

# Worcestershire Health and Care NHS Trust

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# Community health inpatient services

## Quality Report

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This report describes our judgement of the quality of care provided within this core service by Worcestershire Health and Care NHS Trust. 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 Worcestershire Health and Care NHS Trust and these are brought together to inform our overall judgement of Worcestershire Health and Care NHS Trust

# 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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# Summary of findings

## Overall summary

We judged community health inpatient services to be safe, effective, caring, responsive and well led.

We found that some aspects of medicine management needed improvement. It was unclear if unwanted controlled drugs were destroyed or returned to the patient on discharge from Pershore Community Hospital.

There was evidence to show that staff recorded and reported incidents and completed risk assessment and risk management plans. Patient risks were assessed and plans were developed to reduce them.

All five community hospitals were clean and well maintained and staff recognised and practiced infection control procedures.

Patients received care that followed the latest published guidance and best practice with outcomes that were generally in line with national averages.

Care was delivered by nurses, support staff and allied health professionals and was overseen by hospital consultants and general practitioners (GPs).

Patients and their relatives were all positive about the care they or their relative received. We saw staff were respectful towards patients and made sure that they were treated with dignity.

Complaints were managed appropriately and lessons learned. The hospitals had local clinical governance meetings and were represented on the trust's monthly quality meetings.

Staff told us they felt supported to give high quality care by their managers and the trust board. We found that staff were motivated and enjoyed working at the community hospitals.

During the inspection, we spoke with 58 staff, including nurses, occupational therapists, physiotherapists, hotel services staff, admin and clerical support staff, GPs and visiting clinical staff. We also spoke with 32 patients and 8 relatives. We observed interactions between patients and staff and we reviewed 18 sets of care records.

Our judgements were made across all of the hospitals visited, where differences occurred at particular hospitals we have highlighted them in the report.

# Summary of findings

## Background to the service

The trust has five community hospitals providing inpatient care. We visited all five hospitals during this inspection.

The hospitals were, Evesham Community Hospital (71 beds), Malvern Community Hospital (24 beds), Pershore Community Hospital (26 beds), Princess of Wales Community Hospital (60 beds) and Tenbury Community Hospital (16 beds).

Care is delivered by nursing, healthcare and therapy staff. They are supported by local GPs and hospital consultants. Medical cover overnight, at weekends and on bank holidays is provided by the out-of-hours GP service via the 111 system.

The community inpatient service provides rehabilitation services to patients transferred from Worcestershire Royal Hospital and Alexandra Hospital in Redditch. GPs are also able to admit patients directly from the community if they require an inpatient bed but are not an acute hospital admission. Healthcare services also include providing palliative care and management of long term symptoms.

## Our inspection team

Our inspection team was led by:

**Chair:** Dr Ros Tolcher, Chief Executive, Harrogate and District Foundation NHS Trust Harrogate and District NHS Foundation Trust.

**Team Leader:** Pauline Carpenter, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a general medical practitioner (GP), community occupational therapist, three specialist nurses and an expert by experience who had used services.

## Why we carried out this inspection

We inspected this core service as part of our comprehensive Acute and Community health services inspection programme.

## How we carried out this inspection

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 service and asked other

organisations to share what they knew. We carried out an announced visit on 20, 21, 22 and 23 January 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, 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 people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

# Summary of findings

## What people who use the provider say

We spoke with 32 patients and eight relatives during our inspection of community health inpatient services.

Patients told us that staff were very kind and caring.

Patients told us that there was a good choice of food that met their needs and that they were supported to eat and drink enough.

Some of the comments received included:

- “Nurses are good and make me feel like a real person. They are friendly and nothing is too much trouble.”
- “I can’t fault the excellent care I have received.”
- “If I ring for assistance they come very quickly.”
- “Nurses come quickly when I ring my bell. I get my medication on time in the morning and night.”
- “Little hospitals have more time for you. I get a great night’s sleep here.”
- “I have no complaints, if I had any I would go to the Sister.”

## Good practice

Our inspection team highlighted the following areas of good practice:

- We saw good multidisciplinary and integrated working taking place in the hospitals, which clearly placed the patient at the centre of care.

- We found that staff were passionate about their work and the difference it made to patients. They displayed positive attitudes and said they were supported by their managers to provide excellent care and services.

## Areas for improvement

### Action the provider **MUST** or **SHOULD** take to improve

- Nursing staff at Pershore Community Hospital **should** receive further training on the management of controlled drugs.

### Action the provider **COULD** take to improve

<Action here>

Worcestershire Health and Care NHS Trust

# Community health inpatient services

**Detailed findings from this inspection**

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

## Are community health inpatient services safe?

By safe, we mean that people are protected from abuse

### Summary

There were processes in place for reporting and learning from incidents. Staff were clear about what incidents to report and how to do this. Managers were confident incidents were being reported appropriately.

Wards looked clean. We observed hand washing procedures being followed and were informed by staff that regular hand washing audits were undertaken. We saw evidence of these audits.

Equipment was regularly checked and staff told us they had the equipment they required.

Arrangements to minimise risks to patients were in place with measures to prevent falls and pressure ulcers. We saw evidence of good practice including the use of safety dashboards; clean clinical areas and good infection prevention and control practice.

Staffing levels were adequate at the time of our inspection but vacancies and absences put increased pressure on

staff, in particular at Pershore Community Hospital. Bank and agency staff were used to cover staff vacancies and there were processes in place to ensure continuity of care as much as possible.

### Incident reporting, learning and improvement

- Staff reported incidents on the trust-wide electronic reporting system. This was available in all ward areas via the trust intranet home page. Staff told us this was relatively simple to do and many we spoke with had reported incidents. We saw examples of where incidents had been reported, a full investigation was carried out including a root cause analysis.
- Incidents were looked at a weekly meeting to identify any issues or themes arising and to improve accountability and ownership.
- Examples of incidents that were reported included pressure ulcers, falls and inappropriate transfer of patients from Worcestershire Royal or Alexandra Hospitals to the community hospital.

- The trust monitored its performance in pressure ulcers, venous thromboembolism (VTE), falls with harm, catheters and new urinary tract infections using the NHS Safety Thermometer. This is a national improvement tool used for measuring, monitoring and analysing patient harms and 'harm free' care.
- From November 2013 to October 2014 community hospitals reported 1128 safety incidents. Of these 117 were judged to have resulted in moderate harm, 34 resulted in severe harm. The 34 severe incidents were all related to developed category 3 or 4 pressure ulcers. Staff gave examples of feedback received including a more robust assessment of patients at risk of pressure damage. This was through use of the Waterlow assessment, a tool designed to give an estimated risk score for the development of a pressure sore in a given patient, and a five step model for pressure ulcer prevention.
- Lessons learnt were communicated throughout the trust and the hospitals using a variety of methods. These included team meetings, newsletters and on the trust intranet. We saw minutes of team meetings where feedback following safety investigations had been given to staff for discussion and for use as a learning opportunity.
- Staff described changes in practice arising from reported incidents. It was evident that learning took place organisation-wide. For example, a staff member at the Princess of Wales Community Hospital told us how an incident they had reported regarding inappropriate admission to the hospital had led to clearer communication with the acute hospital on the referral criteria.
- We saw the safety dashboard information clearly displayed at all the community inpatient services. This was discussed at team meetings and any changes required were implemented.
- During the period 24 November 2013 to 25 November 2014, there were 28 serious incidents reported in the community inpatient services. The serious incidents reported mainly related to pressure ulcers which accounted for 32% of the serious incidents reported.

### **Duty of Candour**

- Staff we spoke with were comfortable about reporting incidents and familiar with the concepts of openness and transparency. Senior staff confirmed they had received training regarding this regulation. They said

they were cascading the requirements of the newly introduced duty of candour regulations to all staff. We were also told that the trust were reviewing their processes to ensure they met the regulations.

- We were told that the trust's incident reporting system provided a prompt for staff to inform patients and relatives of any incidents. We saw examples of incidents where patients or their families had been informed of the outcome of incident investigations.

### **Safeguarding**

- Staff received training in protecting vulnerable people which was part of the mandatory training programme. Training rates for adult safeguarding across the community hospitals showed that 95% of staff had completed this training for the period ending 30 November 2014.
- The trust had a dedicated safeguarding team, which included clinical nursing staff. The team were able to support staff across all hospital sites, keep them informed on safeguarding issues and provide training across the trust.
- The safeguarding team trained ward nurses at the community hospitals to be safeguarding link nurses within their own clinical area. These link nurses acted as an additional resource for their colleagues and were able to assist with training.
- Staff we spoke with demonstrated an understanding of the principles of safeguarding and could describe the steps they would take if they had concerns or suspected abuse. We saw that information including contact numbers to report concerns was prominently displayed in ward areas.
- All the patients we spoke with told us they felt safe in the hospital.

### **Medicines management**

- Overall, we found that there were adequate systems in place for the safe supply, storage, administration and disposal of patients' medications, although we found some issues that required improvement.
- Medicines were stored securely in locked cabinets or trolleys. We found medicine cabinets and trolleys on all wards were locked. Prescription pads were stored within locked cabinets and that access to all medication keys was controlled by the nurse in charge.

- Medical gases were stored appropriately in all of the hospitals we visited. Staff were trained in safe use and storage of medical gases.
- We looked at drug charts and the drug register and found that, in the main, there were no omissions. However, we found omissions in the recording of medication for three patients at Pershore Community Hospital. We raised this issue with a staff nurse who told us that this would be investigated to ensure the patients had received their prescribed medication.
- Records confirmed that drug fridge temperatures were checked daily at the five community hospitals.
- Medication rounds were observed at three of the hospitals. We saw that the patient name was checked with their identity bracelet and the medication administration record (MAR) chart was signed to indicate that medication had been taken.
- We were told random checks of MARs were undertaken by senior staff. These checks identified any staff learning needs if charts were not accurately completed.
- We sampled controlled drug registers and found there were no stock discrepancies. Controlled Drugs (CD's) are medicines which are subject to additional controls as they are liable to be mis-used. We saw that the ordering and delivery systems for CD's met legal requirements, that the registers were accurately maintained and that CD's were stored appropriately with balances being regularly checked and recorded when administered.
- We found that we were unable to reconcile unwanted or returned CDs for the period, October 2014 to December 2014 at Pershore Community Hospital. There were two nurses' signatures stating that the medication was removed from the CD cabinet, however they did not record what happened to the medication, for example, if it was destroyed or given to the patient when they were discharged. We raised this concern with the deputy clinical director and the ward manager who agreed to undertake an investigation.
- The pharmacist visited each hospital once a week and pharmacy assistants were available at the hospitals five days a week. Pharmacy assistants ensured that stock levels were maintained and provided advice regarding medicines management to both staff and patients. A pharmacy helpline was available to support ward staff when the pharmacist assistant was not available.
- We saw that the chief pharmacist had undertaken a CD and medicines management audit at Pershore Community Hospital on 24 November 2014. The audit

had identified only minor problems and we saw there was an action plan to address the issues raised by the audit, which was recorded as being actioned by the hospital.

### **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. A check of a selection of portable electrical appliances at each hospital demonstrated that they had been tested as per guidance and a rolling programme was evident. Any equipment that was not safe was repaired or replaced as necessary. Records were kept and were up to date.
- 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.
- There were arrangements for checking mattresses to ensure they remained fit for purpose and did not increase the risk of cross infection or pressure damage to patients. We saw checklists that showed mattresses were checked regularly.
- Systems were in place to remove broken or faulty equipment. Staff told us that equipment would be removed from service immediately a problem was identified and the equipment reviewed by the medical engineers. We saw evidence that maintenance issues were documented and any updates were recorded. Equipment was serviced according to manufacturer's instructions.

### **Records and management**

- Records were stored appropriately and readily available when requested. In all locations we found patient identifiable records were locked in secure cabinets or trollies. Only staff that needed to access records was able to do so.
- We looked at 18 sets of care records. We saw these contained detailed information on each patient, including risk assessments and daily evaluations. Staff undertook recordkeeping audits at various intervals, but most records were subject to a monthly audit with findings reported back at ward level.
- Therapy records were well maintained and we found that patients' therapy goals were recorded and agreed with the individual.

## **Cleanliness, infection control and hygiene**

- The areas we visited were clean. Hand-washing facilities were readily available and we observed staff adhering to the trust's 'bare below the elbow' policy.
- We observed staff on the wards washing their hands in accordance with the guidance published in 'Five Moments for Hand Hygiene' published by the World Health Organisation (WHO 2014). We saw that hand hygiene audits undertaken in September and October 2014 at Evesham Community Hospital showed that 100% of staff demonstrated good hand hygiene.
- Training figures given to us by the trust showed that 91% of staff across community services had undertaken infection prevention and control training, as at September 2014.
- Staff had access to personal protective equipment such as gloves and aprons. We observed staff 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.
- Equipment was regularly cleaned and labelled as clean and ready for use.
- The trust employed a team of specialist infection control nurses who were appropriately trained. Ward staff told us they knew how to contact these staff and that they visited regularly and attended team meetings.
- There were procedures for the management, storage and disposal of clinical waste. We observed that clinical waste was segregated and 'sharps' waste was handled appropriately in line with Guidance from the Health and Safety Executive issued in 2013.
- Each ward had its own system for cleaning equipment daily and this was checked by the ward housekeeper. We saw records of cleaning audits undertaken by the facilities manager.

## **Mandatory training**

- We looked at the training records for the five hospitals and they showed that all staff were either up to date with their training or had training days scheduled. For example, records showed an overall compliance of 92.6% for Evesham Community Hospital and 97% compliance for Tenbury Community Hospital.
- We noted that compliance was low at Pershore Community Hospital as records showed that only 75.4% of staff had updated their mandatory training.

The ward manager showed us evidence to confirm that an action plan had been developed to ensure training sessions were made available for those staff that needed to update their mandatory training.

- The staff we spoke with, both individually and at focus group meetings, all confirmed that they were up to date with their mandatory training.

## **Assessing and responding to patient risk**

- Care records we reviewed demonstrated that risk assessments including falls, Waterlow pressure ulcer risk assessment, and MUST (Malnutrition Universal Screening Tool) had been appropriately completed.
- We saw evidence of actions as a result of risk assessments.
- We saw falls were monitored, audited and themes were highlighted that always resulted in changes to care being implemented. For example, we spoke with two members of the 'falls team' who were visiting Princess of Wales Community Hospital during our inspection. They were very enthusiastic about the progress they had made in the last five years and were promoting the falls strategy to in-patient units. Aspects of the service included the development of specific documentation with colleagues in the community on falls for all nurses to use. They said that senior management in the trust were supportive of the falls agenda and the team were working well with community inpatients to develop the falls pathway.
- 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.
- 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 in Tenbury and Evesham Community Hospitals that showed this training was up-to-date.
- Staff we spoke with told us they received information on anticipated admissions, which meant they could access appropriate equipment, if necessary, prior to the patient arriving in the hospital.

## **Staffing levels and caseload**

- The matron at Evesham Community Hospital explained that a recognised tool called the Safer Nursing Care tool (SNC) was used by the trust twice a year to calculate staffing requirements across the inpatient services. The SNC tool assessed the care needs of patients and estimated care hours and suggested care arrangements. We were told that an SNC assessment was currently being undertaken by the deputy director of nursing and the results would be used to determine the staffing establishment on inpatient wards. This meant that appropriate skill mix and staffing levels were planned, which met the Royal College of Nursing safe staffing guidance.
- Each hospital ward displayed a board at the entrance, 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 to visitors or patients. We saw the established staffing and the actual staffing levels were the same or greater on all wards.
- The nurse to patient ratio at the hospitals was set at one nurse to eight patients (1:8 ratio), as a minimum, but we were told that if patients' needs and dependency it was increased to 1:7. The matron and ward manager were supernumerary. We checked staffing rotas for a period of three weeks at four of the five community hospitals and found that these levels had been maintained or exceeded for much of the time.
- Staff felt there were sometimes insufficient numbers of staff, but that patient care was not compromised. At the time of our inspection, the wards were busy; however, patients' call bells were answered within a few minutes.
- Staffing levels, in particular at Pershore Community Hospital, were being maintained by the use of bank and agency staff. Where possible regular bank and agency staff were used to promote continuity of care and minimise risk. New agency staff received a short induction to orientate them to the service prior to commencing shift.
- The ward manager at Pershore Community Hospital reported that there were currently two nursing

vacancies and three healthcare assistant vacancies. The hospital were actively recruiting staff and had managed to appoint three staff who were due to start work when all necessary pre-employment checks had been completed.

- Medical support was available in the hospital five days a week, with support from out of hour's service at night and weekends.
- All staff were aware of how to access medical support both in day-time hours and in the evenings and at weekends.

### **Managing anticipated risks**

- Each hospital maintained its own local risk register and we saw examples of these. We noted that these were current and complete. Staff told us that they felt confident in raising concerns or risks with their manager.
- There were arrangements for sharing national safety alerts with staff. Staff we spoke with were aware of the system and we saw minutes of team meetings where safety alerts had been discussed. We saw records of safety alerts retained in ward areas.

### **Major incident awareness and training**

- The matrons and ward managers were aware of the major incident and business continuity policy and understood their roles and responsibilities within a major incident.
- We saw a copy of the trust's major incident policy. The action plans were specific to different roles and level of responsibility and identified the person responsible for leading and coordinating the responses to a major incident.
- Staff we spoke with were aware of contingency plans in terms of unplanned sickness or adverse weather.
- Staff at some of the community hospitals reported having undertaken evacuation training. They said they found it useful.

# 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

Inpatient services provided effective care to patients. Care was provided in line with national policies, with good multidisciplinary working.

Patient's nutritional and hydration levels were monitored. Patients were positive about the choice and quality of the food provided.

Staff completed a programme of mandatory training. They received an annual appraisal which resulted in a personal development plan.

There was effective multi-disciplinary working to meet patient needs. We observed some staff handovers, these were effective and comprehensive in ensuring staff had information on patient's needs.

We saw there was a focus on planning for discharge from the time of admission. Patients and relatives were involved so that any potential problems associated with the discharge could be identified and dealt with from a very early stage.

## Evidence based care and treatment

- Policies and procedures were developed in line with national guidance and were available for staff on the hospital intranet site.
- We saw evidence that the National Institute for Health and Care Excellence (NICE), such as the policy for the prevention and management of pressure ulcers (CG179) were followed. For example, staff took photographs of any pressure damage, either hospital acquired or present on admission.
- Patients were assessed using recognised risk assessment tools. For example, the risk of developing pressure damage was assessed using the Waterlow Score, a nationally recognised practice tool.
- Falls prevention is one of the NHS Institute for Innovation and Improvement's eight high impact actions, and was evident in all hospitals. Staff undertook falls risk assessments and completed post-fall check lists following patient falls.

- We saw other examples of national guidance being implemented. For example in the area of nutrition we saw that guidance from NICE (CG32) relating to screening for malnutrition was in place.
- Patients had a care and rehabilitation plan devised to meet their needs. Therapy goals and milestones had been identified with review dates documented.

## Pain relief

- Patients told us that their pain was adequately controlled. They told us that pain relief was offered and given immediately it was requested.
- Hospitals received daily visits by GPs or hospital consultants, who were able to adjust prescriptions for analgesia, as required.
- A pain assessment tool was used and documented as part of the care pathway.

## Nutrition and hydration

- Nutrition and hydration assessments were completed on all appropriate patients in the care records reviewed. These assessments were detailed and used the Malnutrition Universal Screening Tool (MUST). We saw that appropriate follow up actions were taken when a risk was identified.
- We looked at food and fluid records and found these were mainly complete, accurate and current.
- Protected meal times took place on all the wards we visited. This allowed patients to eat without being interrupted and meant staff were available to offer assistance were required.
- Patients told us that the food was of good quality and that they had plenty to eat and drink throughout the day.
- Staff had access to advice from dietitians and Speech and Language Therapists (SLT). Dieticians and SLTs visited the hospital on request and were also available to give telephone advice.
- We were told by ward the staff that food that met people's special cultural and religious needs was available, if required.
- The Health and Social Care Information Centre (HSCIC) Patient Led Assessments of the Care Environment

# Are Community health inpatient services effective?

(PLACE) data for 2014, showed that all the inpatient services scored 95.6% which is better than the national average of 88.8% for small community hospitals for the quality and availability of food and hydration.

## Approach to monitoring quality and people's outcomes

- Information provided showed the average length of stay for patients at the community hospitals was 22 days, compared with the national average of 28 days.
- 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. Wound assessment charts we looked at were well completed.
- Community in-patient services all participated in the National Patient Safety Thermometer scheme, and this demonstrated that the patient outcomes measured were in line with national averages.
- Each hospital were subject to a number of local audits, known as metrics, which included ensuring the patients records and medication administration records were completed and the number of falls were monitored. Any themes that emerged were brought to the attention of the staff to ensure quality and consistency of care was being maintained.

## Competent staff

- We saw training records which demonstrated that between 94% and 100% of staff across the five hospitals had participated in an annual appraisal. For example, 100% of staff at Tenbury, Evesham and Pershore Community Hospitals had received an annual appraisal.
- New staff received a trust induction within their first week were supernumerary on the ward for the first two weeks, so to undertake a local induction. A staff member at Evesham Hospital told us they had started working at the hospital within the past twelve months. They had a one week trust induction which included mandatory training and information about the trust. They said they were very satisfied with the level of support they received.
- Staff told us they were supported by their managers to attend training days and to complete online training. Staff said the training they had received was appropriate and relevant to their work role. For example, a staff

member at Princess of Wales hospital told us they had requested to go on a mentorship course. They confirmed this had been agreed by the trust and they will be doing this in the next few months.

- Senior nurses (Band 7) at Evesham hospital had attended a leadership skills course. The twelve month long course had helped them to develop leadership skills. This course was now being offered to other lower grade senior nurses.

## Multi-disciplinary working and coordination of care pathways

- We observed that there was a strong commitment to multi-disciplinary working. Each hospital had a multi-disciplinary team meeting on at least a weekly basis to plan the needs of patients. We saw documentary evidence of a multi-disciplinary approach to discharge planning.
- We observed a weekly multi-disciplinary meeting at Pershore Hospital which was attended by the ward manager, social worker, consultant, occupational therapist and physiotherapist. We saw good team working, clear decision making and saw opinions of each member of the team were valued.
- We observed handovers at three of the hospitals. We saw that 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. We noted that the handover at Pershore Hospital was held in the corridor, which could compromise patients' privacy and confidentiality.
- Ward rounds, which included medical staff, nurses, allied health professionals and, on occasions, social workers, occurred at the bedside with a safety briefing.
- We saw that staff used care pathways such as the stroke pathway and staff were trained in stroke management. This meant the care pathways were followed and patients got the right care to help them recover as much as possible.
- Wards teams reported that they had access to the full range of allied health professionals and team members described good, collaborative working practices.

## Referral, transfer, discharge and transition

- Admission criteria and pathways were in place and patients were, in the main, appropriately admitted to the facilities. A discharge co-ordinator based at the local

# Are Community health inpatient services effective?

acute hospital assessed and screened patients who might be suitable for discharge to one of the community hospitals. Occasionally, patients admitted from the acute hospital had to be re-admitted back to the acute hospital if the patient was found to be medically unfit for discharge.

- We found that there was an appropriate emphasis on discharge planning and observed good practice in this area. Patients, their families, and outside agencies were engaged in discharge planning processes. This meant patients were discharge safely and their needs continued to be met after they left the hospital.
- Where clinically indicated, home assessments were conducted with the patient, relative and a member of the multidisciplinary team before discharge. This is to assess the need for equipment or further community support to ensure safe discharge.
- 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.
- Managers at the community hospitals told us that delayed discharges were not a major problem at the moment. For example, at the time of our inspection of Tenbury Community Hospital, there was only one patient, who was medically fit for discharge waiting for a care package to be put in place by the local authority.
- Patients were referred to appropriate community services to ensure their needs continued to be met in their own homes after discharge. This included referral to community rehabilitation teams to ensure patients' rehabilitation continued post-discharge and that they were supported to achieve their full rehabilitation potential.
- We discussed discharge planning with staff on the wards. They advised that discharge planning started on the day of arrival for the patient. One patient told us how they were involved and fully informed regarding their discharge arrangements.
- Patients were given information on how to contact the ward if they required support after discharge.

## Availability of information

- Patient information was available to all relevant staff in the form of medical records, care records and therapy care plans.
- We reviewed the discharge summaries at three of the hospitals produced for patients, including those sent electronically to GP's. We found they contained all the key information about the patients care and treatment and therapy needs that would allow this to continue in the community setting. We spoke with a visiting GP who confirmed that appropriately completed discharge summaries were always received at their practice.
- Staff used the trust intranet and also had access through the internet to wider information on clinical guidelines and pathways.

## Consent

- Staff involved patients in their care and we observed on a number of occasions that they obtained verbal consent before carrying out any interventions.
- The social work team carried out best interest assessments and staff understood their responsibilities regarding consent for patients who may lack mental capacity and the actions that could be taken to prevent unnecessary restraint.
- Staff were aware of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and those we spoke with had received training. Training records seen demonstrated that Training in the MCA and DoLS formed part of the mandatory training programme. The MCA/DoLS training is classed as "essential for certain staff groups" and is classified as such on the training and development website. The training is called MCA/DoLS awareness training and is classified as essential for all practitioners who have face-to-face contact with patients and who may be required to complete a Mental Capacity Assessment during the course of their working practice.
- We saw evidence that, where required, formal best interests meeting were held to establish capacity and determine best interests in line with the MCA and the Code of Practice. Records were available demonstrate that these meetings had been documented.

# Are community health inpatient services caring?

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

## Summary

Patients spoke positively about the staff and the care they received. They told us that they received good quality care and that they were treated with respect and dignity. They also told us that they felt involved in their care and were given adequate information about their care and treatment.

Nursing and health care assistants checked that patients were comfortable by completing 'care and comfort' rounds at regular intervals.

Staff were aware of the need to obtain patients agreement and consent to deliver care and we observed this in practice.

## Dignity, respect and compassionate care

- Patients were treated with dignity and respect, staff knocked on doors before entering rooms and that care and treatment was provided behind curtains or closed doors.
- We observed that on all of the wards we visited staff completed 'care and comfort' round when, at regular intervals, nursing and health care assistants checked that patients were comfortable. This information was recorded and included whether patients were in pain, needed support to go to the toilet or were hungry or thirsty. We saw documentary evidence of this at Tenbury Hospital.
- We observed staff speak with patients in a compassionate and sensitive way in a variety of situations. For example, at Tenbury hospital we observed a member of staff supporting a patient to the toilet. They spoke quietly and used bed screens while preparing the patient to walk.
- When we were speaking with one patient, they advised that they wanted to be made more comfortable in their bed and we saw staff assist the patient with their wishes.
- 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. For example, we saw that 89% of patients surveyed would recommend Tenbury hospital to their family and friends.

- Patients were cared for in accordance with national same sex accommodation guidelines.
- Patient Led Audit Care Environment (PLACE) in 2014 awarded an overall score of 91.82% for privacy, dignity and well-being which was better than the national average of 85.26% for small community organisations. For example, the PLACE score for Malvern Community Hospital was 93.9%.

## Patient understanding and involvement

- The majority of patients we spoke with were very positive about the support they had been offered by all the multidisciplinary team. We saw evidence in the care records of three of the patients which showed communication had been ongoing with the patient and their relative throughout the patients care pathway.
- We saw that there were good supplies of patient information leaflets which covered a wide range of relevant topics available for patients and their relatives.
- Senior ward sisters were visible on all wards which meant that relatives and patients could speak with them if they had any questions about their care. Ward information boards identified who was in charge of wards for each shift and who to contact if there were any problems.

## Emotional support

- We spent time on of the wards of each of the five hospitals observing interaction between staff and patients. Staff were seen comforting patients and relatives in a supportive manner.
- Visiting hours were limited in most hospitals but visiting was permitted at any time for patients approaching the end of their life.
- Chaplaincy services could be arranged if required. Staff also described being able to access support for those of other religious denominations.
- Some staff told us they undertook psychological support training. For example, at Evesham Community Hospital we were told that support sessions were held for staff if they had experienced a distressing or difficult situation.

## Are community health inpatient services caring?

- We saw thank you cards, expressing the gratitude of patients and relatives for the kindness and support they had received.

### **Promotion of self-care**

- A large number of patients were admitted to the hospitals for rehabilitation. Therapy staff treated

patients on the ward and patients were supported to self-care. Five patients and a family member told us that assistance was given when required, but that patients were encouraged to help themselves when appropriate.

- We observed lunch time on six wards at three of the hospitals. Lunch was supervised by three or four healthcare assistants. We spent time observing how staff interacted with patients. We saw patients were encouraged to eat their meal in a sensitive and caring manner by staff.

# 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

We observed a multidisciplinary approach to the delivery of care involving nursing staff, health care assistants, therapists, medical staff and pharmacy.

Services had been developed to ensure the local population could access care and treatment as close to home as possible.

There were arrangements to meet the specific needs of patients, including people living with dementia.

We saw where concerns and complaints were dealt with at ward level by the ward sisters, often resolving the issue and avoiding the need for a more formal complaint.

## Planning and delivering services which meet people's needs

- Several community hospitals had a greater bed capacity than was currently in operation. This meant that options to increase capacity were available, if required. During our inspection visit we saw that additional beds had been made available at three of the community hospitals. The matrons we spoke with told us additional beds were only opened when they could be adequately staffed.
- Staff were able to request additional nursing staff when it had been identified that a patient required enhanced support. For example, at Pershore Community Hospital we saw one to one care for a patient who was identified as being at high risk of falls.
- On all of the wards, patients were supported to develop social links and take part in activities. We saw there were many different activities for patients and relatives to attend if they wished. We saw evidence of patients being supported to take part in activities such as, art, reminiscence, pampering and music.
- The facilities and equipment were available to meet the needs of the patients. For example, rehabilitation equipment was available and overhead tracking hoists were in place.

## Equality and diversity

- Staff received training in equality and diversity as part of the mandatory training programme.

- The majority of patients we saw at all the hospitals were of white/European ethnicity. Staff informed us that interpreter services were available and would be requested when they were needed.
- 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.

## Meeting the needs of people in vulnerable services

- There was a nurse and care support worker identified as dementia champions at each hospital who raised awareness and were given dedicated time for training and support. For example, at Tenbury Hospital and Malvern Hospital we were shown 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.
- We reviewed the care records of three patients who were living with dementia. There was an 'About Me' form in the notes which staff completed to identify people's preferred routines, preferences and choices. Documentation we reviewed at all the hospitals included information of the patient's likes and dislikes.
- We were told that there were few patients with learning disabilities who use the community hospital. However, there was a specialist learning disability team at the trust who would be able to support staff and patients with a learning disability should the need arise. Staff were aware of the lead for learning disabilities in the trust and knew how to contact them.

## Access to the right care at the right time

- Admissions and discharges were organised and managed by the 'patient flow' co-ordinators in liaison with ward consultants and local GPs with clear admission criteria in place.
- Staff reported out-of-hours medical support as being responsive to their calls. On call GPs provided telephone advice and came to the hospitals when requested.
- Patients and their relatives told us that they were happy to be in a hospital close to home and families.

# Are community health inpatient services responsive to people's needs?

- Staff told us patients received daily reviews of all patients by a doctor.
- Therapy services provided by physiotherapists and occupational therapists were available Monday through to Friday. Speech and language therapy (SLT) services were available on request. We were told that a number of nurses had undertaken specialist training around swallowing assessments.
- Pharmacy services were provided Monday through to Friday and included pharmacy assistant support. The pharmacy assistant we spoke with told us that medications were available on discharge and in a format suitable for the patient.

## **Complaints handling (for this service) and learning from feedback**

- We saw the complaints policy was clearly displayed at each hospital. Staff we spoke with were able to describe the complaints process and explain how they would advise patients to raise a complaint.
- The wards also had leaflets explaining how to access Patient Advice and Liaison Service (PALS) if patients or their relatives wanted support in raising concerns.
- Patients received an information booklet on admission to the hospital. One patient said they would speak with their relative if they were concerned and ask them to raise a concern on their behalf.
- We looked at the complaints process at three of the five hospitals. We saw evidence where complaints had been thoroughly investigated, or were in the process of investigation.
- We saw that the hospitals each had a complaints log. We saw that complaints were positively resolved at a local level at the earliest opportunity. Most staff said they would refer the patient to the ward sister in the first instance, if a patient was not happy with their care.
- Senior ward staff told us complaints relating to their service were shared amongst the teams during team meetings and in staff newsletters. Learning was also shared within matron's meetings and the monthly head of department meetings. There was evidence of feedback, learning and changes to practice as the result of complaints made. For example, at one hospital a complaint had been made about broken call bells. A programme of regular checking of call bells had been introduced as a result of this complaint.

# 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

We saw that the trust values and vision were prominently displayed. Staff we spoke with were aware of the trust's values and said they tried to put these into action as part of their daily work.

There were strong governance arrangements with information regarding performance displayed prominently for both patients and staff.

Staff felt there was clear local leadership and they felt engaged and consulted. They felt able to raise issues with managers, if required. They said that senior managers from the trust visited the hospitals regularly with most staff knowing who they were.

Several members of staff commented that team working was very good and said they were proud of the service they worked in.

## Service vision and strategy

- The trust's vision and values were displayed throughout the hospital, on the staff intranet and formed the basis of the staff development review and appraisal process.
- 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.

## Governance, risk management and quality measurement

- Hospital matrons and senior sisters across all inpatient services demonstrated a good awareness of governance arrangements. They described the actions taken to monitor patient safety and risk. This included incident reporting, keeping a risk register and undertaking audits.
- We saw minutes of ward meetings at Evesham Community Hospital and Pershore Community Hospital. We saw there was a standing agenda that covered areas such as risks, incidents, complaints and audits. Clear actions were described and previous actions were evaluated.
- We were told about the quality update meetings which ensured that quality and safety matters received due

consideration and that actions were agreed and progress monitored. For example, we looked at the review of one of the wards at Evesham Community Hospital and saw it included staff training figures, complaints and falls.

- We saw minutes of the monthly matron's reports to the trust's quality team. These were very detailed and reported on areas such as staffing, acuity, staff sickness levels, pressure ulcers, and risks.
- Quality measures such as the NHS Safety Thermometer data, hand-hygiene audit results and the results of the monthly nursing metrics were posted on noticeboards on each ward. This meant staff, patients and visitors were able to see how well the ward was performing in these areas.

## Leadership of this service

- Ward staff at all the hospitals and at the focus group meetings told us that they felt supported by their direct line management and that ward sisters had an open door policy so they could be approached at any time.
- Staff reported at focus group meetings that the ward managers and matrons provided strong leadership that focussed on the needs of patients in the hospital. For example, staff at Evesham Community Hospital told us that the matron had a visible presence on the wards each day.
- Some members of staff at Evesham and Malvern hospitals told us that the chief executive and members of the board had in the past six months visited the hospitals to meet staff and patients.

## Culture within this service

- All staff that we spoke with advised that they understood the trust's whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed on the wards advising staff of the whistleblowing procedure. This suggested that the trust had an 'open culture' in which staff could raise concerns without fear.
- We saw evidence to demonstrate that there was a programme of leadership training for middle grade staff to attend.

# Are community health inpatient services well-led?

## Public and staff engagement

- We saw minutes that confirmed that staff team meetings took place at each hospital. This meant staff had the opportunity to discuss both local and wider organisational issues, and to be kept updated with trust initiatives and service developments.
- All of the community hospitals had very active League of Friends and fundraising committees. Management told us about the financial support they received to purchase equipment and improved facilities. For example, areas of Tenbury and Evesham hospitals had recently been refurbished.
- Patients and relatives filled in the 'family and friends test' (FFT) and results were displayed on the wards. No other formal feedback surveys were available from patients or their relatives.

- We saw that 415 out of 3918 staff had completed the staff 'FFT' in August 2014. 55% of staff who completed the survey would recommend the trust as a place to work to their family and friend. This was worse than the national average of 62%.

## Innovation, improvement and sustainability

- The ward manager at Pershore hospital had implemented a 'drop in' session once a week, for patients and relatives to meet with them to discuss the care the hospital was providing.
- The community hospitals had developed a process to quickly move patients from acute hospital beds through daily reviews of admissions and potential discharges in the acute hospitals at Worcester and Redditch.

# Compliance actions

## Action we have told the provider to take

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

# Enforcement actions

## Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.