

Wye Valley NHS Trust

RLQ

Community health inpatient services

Quality Report

Tel: 01432 355444

Website: www.wyevalley.nhs.uk

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

Summary of findings

Ratings

Overall rating for Community health inpatient services

Requires Improvement



Are Community health inpatient services safe?

Requires Improvement



Are Community health inpatient services effective?

Requires Improvement



Are Community health inpatient services caring?

Good



Are Community health inpatient services responsive?

Requires Improvement



Are Community health inpatient services well-led?

Good



Summary of findings

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Summary of findings

Overall summary

Overall community health inpatient services require improvement. The leadership and caring nature of services provided to patients was good, with staff demonstrating care and compassion. However, safety, effectiveness and responsiveness all require improvement.

Staff had a good understanding of incident reporting. Not all staff had access to the electronic incident reporting monitoring system but did have access through a paper system. Feedback following the reporting of an incident was not always provided. Some practice was not in line with guidance, such as management of clinical waste and medicines. Staffing levels were not always sufficient to meet the needs of all the patients.

Training was not always undertaken to ensure that staff had the appropriate competencies, skills and expertise to care for and treat patients effectively.

There was good multidisciplinary working between staff, who were caring and respectful.

The minor injury units at Leominster and Ross on Wye Community Hospitals were temporarily closed, but some local patients and other services such as pharmacies were not aware of this.

The trust had increased the resources for the complex discharge team, which was effective in supporting patient discharges. However, some patients remained in hospital because care packages were not available in the community. There were also patients waiting to access assessments, particularly those who lived out of the area.

There was good local leadership for staff, but they felt disconnected from the rest of the trust. The sustainability of delivery quality care was at risk because of the inability to secure consistent and appropriate staffing at Bromyard Community Hospital when additional beds were opened.

Summary of findings

Background to the service

Wye Valley NHS Trust formed in April 2011 by the merger of acute, community health and adult social services in Herefordshire. In September 2013 adult social services became the responsibility of Herefordshire Council. The trust provides services to 180,000 people in Herefordshire and to 40,000 people in Powys, Mid Wales. The catchment area is rural and remote. More than 80% of the people using the services live five miles or more from Hereford city or a market town.

We inspected the service because it is an example of a high risk trust and has had a rapid response review in the Autumn of 2013.

The trust has three community hospitals: Bromyard Community Hospital, which usually has 14 to 18 beds but had 26 at the time of the inspection; Leominster Community Hospital, which has 26 beds and Ross on Wye Community Hospital with 32 beds. There is also an intermediate care setting and stroke rehabilitation unit at Hillside Intermediate Care Unit with 22 beds

GPs are currently responsible for medical cover for inpatients at the community hospitals together with a visiting consultant from Hereford County Hospital. At Hillside Intermediate Care Unit medical responsibility is provided by a private primary care provider and for patients undergoing stroke rehabilitation they remain under the direct responsibility of the stroke physicians.

The community inpatient service provides rehabilitation services from a multidisciplinary team to patients transferred from County Hospital. This is to ensure they are fit and able to be discharged home. 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. Hillside Intermediate Care Unit's 18 beds are dedicated to providing stroke rehabilitation services for patients.

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

Our inspection team

Our inspection team was led by:

Chair: Andrea Gordon, Deputy Chief Inspector, Care Quality Commission

Team Leader: Tim Cooper, Care Quality Commission

The team included CQC inspectors and a variety of specialists: practice nurse; specialist palliative care nurse; expert by experience; community nurses; and occupational therapist.

Why we carried out this inspection

We carried out this scheduled inspection because Wye Valley NHS Trust had been identified by CQC Intelligent Monitoring as a risk, additionally; the trust was subject to a rapid response review by NHS England in autumn 2013 and so considered a high risk trust.

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

How we carried out this inspection

We visited all four community hospitals which provided inpatient care. We spoke with people who used services, relatives and staff.

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:

Summary of findings

- 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 4 and 5 June 2014. 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 people who use services. We observed how people 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.

What people who use the provider say

We talked with 29 patients and five relatives during our inspection visit.

Patients told us that they rated the services they experienced very highly and that nurses were very kind and caring. We were told that staff were very helpful, patients were given a good choice of food and that there were plenty of fluids available.

Good practice

Our inspection team highlighted the following area of good practice:

- Staff were dedicated to providing a good quality service to ensure patients received safe care and treatment.

Areas for improvement

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

- Ensure all clinical waste bins are lockable and cleaned appropriately once they have been emptied.
- Ensure staff are able to attend and carry out mandatory training, supervisions and appraisals.
- Ensure that staff have the appropriate competencies, skills and expertise to care for and treat patients effectively, particularly in the stroke unit.
- Ensure all staff understand the correct process for medication administration.
- Ensure appropriate steps are taken to determine staffing levels in the community inpatient areas to meet patients' needs and identify risks.

- Ensure that all staff understand that they have access to the electronic system for reporting incidents, have the confidence to use the system and receive feedback so practice can be improved.
- Ensure that the discharge process starts at an appropriate stage of a patient's care, so that discharges are not delayed due to the unavailability of care packages.
- Ensure that discharge to out of area authorities is managed in a way that keeps the patient at the heart of their care.

Action the provider **COULD** take to improve

- Ensure that patients are aware of when the local Minor Injury Units are open and closed.

Wye Valley NHS Trust

Community health inpatient services

Detailed findings from this inspection

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

Requires Improvement 

Are Community health inpatient services safe?

By safe, we mean that people are protected from abuse

Safety in community health adult inpatient services requires improvement. Staff had a good understanding of incident reporting. However, not all staff accessed the trust's electronic system (although a paper system was also available) and there was a lack of feedback following incidents. Care and treatment was provided in a clean and hygienic environment in line with recognised guidance, which helped protect patients from infection. Clinical waste was not stored in line with national guidance.

Staff were aware of medication policies. We saw practice that was not in line with the trust policies such as leaving medication for patients to take, which was not documented in their care plan.

Staffing levels did not meet patient needs and we were not assured that appropriate steps had been taken to ensure sufficient staffing to provide safe care and treatment.

Detailed findings

Incidents, reporting and learning

- Staff told us they reported incidents using the trusts electronic incident reporting system. However, some staff groups, including healthcare assistants and porters, told us that they would report incidents to nursing staff to log on the electronic system because they did not have access to these systems, although they could access paper copies they preferred to pass the information on verbally. Porter staff were employed by an external company and also had a reporting system through their employer.
- Examples of incidents that were reported included pressure ulcers, falls and patients who were transferred inappropriately from Hereford County Hospital to the community hospital.
- Staff confirmed that there was a lack of feedback after an incident was reported. Staff were unsure what action was taken as a result or if any changes were made to improve practice.

Are Community health inpatient services safe?

- Senior nursing staff confirmed that if an incident resulted in serious harm a root cause analysis was completed and lessons learnt were shared with teams. This was confirmed in the ward meeting minutes that we reviewed at Ross on Wye Community Hospital. Lessons learnt from incidents across the trust was shared in the team brief however staff stated they did not see this as being relevant to the acute site.
- The number in falls fluctuated at all four hospitals. We reviewed the meeting minutes for the Care Closer to Home and Urgent Care Service Unit Governance meeting in April 2014. The minutes identified that there had been an increase in falls, specifically at Ross on Wye Community Hospital. Actions identified included the completion of an audit by the falls team and promoting patient walk-round handovers. However, the staff we spoke to at the community hospital did not mention this to us.
- Equipment at all four hospitals had 'I am clean' stickers on them, which were easily visible and documented the last date and time they had been cleaned.
- Cleaning schedule identified the frequencies on when equipment was required to be cleaned. This meant staff could be assured that equipment they used was available and clean.
- Infection control assurance audit reports in October 2013 for Ross on Wye, Leominster and Hillside Community Hospitals identified that at Ross Community Hospital, the infection control team were not consulted on the purchase of new bedside tables. However, staff demonstrated that they had learnt from this because the infection control team were consulted in the purchase for a new sofa bed in the relatives' room.
- At Ross on Wye, Bromyard and Hillside Community Hospitals locks on some of the clinical waste bins were broken. We also saw that general waste that had been segregated was collected with the clinical waste and put into one vehicle and no longer separated out.
- Also clinical waste bins were not washed or sanitised after emptying. This was not in line with best practice guidance (Department of Health, The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance) or the trust's own policy. This meant that there was an infection control risk to staff as relevant systems were not implemented accordingly.

Cleanliness, infection control and hygiene

- We were informed by the trust that there had been no incidents of MRSA at the trust for 458 days. We noted that the performance data displayed at Hillside Intermediate Care Unit indicated that there had been a MRSA Bacteraemia 98 days prior to our inspection.
- There had been one incident of hospital-acquired *Clostridium difficile* at Ross on Wye Community Hospital since April 2014.
- Ward areas in all the community hospitals were visibly clean and hand gel was available on entry to each bay and side room.
- Patients at Bromyard Hospital told us that they thought the ward areas were clean and saw the cleaner twice a day.
- The majority of our observations demonstrated that staff worked in accordance with best practice for infection control. This included good hand hygiene, wearing personal protective equipment (PPE) when appropriate and being 'bare below the elbows'. Although we did observe two examples, at Leominster Community Hospital and Hillside, where staff did not adhere to hand hygiene guidance, and we saw that some staff wore false nails.
- Staff at Ross on Wye Community Hospital informed us that the infection control team telephoned the wards each day and were very supportive. They discussed each patient and identified if the ward needed additional support to deal with infection control risks.

Maintenance of environment and equipment

- Records confirmed that emergency equipment, including resuscitation equipment, was checked every day by the night staff at Ross on Wye, Leominster and Bromyard Community Hospitals.
- Pressure relieving equipment was available on site and available for patients in 24-hours once the need had been identified.
- We checked a random sample of equipment and noted that all equipment was labelled when it was last seen, which indicated if it had been tested, received pre-planned maintenance and if it had been safety-tested.
- All equipment had been checked in recent months and was labelled as such with the exception of hoists at Ross on Wye Community Hospital, which were labelled as last checked in October 2012. However further evidence was provided that these had been checked on the 12 July and 22 November 2013.

Are Community health inpatient services safe?

- At Ross on Wye Community Hospital we found that the key pad for entry to the ward was on the wrong side of the door. Staff also raised this as an issue with us, but it had not been escalated to the risk register. Staff informed us that they were concerned for the safety of the patients, particularly because there had been one incident where a patient with limited mobility and dementia left the ward without anyone noticing.

Medicines

- During medication rounds nursing staff wore a red bib that indicated that they should not be disturbed. However, nursing staff at Ross on Wye Community Hospital told us that because of staffing levels colleagues would disturb them during this time and ask important questions about patients. Although we found no incidents as a result of this interruptions could increase the risk of errors.
- We saw that when staff administered a controlled drug (medications that are governed by specific legislation) this was done in line with trust policy.
- Staff informed us that a pharmacist visited the ward areas weekly to review patients' medications. A review of medication At Ross on Wye Community Hospital indicated that some was due to expire at the end of the month and we were told that new stock would be ordered a week before its expiry date.
- Records confirmed that fridge temperatures were taken daily as would be expected. However, we noted that room temperatures at Ross on Wye Community Hospital where medication was stored were not taken. Therefore, we could not be assured that medication was stored at an appropriate temperature at all times to ensure they were effective.
- Nursing staff were aware of medication policies and relevant assessments, including patient self-medication. However at Leominster Community Hospital, we observed medication left on a table for the patient to take. We were informed that it had been decided that the patient could self-administer, but we could not identify where and when this decision had been made in the care plan.
- One patient at Hillside, who was self-administering medication, told us that they were unaware of what they were taking but there was a list "somewhere".
- At Ross on Wye Community Hospital one staff member told us that patient medication was left on the bedside table and then healthcare assistants would be told to

administer it. The staff member said that healthcare assistants did not carry this out because they did not feel comfortable or competent to give medication. This possibly resulted in some patients not taking their medication.

Safeguarding

- Staff members were able to tell us they process for reporting safeguarding concerns and also showed us where they would access the safeguarding policy and procedures.
- The safeguarding matrix was displayed in the ward manager's office at Bromyard Community Hospital.
- Staff informed us that they would be alerted to any safeguarding concerns on the information system.
- Most staff had completed safeguarding training. The trust's safeguarding adult training records demonstrated that 89% of the staff working in community inpatient areas had completed their training. (Hillside 88%, Ross on Wye 94%, Leominster and Bromyard both 87%).

Records

- We reviewed 10 patient records across the four hospitals and noted that most care plans and assessments were completed. This included skin bundles, vital signs, food and fluid monitoring and pressure ulcer risk assessments. However, we noted that care plans for the emotional and wellbeing of patients were not completed, and care plans and needs assessments were completed with limited and inconsistent information. Therefore, assessments did not give an understanding of patients' needs or how they informed the development of care plans.
- At Bromyard Community Hospital we were told about, and observed, one patient who was receiving one-to-one care. We reviewed the records and were unable to see any plans for the provision of guidance to staff when delivering care and treatment. We also noted that the patient's weight was being recorded on a weekly basis, but it had not been done for just over a week. We tried to identify why the patient's weight needed to be taken and if there was a target weight range, but this was not evident from the records.
- Staff informed us that appropriate records were not always transferred with patients when they were transferred from Hereford County Hospital to the community hospital. Reviewing the records of a patient

Are Community health inpatient services safe?

who was transferred from Hereford County Hospital, we could not find any documentation about the patient's home circumstances. Staff informed us that this would be completed at Hereford County Hospital.

Adaptation of safety systems for care in different settings

- Staff informed us that the safety systems, such as actions to limit risks to patients, were at times not consistent with encouraging patients to be more independent in preparation for their discharge home. They felt that they were not always able to do what was best to meet patients' individual needs and accept risks that may occur when a patient was more independent.

Assessing and responding to patient risk

- We spoke with a GP who told us that the number of unsuitable patients admitted to the community trust had decreased over the last year. This was because appropriate assessments had been carried out correctly by nursing staff.
- Data for the number of patients re-admitted to Hereford County Hospital from the four community hospitals showed that there were 201 re-admissions between April 2013 and March 2014. This was equivalent to 11% of patients from Bromyard Community Hospital, Leominster Community Hospital and Ross Community Hospital, and 23% of patients from Hillside Intermediate Care Unit.

Staffing levels and caseload

- Staff members told us that staffing levels were a problem and there was high use of agency and bank staff.
- Staff at Bromyard Community Hospital said that they tried to use the same agency and bank staff to ensure continuity of care for patients, but this was not always possible.
- Nursing staff explained that due to work pressures there was limited time to teach or mentor student nurses and that there was a shortage of registered nurses working in the community hospitals.
- There was no porter cover on a Sunday morning at Ross on Wye Community Hospital, which increased the workload for healthcare assistants.
- We reviewed staffing numbers on wards and noted that at Ross on Wye Community Hospital there was 1.5 registered nurses to 18 patients in one area and 1.5

registered nurse to 14 patients in the other area. The third nurse was the ward manager. We asked to review the staffing tool used to establish the staffing levels for community wards. There is currently no approved community nursing acuity tool in existence nationally therefore the trust was using the Safer Nursing Care Tool provide assurance to its board. We were provided with a report that showed staffing data for community hospitals, but it did not identify risks related to staffing levels. This meant we could not be assured that staffing levels were calculated on the needs of the patients as well as the size of the ward.

- Staff at Bromyard Community Hospital informed us that they had been given short notice about the opening of additional beds that required additional staff. Agency and bank staff were authorised but it was not always possible to secure these additional staff. This presented a risk because of the nature of the care and organisation of services in that care was predominately nurse-led with GP or out-of-hours medical support.
- Staff members were knowledgeable about the medical cover needed for the community inpatient areas. We were informed that at times GP care out of hours was sometimes outsourced and that a consultant attended Hillside Intermediate Care Unit weekly to carry out a ward round.

Deprivation of Liberty safeguards

- Senior nursing staff were aware of Deprivation of Liberty Safeguards (DoLS), including the recently updated legislation. We noted that on the days of our inspection nursing staff were carrying out a review of the current assessments. Records we reviewed confirmed that appropriate assessments had been carried out and noted the date assessments were due for review.
- Senior nursing staff had received training and were responsible for the assessments. Training in the Mental Capacity Act and DoLS was being rolled out to other staff.

Managing anticipated risks

- Staff had been trained in basic life support, and nursing staff had been trained in advanced life support. Some staff also informed us that if a patient had a cardiac arrest at the community hospitals, they would call the emergency 999 number.

Are Community health inpatient services safe?

- Community inpatient areas at Ross on Wye Community Hospital displayed information for staff on the correct use of the national early warning score (NEWS) to ensure appropriate action was taken to prevent a patient's health from deteriorating.
 - Although there was a system in place to update all the sisters and junior sisters at least four times a day by email of the trust's capacity status staff told us that if the trust declared themselves at level four (no bed capacity), they were unaware of the formal process to inform the community hospitals. They explained that they were often notified by other staff, including the discharge nurse when they attended the ward to review patients for discharge.
- Major incident awareness and training**
- We spoke with staff at Bromyard Community hospital, they were unaware of what their role was in the event of a major incident and informed us that they had not received any training and were unaware of a major incident policy.

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.

The effectiveness of community health adult inpatient services requires improvement. Clinical management guidelines were reviewed and acted on to ensure patients' needs were met. However, staff training was not always carried out to ensure staff had the correct competency, skills and expertise to care for and treat patients effectively. There was no ortho geriatrician support.

Monthly audits were carried out regarding patient safety, patient experience and the environment. This was to ensure patients were cared for and treated appropriately and received the best possible outcome.

Detailed findings

Evidence based care and treatment

- The trust had a policy in place for the care and treatment of pressure ulcers that reflected best practice guidance, including clinical guidelines produced by the National Institute for Health and Care Excellence (NICE).
- Staff were aware and knowledgeable about the guidance available about the prevention and management of pressure ulcers.
- Staff informed us that patients who had sustained a fractured neck of femur were transferred to a community hospital too quickly after the operation. They also informed us that there was no orthogeriatrician medical support (a doctor who works in close cooperation with orthopaedics and has a focus on care of the elderly and rehabilitation). However, they had good support from a GP who specialised in geriatric medicine.
- We asked if there was a criterion for patients that were on the fracture neck of femur pathway for discharge to a community hospital. The trust informed us that if a patient needed to be discharged to a community hospital, the aim was to achieve this in three days. NICE guidance for hip fractures recommends continued rehabilitation in a community hospital with continued multidisciplinary input, and that the patient must meet certain criteria before transfer.

Nutrition and hydration

- Patients were given a choice of food and there was a "good supply of vegetables", and they said that the food was good and tasty. One patient (at Bromyard Community Hospital) said: "The food is good. There is always a supply of drinks." Another patient (Ross on Wye Community Hospital) told us that the quality and choice of vegetarian food was variable from good to dreadful.
- At Hillside staff informed us that the menus had improved recently following feedback and complaints received from patients.
- We observed staff at Ross on Wye Community Hospital supporting patients when needed to review the menu choices and make their selection.
- Healthcare assistants (Ross on Wye Community Hospital) provided assistance to patients who required help when eating. However, healthcare assistants informed us that the expectation was that relatives would assist patients because there were not enough staff.
- We observed that protected meal times were in place at all the community hospitals.

Patient outcomes

- Ward audits were carried out at each community hospital inpatient area. Staff informed us that these audits were compulsory and mainly undertaken by night staff, such as the use of the dementia screening tool and medication assessments.
- Staff at Bromyard Community Hospital informed us that there had been an increase in the number of falls in the last month, but it was not clear why or whether there were any themes or trends however this would be reviewed at the monthly service unit performance meeting in June.
- An audit had been carried out regarding the work of the discharge coordinator. However, there were no audit results available at the time of our inspection and the coordinator was unaware of the results.

Are Community health inpatient services effective?

Performance information

- Performance information was displayed on staff boards in all the community inpatient areas. The information included figures for participation in the safety thermometer programme, for example in falls and pressure ulcers. This demonstrated how the ward performed in relation to patient outcomes. We noted that this information was from April 2014 and were told that the ward managers were unable to update this data because it was provided by the trust and they were awaiting more up to date information.
- This information included the figures for MRSA and c. diff. At Ross Community Hospital we noted that the figures showed that the hospital had one MRSA and no hospital acquired c.diff since April 2014. However, this differed to other data that we had been provided with by the trust prior to our visit and staff confirmed that they had one hospital acquired C.diff and no incidents of MRSA.

Competent staff

- Staff had received an annual appraisal, but supervision generally did not take place. At Hillside Intermediate Care Unit we were informed that stroke competencies for staff were not formalised and that staff learnt from experience.
- Wards maintained a local training matrix to identify which staff received mandatory training and when. Staff at Ross on Wye and Bromyard Community Hospitals informed us that time for training was not protected, and it was therefore difficult to access. Mandatory training included: information governance; tissue viability; aseptic technique; moving and handling; and safeguarding. Staff also told us that they received additional training in dementia care. The data provided by the trust identified that 66% of nursing and midwifery registered staff in the care closer to home and urgent care service unit received mandatory training. We asked if community staff could be extracted from this data and were informed that 39.23% of community staff had received mandatory training.
- Nursing staff informed us that a skills bus went to the different community hospitals to provide virtual training lectures and skills assessments. We noted in ward meeting minutes at Ross on Wye Community Hospital that all staff were encouraged to visit the skills bus if possible.

- Healthcare assistants informed us that there was a cadet course that lasted for one year and one day. Following the successful completion of the course cadets were able to apply for healthcare assistant positions. One staff member at Ross on Wye Community Hospital told us that they were successful in getting a job after completing the cadet course.

Use of equipment and facilities

- Bay areas were clean and uncluttered, but equipment was stored in the corridors of the ward areas. A staff member at Ross on Wye Community Hospital confirmed that there was a new clean storage area for equipment, but there were still storage problems.
- A staff member said that new equipment for the ward at Ross on Wye Community Hospital had been funded by Friends of the hospital. We saw that this included beds, mattresses, televisions, clocks, bed tables and a new relatives' room. These charitable funds helped to fund necessary equipment to ensure quality and safe patient care.

Multi-disciplinary working and working with others

- At all the community hospitals there was good communication between different healthcare professionals involved in the care and treatment of a patient. This included consultants, GPs, nursing staff, occupational therapist and physiotherapy. Staff told us that they worked as one team.
- Consultants were available for telephone advice as they were not always present on the ward to discuss the patients' needs. At Bromyard Community Hospital, we were told that a GP visited six days a week and would return if they were contacted by ward staff.
- Handovers were conducted by using updated printouts that provided staff with brief details of the patients and their needs.
- Healthcare professionals on the ward held 'huddles' (updating meetings).
- A weekly multidisciplinary meeting was held at Leominster Community Hospital, which included the social worker, GP and other relevant healthcare professionals.

Are Community health inpatient services caring?

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

Patients and relatives we spoke with told us that they received good quality care and that they were treated with respect and dignity. However, patients told us that they were unsure what their discharge plans were and when they could go home.

Compassionate care

- Patients and relatives at all four sites told us that nursing staff were very caring.
- One patient told us: “All in all, very good and the nurses look after me very well.”
- One relative said that they stayed with their relative to tend to their care and comfort needs where possible.
- We saw that staff were polite and friendly towards patients. When we were speaking with one patient at Bromyard Community Hospital, they expressed their wishes to move and lie down and we saw staff assist the patient with their wishes.
- Our observations demonstrated that staff were very caring. However at Bromyard Community Hospital, we were informed that at times patients’ movements were discouraged if they were identified as at risk of falling.

Dignity and respect

- Patients and relatives at Hillside informed us that they felt respected by staff and that staff were kind, sensitive and always gave them time and support.
- Patients at all four hospitals were cared for in accordance with national same sex accommodation guidelines.
- 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.
- At Ross on Wye Hospital we did see one incident when a patient had been left in an undignified manner. Staff also informed us at Leominster Community Hospital that they were told to leave curtains open when assisting patients so they could see other patients who may need their attention.

Patient understanding and involvement

- We noted that information leaflets were available for patients and relatives regarding care and treatment. Leaflets were also available on entry to all the hospitals, which included information on visiting times and meal times.
- Patients at Ross on Wye Community Hospital told us that general practitioners (GPs) did not identify themselves, although nurses explained what was happening and informed them of any progress. They told us that they understood the need for assistance from physiotherapy and occupational therapy services and felt the benefits from the support received.
- Most patients informed us that they did not know when they would be discharged home or what plans were in place for their discharge. One patient at Bromyard Community Hospital told us that they felt as though they had been waiting a long time for their discharge plans, although they knew that occupational therapy had completed a home visit that morning and waiting for feedback.
- Relatives at Hillside told us that they were unaware of the care pathway that their relative was on or what the discharge plan was. However, they went on to tell us that they planned to speak with the relevant staff to get a better understanding.

Emotional support

- Patients informed us that they did not have a named nurse, although we noted that patients were allocated a key worker for therapy services.
- Patients at Ross on Wye Community Hospital told us that when their door was open to their bay or side room, they would prefer nurses and healthcare assistants to speak to them more often because it could be lonely.
- We were informed by one patient that there was no continuity in how staff cared for patients at Ross on Wye Hospital. Each staff member would do things differently to the person the day before.
- Staff informed us that members of the local diocese visited at least weekly and that other faiths could be contacted if needed for a patient.

Are Community health inpatient services caring?

Promotion of self-care

- One patient (at Hillside) told us that they felt rushed at times. They were due to be discharged in a few days and felt they still required some confidence-building and re-assurance through their rehabilitation.
- Staff members we spoke with at Ross on Wye Community Hospital confirmed that some patients did

tell them that they did not feel as though they had received enough rehabilitation and wanted further physiotherapy before discharge. This meant patients did not feel that they were always given adequate time to promote self-care before being discharged home.

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

Requires Improvement 

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

Responsiveness requires improvement. Staff were unable to be responsive to people's needs at all times due to the increase in the complexity of patients' needs. There were often delays in patient discharges due to the availability of social care packages.

There was an effective process in place to ensure staff were responsive to the specific needs of patients living with dementia.

Detailed findings

Service planning and delivery to meet the needs of different people

- Staff at Bromyard Community Hospital said that patients would often need one-to-one specialised support. An acuity tool was completed and submitted on a weekly basis to ensure staffing levels were appropriate for the needs of the patients, but with the increase in bed numbers it was not always possible to get all the shifts covered.
- If patients were identified as at risk of falling, they would be moved closer to the nurses' station for observation.
- Staff described how delivering care to patients was becoming more challenging as their needs became more complex. This included patients being transferred to community hospitals post-operation, and under orthopaedic care and requiring intravenous fluids.
- One staff member told us they feel continually under pressure due to the demands and complexity of patients and the lack of staff.
- There were challenges at all four sites relating to the discharge process because some patients were transferred to the community hospital only requiring social care packages to be arranged in order for them to be discharged home. However as this process had not already commenced at Hereford County Hospital it meant they had to wait in the community hospital for the arrangements to be made.

Access to care as close to home as possible

- Staff informed us that most patients admitted to the community hospitals lived locally, which meant relatives and friends could visit them.

- We observed a patient who had been transferred from another community hospital to Bromyard Community Hospital because it was closer to their home.
- There were a small proportion of patients who lived out of the area, which delayed discharge plans.
- Prior to our inspection we were told that the two Minor Injury Units (MIUs) at Ross on Wye Community Hospital and Leominster Community Hospital were closed temporarily. Staff in the community inpatient areas explained that this had an impact on their staffing because a number of patients would still turn up. Since the temporary closures of the MIUs a total of 166 patients had attended the units for treatment and had to be redirected to another service. On two occasions staff had called the emergency 999 number to transfer patients from Leominster Community Hospital to Hereford County Hospital. This meant that the public were not fully informed of the temporary closures, which could result in delayed care and treatment. This also impacted on the workload of the community inpatient staff and the care and treatment inpatients received.

Access to the right care at the right time

- The complex discharge team had been expanded and we were informed that some of the challenges they faced included the need for additional support to facilitate social care packages on discharge.
- A complex discharge coordinator informed us that support from a rapid response reablement (helping people do things for themselves) team would provide quick support for patients while social care packages were agreed.
- A GP confirmed that patients were admitted to community hospitals who were medically fit for discharge home, but required social care packages before they could go home.
- During our visit, it was brought to our attention that there were many patients waiting to be discharged home, but no social care packages available or a delay in putting the packages in place. This particularly affected patients at Bromyard Community Hospital who did not live locally.

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

Requires Improvement 

- There were two instances in which patients who lived in Powys required a social care package. We were informed that the relevant staff from Powys were unable to travel to the community hospital. This meant that the patients had to wait for a community bed to become available in Powys, transfer there and then be reassessed for a social care package. The transfer to another hospital could have been avoided. It is acknowledged that these issues relate to the wider health and social care economy issues and impact on Wye Valley NHS Trust.
- We were told that patients were transferred with their medical records, but if the patient had more than one volume of medical records the ward clerk would have to request them.
- Staff at all four hospitals informed us that during times when there was severe pressures on bed capacity they received inappropriate transfers of patients from Hereford County Hospital late in the evening or during meal times. This meant that patients sometimes did not get a choice for their meal and there was limited assurance that patients were cared for appropriately because of the late transfer.

Meeting the needs of individuals

- Patients at Hillside and Ross on Wye Community Hospitals informed us that staff could be a bit slow in responding to call bells and that on occasions staff walked past their room when their call bell was ringing.
- Staff informed us that interpreter services were available and requested when they were needed. During our visit we met a patient at Hillside who spoke limited English, who explained that a relative attended to interpret for them.
- We saw the effective use of the 'Forget Me Not' scheme for patients living with dementia. Staff were able to describe the benefits of using the paperwork when caring and treating patients, and they told us that if a patient was admitted from a care home they would use the patient passport (written information about a patient's likes, dislikes and needs often used for people who are vulnerable).
- Documentation we reviewed at Ross on Wye Community Hospital included information for what the patient liked best and what upset them.
- The trust had a standard operating procedure in place for the discharge of patients from Hereford County Hospital to a community hospital. This included a medical review (if needed), a nurse assessment and telephone report.
- A patient's pressure ulcer status was requested on all transfers, which was reported as a clinical incident if staff at Hereford County Hospital failed to inform them.

- A GP told us that they were concerned about the use of advanced discharge letters because patients' needs could change by the time of discharge and the letter would be incorrect. Also we were told that the GP relied on sending emails because there was no electronic discharge letter or secretarial support. This meant that there were fears that the appropriate people would not receive timely information about a patient's discharge.

Complaints handling (for this service) and learning from feedback

- Patients at all four hospitals informed us that they had no complaints at all about the service they received. One patient said that although they had no complaints, if they did, they would not feel confident to make it. They went on to explain that they were given an information pack the day before but did not know what information it contained.
- Staff we spoke with were able to describe the complaints process and explain how they would advise patients to raise a complaint.
- Staff confirmed that they had received complaints training.
- We saw compliments and thank you cards displayed in all ward areas for staff, patients and visitors to read. Any comments for improvement, including complaints would also be displayed in this way. However, at the time no complaints had been received.

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.

Vision and strategy for this service

- The trust had a vision with specific values and objectives. This included putting people first and promoting thriving communities.
- In the trust objectives, the trust had set itself clear service improvement initiatives and highlighted the areas of good practice.

Guidance, risk management and quality measurement

- Staff informed us that the chief operating officer and director of nursing had visited Bromyard Community Hospital and staff raised any concerns with them. We were told that minor issues such as lighting were fixed, but there was no feedback about actions on more complex issues such as long term staffing arrangements or the appropriate use of beds.
- Staff explained that the community hospitals had started to complete mini audits at each other's sites that covered reviewing wound charts, bowel charts and dementia assessments. The results of the audits were review by senior managers and fed back to staff, but there were no action plans as a result.
- Monthly ward meetings at all four sites were held that discussed mandatory training, incidents, trust developments, audits, recruitment and the use of induction forms for agency and bank (staff who work overtime in the trust) staff for short term durations. Records we reviewed confirmed this.

Leadership of this service

- Staff at all four hospitals informed us that a new buddy system had been introduced that involved trust board members being a buddy to a service or community area. Staff were knew which director was assigned to community inpatient services. They said that it was a new process and were still waiting to find out how it would be implemented.
- Ward staff at all four hospitals informed 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.

- Ward sisters at Ross on Wye Community Hospital explained that there was no time allocated for management activities or paperwork, and that this affected the level of support they were able to provide to their staff.
- Staff in community inpatient areas told us that the head of nursing was visible in the service, but they did not always find that they were supported or helped to meet patients' needs.

Culture within this service

- Staff at all four sites felt that due to pressures in the service, additional hours were worked but that this was not recognised because the attention of the trust board was centred on Hereford County Hospital.
- Staff told us that although the team talk was distributed across the trust it was less relevant to the community hospitals because it mostly focused on Hereford County Hospital.

Public and staff engagement

- A staff involvement and engagement action plan was put in place following the publication of the results from the Staff Survey 2013. The trust provided us with a document that highlighted how service units would need to develop action plans to improve staff satisfaction.
- The trust action plan had been developed with the assistance of staff side (recognised trade union) representatives.
- The trust participated in the Friends and Family Test, and the results were displayed outside wards for all staff, patients and visitors to see.
- The results of the Friends and Family Test were largely positive.

Innovation, improvement and sustainability

- Some staff at Bromyard Community Hospital informed us that they received their appraisal the previous year, but no individual objectives had been agreed or set. The trust's appraisal rate in March 2014 was 76% (the trust target was 90%). We were unable to see the figure

Are Community health inpatient services well-led?

broken down to include only community inpatient staff. This meant that staff were not always receiving appropriate support and development through the use of the appraisal system.

- Although the official number of beds recorded for Bromyard Hospital was 14 beds, staff told us that they had been using 18 beds for some considerable time and that they could generally staff this number. However, the week before the inspection a further six beds were

opened with permission for the hospital to increase its nursing staff capacity. But, they were not always able to secure sufficient resources due to the lack of available bank or agency staff and permanent staff were working longer hours to meet patient needs. This was unsustainable in the medium or long term. No additional resources had been provided for therapy staff.