on comment cards completed by patients in the hospitals included, "some days the food is good, other days it's not so good" and "the food is good, there's always a choice of hot food and I'm able to drink lots". Other comments included "it's (the food) really nice, I have been pleasantly surprised".
- One patient, who was a vegetarian, told us that they always had meals provided that were acceptable and they were they always asked what they would like.
- We saw some afternoon drinks trolleys had cakes and biscuits available to the patients. In some hospitals we were told a fruit platter was also offered to people between meals and this had proved very popular.

Access to the right care at the right time

- The community hospitals had a variety of arrangements for provision of medical cover, with most having cover at some point during the day from Monday to Friday. Staff reported the GPs were usually quick to respond to their requests and saw the patients within a reasonable timescale. Out of hours cover was provided by the out of hours doctor service via the 111 system. Staff told us there was sometimes a delay when waiting for a call back from this service.
- Some hospitals had therapy input at weekends, however, most only had physiotherapist and occupational therapist input from Monday to Friday. Whist some patients had therapy plans to promote the continuation of the therapy at weekends, this was not a consistent approach across all hospitals. This meant patients were at risk of not continuing their therapy regimes seven days a week.
- We saw that arrangements were made for inpatients who had outpatient appointments at the local acute hospitals to ensure they were able to attend their appointments. This included booking the most appropriate form of transport for the patient and, if necessary, an escort for them or arranging for relatives to meet them at the relevant hospital.
- In cases where an outpatients appointments had needed to be cancelled due to the patient's condition another appointment was booked for them as soon as possible. If the patient was not well enough to attend an appointment arrangements had been made for the practitioner to visit the patient in their current setting, if possible. Each morning the person in charge of each community hospital attended a teleconference, along with acute hospital discharge teams to discuss potential discharges from the community hospitals and review suitable admissions from the acute hospitals to the community hospitals. Staff reported these daily conversations were helpful when planning resources.
- The monthly performance reports to the board highlighted the number of delayed discharges and gave information on areas of concern. Such as in Oct 2014 delays were noted to be impacted by due to changes in the way the community based Early Intervention Service EIS worked and lack of capacity for packages of care in the community.

Complaints handling (for this service) and learning from feedback

Good

Are Community health inpatient services responsive to people's needs?

- Leaflets were available in the community hospitals explaining how to access the Patient Advice and Liaison Service. However, senior staff told us they always tried to talk directly with people who raised any concerns as they felt this helped to resolve concerns quickly and informally.
- Between December 2013 and December 2014 the organisation had received 90 complaints in relation to care provided by eight of the community hospitals (these may not all be related to inpatient care as the hospitals also provided outpatient and minor injury unit services). All had been dealt with using the organisation's complaints procedure. 'All aspects of clinical care" and 'attitude of staff' were the most common concerns reported.
- Matrons told us complaints relating to their service were shared during team meetings and in communications bulletins. Learning from complaints relating to other community hospitals were shared within matrons' meetings and locality manager meetings, that had recently been introduced.
- Staff told us, "patients are given a form to fill in at the end of their stay" and "I tend to ask them if everything is okay and can I do anything to make them more comfortable".
- Patients told us, "I would be able to go to staff if I had a problem" and "I would talk to staff and complete a feedback form".

Good

Are Community health inpatient services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

Staff were aware the organisation may be going through some changes in the future but felt that the information about this was communicated to them appropriately. Staff told us that members of the executive team had visited their wards and taken time to speak to them and reassure them. All staff we spoke to felt the Interim Director of Operations, the Chair of the board and the Chief Executive Officer (CEO) were approachable and listened to their concerns. Staff were generally very happy with their local leadership arrangements and felt they could talk freely to their managers.

Governance systems were in place to monitor the organisation's performance against local commissioning and nationally set targets.

We saw the organisation encouraged personal development and initiatives and was open to new, innovative ideas and practices. There were several examples of innovations that had developed the service offered to patients.

Detailed findings

Service vision and strategy

- Staff were aware that the providers contract to provide the current services was due to end in 2016. In planning form this staff were aware there had been some discussions about potential mergers with other organisations and told us the organisation had kept them informed.
- Staff told us they were aware of the recent changes in senior positions and were heartened by the appointment of the Interim Director of Operations who they felt was approachable, supportive and put the patient at the heart of decisions.
- Staff were able to describe the values of the organisation and we saw them prominently displayed in the community hospitals. Staff told us they felt listened to and felt the welfare of the patients and wellbeing of the staff was very important to the organisation.
- Staff felt the values the organisation was built on would remain the same even if they were merged with another local trust.

Governance, risk management and quality measurement

- Risks, incidents complaints and audit results were discussed at regular meetings within each hospital. These were then reported overall to the organisation's various governance meetings that included the professional practice forum.
- There was an organisational risk register, which detailed all risks. Community hospitals were identified as having three risks ranging from a score of eight to 20 (eight being the lowest score that could be achieved and 25 being the highest). The risks included the lack of pharmacy technician support in community hospitals (review date January 2015) and risk of non-attainment of the commissioning for quality and innovation (CQUIN) targets in respect of numbers of completed of friends and family tests (FFT), dementia pathways and frailty pathways (review date December 2014).
- Staff were aware of the risk register and said any issues about their area would be discussed at staff meetings. Staff told us they reported their concerns to their line manager and/or completed an incident report. They felt the concerns would be taken seriously and added to the risk register if appropriate.
- Information from governance meetings fed into the trust quality and safety committee, which in turn, fed information directly to the board.
- Quality measures such as the hand-hygiene audit results, Patient Led Assessment of the Care Environment (PLACE) results and action plans (January to June 2014) and results of FFT were displayed at ward entrances. This meant staff, patients and visitors were able to see them.

Leadership of this service

- The locality managers, matrons and ward sisters were known by all their staff. All but one hospital reported good local leadership and felt they could approach their

senior staff and be listened to. All staff were aware of the appointment of an interim director of operations and were all pleased with the appointment as they knew the person well and had confidence in their ability.

- All staff we spoke with, without exception, knew who the CEO was and felt they knew about the issues that each individual hospital faced. All staff felt they could contact the CEO or any member of the board and be listened to. Staff gave us examples of when they had done this and how positive the experience had been.
- Ward staff told us they had been visited by members of the board, including the CEO and had been able to talk to them about their concerns. Staff said they felt they had been listened to.

Culture within this service

- Staff told us about a changing culture that was open and a learning culture. They felt able to raise issues with managers, if required. Matrons and locality managers were visible on the wards.
- The organisation had a whistleblowing policy, which was available for staff on their intranet.
- Staff told us they liked working for the organisation and that they felt supported to develop their skills.
- Staff at each hospital felt their local management was effective. They felt supported by their ward sisters and matrons. They said if they were not able to speak with anybody at their hospital they knew staff at the other local hospitals they would be able to speak with.
- Staff who worked at more than one hospital, either due to closure, (in the case of Stratton Hospital), or skill mix (which can be the case at St Barnabas Hospital), said it was good to mix with other staff and share experiences and knowledge.

Public and staff engagement

- Most of the community hospitals had a very active League of Friends and fundraising committees. We saw evidence of significant community investment in the community hospitals. For example, at Liskeard Hospital and St Barnabas Hospital they had been asked to provide pieces of equipment and playing cards for patients who wanted to engage in activities.
- Newquay Hospital had recently been donated £2000 from a local hotel to buy a 1950's style reminiscence pod to help encourage reminiscence, conversation and feelings of wellbeing amongst the patients, some of whom were living with dementia.
- The organisation was engaged in the FFT and results were displayed on the wards. The feedback was overwhelmingly positive. Where there were scores of less than 100% an action plan was displayed detailing improvements to be made.
- Staff received feedback via team meetings, newsletters and bulletins from the locality managers and the CEO. Staff felt, in general, that they were well informed.
- We were told us about the NHS 'Care Makers' programme and that a number of staff had become Care Makers. Care Makers were volunteers who acted as ambassadors for the 6C's* and were made up of staff from the health and social care sectors. We saw the NHS Care Maker newsletter from December 2014 that showcased two PCH staff who were national 'Care Makers of the Month'. They were being praised for presenting their roles as care makers at the PCH Annual General Meeting to encourage others to take on the role.

*The six enduring values and behaviours that underpin 'Compassion in Practice'.

Innovation, improvement and sustainability

- There were areas of innovation. For example, a memory café had just been established at Newquay Hospital which invited members of the public to join in. Some initiatives were local to a specific hospital but in some cases, as with 'dementia friendly' environments and memory cafes, there was a plan for them to be rolled out at other hospital sites. There were a range of organised activities for patients, including cream teas, music from a male voice choir and a 'rabbit whisperer' performing during the afternoon.
- Launceston Hospital staff told us about working with the local Age UK team as part of their 'Living Well programme' aimed at identifying areas of a person's life they may like support with once they had left the hospital. They told us this had enabled patients to revisit hobbies they had enjoyed before becoming ill and Age Uk had helped them to access transport to local clubs and provided staff to accompany them, for example.
- At Helston Community Hospital one bed was kept for the use of a locally run alcohol detoxification program, which was run in conjunction with a local GP service. Patients using the service were also supported by a worker from Addaction – Cornwall. . Patients signed up for a course of treatment and a set of conditions for their

Good

Are Community health inpatient services well-led?

stay. The ward sister said the programme had so far been successful and had helped several patients move on to other therapeutic centres to continue with their treatment for alcohol related problems.

- Locality managers told us that on order to ensure newly appointed registered nurses and healthcare assistants were able to work effectively soon after they had started with the organisation, they were encouraged to attend a week of clinical skills training following their corporate induction. Topics covered included pressure ulcer care, continence awareness, venepuncture, A-Z of wound care and falls, frailty and Parkinson's awareness. Staff who had attended this week told us it was invaluable and "great to help me get started".