

Sandwell and West Birmingham Hospitals NHS Trust

RXK27

Community health inpatient services

Quality Report

Leasowes Intermediate Care Centre, 139 Oldbury
Road, Smethwick
West Midlands, B66 1JE
Tel: 0121 554 3801
Website: www.swbh.nhs.uk

Date of inspection visit: 14-17 October 2014
Date of publication: 26/03/2015

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

Summary of findings

Ratings

Overall rating for Community health inpatient services

Good



Are Community health inpatient services safe?

Requires Improvement



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

Contents

Summary of this inspection

	Page
Overall summary	4
Background to the service	5
Our inspection team	5
Why we carried out this inspection	5
How we carried out this inspection	5
What people who use the provider say	6
Good practice	6
Areas for improvement	6

Detailed findings from this inspection

Findings by our five questions	7
Action we have told the provider to take	21

Summary of findings

Overall summary

There were systems in place for reporting and investigating incidents involving patients, and evidence that learning from incidents occurred within the service. Staffing levels were not routinely reported as incidents in the same way.

Both community inpatient services (the Leasowes Intermediate Care Centre and Henderson Ward at Rowley Regis Hospital) were clean and well maintained. Equipment had been cleaned, labelled, and was ready to use.

Staffing levels were problematic in the Leasowes Intermediate Care Centre, particularly the nursing staffing numbers at night-time. This was having an impact on patients who were waiting for long periods for their call bells to be answered. It was also a risk to the safety of patients at the centre. The issue had been recognised by the trust and permission given to increase the establishment by one qualified nurse overnight. However, at the time of our visit, no action had been taken to increase the staffing levels. They were subject to review across the trust and the number of therapists was also being increased at both services. Some patients told us about the lack of staff, particularly during the night.

All staff received mandatory training, and an emphasis was being placed on the completion of performance development reviews and the effective management of attendance. Risk management processes were in place.

There was good evidence of multidisciplinary team working across therapies, nursing and medicine, and good integration of care for patients at both services. Staff offered compassionate care and respected the dignity and privacy of patients. Risks were identified around nutrition and hydration, and patients enjoyed a choice of food and drink.

Services were organised to respond to the individual needs of patients, including those requiring dementia care or interpreting services. Patients were involved in setting out their goals for rehabilitation, and therapies were delivered with care, professional expertise and compassion. Patients we spoke with were happy with the care and treatment they had received.

Summary of findings

Background to the service

We visited community inpatient services at two locations. These were described by staff as re-enablement and rehabilitation wards. The first was the Leasowes Intermediate Care Centre in Smethwick. This was a modern, purpose-built, 20-bed community intermediate care service. Two of the beds had been commissioned to provide palliative care for those patients approaching the end of their life and whose needs could not be met at home.

The second was the Henderson intermediate care service based at Rowley Regis Hospital. This was a 24-bed community intermediate care service offering

rehabilitation and person-centred discharge planning. Patients on this ward had been transferred from other hospital services and were helped to achieve independence before returning home or moving to other care services.

Both these services had been designed to avoid unnecessary hospital admissions, shorten the length of stay in acute care and reduce the reliance on long-term care. Nursing care was provided 7 days a week, 24 hours a day. A GP and consultant geriatrician service was also available. Physiotherapy and occupational therapy were available five days a week.

Our inspection team

Our inspection team was led by:

Chair: Karen Proctor, Director of Nursing & Quality, Kent Community Health NHS Trust.

Team Leader: Tim Cooper, Head of Hospital Inspections, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: occupational therapists, community nurses and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Why we carried out this inspection

We inspected this core service as part of our Comprehensive wave 3 Combined 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

announced visits on 15, 16 and 17 October 2014. During the visit we held focus groups and interviews with a range of staff who worked within the service, such as palliative care nurse specialists, district nurses, nurses, healthcare assistants and senior clinicians. We talked with people who use services. We observed how people were being cared for, 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

“I have been here since I came from hospital. I have been well cared for and staff have been very sensitive in protecting my privacy.”

“The food is very nice with plenty of choice and variety.”
“The food is like you get in a hotel.”

“The carers are lovely, compassionate people and they would do anything for me. The one thing was that, during the night, the nurse call was going off for long periods. Staffing was OK during the day but they certainly need more staff during the night.”

“As far as hospitals go, it’s alright. Staff are kind and look after me and give me my medicine. My bed linen is always clean. I am a bit bored because there is nothing much to do here.”

“We find it frustrating that he is still here. We were told that it was for a few days. His discharge package was agreed at Sandwell. His bed has been delivered so everything is in place but staff aren’t telling us what’s happening.”

Good practice

Managers at a focus group and working in the two services told us about the relentlessness of the leadership messages. They said that it was the consistency and repetition of the messages that were enabling the changes and improvements to take hold.

Areas for improvement

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

Action the service **SHOULD** take to improve

- The trust should ensure sufficient numbers of staff in the early evening and at night.
- The trust should ensure sufficient supply of hoists resulting in people not having to wait to be transferred at busy times (for example, after meal times and at bed times).

Sandwell and West Birmingham Hospitals 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

Summary

There were insufficient qualified nurses working at night at the Leasowes Centre. One qualified nurse for 20 patients on two floors, including two set aside for end of life patients was insufficient and created a significant risk. The trust had agreed to increase night time nursing cover to two; however, this had not been introduced. Safety would continue to be compromised until the second post was filled. The process for the anticipation and assessment of risk was effective. However, the action taken to reduce the likelihood of the risk occurring was slow.

Patient incidents were reported and learning took place from these incidents. However, incidents, or potential incidents, relating to staffing levels were not reported routinely. This may have been contributing to an 'acceptance' of the staffing levels and the lack of urgency we found in relations to responding to this matter.

Standards of cleanliness and infection control were good, and were monitored through local monthly audits and

quarterly ward reviews. Equipment was cleaned, disinfected and appropriately labelled ready for use. Medicines were stored safely, but there were some gaps in the records of routine checks. We also noticed that the drug round in the morning was taking too long, and we were told that this was also the case in the evening. This meant that patients did not always receive their medication at the time prescribed by their doctor, which may have had safety implications for certain medications.

Incidents, reporting and learning

- We asked the trust for information that showed that incidents were being reported, investigated and monitored. The staff we spoke with said that they were aware of the reporting process for incidents.
- In total, 13 incidents were reported through the trust's reporting system from beginning of July 2013 to end of June 2014. Seven of these incidents occurred during clinical assessment and were related to procedures relating to diagnosis. Two incidents occurred during

admission, transfer or discharge, and four involved medications, infection control or other patient accidents. This showed that staff were aware of and using the incident-reporting system and that the level of incidents was at the expected level for the service.

- Two serious incidents occurred in the same period, one at the Leasowes Intermediate Care Centre and one on Henderson Ward. Both incidents involved patients who sustained a fall that caused a bone fracture. The patient's fall at Leasowes was classified as unavoidable but the one at Henderson was avoidable and resulted from a lack of appropriate supervision for a patient with dementia. We found that learning had taken place and staff said that increased supervision was being offered to patients with dementia.
- At Leasowes, the centre manager said that "everybody reports incidents including falls and pressure sores". We were told that these issues were covered in the handover meetings at the beginning of every shift. At a discharge meeting, we heard discussion of falls prevention such as one-to-one observation and the use of sensor mats and pads, traditional alarms and increased supervision. At the multidisciplinary meetings we attended, we also noted that attention was given to pressure care issues.
- However, staff only reported incidents that related to patients. We were informed that they did not report incidents such as reduced staffing levels that affected patient care and may have put patients at risk.

Cleanliness, infection control and hygiene

- Cleanliness and infection control was the first item on quarterly ward reviews and included information on preventative measures, including decontamination of the ward environment and equipment, and the action taken in response to any outbreaks.
- Screening for MRSA was 100% compliant; there had been no new cases reported in the first half of 2014, and no bed closures due to infection on Henderson Ward or at the Leasowes Centre. There had been one case of clostridium difficile at Leasowes and this involved a patient who had been transferred in from outside the trust.

- Generally we noted a good level of infection control and prevention techniques, and all the areas we visited appeared to be clean. We observed cleaning in a bay on Henderson Ward and saw that it was thorough, with cleaning under the beds and in and around trolleys.
- The carpets had been removed at Leasowes and replaced with vinyl flooring; this proved easier to clean and more effective for infection control.
- We found that staff had completed mandatory infection control training; the ward environment and equipment were cleaned regularly and this was noted in a cleaning book. Staff and visitors used the hand gel provided and there were leaflets available on infection prevention and control.

Maintenance of environment and equipment

- The defibrillator, kept on Henderson ward, was well maintained and ready for use. We checked the resuscitation trolley and found that all items were present and correct. Other equipment, including wheelchairs and handling aids, was cleaned and disinfected after use, and labelled as clean and ready to use.
- The environment at Leasowes was light and airy and appeared to be well maintained. There had been some recent refurbishments after an accident when a lorry had driven into the building and caused damage.

Medicines management

- On Henderson Ward, we noted that the resuscitation trolley was checked daily. We looked at the records for 2 months and found that 3 days had been missed in total. We looked at the oxygen and suction checks for the same period and found that 6 days had been missed.
- At Leasowes, we saw that the clinical room was kept locked and clean and tidy. Medicines were stored safely, although the room was cluttered and easy access to medication was obscured by a large trolley. There was a risk of staff not being able to access drugs in an emergency.
- The fridge temperature was checked daily and there were no out-of-date medicines. Controlled drugs were stored correctly and the stocks of medicines kept on the ward were checked regularly by the pharmacy and ward staff. The resuscitation trolley was checked daily and the

defibrillator was plugged in and charged. Syringe drivers were stored appropriately and blood sugar monitors were calibrated daily to ensure that they remained accurate.

- On Henderson Ward, we were informed that the nurses were not checking controlled drugs routinely with the night staff. We noted that this was contrary to standard practice and might make it more difficult to be precise about when a discrepancy in medication had occurred.
- At Leasowes, the morning drug round, which began at about 8am, was not completed until 10.45am. We asked the ward manager why it was taking so long and they were not able to explain. We were concerned that there was a lack of understanding of the importance of ensuring that patients were taking their medication on time.
- We were informed by another nurse that the evening drug round was also taking a long time. The nurse said that patients had complained 'informally' about having to stay awake in the evening to wait for their medications. The trust had changed the start time of the evening shift to start earlier to address this but it was still presenting an issue for both patients and staff.

Safeguarding

- At the multidisciplinary meetings we attended, staff demonstrated a good knowledge of the Mental Capacity Act, deprivation of liberty safeguards and best interest decision making.
- Staff demonstrated a clear understanding of safeguarding issues how and when to raise alerts. There was mandatory training on safeguarding. We were informed that there was a specialist safeguarding team of two nurses who were able to help with cases involving safeguarding concerns, and who visited wards to give talks about mental capacity and best interest decisions.
- We discussed some examples. One was of a patient who wanted to be discharged but the nursing staff thought they did not have the mental capacity to make the decision and the family were reluctant to get involved. We were told that the staff were discussing the possibility of a best interest decision with the social worker.

- An older patient, who had been locked up at home by a mentally unwell relative, was discussed at the multidisciplinary team meeting at Leasowes and reported to safeguarding. There was an appropriate referral made and the relative was admitted to hospital. The patient wanted to return home and a package of care was being discussed for the future as part of their assessment.

Records systems and management

- We inspected several care plans on Henderson Ward. We found that 'nursing aims' were documented and there were evaluations (for example, for assessing blood sugars and for pain management). However, we found that care plans were incomplete and the action taken to implement them was not always evaluated. For example, in one care plan, we saw that the falls prevention plan was not ticked to indicate that it was being implemented or evaluated. In another plan, a memory scan tool had been completed and the score had indicated that a medical review should take place; however, there was no indication that this had occurred.

Assessing and responding to patient risk

- We heard some insightful discussions at the multidisciplinary team meetings about the management of risk in relation to patients vulnerable to falls and those with needs around manual handling. There was a good balance of judgement in relation to managing risk, supporting discharge and accessing packages of care.
- We witnessed an incident while we were visiting Henderson ward. A patient had been assessed as at high risk of falls and was being continually observed 'focused' by one nurse. However, the ward manager told the nurse that the patient could be left and the nurse could attend to other duties. While the nurse was working elsewhere, the patient tried to get up and an alarm on the sensor equipment alerted the nurse who returned just in time to prevent a fall. We were informed by the ward manager that an incident report would be completed for the 'near miss', and extra systems were put in place to prevent further risks to the patient. The manager said the patient had not been trying to get up

all morning and so they had thought the continual observation was no longer necessary. They said that they had got it wrong because, as soon as the nurse was withdrawn, the patient tried to move.

- We saw that therapists worked safely with patients explaining tasks and offering support during transfers (for example, from bed to chair). We observed a joint (occupational and physiotherapist) mobilising session with a patient who was using a walking frame with the goal of walking the distance equivalent to that to and from the stair lift at home. The therapists supported the patient during their walk, and were able to discuss risks and articulate positive risk taking as part of the rehabilitation.

Staffing levels and caseload

- The head of service informed us that the acuity of patient's needs had increased and staff were finding it difficult to deliver the service within the staffing levels available. As a result, a workforce review had been undertaken and approved staff levels had been increased. We were informed that recruitment was taking place and, in the meantime, bank and agency staff would be used to cover vacant posts. We were also told that there was some difficulty filling some nursing posts when candidates were scarce.
- Staffing levels at Leasowes were discussed with staff and patients. The ward manager told us there were two qualified nurses working during the day time, four healthcare assistants in the morning and three in the afternoon and early evening. This meant that there was a qualified nurse available on each floor and two nurses present and able to authorise and administer drugs. One member of staff said that the daytime staffing levels were reasonable although "occasionally staff are needed to accompany patients to appointments and this leaves the ward short".
- However, at night there was just one qualified nurse on duty and two healthcare assistants. One qualified nurse was insufficient for up to 20 patients. These levels were particularly challenging given the geography of the centre where the patients were in separate rooms and over two floors.
- We were also informed that, if medication needed to be administered at night, then it was necessary for the qualified nurse to ask a district nurse to attend and

jointly sign off the medication. This meant that medication was delayed, which could be significant, particularly with end of life patients needing immediate pain relief. The ward manager said that the delay was not long and usually no more than 15 minutes.

- We spoke with several members of staff at Leasowes and they told us that staffing levels were insufficient, particularly at night. One of the qualified nurses we spoke with said they were concerned about night-time staffing levels and that working with just one qualified nurse "impacted on our ability to provide timely care". This nurse said they were aware that sometimes patients had to wait some time for a response. Leasowes was spread over two floors and staff informed us that it was difficult for the one qualified nurse to work over the two floors. One patient at Leasowes told us, "I pressed my nurse call at 6pm because I needed to go to the toilet and I kept pressing it until they came at 9.50pm." The manager could not comment on the individual case, but agreed that it was very busy at the centre in the early evening and overnight, which was why they were increasing the staffing levels.
- One nurse said they were concerned about the risks of managing end of life patients with just one qualified nurse on duty at night. The nurse said that she had not raised this as an incident but reflected that "I probably should have done".
- The head of service and the intermediate care manager at Leasowes informed us that it had been agreed that a second qualified nurse would be added to the night-time establishment. Approval for this extra post had just been granted and recruitment was yet to take place. At the time of our visit, there were no plans to cover the extra post with a bank or agency worker, but the matron told us that they would be moving the out-of-hours district nursing team to Leasowes until they had recruited. In our view, until this post was filled, patient safety at Leasowes Centre remained compromised.
- We were given a copy of the 'ward demographics' for Henderson for the second quarter of 2014. This showed a funded nurse establishment of 30.3 (whole time equivalent [WTE]). Vacant posts against funded establishment at the time of assessment amounted to an overall 7% nursing vacancy rate and a 7.3% support worker vacancy rate GP cover was available on Henderson Ward and at the Leasowes Centre.

Henderson Ward was nurse led with a GP practice providing medical cover. Originally, this had been on Monday, Wednesday and Friday but, since the primary care assessment and treatment (PCAT) unit had opened at the Rowley Regis Hospital, GPs were also offering a pop-in service on Tuesdays and Thursdays. At the weekends, the ward used the out-of-hours service or called 111. This was a satisfactory arrangement and patients received timely medical attention.

- At Leasowes, there was also GP cover on a Monday, Wednesday and Friday. On a Thursday, there was consultant presence and a ward round. At the weekend, the centre used the GP out-of-hours service or the 111 and emergency services. We were satisfied that timely medical attention was available for patients.
- Therapy staffing levels had also been reviewed recently and the numbers increased. The team leader told us they wanted to ensure that patients were seen more quickly and more frequently. On Henderson Ward, there were two full-time occupational therapists and one full-time and one part-time physiotherapist. There was also a full-time physiotherapist working across both Leasowes and Henderson Ward.
- There were also two part-time rehabilitation support workers based on Henderson Ward, although we were informed that, because of staff shortages, they had been assisting the nursing establishment. The therapy team leader told us that the nursing establishment needed to be increased. Following the inspection the trust informed us that at that time this was part of the rehabilitation support workers role to assist nursing staff. At the time of our inspection the trust was undertaking establishment reviews.
- Therapy staffing levels had also increased significantly at Leasowes and this provision would provide support to two wards at the hospital. There were now posts established for three occupational therapists and two

physiotherapists. There were also four rehabilitation support workers for the afternoons. Not all these posts had been filled but, when they were, the team leader said that we would be “looking at 7-day working”.

Managing anticipated risks

- We looked at the risk registers for the Leasowes Centre and Henderson Ward. The risks identified related to patients being harmed by falls, “given the patient mix, the environment and rehabilitation ethos”. We noted that action had been identified and taken to manage these risks, including personalised care and treatment planning, the use of motion sensors and low-risk beds, staff training, and incident reporting and monitoring. There was also a risk identified of ‘maintaining effective staffing levels to meet patients’ needs’. The proposed actions to mitigate the risk included the use of bank and agency staff and management oversight with escalation systems available at all times.
- However, there were also risks identified that were associated with an over-reliance on bank and agency staff. This would remain a risk until the safer staffing review was completed, the uplift to staffing agreed and the extra staff in post. The risk register identified a further risk, which was the difficulty in recruiting the number of band 5 nurses needed to deliver safe staffing levels. This difficulty was confirmed by the manager at Leasowes and by the head of the service. The risk register indicated that the issue had been escalated appropriately to the chief nurse, who was looking at the matter in the context of the trust-wide workforce review.

Major incident awareness and training

There was a detailed understanding of the issues in both services as a result of the incident at the Leasowes Centre when a lorry had collided with the building. The staff had recent experience of managing a major incident and evacuating patients from the centre. We were informed that the incident was used as an opportunity to help staff to learn from the experience.

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

Staff worked to deliver assessment and treatment in accordance with standards and evidence-based guidance. There was some monitoring of people's outcomes, although more could be developed in this area to improve effectiveness.

Multidisciplinary team working was effective. Staff were competent and worked well as an integrated team in the interests of patients.

Evidence based care and treatment

- We spoke with an occupational therapy student who said that there was a marked emphasis on rehabilitation and therapy at Leasowes, and on multidisciplinary team working in the interests of patients.
- One of the team leaders we spoke with said that evidence-based practice needed to be improved in the community so that it was in line with the standards in the acute hospitals.
- We observed an initial assessment undertaken by a physiotherapist using the elderly mobility assessment scale tool. We also saw therapists working with other assessment tools to measure mobility, balance and gait. The physiotherapist was able to explain the rationale behind the assessment and the outcome measures they was using. They were able to articulate their approach in line with best practice and guidance for physiotherapy with older people.
- We observed a physiotherapist conducting a mobility assessment with a patient and setting goals. The member of staff also used a memory assessment screening tool and asked the patient to remember three objects to assess their short-term memory. They tested the patient's joints for range of movement and conducted an assessment of pain, muscle resistance, standing transfers and walking with a frame.
- We saw that there was a cinema for reminiscence films at Leasowes and similar resources were used on Henderson Ward.

- On Henderson Ward, we found that care plans were not always acted on. For example, we read that a pain management assessment had taken place using a pain assessment tool. However, the agreed action had not been completed and the pain had not been reassessed after the intervention.
- We were informed that Henderson Ward and the Leasowes Centre used the national early warning score (NEWS) system to monitor patients whose health might deteriorate. We saw a copy of the observation chart used at Leasowes. Respiration, temperature, blood pressure and heart rate were monitored, and triggers were provided for points of escalation and for life-threatening emergencies.
- In a patient's room in Leasowes, we saw information for staff on the wall about mobility and transfer, with details of the equipment that was to be used and how many staff were needed to assist.

Pain relief

- We saw that the NEWS observation chart had a pain score, and that pain relief was available at all times. This was particularly important for those patients receiving end of life care at the Leasowes Centre.
- One patient on Henderson Ward said, "I am frequently in pain and the staff respond straight away."

Nutrition and hydration

- The two services we inspected used a malnutrition universal screening tool to identify any patients who were under or overweight, or at risk of malnutrition. The services used a system of red trays and beakers for those patients who needed help with eating; they weighed patients regularly and escalated any issues. Patients we spoke with said the food was tasty and drinks were readily available. One patient told us, "The food is very nice with plenty of choice. There are drinks and snacks during the day." Other patients told us that, "The food is like you get in a hotel."

Are Community health inpatient services effective?

- One patient on Henderson Ward said, “I don’t like eating here and I’ve lost some weight. The doctors have talked to me and are trying to help me to eat a bit more.”
- We saw a meal being served on Henderson Ward and noticed that staff checked the food with a heat probe to ensure that it was cooked and at the right temperature. The staff serving the food were wearing personal protective equipment. Staff informed us that, as far as possible, they protected meal times from interruption from visitors and staff. Nutrition and hydration and unintended weight loss were audited as part of the quarterly ward review.

Approach to monitoring quality and people’s outcomes

- The head of service provided us with copies of the quarterly ward review that was being used on Henderson Ward and in the Leasowes Centre. The process was undertaken by the head of nursing, ward matrons and senior ward sisters. The outcome of the review formed part of a directorate performance review. We were informed that there were also local audits each month. The community patient NHS Safety Thermometer was used effectively at both services to track their safety records on pressure ulcers, falls, urine infections and venous thromboembolism. Grade 2-acquired pressure ulcers were a focus for action in both services and grades 3 and 4 pressure sores were monitored across community and therapies.
- The head of service gave us data in relation to the length of stay for patients at each of the services; the average was about 28 days. Both services were trying to improve this average by working more effectively with social services and improving discharge arrangements before admission.
- We were also given some patient outcome data showing that all patients had goals for rehabilitation and a weekly formal multidisciplinary team review. Data was also collected and analysed in relation to destinations on discharge, and the percentage of patients admitted from the intermediate care services into acute care. The range here was between 10% and 20%.
- We spoke to an occupational therapist about outcome measures used in therapy and they said that this area of the work was underdeveloped because “it has been a

matter of surviving until now”. They said that the improved staffing levels in therapy will allow a more effective approach to assessments and outcome measures.

- One of the patients we spoke with at Leasowes seemed unsure of the arrangements for her discharge and did not feel that what was going to happen had been explained to her. We observed a conversation between a member of staff and a patient arranging an access visit to the patient’s home; the discussion took account of the patient’s wishes and preferences about the arrangements for discharge.
- The therapies team leader told us that discharge could be improved with more frequent board rounds.

Competent staff

- We found that the staff were competent and knowledgeable in their roles. They appeared to be confident, with a good grasp of techniques and skills. This was also the case with the therapists whom we observed working with patients and offering advice and reassurance. We saw data indicating that 95% of staff on Henderson Ward had completed their mandatory training and 100% at the Leasowes Centre.
- A physiotherapist we spoke with on Henderson Ward said, “I am very happy in my work because I know we are able to offer good rehabilitation care.”
- We were informed that, at Leasowes, formal clinical supervision was not taking place regularly, but an internal supervision system was in place. We were told that there were annual appraisals of performance but no one-to-one meetings in between. We saw that an emphasis had been placed on appraisal, and the rates were improving.
- We spoke with a healthcare assistant who told us that two end of life beds had been added to the unit, as a pilot, a year ago, and staff had received initial training from the hospice at home team. They said that, because the beds were to be retained, a further 2-day training course had been planned to ensure that staff were equipped to provide the necessary ongoing care. The healthcare assistant reported that they had received all

Are Community health inpatient services effective?

their mandatory training. However, we saw that only 50% of healthcare assistants had received end of life training. This was escalated to the manager who had plans to train all staff over a 3-month period.

- The Leasowes Centre manager confirmed that all staff had mandatory training. We were also informed that there was extra training for conducting basic observations (such as oxygen and fluid levels) and for end of life care, and support for healthcare assistants to obtain vocational qualifications and to progress into nursing roles.
- We observed therapists and their assistants working safely and effectively with patients. One patient on Henderson Ward said, “Staff know what they are doing and they know what I need. They talk to me so that I can understand what they mean. They are great and deserve an Oscar!”
- We noticed that bank nurses, who informed us that they worked regularly on Henderson Ward, were wearing different uniforms from those worn by other nurses. They informed us that they were not permitted to wear the same uniform. We saw a healthcare assistant wearing the same uniform as the manager. The trust informed us the person may have been an agency worker. We thought that this was not good practice and might be confusing for patients.

Use of equipment and facilities

- We noted that there were two mobile hoists at Leasowes and we queried whether these were enough for 20 patients, a number of whom may need to use this equipment regularly. The member of staff said that there was an occasion when five patients needed to use the equipment and they had to wait. However, we were informed, following the inspection, that more were available from the local joint equipment store if staff required additional hoists.
- We observed equipment and facilities being used safely and effectively on Henderson Ward and in the Leasowes Centre. We saw therapists working with patients with grab rails, frames and chairs.
- One of the occupational therapists told us that the accident earlier in the year (when a lorry had crashed into the building) had enabled a considerable amount

of refurbishment to take place. They had created a more dementia-friendly environment and had built a conservatory, day room, sensory garden and a cinema/activity room.

Multi-disciplinary working and coordination of care pathways

- We attended two multidisciplinary discharge meetings, one at each location. At these meetings we saw inclusive multidisciplinary working involving doctors, nurses, therapists, rehabilitation assistants, ward clerks, team leaders and pharmacists. Both meetings were supported by a white board listing all the patients, and progress, updates and planned discharge dates were discussed in relation to each one. Reference was also made to the input of other professionals working collaboratively and coordinating the care for patients. This included colleagues from general practice and social care. All members of the team contributed with views and updates during the meetings.
- In the discharge meeting at Leasowes, rehabilitation goals were discussed for each patient. Staff demonstrated a good knowledge of each patient, their individual care needs, the care and treatment being provided and any support available from families and at home.
- One patient had recently been treated with three courses of antibiotics for a chest infection but had still not improved. Samples had been sent for analysis and a chest x-ray performed. The consultant present at the meeting agreed to review the patient and make an assessment.
- Another patient who was discussed in the discharge meeting had scored on the borderline in a mini mental assessment. Staff wanted to refer them to a memory clinic. However, the consultant at the meeting indicated that there was no longer a memory clinic to refer them to, and that there was therefore a gap in service provision. We were later informed that this doctor was a locum doctor who was unfamiliar with the area and was mistaken. However, colleagues present did not offer a correction at the discharge meeting.
- At Leasowes and on Henderson Ward, the managers were working towards increasing levels of integrated working. This meant that, at busy times, therapy staff

Are Community health inpatient services effective?

would help out with general care and support duties. Similarly, a nurse working on Henderson Ward said that they were “working as one unit in the interests of the patients”.

- We spoke to an occupational therapist who said that they often conducted assessments jointly with physiotherapists. Also, one of the occupational therapists began work early so that they could join the nurses’ morning handover.
- The team leader in the therapy service said that they were working to make the care pathway from the acute hospital to intermediate care “smoother and clearer and with less duplication”. They said that they wanted to make the assessment process from admission to accident and emergency through acute and into the community without duplication of information.
- We were informed that a social worker attended a multidisciplinary team meeting on a weekly basis but

told us they did not see themselves as a fully integrated member of the hospital team. We also heard a discussion in which a referral to district nurses had not been considered efficient in this particular case for a patient needing compression bandages when there was no nurse on the ward able to supply these. It was felt that the referral process for district nurses was overly bureaucratic even though they were based in the same office.

- People who did not have the ability to make decisions independently were supported with a mental health assessment which was placed in the records accessible to all staff.
- The assessments were undertaken by clinicians who knew the patient’s needs well.
- During handover staff discussed patient’s mental capacity issues and demonstrated they had a clear understanding of each patients mental health needs

Are Community health inpatient services caring?

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

Summary

Staff in both services were providing compassionate, sensitive care. Patients were encouraged to be involved in setting their goals for rehabilitation and to understand their treatment and care. Patients we spoke with, and their relatives, felt that they were treated with dignity and respect.

Compassionate care

- We saw that staff treated patients in a caring manner. We observed rehabilitation sessions where a patient was transferring from a chair to the bathroom and back again. We noted that the rehabilitation assistant explained what she wanted the patient to do, and adopted a calm and gentle approach. The assistant responded to the patient's fatigue by tailoring the activity. The patient was treated with kindness and respect throughout.
- We spoke with the patient afterwards and she said that the care was very good. She said that the response to the call bell was quick and, if staff were busy, they would check with her about urgency.
- We noticed staff reassuring patients during therapy sessions and offering verbal prompting.
- One patient at Leasowes said, "The carers were lovely, compassionate and would do anything for me. The one thing was that, during the night, the nurse call was going off for long periods. Staffing was OK during the day but they certainly need more staff during the night."

Two relatives of another patient at Leasowes confirmed this. One said, "We feel she gets very good care during the day. The food is very good."

- One patient on Henderson Ward said that the staff were "little angels with extra wings. They are fabulous and this hospital is brilliant. The staff are wonderful, caring, and compassionate and there are plenty of people to look after me."

Dignity and respect

- At Leasowes, patients had their own rooms and could choose to stay in them all day if they wanted to. The staff said they encouraged patients to come to the

dining room for meals if they could, both for the company and to help their rehabilitation and mobility. However, patients could have their meals in their rooms if they preferred.

- One of the therapists we spoke with said that with patients in their own rooms there was a "risk of individuals becoming isolated. The challenge is to find a balance between individual choice and the need to engage patients in social activities and more movement around the centre."
- We witnessed care from a range of staff including healthcare and rehabilitation assistants, nurses, therapists and doctors. All approached patients and their relatives in a caring, sensitive manner.
- Each individual at Leasowes had their own room with en-suite facilities. The patients with more complex needs were accommodated on the ground floor and there were tele care facilities in these rooms including alarms, beds sensors and falls detectors.
- On Henderson Ward, we saw that staff closed curtains for privacy before any personal care. They explained what they were planning to do and obtained the patient's consent before starting.
- The Leasowes Centre and Henderson Ward operated with a policy of protected meal times and, when patients needed help with eating and drinking, we saw that this was done discreetly and with care.

Patient understanding and involvement

- We saw two former patients at Leasowes who were visiting staff. We spoke with them and found that they visited regularly. They were involved with the establishment of a new garden and had brought chocolates and biscuits for the staff. One of them told us, "They looked after me so well here. I have fond memories of all the staff and I come and visit often."
- Patients were encouraged to be involved in the activities taking place at the centre. They were invited to make friends, join in the entertainment, and take part in the gardening group, for example.

Are Community health inpatient services caring?

- There were regular patient forums at Leasowes and on Henderson Ward where patients would be asked for feedback on their care and treatment. We were told by the ward manager at Leasowes that some patients had said at the forum that dinner was served too early; it was between 5.30pm and 6pm, so patients were hungry again later in the evening. It had been agreed, therefore, that patients could have an extra snack if they wanted one later in the evening. Also, patients had requested that the time, day and date were shown at the Leasowes Centre each day. We saw that these were displayed prominently.
- We spoke with a patient who had been working with two therapists. He said how pleased he was with the quality of care and said that he felt involved in the setting of his rehabilitation goals.

Emotional support

- A patient on Henderson Ward said, “Staff stop and chat with me and make sure I am OK.” Another told us that

her husband had had “an angina attack while he was visiting me. The staff were very good treating him and reassuring me.” We saw staff offering reassurance and emotional support. We also saw therapists encouraging patients with their rehabilitation, while being careful to watch for fatigue.

Promotion of self-care

- We noted that patients were given exercises to do on their own on the ward and when they returned home. One patient said, “They helped me with showers, it felt respectful and dignified, and they would only do the things that I couldn’t manage.”
- Another patient said, “They used to do everything for me but now, as I am getting better, I have to do as much as I can for myself.”
- A patient on Henderson Ward said, “When they give me a bed bath they pull the curtain round for my privacy. I do most of it myself; they just help me with my back”.

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

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

Summary

Services were planned and delivered to meet the needs of patients and their families, and the workforce had been reconfigured in response to people's changing needs. We found that rehabilitation services were also increasing in response to people's needs for more frequent sessions of therapy, and there was good access to translation services.

Service planning and delivery to meet the needs of different people

- The head of service informed us that the dependency of the patients in the two services had not been as anticipated, and that their 'enhanced' needs had resulted in a greater provision of one-to-one nursing care. The services were adapting to meet these needs and were delivering workforce changes to minimise clinical risk and safety concerns. We saw that the service was responding to the needs of an increasing number of patients with dementia, and rehabilitation therapies were being made more readily and frequently available.
- The trust used a comprehensive electronic bed management system to plan and manage the flow of patients. One member of staff at a focus group described it as their "air traffic control system", and the head of the service said it was an "effective, helpful system" for managing admissions and discharges. We saw the system with one of the ward managers who told us that the trust was not using the full functionality of the system to manage admissions and discharges.

- We heard a mix of opinions about the use of interpreters across the service. In general, we found that they were used when required, and in some cases staff were able to translate for members of a patient's family.

Two relatives of another patient at Leasowes confirmed this. One said, "We feel she gets very good care during the day. The food is very good."

Access to the right care at the right time

- Staff shortages at night meant that the right care could not always be delivered at the right time.
- When we visited, we found that Leasowes was very busy with call bells ringing for extended periods of time before they were answered. Patients confirmed this.
- However, this had been recognised and there were plans to increase night-time staffing at Leasowes.

Complaints handling and learning from feedback

- The trust's complaints policy was in place and accessible to all staff; leaflets were displayed on the units setting out the complaints process. The process was clear and eight complaints had been received and responded to in the calendar year up to August 2014. However, a number of the patients we spoke with said they did not know about the complaints process or whom to complain to.

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 found evidence of a clear vision and strategy where the top priorities for the trust were safety and care. The culture was becoming more open with high levels of honest communication and increasing levels of participation. Staff and managers in the community and therapy services told us they felt that their status had improved.

Vision and strategy for this service

- All the managers and the front-line staff we spoke with said that they were more aware of the vision and strategy since the new chief executive had joined the trust. They said that ‘safety and care’ were the top priorities for the trust. The head of service told us, “Quality and safety have gone up the agenda and so have communities and therapies. This has made a significant difference. The Chief Exec is relentless with his message about networks and engagement. He continues to make every effort to meet everyone.”
- We saw and heard evidence of this, such as the monthly ‘hot topics’ sessions, the commitment through ‘Our promises to you’ and the ‘10 out of 10’ patient safety standards checklist. Staff at a focus group said that there was a “stronger staff voice through all modes of communication including social media”. One manager said that “the community and therapies directorate structure was beginning to take shape as an integrated team”.

Governance, risk management and quality measurement

- In the two services we visited, we saw evidence of effective governance, risk management and quality measurement. There were quarterly ward reviews and monthly local audits in areas including safe storage of medicines, memory screening, cleanliness and infection control, and equipment checks. Quarterly ward reviews were linked into regional and trust-wide processes. One of the managers at a focus group said, “There is greater emphasis on story telling at all levels right up to the board.”

- Risk registers were used in the two services and risks had been appropriately identified in relation to staffing levels. Adjustments were being made to align staffing levels more closely with the increasing needs of patients and demands on the service.

Leadership of this service

- At a focus group we attended, all four participants told us that, since the arrival of the current chief executive, the emphasis on quality and safety had improved, and nursing in the community had become a greater priority. One member of staff said that a new executive working group had been established with GPs and that had improved engagement. They said that the chief executive was relentless with consistent messages across all networks, and that this was beginning to improve leadership across the trust. One therapist we spoke with said, “I can see how the new more engaging leadership style is being cascaded and is touching all parts of the service.”
- One member of staff at the focus group said she had just had a letter from one of the non-executives congratulating her for not taking time off for sickness. Another member of staff at the focus group said the trust was getting better at managing sickness absence by allowing staff undergoing extended healthcare treatments flexibility in their work.
- We were informed by an intermediate care manager that all managers were required to attend a managing sickness training programme. This training was improving the practice within the service and managers were conducting sickness reviews and return-to-work interviews.
- There had also been a drive to improve appraisal rates; staff and managers were being given the time to do this properly and it was taken seriously. We were informed that there was a new emphasis on management and leadership training, and several staff spoke to us about ‘action-centred leadership’.

Are Community health inpatient services well-led?

Culture within this service

- We spoke with managers at a focus group about the culture of the service. They all described it as a more “open, honest culture – with greater communication both ways”. One manager said it was “challenging because there are lots of demands, very appropriate demands, around safety and quality and leadership”. Staff said that the management of sickness absence and the appraisal process were good examples of the changes.
- Another manager spoke with us about ‘uncertainty’ and not being able to make informed decisions about the future “because of the workforce reviews and consultation about the future in the pharmacy team”.

Public and staff engagement

- Overall, we found that levels of public and staff engagement had improved. One member of staff said, “I was a little sceptical at first but now I have to say that staff feedback is genuinely listened to and, in some cases at least, action is taken.” This member of staff had an example of having written to the chief executive about the location of a smoking area. She said that her concerns were acted on and rapid action was taken to change the location of the smoking area “exactly as I had suggested”.

- However, we also spoke with a pharmacy technician on Henderson Ward who reported that their job was likely to become ‘at risk’ of redundancy. They expressed some anxiety and said that this was causing low morale and insecurity, which were exacerbated by “the leadership not keeping staff informed of potentially life-changing decisions.”
- Patient experience questionnaires were used at the Leasowes Centre and on Henderson Ward to collect feedback. The feedback indicated that 100% of patients were made to feel welcome, were involved in their care and treatment, and were given enough time to discuss their worries and concerns. There were also high levels of satisfaction with privacy and kindness and consideration.

Innovation, improvement and sustainability

- Managers at a focus group and working in the two services told us about the relentlessness of the leadership messages. They said that it was the consistency and repetition of the messages that were enabling the changes and improvements to take hold.

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.