Cambridgeshire Community Services NHS Trust

RYV

Community inpatient services

Quality Report

Brookfields Hospital
Intermediate Care Unit
North Cambridgeshire Hospital
Princess of Wales Hospital
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This report describes our judgement of the quality of care provided within this core service by Cambridgeshire Community Services 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 Cambridgeshire Community Services NHS Trust and these are brought together to inform our overall judgement of Cambridgeshire Community Services NHS Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Cambridgeshire Community Services NHS Trust provides inpatient rehabilitation care across Cambridgeshire and Peterborough in four hospitals.

We inspected the Regulated Activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

Community health inpatient services mostly had systems and processes in place to keep patients safe. We observed a clean environment across all wards and there were robust infection prevention and control guidelines in place. All the wards were using the NHS Safety Thermometer system to manage risks to patients, such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections, and to drive improvement in performance.

The Trust had an online incident reporting system, but not all staff were clear on the guidance as to which incidents were reportable. We found there was a lack of systems in place to monitor the safe management of medicines. As a result of our concerns, we judged the provider was not meeting Regulation 13, Management of medicines. We have asked the provider to send us a report that tells us what actions they are taking to meet this essential standard.

The guidance from the National Institite for Health and Care Excellence (NICE) on Stroke rehabilitation was not being followed. Staff were not supported to develop specific skills in this area; attendance at mandatory training was poor. Staff followed a nationally recognised tool for the monitoring and recording of patient observations. However, not all staff were following Trust guidance to ensure deteriorating patients were monitored safely.

Staff were committed and hardworking. All of the patients we spoke with had a positive experience, felt their privacy and dignity was maintained and that things were explained to them in terms they could understand. The interactions we observed between staff and patients were all positive and the staff responded to patients' needs, including emotional support.

Community inpatient services were responsive to patients' needs. Staff managed discharge planning using a multidisciplinary approach. Staff felt supported and valued, and were clearly passionate about delivering good care. However, not all staff received feedback following incidents and learning was not widely shared across community inpatient services.

Summary of findings

Background to the service

Cambridgeshire Community Services NHS Trust was first registered on 1 April 2010 and delivers community health inpatient services. It provides rehabilitation care across Cambridgeshire and Peterborough.

Inpatient services for adults were provided at four locations:

1. The Intermediate Care Unit at Peterborough, with 34 beds
2. Trafford ward at North Cambridgeshire Hospital, with 17 beds
3. Lord Byron ward at Brookfields Hospital, with 20 beds
4. Welney ward at the Princess of Wales Hospital, with 20 beds.

Care was delivered by GPs, nurses, support staff and allied health professionals.

We attended all four locations over two days. During an unannounced visit we revisited two locations. We spoke with 16 staff, 37 patients and 5 relatives. We looked at individual plans of care for 19 patients, risk assessments and a variety of team specific and service based documents and plans. We also sought feedback from external partner organisations.

Our inspection team

The inspection team included two CQC inspectors, a community nurse, physiotherapist, and an expert by experience who has 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 2 pilot community health services inspection programme. The focus of wave 2 is on large, complex organisations which provide a range of NHS community services to a local population.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 28 and 29 May 2014. During the visit 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 carried out an unannounced visit of two wards on 7 June 2014.

Summary of findings

What people who use the provider say

We spoke with 37 patients during our inspection. All of the patients we spoke with were very positive about the quality of the care and treatment they were receiving. They told us staff attitudes were good and that they felt involved in decisions about their care.

Patients told us, "This is a wonderful place and the staff are very good", "Staff are very patient" and "I have been here over four weeks and have nothing but praise".

Results received via the Trust wide service user survey January to March 2014 showed patients were satisfied with the care they received.

Good practice

- Good use of the safety dashboard in all areas displaying performance information in relation to patient safety.
- Use of the Northwick Park patient dependency tool to monitor patient acuity and plan staffing levels.
- The community rapid response service pilot used to provide services in the patients home and instrumental in avoiding admission to hospital.
- The 'Magic May' activity programme on Lord Byron ward used to support patients to develop social links and take part in activities.
- Patient status at a glance boards provide a visual display of patient and team information allowing staff to constantly monitor the patients' progress throughout their stay.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The provider must ensure there are adequate systems in place to monitor and prevent medicines omissions.

Action the provider SHOULD take to improve

- The provider should provide clear guidance for staff in respect of which incidents are reportable to ensure that staff report incidents appropriately.
- The provider should review the national clinical guidance for stroke care to provide assurance that care delivery meets the ongoing needs of the patient and their family or carer.
- The provider should review staff compliance with the deteriorating patient policy to ensure staff are recognising and managing patient deterioration confidently and competently.
- The provider should review the training required for staff involved in the rehabilitation of stroke patients.
- The provider should ensure staff attendance at mandatory training.
- The provider should ensure all oxygen cylinders are stored in line with current Health and Safety Executive guidance.
- The provider should closely monitor the risk to staff welfare and any difficulties patients may have in mobilisation around the bed spaces on Welney ward.

Action the provider COULD take to improve

- The provider could put in place benchmarking against other wards within the service, to increase opportunities for learning across inpatient services.
- The provider could consider systems to monitor 'intentional rounding' to ensure this practice is consistently applied across all wards.

Cambridgeshire Community Services NHS Trust

Community inpatient services

Detailed findings from this inspection

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

Requires Improvement

Are Community inpatient services safe?

By safe, we mean that people are protected from abuse

Summary

Overall we found safety in inpatient services required improvement.

There were systems in place to identify, investigate and learn from patient safety incidents but we were concerned that not all patient safety incidents were raised through the Trust online reporting system. Most staff we spoke with were aware of incidents within their ward areas that had been raised and confirmed that they received feedback.

Arrangements to minimise risks to patients were in place with measures to prevent falls and pressure ulcers. We saw elements of good practice including the use of safety dashboards; clean clinical areas and good infection prevention and control practice. In all the ward areas we visited staff were aware of the policy and guidance about how to respond to a patient's deteriorating condition. However, not all staff reponses to variations in clinical observations were in accordance with the policy.

Medicines were stored safely and we observed good practice where staff followed a safe medicines administration procedure. However, we were concerned about the number of medicine omissions and the inadequate monitoring of this. As a result of our concerns, we judged the provider was not meeting Regulation 13, Medicines management. We have asked the provider to send us a report that tells us what actions they are taking to meet this essential standard.

Detailed findings

Track record on safety

No never events were reported as occurring within Cambridgeshire Community Services NHS Trust between March 2013 and March 2014. Never events are classified as such because they are so serious that they should never happen. Information received prior to our inspection

Are Community inpatient services safe?

showed between April 2013 and March 2014, 255 serious incidents occurred at the Trust requiring investigation. Two of these incidents occurred within inpatients and related to a fall and a severe pressure ulcer.

The Trust monitored its performance in pressure ulcers, venous thromboembolism (VTE), falls with harm and catheters and new urinary tract infections using the NHS Safety Thermometer. This is an national improvement tool used for measuring, monitoring and analysing patient harms and 'harm free' care.

The Trust-wide rates for pressure ulcers for ten out of 12 months preceding our inspection were above the England average. Within inpatient services one area had an avoidable hospital acquired pressure ulcer within the two months preceding our inspection. Ward sisters told us a root cause analysis (RCA) investigation had taken place in the past following any incident resulting in patient harm. Any actions or learning from the RCA would have been fed back at ward meetings, on staff notice boards and at handover.

Most staff we spoke with confirmed that they received feedback following incidents or an RCA. Staff gave examples of feedback received including a more robust assessment of patients at risk of pressure damage. This was through use of the Waterlow assessment, a tool designed to give an estimated risk score for the development of a pressure sore in a given patient and, a five step model for pressure ulcer prevention called the SSKIN care bundle.

All wards had a safety dashboard on display so that the patients and the public could see how the Trust was performing in relation to patient safety. The dashboard also included ward staffing levels, number of recent falls, patient feedback and, medication incidents. Examples of medication incidents reported via the Trust's online reporting system included the wrong dose of Warfarin being given to a patient, incorrect storage of controlled drugs, and medications being prescribed incorrectly.

Incidents, reporting and learning

Staff we spoke with were aware of, and had access to, the Trust's online incident reporting system. This allowed staff to report all actual incidents and near misses where patient safety may have been compromised. Staff we spoke with gave examples of incidents they considered reportable: falls, pressure ulcers, moving and handling incidents, staffing levels and medication errors.

Not all staff were clear on the guidance in respect of what was reportable, and did not report all patient safety concerns. During our inspection we found 12 occasions, across three of the wards, where one or more medications had not been signed for as given. When we discussed this with the ward sisters only three of the 12 occasions had been raised by staff, via the Trusts online reporting system, as a patient safety incident. On another ward a member of staff told us staff were discouraged from reporting incidents regarding staffing issues because the Trust was already aware of the risks. This meant staff were not recognising the importance of raising patient safety incidents in order to allow the Trust to recognise, investigate and prevent future occurances.

Cleanliness, infection control and hygiene

All the wards we visited were clean and well maintained. There were procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance. We saw where water temperatures had been checked monthly to ensure appropriate temperatures to reduce the risk of Legionella contamination.

Two of the inpatient areas comprised solely of single rooms. We saw room cleaning schedules, signed by staff when that room had been cleaned. This schedule also indicated the specific cleaning tasks taking place in each room. Patients told us, "The staff clean the room once or twice a day"; "Nurses are always washing their hands and wearing gloves". "They are very fussy about cleaning here" and, "{the cleaner} is fantastic and does a proper job of cleaning my room".

During our inspection we saw one patient who was nursed in isolation to prevent the spread of a health care associated infection. We saw a notice on the door of the patient's room outlining the infection control precautions required in order to prevent cross infection. Staff were observed adhering to these precautions throughout our inspection.

Maintenance of environment and equipment

We observed all patient-care equipment to be clean and ready for use. However, we did observe one member of staff not cleaning an item of patient-care equipment following its use.

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Fire equipment we checked was in date and we found most wards to be safe from the risk of fire. However, on one ward we did observe oxygen cylinders stored in the clean utility area on the floor. Health and Safety Executive (2013) guidance was not followed. Oxygen cylinders were not chained or clamped to prevent them from falling over, stored in use in a well-ventilated area nor did we observe a warning notice prohibiting smoking and naked lights on the door to the clean utility area.

Medicines

Medicines were stored safely. We looked at the clinic room on all the wards where medicines were stored and found that the medicines fridge temperature was being monitored and recorded regularly. The temperatures recorded were within recommended safe limits.

We reviewed the storage and administration of controlled drugs. We found them to be stored appropriately and drug records were accurately completed. In one ward a signature sheet was in use for agency and bank staff. This allowed the ward sister to identify where medications had been administered by this staff group. We observed good practice where staff followed a safe medicines administration procedure. Patients told us, "The nurse stays with me while I take my medication" and "The staff have told me all about my medication and I do understand what it's all for".

The Trust's Medicines Management Policy states a clear, accurate and immediate record of all medicines administered must be made on approved documentation… ensuring any written entries are clear and legible and are signed and dated. We looked at 40 medicines administration records (MARs) in use for the month of May 2014. We saw on nine occasions, on three of the wards, there were one or more gaps in the signatures on the MAR which suggested that medicines were not being administered as prescribed by the patient's doctor. These included medicines to treat depression and angina, and anticoagulant medications. On three occasions the ward sister was aware of the omissions, incident reports had been raised and the ward sister was investigating. However, none of the ward sisters were able to tell us if this meant the patients had not received their medications as prescribed or, if the nurses had given the medications but failed to sign the MAR.

Annual medication audits were conducted by pharmacy across all the wards and, the ward sisters told us they complete 'random' checks of MAR's to identify any omissions. On the second day of our inspection we returned to one of the wards where we had previously identified a medicines omission. We found further gaps in the signatures on the MAR where it was unclear if pain killing medication had been given. The ward sister told us she had fed back our concerns to staff the previous day. Our unannounced inspection also identified a further two occasions where there were gaps in the signatures on the MAR. In one patient's case it was unclear whether they had received their medication to treat their Parkinson's disease, which is important to take at specific times during the day.

This meant the systems in place were not effective in identifying medicines omissions, and it was not possible to tell whether people received their medicines or not. We reviewed the Trust incident data for the six months November 2013 to April 2014. Of the 25 medication related incidents only five related to omission of medication. As we found nine omissions during May 2014, this indicated to us that they were rarely reported as incidents, which meant that opportunities for managing the risks and improving practice were lost.

Staff uptake of medicines management training was 100% on two of the wards, 90% on one ward and 40% on one ward. On those wards where 100% uptake had not been achieved a medicines management session was planned for June 2014.

Safeguarding

Most staff had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns. One member of staff gave us an example of where they had raised a safeguarding concern as a result of bruising noted on a patient who had been admitted from home. Information received from the Trust prior to our inspection showed safeguarding training amongst staff to be greater than 90% compliance. The Trust target was 95% compliance for adult safeguarding training.

We saw there was a safeguarding procedure on display in all of the wards. Further information and guidance was also available through the ward safeguarding lead and a safeguarding folder.

Are Community inpatient services safe?

Consent was sought from patients prior to the delivery of treatment; patients we spoke with told us that they felt involved in decisions about their care. Consent was recorded in all of the notes that we reviewed.

Records

During our inspection we observed that medical records were securely stored in either a locked cabinet or dedicated room. This meant the Trust had systems in place to ensure patient records remained confidential.

Lone and remote working

We spoke with a member of staff who often worked in isolation as part of the Rapid Response service. They told us they were aware of the Trust policy for lone working. To minimise the risk of lone working they rang the ward before and after they visited a patient's home, they also told us they had access to a work mobile phone.

Adaptation of safety systems for care in different settings

On all of the wards we visited ward managers were aware of local risks within their area and had raised these through the online reporting system or through the Trust's Quality Early Warning Trigger Tool (QEWTT). In one area we saw evidence of the ward sister's local risk assessments. Examples of risks in other areas were establishing a cohesive team of staff and use of single rooms and their impact on falls prevention.

Assessing and responding to patient risk

In accordance with the Trust's deteriorating patient policy staff used an early warning system to record routine physiological observations such as blood pressure, temperature and heart rate, and monitor a patient's clinical condition. This was used as part of a "track-and-trigger" system whereby an increasing score triggered an escalated response. The response varied from increasing the frequency of the patient's observations up to urgent review by a senior nurse or the doctor. We looked at the nursing notes for 19 patients. In seven of these we found a number of examples where Trust policy had not been followed; patient observations were such that a specific response had been required and observations had not been repeated in accordance with the policy. On most occasions staff had chosen not to repeat the observations because the patient had a predisposing condition that affected their observations. For example one patient had heart disease and was therefore known to have a fast heart rate. On these occasions staff had not documented their reasons for not following Trust policy in the patient's health records.

The rates for falls for five out of 12 months preceding our inspection were above the England average. Within inpatient services the ward sisters we spoke with were proactive in the management of falls. We were told of examples where ward sisters had looked at any themes from patient falls, such as a number of falls occurring in a particular area of the ward. In this case , their investigation showed there was a raised lip between the bathroom and bedroom causing patients to fall. This has since been removed. Another told us falls on their ward were occurring early evening, so now employ either ward staff or bank/ agency staff to provide additional cover during this time.

Staffing levels and caseload

Throughout inpatient services, we saw that there were mostly sufficient staff, of an appropriate skill mix, to enable the effective delivery of care and treatment. We looked at staff rotas and saw where reduced staffing had been identified there were plans in place to address the risk to care delivery. We were also told where staffing would be increased due to patient need. All the ward sisters used the Northwick Park dependency score, which is a scoring system that helps determine how many nursing staff are needed.

We were told staffing levels were reviewed by the ward sister on a daily basis and escalated further through their immediate managers. There was also evidence where staffing issues had been raised through QEWTT. This ensured the Trust had an ongoing awareness of staffing levels throughout inpatient services.

Overall, we observed call bells to be answered quickly. Patients told us, "The staff are mostly quick to answer the call bell" and "The staff answer the buzzer pretty quickly but they are in and out of my room all day anyway".

Deprivation of Liberty safeguards

Most staff we spoke with demonstrated a good understanding of their responsibilities regarding the Mental Capacity Act 2005 and knew what to do when patients were unable to give informed consent. Staff spoke of best

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interest decisions and use of the two-stage functional test in line with legal requirements in order to make an assessment of the patient's capacity before carrying out any care or treatment.

Managing anticipated risks

We saw an electronic system for recording risks. All risks were reported via the online system or through QEWTT. The board assurance framework enabled the Trust to have an overview of risks which may affect the safe running of inpatient services. All staff were aware of the electronic reporting system and most staff were able to see where actions had been put in place to prevent a reoccurance of the incident. Information received from the Trust prior to our inspection identified staffing as a risk within inpatient areas.

One area within inpatient services used a computer based record system to record patient care data. Within this area we found inconsistencies between information recorded electronically and information stored at the patient's bedside. One patient we reviewed did not have a moving and handling assessment form stored at the patient bedside. This meant staff were unable to identify the handling activities for this patient.

Major incident awareness and training

All the ward sisters we spoke with were aware of the Trust's major incident plan and business continuity plans, in place to ensure minimal disruption to essential services.

Staff we spoke with were aware of the Trust's fire safety policy and their individual responsibilities. Ward sisters told us of fire drill discussions with staff on an ad hoc basis. Information received from the Trust after our inspection showed fire training amongst staff within inpatient services to be 96% of staff receiving training via e-learning, exceeding the Trust target of 90%.

Requires Improvement

Are Community 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

Overall we found effectiveness in inpatient services required improvement. Services used recognised screening and assessment tools and focussed on achieving a positive outcome for patients. All wards demonstrated effective multidisciplinary working to support and coordinate care and discharge arrangements.

However, average length of stay was long on some wards and staff teams were not all not up to date with standards of care for people who have had a Stroke. We found that most staff had received little or no training in stroke care and national guidance in stroke rehabilitation was not always followed. Staff uptake of mandatory training appropriate to their role at 60% was significantly below the Trust's target.

Detailed findings

Evidence based care and treatment

During our inspection we looked at the care records of 19 patients across inpatient services. Most of the records were well organised and information was easy to access. Records were complete and up to date and included transfer of care assessments forms, biographical details and contact details for next of kin.

Patients' performance in activities of daily living was measured using the Community Dependency Index. This provided staff with a measure of the patient's ability to perform daily self-care activities.

We saw where patients were involved in reviewing their progress throughout their inpatient stay. Using the EQ-5D tool, a standardised instrument for use as a measure of health outcome, patients rated their performance in activities of daily living at the beginning and end of their inpatient stay allowing staff to evaluate patient progress.

We observed a multidisciplinary approach involving nurses, physiotherapists and occupational therapists. Recognised rehabilitation measures were used by the physiotherapists and included the 10 Meter Walking Test and the Timed Up and Go test to assess the patient's mobility and, the Tinetti Performance Oriented Mobility Assessment designed to measure balance (including fall risk) and gait function. Records showed where staff had included an assessment of the risks presented by the patient's conditions by using recognised risk assessment tools. For example the risk of developing pressure damage was assessed using the Waterlow Scale, a nationally recognised tool. Where pressure damage was identified as a risk there was a management plan in place for prevention. Where patients had been admitted with pressure damage there were wound assessment notes and body maps to monitor progression of healing. Care plans were regularly evaluated and revised as appropriate as patients progressed through their care and treatment.

Ward sisters told us some patients were admitted following a stroke. Across two of the wards nine patients had been admitted in the three months preceding our inspection following a stroke. We were not told how this related to the total number of admissions for the two wards. Ward sisters said they were not commissioned to provide a service for patients who have had a stroke and so did not follow NICE guidance on stroke rehabilitation. This guidance suggests services for patients in a primary care setting should continue at the same level of intensity and expertise that they would have received in an acute inpatient setting. During our inspection we could not see where additional or specialist therapy sessions were in use for stroke patients.

Regular multidisciplinary team meetings occurred and individual goals for patients were set. However, none of the staff we spoke with could tell us if stroke patients were receiving the recommended level of therapy or treatment and most of the staff we spoke with had received little or no training in caring for this group of patients. None of the ward sisters could tell us why patients recovering from a stroke were referred to the ward, or if concerns had been raised with the relevant commissioners.

We had received information before our inspection identifying concerns about the lack of training and the impact this had on caring for patients recovering from a stroke. In one ward area we spoke with a senior nurse who

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had recently worked in a specialist stroke unit in a nearby acute hospital. They told us they were eager to introduce training for their colleagues on stroke care and planned to discuss this with the ward sister.

Information received following our inspection showed that on one ward three out of five patients who had been admitted following a stroke had received physiotherapy or therapy support worker input daily as a minimum as recommended by the NICE guidance. However we were unable to determine if each intervention was at a level recommended for stroke patients. We were told all of the rehabilitation measures used across inpatient services were not specific to stroke patients. We were not therefore assured that plans were in place to manage the ongoing needs of the patient and their family or carer.

Pain relief

We talked to patients about how well they felt their pain was managed. Patients told us they were asked most days about their level of pain. One patient told us, "The pain killers that I'm given are fine, I never need more".

We observed from the care records that staff used a pain assessment tool to determine the patient's level of pain. This score would then be entered on the patients observation chart. However, in four of the care records we reviewed information recorded on the observation chart did not correlate with the information recorded on the pain assessment chart, nor was there evidence to suggest staff were monitoring the effects of pain relieving medications. This meant staff did not always take appropriate action to assess and treat the symptoms of pain appropriately.

Nutrition and hydration

Across all of inpatient services we saw patients were screened for malnutrition and the risk of malnutrition on admission to hospital using the Malnutrition Universal Screening Tool (MUST). Care plans were in place to minimise risks from poor dietary intake as appropriate. We saw evidence where care plans were regularly evaluated and revised as appropriate as patients progressed through their care and treatment.

Protected meal times took place on all the wards we visited. This allowed patients to eat without being interrupted and meant staff were available to offer assistance where required.

We observed signage throughout the wards showing snacks available day or night. Patients told us, "The food here is nice and acceptable", "The food here is acceptable and is always hot", "The drinks are plentiful and I never need to ask" and "The food isn't bad at all".

Patient outcomes

Ward sisters provided us with many examples of how they monitored clinical outcomes for patients. These included a monthly documentation audit, twice yearly call bell audit and infection prevention and control audits based upon the Essential Steps and Clean Your Hands campaign.

On one ward the infection prevention and control audit had identified 12 patients with new urinary tract infections (UTI). The ward sister told us staff now screen every patient on admission to hospital, staff would monitor the fluid input and output of all patients with a confirmed UTI and a suggested daily fluid intake would be calculated in accordance with the patient's weight.

In the care records we reviewed we saw where risk assessments had been updated weekly or whenever there were significant changes to the patient's clinical condition.

Performance information

All the wards we visited had a performance information dashboard on display in the clinical area. We saw evidence where this was updated on a monthly basis. Ward sisters told us they shared performance information at monthly operational team meetings and relevant governance meetings. One of the ward sisters also said she shared performance on a twice monthly basis with the commissioners of the service.

Patients' average length of stay on two of the wards was identified in the Trust performance report for April 2014 as lower than the performance target set by commissioners, at 17 and 19 days. On the other two wards average length of stay was much longer at 24.8 and 34.5 days. The Trust had identified these areas as a priority and given them a high risk rating. The unit manager explained to us that within one area there had been significant staffing issues. These had now been addressed allowing staff time to manage and improve the patients length of stay. At Board level the Trust plans were to strengthen the multidisciplinary team working and ensure timely access to additional support at home. To assist in managing length of stay ward sisters were proactive in triaging referrals

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made to their areas to determine the appropriateness of the referral. However, none of the ward sisters appeared to be able to influence the admission of stroke patients and their effects on length of stay data.

Competent staff

We looked at the NHS staff survey results for 2013 and saw that the levels of staff receiving job-relevant training, learning or development in the 12 months leading up to the survey were average when compared with other community trusts. Before the inspection we received concerns from a member of staff about inadequate staff support and training for therapists in the Peterborough and Cambridgeshire community teams. The majority of the concerns raised were about how stroke patients were cared for. We raised this with the manager at our inspection and were told about developing initiatives to care for people with neurological rehabilitation needs. This included the establishment of a "neuro rehab community team" which would care for people who needed physiotherapy for conditions such as a stroke, motor neurone disease or multiple sclerosis. Although many therapists had atttended a specialist course for neurological conditions, called Bobath, it was acknowledged there was a gap in this training for some ward based staff.

In addition, the manager of this service told us that at present there was no detailed training and development programme in place to develop more junior members of staff. We were told that this was under review. The manager of this service could also not be assured that all staff within the unit received appropriate support through supervision meetings. Routine monitoring was not taking place.

We received mixed feedback from staff about mandatory training. Some staff told us they were up to date in their mandatory training and gave examples of e-learning and face to face training. One member of staff who had been employed by the Trust since November 2013 told us of a comprehensive induction process that had covered mandatory training requirements of the Trust. Other staff told us they weren't up to date and in some instances received only "bite-size" training in areas such as falls and pressure ulcer prevention.

Information received from the Trust after our inspection showed that just over 60% of inpatient staff were up to date with mandatory training appropriate to their role. The Trust was proactive in aiming for an overall target of 90% compliance and had actions in place involving business unit leads, accuracy of recording, regular communication at both ward and board level and the commissioning of additional training sessions.

Trust information showed that bank/agency staff spending had been higher than planned every month of 2013/14. In one inpatient area bank/agency staff use had been over 50%. We were unable to determine for how long a period 50% bank/agency staff had been used. All the ward sisters told us how they managed the risks associated with employing temporary staff. Examples included inductions for agency staff, use of three-month contracts, use of staff familiar with the ward area and always having a permanent member of staff in charge of each shift. During our inspection we saw documented evidence where temporary staff had received an induction at ward level. One agency nurse told us, "staff are very supportive, I feel part of the team and if I didn't enjoy working on the ward I wouldn't come back".

Use of equipment and facilities

The resuscitation equipment we inspected was clean. Single-use items were sealed and in date, and emergency equipment had been serviced. We saw evidence that the equipment had been checked daily by staff. This meant the equipment was safe and ready for use in an emergency.

Throughout inpatient services we observed the staff and the environment to be delivering same sex accommodation in order to safeguard patient's privacy and dignity and, comply with the Government's requirement to eliminate mixed-sex accommodation.

Sufficient pressure relieving equipment was available. On one of the areas that provided single room accommodation pressure relieving equipment was available in every room.

In one ward we observed beds positioned against walls in the bay areas. Staff told us this was because space was limited. This meant that staff had to move beds, furniture and surrounding equipment before making up a bed or moving a patient safely. This could be a risk to staff if they are busy and fail to make the bed area safe before moving or positioning patients or providing care. The overall ward space did not allow for easier placement of beds given the number of beds accommodated. Staff were aware of the issue and routinely moved beds and furniture but the matter was not currently recorded on the risk register.

Requires Improvement

Are Community inpatient services effective?

Multi-disciplinary working and working with others

A multi-disciplinary team (MDT) approach was evident across all of inpatient services. We observed good MDT working in the wards we inspected. We observed nursing staff assisting with patient therapy sessions through encouragement of mobilisation and self-care activities and therapy staff assisting in patient self-care activities. On one ward we observed a physiotherapist assisting a patient to the toilet. Staff at all levels on the wards demonstrated an understanding of each patient's pathway.

MDT case conferences took place on all the wards on a weekly basis to review the progress of each patient towards discharge. Each MDT case conference involved the patient, a doctor, a nurse, a physiotherapist and an occupational therapist. We attended an MDT case conference on one of the wards and noted it was well organised. We observed in depth discussion by all members of staff of the patient's rehabilitation pathway including discharge. Staff demonstrated sensitivity and respect during their discussion to ensure that the preferences of the patient and their relative had been considered. During the case conference, where the patient and relative had not understood the patient pathway, we observed a member of the MDT return to the patient to explain further.

The rapid response service was a collaborative MDT approach involving community matrons, advanced assessment nurses, therapists and staff nurses, backed by multi-skilled healthcare assistants and a pharmacist. This service was effective in delivering urgent support to patients in their own home when they needed it.

Across all of the wards within inpatient services communication between the MDT team was integral to the patient's pathway. To facilitate effective communication there was a communication book for medical staff, white boards above patients' beds, collective use of the nursing documentation and an MDT approach to patient activities.

Co-ordinated integrated care pathways

In the care records we saw excellent integrated care pathways. There was a multi-disciplinary discharge checklist that set an estimated length of stay and set out goals for safely achieving this. There were notes from multidisciplinary meetings that showed where rehabilitation plans were regularly reviewed and also a weekly SOAP note used for documenting the progress of patients during treatment. This was completed with, and signed by, the patient. This showed that patients were involved with reviewing their progress throughout their inpatient stay.

Good

Are Community inpatient services caring?

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

Summary

Inpatient services at the Trust were caring. Patients and relatives were extremely positive about the quality of the care and treatment they were receiving and with the approach of the staff. Across all four wards we saw staff treating patients with dignity and respect.

Detailed findings

Compassionate care

We spoke with 37 patients and five relatives. Patients were consistently positive about their experience within the inpatient services. Patients told us, "The staff are kind", "I can't praise the staff enough over my care and not even one member of staff has been unkind", "I have been here over four weeks and have nothing but praise" and "Staff go the extra mile". One patient told us they had been admitted to a ward during the night at a time when they were confused and disorientated. A member of staff had stayed with them all night to provide reassurance.

All the wards we visited had adopted the six values: care, compassion, competence, communication, courage and commitment (6 C's) as outlined by the Department of Health to support professionals and care staff to deliver excellent care. Staff we spoke with were aware of the 6 C's and wards had the 6 C's on display. On all of the wards we visited staff completed 'Intentional Rounding', when nursing and health care assistant staff checked that patients were comfortable at regular intervals. This included whether they were in pain, needed support to go to the toilet, or were hungry or thirsty. Staff signed specific intentional rounding documentation once their check had been made. During a conversation with one member of staff they excused themselves because they needed to complete their hourly check. We noted however, that ward managers did not always review this process regularly to assure themselves that the checks were being made.

Dignity and respect

In the Trust wide patient survey January to March 2014, 90% of patients strongly agreed with the statement 'The person I saw treated me with respect and dignity'.

We observed staff treating patients respectfully and with dignity on all the inpatient wards. All staff were welcoming towards patients and supported them in a professional and sensitive manner. We noted that there were good working relationships between different professional groups, and there was an apparent mutual respect between staff. We observed staff introducing themselves and interacting with them in a warm and positive manner. One patient commented, "When I came in here they {the staff} asked me what I liked to be called". Privacy curtains were inside the entrance to all side rooms. Signage on the curtains stated 'respect my privacy'.

Patient understanding and involvement

In the Trust wide service user survey January to March 2014, nearly all patients said they were involved as much as they wanted to be in decisions about their care /treatment. Patients told us they were involved in planning their care and understood what was happening to them. Patient comments included, "I've been told about my treatment and how long I'm expected to be here", "The staff especially {the nurse}, have kept me well advised about my treatment and I feel all the staff are interested and want me to get on" and They {the physio} keep me informed about my treatment and how I'm progressing". We saw patient information packs at each bedside and staff told us they were given to patients on admission.

Emotional support

All the patients we spoke with were very positive about the support they had been offered by the multidisciplinary team. We saw evidence in care records that communication with the patient and their relatives was maintained throughout the patient's care. One patient told us, "Very friendly staff and very helpful and accommodating, with requests. I woke up hungry and asked for something to eat. I was brought some nice hot toast". On one of the wards we visited we observed staff passing a written note to a patient with a message from their relative. This demonstrated that staff were informing patients when their relatives had made contact.

We asked staff about the emotional support available to patients who were admitted for rehabilitation. Staff told us patients had an assessment of their emotional status when

they were admitted. Where additional support such as counselling was needed then staff said they had access to the community mental health team and clinical psychologist support on the hospital site.

Promotion of self-care

Patients were encouraged to do as much as they could for themselves. Patients told us, "Staff encourage me to go the dining room to eat" and, "They {the nurses} always come in during the morning and ask when I want to get out of bed or have a wash".

White boards above the patient's bed were used to communicate personal goals to staff and patients. Examples we saw said, 'to be able to transfer using slide board', 'to return home' and 'to improve function in upper right limb'. Whilst we considered that this may be undignified and breaching confidentiality for the patients, no concerns were raised by patients or their relatives regarding the display of such information.

On all of the wards, patients were supported to develop social links and take part in activities. We saw there were many different activities for patients and relatives to attend if they wished. We saw evidence of patients being supported to take part in activities such as, art, jewellery making, reminiscence, pampering and music. On one ward they had developed an activity programme 'Magic May' with activities arranged for the month of May. On another ward we saw patients taking part in a 'therapy breakfast'.

Good

Are Community inpatient services responsive to people's needs?

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

Summary

Inpatient services were responsive to patients needs.

We observed a proactive service that managed discharge planning using a multidisciplinary approach. We saw there was an obvious focus on planning for discharge with discussions with patients and relatives taking place promptly and potential barriers to discharge identified at an early stage of the patients pathway.

We observed a multidisciplinary approach to the delivery of care involving nursing staff, health care assistants, therapists, medical staff and pharmacy. We saw where concerns and complaints were dealt with at ward level by the ward sisters, often resolving the issue and avoiding the need for a more formal complaint.

Detailed findings

Service planning and delivery to meet the needs of different people

Patients were admitted to inpatient services from either a nearby acute trust or from their own homes or residential care, referred by their GP or a community matron. The reason for the patient's admission was assessed, using specific referral criteria, through a single point of contact. We were told by the ward sisters that using referral criteria sometimes helped to avoid inappropriate admissions that may delay rehabilitation services for another patient. However, the ward sisters were concerned that stroke patients were included in the referral criteria especially when staff, both nursing and therapy, had not had specific training in stroke care.

We observed an integrated approach to care delivery across all the wards involving nursing staff, therapists, medical staff and pharmacy. Across all staff groups we observed a commitment to facilitating a timely, but safe and person-centred discharge for the patient. One ward sister gave an example of discharging a patient to a residential care facility in a location close to the patient's relatives. Initially a placement had been found a considerable distance away from the patient's family. However, following discussion within the MDT the patient's discharge had been delayed until a more suitable placement could be found.

Home assessments were conducted with the patient, relative and a member of the multidisciplinary team before discharge to assess the need for equipment or further community support after discharge. One patient told us, "They took me home last week but I couldn't manage. They tell me I'll have three carers when I go home".

Access to care as close to home as possible

We found the Trust was committed to ensuring inpatient services were delivered as close to home as possible. Ward sisters told us part of the triage process involved consideration of where the patient lived to reduce the amount of travelling visiting relatives may have to do. On one ward the ward sister told us how they were involved in reviewing the waiting lists at the nearby acute trust. This engagement allowed them to plan services on the ward appropriately. We did not observe this practice to be widely shared across inpatient services.

On one ward we were told of the community rapid response service, a year- long pilot for patients registered with GP practices within a specified geographical area. The multi-disciplinary service assessed patients in their own home to determine the type of care and support they needed. A decision was then made either to care for the patient at home or a short stay in a community hospital. The ward sister told us this service prevented a number of admissions to hospital within this area. It also enabled staff to discharge patients earlier whilst still ensuring patients had support at home. We were told the community rapid response service played an important part in meeting the needs of the local elderly population.

Access to the right care at the right time

Staff told us MDT case conferences occurred weekly and the first review would be held as close to the patient's admission date as reasonably practicable. This allowed for an early assessment of the patients plan of care, discussions with the patient and their relative and, to identify any potential barriers to discharge.

Staff described a service that provided daily reviews of all patients by a doctor, including weekends. Access to medical support overnight was dependent on the location

Good

Are Community inpatient services responsive to people's needs?

of the ward with some wards having 24 hour access to medical support from other areas of the hospital site. In those wards where medical cover wasn't easily accessible 999 services would be contacted.

Therapy services provided by physiotherapists and occupational therapists varied across inpatient services. Three of the wards received therapy services Monday through to Friday and one ward received an additional service on a Saturday. Speech and language therapy (SALT) services were available on request but not over a weekend or bank holiday. We asked a ward sister what would happen if a patient, who was admitted on a Friday evening, required specific therapy services over the weekend. We were given an example of a patient requiring a SALT assessment due to swallowing difficulties. If the assessment was not completed on the Friday then, because the service does not provide intravenous fluid therapy, the patient would be returned to a nearby acute hospital until the following Monday.

Pharmacy services were provided Monday through to Friday and included pharmacy technician support. The pharmacist we spoke with described their role in the discharge process as ensuring medications were available on discharge and in a format suitable for the patient. During our inspection no concerns were raised by patients or their relatives regarding discharge medications.

Information received from the Trust after our inspection showed, over the six month period preceding the inspection there were 52 delayed transfers of care within inpatient services. The top three reasons for the delay were patients requiring additional support at home, residential home or nursing home placement. Of these delays 23 were attributable to the Trust. The ward sisters told us delays were caused largely by patients waiting for additional support at home to be commenced and, availability of equipment. One ward sister told us the rapid response team pilot programme had helped because they were now able to discharge patients under the care of this team whilst they were waiting for additional support to start. However, the rapid response team currently did not provide this service across the Trust.

Overall, across inpatient services, we observed a proactive service that managed discharge planning using a multidisciplinary approach. Staff described a process that involved assessment and discharge planning from day one of admission.

Flexible community services

We noted during our inspection that most of the patients we saw within inpatient services were of white/european ethnicity. The ward sisters confirmed that this reflected the demographic for elderly patients transferred from nearby acute hospitals.

In the care records we reviewed we saw evidence that some diversity data was collected. Information received prior to our inspection demonstrated that the Trust was committed to equality for both patients and staff throughout the Trust.

Across inpatient services the average uptake of equality and diversity training amongst staff was 58% compliance. The NHS staff survey results for 2013 saw that the percentage of staff believing the trust provides equal opportunities for career progression or promotion and, not experiencing discrimination at work were better than average when compared with other community Trusts.

Meeting the needs of individuals

Across all wards we observed a commitment to providing services to patients who did not have English as their first language. We saw information on display concerning interpreting services and all the leaflets provided on the wards were available in a number of different languages. Staff told us they knew how to access interpreting services and how to use them to support patients who needed to make decisions about changes to their care pathway. Staff gave examples of where a ward had used an interpreter to support an Indian patient when discussing their discharge, another told us of when they had used a member of staff to interpret for a patient of Chinese origin.

In all the care records we reviewed the patients' religious needs were assessed on admission. Staff told us patient care would be tailored according to their needs. In one of the care records we reviewed we saw evidence of a patient's preference to be attended to by female nurses only. On three of the wards we visited we saw a 'patient status at a glance' board. By providing a visual display of patient and team information this allowed staff to constantly monitor the patients' progress throughout their admission and helped the multidisciplinary teams to make decisions about the care a patient had received, or needed to receive.

Moving between services

Good

Are Community inpatient services responsive to people's needs?

All the patients we spoke with told us they were involved throughout their care pathway and theirs and their relative's wishes were considered. On one of the wards we visited the MDT were in the process of arranging a patient's discharge. Both the relatives and the staff felt, because of extensive mobility issues, the patient should not be discharged to their own home and a care home should be considered. The patient's decision was that they wanted to be discharged to their own home. Following the MDT case conference it was decided the patient had capacity and could therefore decide where they would be discharged to. A decision was made that, with enhanced community support, the patient should be allowed to return home. This meant staff were respecting the patient's right to make a decision about their discharge.

One of the ward sisters on another ward told us that staff would sometimes accompany a patient home on discharge. This allowed staff to ensure the patient had food and heating available to them once they had returned home.

Complaints handling (for this service) and learning from feedback

Across inpatient services we saw many examples of compliment letters and thank you cards displayed in ward areas.

We saw there was a complaints procedure on display in all of the wards. Staff told us that during their admission process patients were routinely given a leaflet containing information on how to make a complaint. Patients we spoke with confirmed this. Patients told us, "If I had to complain then I'd call {the ward sister}" and, "I've no reason to complain but I would go to the office if I needed to".

From April 2013 to March 2014 the Trust had received 187 formal complaints, three of which related to inpatient services. Two related to clinical care and one to discharge arrangements. We were concerned at the low number of complaints for the service. However we were reassured that all the ward sisters were aware of the Trust's complaints procedure. They told us the importance of local resolution in the first instance. Most staff said they would refer the patient to the ward sister if a patient was not happy with their care.

Information received prior to our inspection identified actions the Trust was planning to take to continue to manage the level of complaints within the Trust. Examples included: complaints training for all staff from April 2014 and a review of discharge processes and action plans to improve the involvement of patients and their carers.

The Trust also collected patient feedback using the friends and families test, a single question survey that asks patients "How likely is it that you would recommend this service to friends and family?" The trust reported that it was achieving "net promoter" scores better than NHS Midlands and East for all but one month. On one of the wards we visited we observed their net promoter score to be the maximum of 100.

Good

Are Community 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

Inpatient services were mostly well led.

Most staff felt valued and listened to and felt able to raise concerns. However some staff felt they weren't involved in improvements to the service and did not receive feedback from patient safety incidents.

All staff were committed to delivering good, safe and compassionate care. Staff spoke of 'back to the floor' visits by the Chief Executive and members of the wider executive team.

The Trust had acted rapidly in response to staff concerns about the quality of care on one ward. On this ward the managers had made effective changes to the structure and had made staff changes to ensure patient safety. We found that opportunities for shared learning across inpatient services could be strengthened.

Detailed findings

Vision and strategy for this service

All the ward sisters told us they felt part of the Trust and most staff described a Trust that listened to, valued and supported staff. We looked at the NHS staff survey results for 2013 and saw that the levels of staff satisfaction at work were better than average when compared with other community trusts.

All of the staff we spoke with were passionate and committed to ensuring patients received the care and treatment they needed. Staff demonstrated the Trust's values and vision. Mutual respect between staff was apparent during our inspection. Staff told us, "I enjoy working on {the ward}", "We are a team, we all pull together" and, "Everybody who is here wants to be here".

Governance, risk management and quality measurement

Ward sisters across all inpatient services demonstrated a good awareness of governance arrangements. They detailed the actions taken to monitor patient safety and risk. This included incident reporting, keeping a risk register and undertaking audits. However, on one ward we found that there was a lack of understanding in relation to how learning from incidents was implemented. For example, we asked about how a recent patient story had impacted on the care provided by the unit. Although learning actions had been identified staff did not know how these had been considered locally.

We also spoke with four members of staff on the ward who told us that they received no feedback on incidents that had been reported so did not know how these led to improvements within the service. Staff were not aware of innovations within the ward and we found staff were uninspired about new ways of working and making positive changes to take the service forward.

We found that the service was not benchmarking itself against other services within the Trust; we were told ward managers met at least every six weeks, but wider staff meetings across wards rarely happened. This meant that opportunities for learning across inpatient services could be strengthened. However, all staff were clear about their responsibilities to report incidents and all demonstrated caring attitudes believing that patients were at the centre of the work they carried out.

Leadership of this service

The NHS Staff Survey 2013 saw the percentage of staff in the Trust reporting good communication between senior management and staff as better than average when compared with other community Trusts. Throughout our inspection we were given many examples by staff of the visibility and commitment to the organisation of executive and non-executive members of the board. Staff told us of 'back to the floor' visits by the Chief Executive and members of the wider executive team.

On one ward we saw that Trust managers had acted rapidly in response to staff concerns about the quality of care. On this ward the managers had made effective changes to the structure and had made staff changes to ensure patient safety. The senior nurses on the ward and new staff were carefully selected to ensure patients were cared for safely

Good

Are Community inpatient services well-led?

and with compassion. Most of the wards we inspected were well-led. Most staff reported good support from their line manager and spoke positively about leadership at ward level.

Culture within this service

Across all of inpatient services staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered. Generally staff felt listened to and involved in changes within the Trust. Staff spoke of involvement in staff meetings, receiving ward newsletters and a Trust-side weekly 'communication cascade.'

"Feeling part of a team" and "teamwork" were repeatedly mentioned by staff throughout our inspection. This was reflected in the NHS Staff Survey 2013 where the percentage of staff in the Trust recommending the Trust as a place to work or receive treatment was better than average when compared with other community trusts.

Public and staff engagement

All the staff we spoke with assured us they understood the Trust whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed on the wards advising staff of the whistleblowing procedure. This suggested that the Trust had an 'open culture' in which staff could raise concerns without fear.

We saw patients were asked for their views about the care they received. Views were displayed on a 'You said We did' board in patient areas. On one ward we saw where patients had commented that there was not a television in the individual rooms. In response the ward sister had secured funds through a charitable organisation to provide televisions in all single rooms.

Innovation, improvement and sustainability

All the ward sisters talked of involving staff in service developments and shared learning from incidents. One ward sister told us how, in order to involve staff, they arranged a time-out day and encouraged their staff to organise the layout of the ward following a period of refurbishment. The ward sister allowed staff to arrange the ward in a way that best worked for them.

On the same ward staff had discussed problems with not all staff printing their name and role against nursing documentation entries. Through joint discussion the team agreed on a solution and now each individual staff member has a 'name stamp' unique to them. By using the name stamp staff no longer have to write their name and designation against every entry. The ward sister told us that this saves staff time but also assists in meeting record keeping guidance from the Nursing and Midwifery Council.

Information received prior to our inspection showed that up to February 2014, 83.5% of staff across the Trust had received an appraisal in the last year. Figures we received during the inspection showed across inpatient services that an average of 84% of staff had received an appraisal. The Trust target is 90% compliance for staff having received an appraisal.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines** **How the regulation was not being met:** The registered person failed to protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the safe recording and administration of medicines. Regulation 13.