HCRG Care Services Ltd

Paulton Memorial Hospital

Inspection report

Salisbury Road
Paulton
Bristol
BS39 7SB
Tel: 01761412315

Date of inspection visit: 26-27 July 2022
Date of publication: 06/10/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

HCRG Care Services Ltd provide services in the local community. There are two community hospitals serving the population of Bath and North East Somerset, situated at St Martin's Hospital (29 beds) and Paulton (28 beds). Paulton Memorial Hospital offer "step-up" beds (to prevent admission to an acute hospital bed), a minor injuries unit and an out-patients department. There is a physiotherapy service and an x-ray service is provided from Monday to Friday by another healthcare organisation.

We rated this location as requires improvement because:

- The target for mandatory training in key skills for in-patient staff was not met.
- Ward staff assessed risks to patients, but assessments lacked evidence of escalation where high risks were identified.
- Care plans did not detail inpatients' preferences on how their needs were to be met. Their care plans were not developed on all areas of need or on their discharges. Action plans did not provide guidance to staff on how assessment needs were to be met or reviewed where assessments had identified further action with monitoring potential deterioration.
- Medicine systems on the ward were not fully safe. There were gaps in the recording of medicines administered. Staff did not always record the reasons for not administering medicines.
- Whiteboards with patient's details were in full view of patients and visitors to the ward.
- Although steps were taken to recruit and retain staff, high levels of agency staff were used on the ward to maintain basic staffing levels.
- Ward staff did not feel valued by the organisation due to the lack of resources and staff shortages.
- The x-ray department was not open during the evening or at weekends. This was provided by another hospital and not within the service's authority to change opening hours.

However:

- The minor injuries unit (MIU) had enough staff to care for patients and keep them safe.
- All staff were committed to delivering good standards of care. The clinical lead in the MIU monitored the effectiveness of the service and made sure staff were competent.
- Staff treated patients with compassion and kindness, took account of their individual needs and helped them understand their conditions.
- Senior staff in the MIU planned care to meet the needs of local people and took account of patients' individual needs. Patients could access the service when they needed it and did not have to wait too long for treatment.
- The leadership, governance and culture in the MIU were used to drive and improve the delivery of high-quality person-centred care.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health inpatient services	Requires Improvement 	We rated it as requires improvement because: • The target for mandatory training in key skills such as Basic Life Support, Moving and Handling and Fire awareness was not met. • Staff assessed risks to patients, but assessments lacked evidence of escalation where high risks were identified. • Care plans did not detail patients' preferences on how their needs were to be met. Their care plans were not developed on all areas of need or on their discharges. Action plans did not provide guidance to staff on how assessment needs were to be met or reviewed where assessments had identified further action with monitoring potential deterioration • Medicine systems were not fully safe. There were gaps in the recording of medicines administered. Staff did not always record the reasons for not administering medicines. • Whiteboards with patient's details were in full view of patients and visitors to the ward. • Although steps were taken to recruit and retain staff high levels of agency staff were used to maintain basic staffing levels. • Staff did not feel valued by the organisation due to the lack of resources and staff shortages. However: • Staff were committed to delivering good standards of care and their feedback related to the shortfalls with staff vacancies and meeting the needs of patients. • Staff treated patients with compassion and kindness and took account of their individual needs and helped them understand their conditions. • Patients and relatives felt confident to approach staff and managers with concerns. • Managers investigated concerns and made recommendations on how to improve the service for patients.

Summary of findings

Community urgent care service

Good

We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services provided by the hospital were available seven days a week, although the x-ray service (provided by another hospital) was not open at weekends.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care. The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. Patients could access the service when they needed it and did not have to wait too long for treatment.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were

Summary of findings

focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The x-ray department was not open during the evening or at weekends. This was provided by another hospital and not within the service's authority to change opening hours.
- There was a pain tool in use and pain levels were assessed. However, inconsistencies in documentation indicated that pain levels were not assessed or recorded in 50% of cases.

Summary of findings

Contents

Summary of this inspection

Background to Paulton Memorial Hospital

The two main services at Paulton Hospital are urgent care (a minor injuries unit) and adult community health services (an inpatient ward).

The minor injuries unit (MIU) is an urgent care walk-in facility run by emergency nurse practitioners and emergency care practitioners (experienced and specially trained nurses and paramedics who are qualified to diagnose and treat minor injuries). The unit is open seven days a week between the hours of 8am and 8pm and offers treatment for adults, children and young people for a wide range of minor injuries. For example, cuts, bruises, sprains and simple fractures, which do not require the specialists of an Emergency Department.

Patients can walk in without an appointment or be referred by their GP or other healthcare professionals. From 9am to 5pm during the week, the service is able to refer patients to the on-site X-Ray department which is run and managed by another healthcare organisation. The unit has a registered manager and see an average of 450 patients a month. Twenty nine percent of patients are children under the age of 18 years.

The aim of the inpatient service is to enable people to regain health and wellbeing through rehabilitation and recovery. The service also plays a role in supporting adults nearing the end of their lives. It provides a bridge between care at home and care in an acute hospital setting for adults through the provision of:

- timely sub-acute treatment for individuals living at home who need a short period of intensive care and treatment for an acute illness, that can appropriately be provided in a community hospital setting
- active rehabilitation for individuals who have suffered a trauma or illness, to facilitate their ongoing independence and return to their normal place of residence as quickly as possible
- intensive and specialist rehabilitation for individuals who have suffered a stroke and are unable to return home directly from the Acute Stroke Unit
- palliative and end of life care for individuals who chose not to die at home.

This was the first inspection for this service under this provider. Paulton hospital was previously registered under a previous entity.

How we carried out this inspection

To fully understand the experience of people who use services, 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?

We carried out an unannounced comprehensive inspection with a team comprised of three CQC inspectors, two specialist advisors and an expert by experience. During the inspection we spoke with 19 members of staff, 16 patients and three family members. We observed patient care and reviewed internal documents and eighteen sets of patient records.

Summary of this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

Urgent Care

There were innovative approaches to providing integrated person-centred pathways of care involving other service providers. The minor injuries unit (MIU) worked closely with a neighbouring emergency department to reduce the number of patients with minor injuries who had to wait there overnight.

The unit was also working with the local ambulance service to divert some patients from emergency departments to the minor injuries unit. This would prevent some ambulances having to wait outside emergency departments and allow them to respond to emergency calls more quickly.

During the COVID-19 pandemic the clinical lead developed a "virtual MIU" to maintain the service while reducing the risk of infection. This concept was later adopted by other MIUs.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Community Inpatients Service

- The service must ensure that staff attend mandatory training including basic life support, to ensure the safety of patients and their needs are met. Regulation18.
- The service must ensure records provide sufficient information and detail to enable staff to support patients. Assessment tools must be completed according to guidance and include evidence of escalation where risks were identified. Patients preferences on how their needs are to be met must be sought. Care plans must be developed from assessments, provide guidance to staff on how to consistently meet the identified needs and reviewed to determine the progress made on the action plans and where appropriate adjust the plan. Regulation 9.
- The service must ensure medicine systems are safe. The service must ensure they have assurances that patients have medicines as prescribed. Prescription charts must detail the reasons for not administering medicines. Equipment checks of the resuscitation trolley must be robust. Regulation 12.

Action the service SHOULD take to improve:

Urgent Care

- The service should ensure that patients' pain levels are recorded.

Summary of this inspection

- The service should monitor any delays in the initial assessment (triage) of patients.
- The service should continue to work with other organisations to support the wider provision of X ray services throughout the opening hours of the minor injuries unit.

Community Inpatients Service

- The service should ensure that with patient's name and details of checks and progress are not in full view of visitors, staff and other patients.
- The service should consider developing a dementia friendly environment.
- Rehabilitation care plans should be developed on how patients were support to regain independence and skills including discharge plans.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
Community urgent care service	Good	Good	Good	Good	Good	Good
Overall	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement

Requires Improvement

Community health inpatient services

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Good
Well-led	Good

Are Community health inpatient services safe?

Requires Improvement

Mandatory Training

Mandatory training in key skills was set by the service. Staff were not all up to date with mandatory training.

The overall figures for training attended across the service was above the mandatory training target of 85%. However, on John Stacey Ward, mandatory training attendance figures were 71%

Many staff were not up to date with their mandatory training. The training matrix showed that only 57% had attended Basic Life Support training, 33% had attended Fire Awareness training and 57% had completed moving and handling training.

Staff had access to e-learning packages which allowed them to complete training virtually. However, they told us it was difficult to find the time to complete training due to staffing pressures.

Safeguarding

Staff understood the principles of the safeguarding adults' procedures including the types of abuse.

Staff attended safeguarding adults training including PREVENT awareness. The safeguarding adults training target was 85%. The training matrix provided showed that 100% of staff had attended level 1, 71% had attended level 2 and 81% level 3. The target for attending children's safeguarding was 85% and 100% had attended level 1 training.

Staff felt confident to raise safeguarding adults' referrals and to report any poor practice they may witness.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Cleanliness, infection control and hygiene

Requires Improvement

Community health inpatient services

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Housekeeping staff followed the cleaning schedules available on the ward. We noted day rooms had been used to store equipment which limited the space for patients.

Staff followed infection control procedures where there were COVID outbreaks, including the use of personal protective equipment (PPE). Hand sanitizers and masks were available at the front entrance and around the ward.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

Environmental risk assessments were completed by HCRG Care Services Limited property services. Staff told us they reported faults and remedial action was prompt from the team.

External contractors checked equipment annually to ensure they were safe for use. For example, hoists were assessed as being safe.

Patients could reach call bells, but they said a prompt response was not always possible due to low staffing levels on the wards.

The service had suitable facilities to meet the needs of patients' families. For example, a large conservatory.

Fire risk assessments were completed by NHS property services and there were regular checks of fire equipment. A fire warden was designated to the wards and patients had Personal Emergency Evacuation Plans (PEEPs) identifying how they were to be supported to a place of safety in the event of fire.

The clinical room where patients received care was kept locked, clean, well equipped, and well organised.

Assessing and responding to patient risk

Risk assessments were completed for each patient by staff but were not reviewed to demonstrate the risk was reduced or removed.

Nationally recognised tools were used for assessing patients at potential risk of health deterioration. These included National Early Warning Score (NEWS), Malnutrition Universal Screening Tool (MUST) and Waterlow for patients at risk of pressure injury.

NEWS assessments were not consistently completed for patients assessed at risk of health deterioration. The NEWS scores for four of the six records reviewed lacked evidence of escalation when the risk of health deterioration was high. The head of community hospitals was confident that although records were not detailed the information was passed on verbally.

Requires Improvement

Community health inpatient services

Handovers took place when shifts changed and staff were provided with handover sheets which included key information to keep patients safe. Accompanying risk assessments and care plans were not always in place to reflect needs identified in the handover sheets. Staff said the handover sheets were useful and kept them updated with current risks.

Staffing

The service operated on minimum staffing levels including nurses and support workers. Agency and bank staff were used to maintain staffing levels.

There were nursing and support staff vacancies.

Agency and bank staff were used where vacancies existed. The vacancy rate was 25% and the sickness rate for June 2022 was above the 4% target. Steps were being taken to recruit and retain staff. For example, for internal adverts there were incentives and progression opportunities for both substantive and bank posts. The service was undertaking overseas recruitment for registered nurses and 12 staff had been recruited.

On the day of the site visit both nurses on duty were agency nurses, including the nurse in charge. There were four health care assistants and one was from an agency. Where possible regular and familiar agency staff were used. A brokerage service was used to book agency staff. The brokerage service ensured the regular agency staff used to cover vacancies were qualified and skilled to meet patients' needs.

Medical staffing

The service had medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The therapy team supporting people with developing skills and regaining independence consisted of two occupational therapists (OT), two assistant occupational therapists, two physiotherapists and two physiotherapy assistants. Therapy staff commented that there were insufficient staff to support patients needing assistance with rehabilitation. For example, more therapy staff were needed to support patients that lacked capacity due to cognitive impairments such as dementia.

The service had a good skill mix of medical staff on each shift with out of hours medical support from an external provider.

Records

Staff kept records of patients' care and treatment. The records were stored securely and easily available to all staff providing care but not always up to date.

Assessment tools were not completed correctly or evaluated for action. Records that provided guidance on how to support patients were not comprehensive. For example, personal care and discharge plans were not developed including information from risk assessments. Monitoring charts such as NEWS scores were not completed and didn't detail actions to mitigate the risks. This meant patients' care and treatment needs may be delayed, and nursing staff not updated on the patient's current needs.

While staff maintained daily records, daily notes along with outcomes of assessments and interventions were not gathered and used for planning patients care. This meant that staff had to review all notes when seeking outcomes of medical procedures and tests.

Handover sheets were detailed but were not associated to a care plan or risk assessment. For example, the handover sheet for a patient stated that assistance with personal care was needed from two staff. Intentional rounding charts were used by staff to check patient's hourly needs relating to positioning, pain and personal care. The chart for the 27th of July was completed once and not hourly. This meant nursing staff were not updated on escalating risks.

Medicines

The service used systems and processes to prescribe, administer, record and store medicines.

The audits of medicine systems were completed by an internal pharmacist. The audit for March 2022 had identified a number of recommendations and ward staff were to complete an action plan on how recommendations made were to be actioned**.** The findings from the audit was that the medicine procedures known as standard operating procedures (SOP) was not available on the ward and consistent with our findings. We found gaps in the recording of medicines administered although the audits indicated that the standard was fully met.

Medicines with additional control measures for storage and recording of administration were kept locked according to NICE guidance. Records were not always signed to evidence nightly checks. For example, there were five days where the records were not signed in June 2022 and two days in July 2022. There was potential for staff not to be aware of missing medicines promptly. This meant there was no reassurance that audits had identified all gaps in the medicine system.

Prescription charts showed that staff were not administering medicines within the prescribed intervals or at consistent times. The registered manager told us the SOP stated that medication could be administered within two hours of the prescribed time. Following the inspection site visit the SOP was to be made available on the ward for staff's reference.

The National Institute for Health and Care Excellence (NICE), a national recognised body for good practice guidance was not followed for recording of medicines administered. Staff were not following systems and processes with the recording of medicines administered. We found gaps of staff signatures in four of the six medication charts. Codes were not used to explain the reasons for not administering the medicine. This meant there was no assurances that patients had been given their medicine correctly.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The Quality and Safety meeting minutes for April 2022 reported on the highest category of incidents related to pressure injury, medication errors and falls. It was also reported that actions were in place for the incidents identified.

All staff knew what incidents to report and how to report them. Incidents and accidents were reported to the nurse in charge and during handover staff were updated on changes of care following an incident or accident.

Requires Improvement

Community health inpatient services

Managers investigated incidents thoroughly using SBAR (situation, background, analysis and recommendation) formats. SBAR reports for five incidents reviewed following the site visit identified the actions taken to prevent reoccurrences of similar incidents and where appropriate acknowledged learning. The reports also stated that managers apologised to the patients where discomfort was caused.

Are Community health inpatient services effective?

Requires Improvement

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Staff followed up-to-date policies to plan and deliver care according to best practice and national guidance including National Institute for Health and Care Excellence (NICE) guidelines and quality standards. Policies, care and treatment pathways, and clinical protocols had been developed in line with national best practice recommendations. Staff used recognised rating scales to assess and record severity and outcomes.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

However, nationally recognised management guidelines were not consistently followed for patients assessed as at risk of malnutrition. Where malnutrition universal screening tool (MUST) assessments had identified patients as at risk of poor hydration, fluid intake charts lacked detail or evaluation. We looked at food and fluid intake charts for six patients. The intake targets were missing, and charts were incomplete. For example, the food chart for one patient at risk of weight loss lacked detail and actions when they had consistently lost weight. This meant the outcomes used to inform planning were not up to date or accurate for patients at risk of poor hydration and weight loss.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patient outcomes

Patients' needs were assessed on admission. Records did not provide evidence that patient's needs were effectively monitored.

Requires Improvement

Community health inpatient services

Patient's needs were assessed on admission. Admission checklists were based on all areas of patients' physical, emotional and social care needs. Risks identified during the admission process were assessed. Patients preferences was not sought on how their needs were to be met. Care plans were not devised on how staff were to consistently meet the needs identified from the information gathered during assessments for the nine patients records reviewed. Action plans were not reviewed where assessments had identified further action with monitoring potential deterioration. This meant the results from assessments and information gathered were not always used to improve patient outcomes.

The therapy team raised concerns about the effectiveness of the rehabilitation programmes due to some patients having cognitive impairments such as dementia. They were concerned about the effectiveness of patient's rehabilitation towards successful discharge. For example, there was an indication that patients had cognitive impairments from the number that needed mental capacity assessments.

The therapy team told us rehabilitation programmes centred mainly around kitchen assessments but was not always appropriate for patients with cognitive impairment or with an emerging dementia diagnosis. Rehabilitation therapies included a breakfast and lunch group and the stationary exercise cycle in the conservatory for patients with physical impairments.

Patient discharges were delayed. The discharge coordinator said there were 15 patient's discharges were longer that the target of 30 days. Delays in discharges arose when a patient stayed in the ward although they were medically fit for discharge. This was largely due to patients waiting for a package of care to live at home or waiting for a placement within a care home.

Competent staff

Staff had not all attended mandatory training to ensure they were competent for the roles they were employed to perform. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Some staff raised concerns about the skills and qualification of agency staff. The registered manager and head of community hospitals explained some staff vacancies had arisen from progression to different banding. They acknowledged that high levels of agency staff were used. However, a brokerage service was used to book agency staff and there was a clear directive that only skilled and qualified agency staff were to be booked to work at the hospital.

Agency nurses received a brief induction which included a tour of the ward and familiarisation with fire procedures. They were provided with handover sheets but time to read care plans was limited if they were assigned to administer medicines.

Mentors were assigned to students on placements. Students on placements were positive about the support from mentors except for when agency staff were on duty or in charge of the ward their opportunities for learning and for developing their skills were limited. This was because of their lack of knowledge on their role with support learning expectations.

Staff told us they received regular line management supervision. Annual appraisals were from April and currently 84% of staff had their appraisal.

Managers received an automatic notification of registered staff who were nearing their revalidation date which allowed them to monitor and support registrants to revalidate.

Requires Improvement

Community health inpatient services

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Multidisciplinary team meetings took place on the ward to ensure a full medical overview was maintained and actions completed. A paper file and electronic records were used to record outcomes of meetings. This resulted in some conflicting systems. For example, MDT actions and updates were kept on the shared drive which included OT actions, discharge and nursing actions. However, this information was not copied into the paper files or shared with staff.

The discharge coordinator explained the MDT action plans kept on the shared drive were updated where there were discharge plans. Staff then updated the handover sheet and the whiteboard to share this information.

Staff worked collaboratively to ensure continuity of care to patients and ensured appropriate professionals were involved in care and treatment. GPs, nursing and therapy staff worked together to facilitate care and treatment and to assist patients.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Health promotion posters were not on display around the ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions.

Nursing and clinical staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). For example, 74% of staff had attended DoLS training. Staff could access advice and support on the Mental Capacity Act from the lead at Bath and North East Somerset (BaNES).

Staff knew the principles of the MCA regarding seeking patients consent before delivering personal care and the daily decisions they were able to make. For example, food choices, activities and their clothes.

Handover sheets listed where mental capacity assessments were completed along with the outcome. It was unclear on the specific decisions 11 patients assessed as lacking capacity were not able to make. This meant staff were not aware of the decision's patients were able to make for themselves. A referral was made for an Independent Mental Capacity Advocate (IMCA) to support patients where appropriate.

Relatives or significant others with power of attorney for finance or health and personal welfare were listed in the handover sheet but lacked detailed on whether the power of attorney was registered.

Requires Improvement

Community health inpatient services

Deprivation of Liberty Safeguards were granted by the supervisory body (lacking capacity to consent to be there, deprived of their liberty, under continuous supervision and control, For example, not recognising the consequences of not having medical care and leaving the hospital ward without support from staff.

Mental capacity assessments were completed by the occupational therapists before discharge and although copies were kept on the shared drive a copy was not held in the paper files. Handover sheets detailed that two patients had capacity to make decisions about their discharge.

ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) forms were well completed by health care professionals with the patient and family and documented future treatment decisions such as serious illness, acute deterioration or end of life treatment.

Are Community health inpatient services caring?

Good

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Patients and those close to them received help, emotional support and advice when they needed it although their time with staff limited. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

The head of community hospital told us how they ensured staff were kind and compassionate towards patients. Staff were praised when their practice was within the values of the organisation. The friends and family test were applied during recruitment, patients and relatives were open with feedback.

Requires Improvement

Community health inpatient services

Staff we saw interacting with patients were friendly and approachable. They took time to interact with patients and those close to them in a respectful and considerate way.

Patients knew about the reasons for their admission. However, they were not aware of their care and discharge plans.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Visiting to the hospital was reinstated following the COVID pandemic. Staff made sure patients and those close to them understood their care and treatment.

Patients had support from staff to make informed decisions about their care. Staff talked with patients, families and carers in a way they could understand,

Patients gave positive feedback about the service. Mixed comments were made by relatives about the therapies available to support discharges.

Are Community health inpatient services responsive?

Good

Service planning and delivery to meet the needs of the local people

The service provided care in a way that met the needs of local people and the communities served.

Although Paulton Memorial Hospital was a community inpatient resource the referrals for admission were from the Royal United Hospital and on occasion from local GPs. The registered manager and head of community hospital said there was a strong league of friends who supported the hospital and raised funds to make inpatient stays more comfortable.

Facilities and premises were appropriate for the services being delivered. Patients were admitted to single sex wards arranged into four en-suite bays of six patients and six side rooms.

The service had systems to help care for patients in need of additional support. Two side rooms were allocated to provide end of life care when required. There were end of life leads and a band 6 facilitator. The registered manager said the local community valued the resource, particularly those that preferred to receive their palliative care close to their local community.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Requires Improvement

Community health inpatient services

Wards were not designed to meet the needs of patients living with dementia. For example, leisure, social interaction, and dementia friendly environment**.** The handover sheet listed four patients with a diagnosis of dementia and two with other cognitive impairments such as memory loss. Therapy staff explained that because patients with dementia had to be supervised, daily activities usually centred around the exercise cycle in the conservatory for three or four patients at any one time. The environment lacked points of interest which meant that patients with dementia were not able find places of interest when they moved around the ward or joined in social activities.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Managers monitored delays with transfer of care against the service own set targets. Delays with transfer of care occur when an adult patient remains in hospital although they were deemed medically fit for discharge. The service monitored the total number of lost days due to delays in transfer of care. For example, 371 days was the total number of lost days due to delays with transfer of care in March 2022. The average length of stay was 35.6 days, above the target of 30 days.

The discharge coordinator said delays with transfer of care arose when they were unable to finalise arrangements for continuing care in the community. For example, some patients were difficult to place in the community due to their complex needs.

Patients identified for discharge were listed in the handover sheet. There were delays for 15 patients and for 12 the discharge was either not yet identified or their say was less than 30 days timeframe for delays not yet met. The discharge coordinator told us for one patients discharge was delayed by 96 days.

Discharge plans were not in place, although electronic notes and handover sheets included information on transfer of care. Discharge plans were missing for six of the nine care records reviewed. This included identifying any rehabilitation needs and services needed to support the person to leave the hospital. The discharge coordinator told us that nurses knew the plan for patients to progress to discharge assessment beds, but this was not clearly recorded. We were told that steps were taken to ensure transfers of care were smooth. Discharges were arranged to suit the carers and they ensured the timings of discharge were best for carers.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Managers investigated complaints and identified themes.

Requires Improvement

Community health inpatient services

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Are Community health inpatient services well-led?

Good

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable for patients and staff. They supported staff to develop their skills and take on more senior roles.

The registered manager leadership style was credible, visible and leads through engagement and coaching. “We” was the terminology used as staff worked as a team. The challenges to the service related to retention and recruitment of staff. These were addressed by creating a band seven post to strengthen the hubs, a clear ladder of progression. and accepting nurse students of placements There was potential for creating more nursing associate roles because progression of staff had created band five post vacancies.

Ward managers were supported by a head of community hospital. The expectations of this role included developing the model of care to more holistic, person centred and reablement of patients.

Local leadership was provided by ward managers although some staff gave feedback that issues weren’t always addressed when these had been reported.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

The registered manager and head of community hospitals explained they worked well with ward managers. There was an acknowledgment that steps to recruit were being taken but that staff struggled with the timescales and progression of staff to bring about retention. There was to be earlier involvement with families, more effective reablement and meaningful activities such as gardening and pottery.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

The registered manager and head of community hospital recognised that staff were “unsettled” due to changes with providers. In 20 months, new bids for contracts will have to be submitted. This could potentially result in another provider with their own policies, processes and procedures that staff would need to embrace.

The organisations visions and values were known to staff.

Requires Improvement

Community health inpatient services

Staff told us that morale was low due to ongoing COVID outbreaks and the stress placed on resources in the ward. Staff described feeling "out of control" with too much to do due to the lack of activities and reablement. Some staff said the skills of agency staff also attributed to low morale.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Managers recognised staffing was the major risk to the service and had put recruitment and retention initiatives in place to attempt to mitigate the risk.

There were monthly management meetings to review learning and how changes in practice were embedded after an incident. There were monthly standing operating procedures clinical leads monthly meetings.

There were changes with the national and local governance structure has challenged the ways of working. The impact was not yet known to the service as there were changes occurring with the introduction of the integrated care system (ICS) a partnership organisation merged with Clinical Commissioning Groups (CCGs). The ICS will have an impact on the health and wellbeing of the local population and although Community Impatient services were members, they were not part of the Integrated Care Board.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The service had a risk register which included missing budgetary targets, staff vacancies, incidents reporting and uncertainty for the future contractual provision of health and social care in BANES community as a result of the contract not being extended beyond March 2024

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

There were two systems used to record MDT notes. Electronic notes were not accessible to all staff or transferred to paper. Care plans, risk assessments and daily notes were in paper documents kept in files. System One was not yet introduced to the ward although it was used across other services within HRCG. This meant that information was not widely shared or easily accessed by other internal and external teams that used the same system.

Requires Improvement

Community health inpatient services

The provider shared data securely with the Care Quality Commission and other agencies in accordance with legislation. Serious reportable incidents were reported when they occurred in line with the National Reporting and Learning System (NRLS) requirements.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

While we observed staff consulting with patients during the admission process, managers recognised that patients voice was missing from their plans of care. We were given assurances that a full review of documents would be undertaken.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. Staff we spoke with were committed to making improvements. The service leaders recognised the need to drive improvement across the service. They understood the issues within the service and were committed to improving the quality and safety of the service**.** For example, initiatives on recruitment and retention of staff, review of documents and communication.

A BaNES nursing conference to celebrate coming through the recent pandemic with staff was held in 25 May 2022. The celebrations included learning, and invitations were extended to students, representatives from all teams and the Southwest Regional Chief Nurse from NHS England. There were workshops on pathways of care including continence, end of life, tissue viability and frailty.

Good

Community urgent care service

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are Community urgent care service safe?

Good

We rated safe as good.

Mandatory training

The service provided mandatory training in key skills, including the highest level of life support training to all staff, and made sure everyone completed it.

All staff received and kept up-to-date with their mandatory training. Records showed that 96% of staff who had been in post for more than a year were up-to-date with training in key skills. All clinical staff had training in immediate life support for adults and children.

The mandatory training was comprehensive and met the needs of patients and staff. Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Email alerts were sent automatically to staff when they needed to update training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Although all clinical staff had received training in adult and child safeguarding, three qualified staff were not up-to-date. However, two had started work at the unit in the previous six months and it had not yet been possible to book a place on an appropriate course. The third member of staff had a place booked on the next available course.

All staff took part in regular safeguarding clinical supervision where they could discuss any difficult cases or concerns. In this way they could enhance their knowledge by discussing safeguarding issues in their own service and other services provided at the hospital.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We reviewed the records of a child who had recently been seen in the unit . Although they had attended with a minor injury the nurse who had assessed them had noticed signs that indicated they may have been at risk of abuse. When children attended the unit, their details are always checked with the national Child Protection Information Sharing System (CP-IS).

This showed that the child was not subject to a Child Protection Plan but the nurse felt that there may be a risk of future abuse. The nurse was able to gain the trust of the child and family members and they agreed to a further examination in order to check for signs of abuse or neglect.

Although the child was in no immediate danger, the details were discussed with the hospital's safeguarding lead and it was decided to raise a safeguarding alert. In addition, the nurse directly discussed her findings with the child's social worker and their GP.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff that we spoke with were familiar with the process of making a referral. They could all name the hospital's safeguarding lead and knew how to contact them. They told us there was always someone with advance safeguarding knowledge available whenever the unit was open.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff complete handwashing and using hand gel after every patient contact. All staff observed 'arms bare below the elbows' and they wore personal protective equipment as required by local policy. Results of hand hygiene audits were consistently good. The trust provided training to staff in infection prevention control and handwashing. There was a comprehensive annual infection control audit carried out by an independent expert. Results showed that practice in the unit was safe and complied with hospital policy.

There was an infection control link nurse who kept staff informed of any new developments. For example, there had been a meningitis outbreak in a nearby city and so staff were able to update themselves on the initial symptoms of the infection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients in the waiting room could not be directly viewed by staff although the receptionist could hear activity or anyone calling for help. Staff were aware there was a small risk of a patient deteriorating in the waiting room and had made changes to reduce the risk. CCTV cameras had been installed, with monitors at the staff base, reception and in the triage

room. Staff had a clear view of the waiting room via the monitors. There were signs at reception and in the waiting room, informing people of the CCTV. The triage nurse was aware that it was their role to monitor patients in the waiting room and we observed them regularly viewing the CCTV monitor above their desk. They directly checked activity whenever they called their next patient.

The service mostly had suitable facilities to meet the needs of patients' families. There was a range of toys available to distract children while they were being examined or treated. There were also breastfeeding and nappy changing areas available. The waiting room was light and spacious with room for prams and buggies. However, there was not a designated children's waiting area with visual and audio separation from adults. Staff told us that if there was a disturbing incident in the waiting room, they would remove any children from it. They had investigated providing separate facilities but this would involve extensive building works.

Chairs were arranged in the waiting room to provide enough space for social distancing during the COVID-19 pandemic.

The service had enough suitable equipment to help them to safely care for patients. The unit was well equipped and equipment was checked daily to ensure that it was ready for use. We saw maintenance records showing that a regular programme of maintenance and servicing was in place.

Staff carried out daily safety checks of specialist equipment. We were shown a range of specialist equipment, including adult and children's resuscitation equipment. This was contained in a large "tamper-evident" trolley and was clean, clearly organised and well maintained. It had been checked on a weekly basis in line with hospital policy.

Staff disposed of clinical waste safely. Waste management was handled according to hospital policy with separate colour coded arrangements for general waste, clinical waste and sharps. Used bins were sealed securely and were not overfilled.

Assessing and responding to patient risk

Staff completed risk assessments for each patient. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly. Patients attended the minor injuries unit with a wide variety of conditions ranging from minor cuts and broken bones to chest pain and shortness of breath. The risk assessment was required to determine the seriousness of the patient's condition and to make immediate plans for their on-going care. This is often known as triage. Standards set by the Royal College of Emergency Medicine (RCEM) state that this should take place within 15 minutes of arrival and we observed this happening throughout our inspection.

Waiting times for triage were clearly displayed on computer screens throughout the department. We observed reception and clinical staff constantly monitoring the time that patients were waiting. If patients were at risk of waiting longer than 15 minutes a second nurse would be deployed to assist the triage nurse. We observed the triage of two patients (with their consent) and found it to be thorough and effective. The nurse had completed special training in the triage of adults and children and had been assessed as competent before undertaking the role.

Managers did not routinely monitor any delays for triage. Although staff were confident that very few patients waited more than 15 minutes, we could not be certain that this happened all the time.

In addition to nurse assessment, reception staff had been provided with a clear guide to 'red flag' conditions such as chest pain, difficulty breathing, and severe bleeding. Reception staff that we spoke with were familiar with this guidance. In addition, they had all been trained in basic life support so that they could begin resuscitation if a patient collapsed in the reception area or waiting room.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. When patients were assessed, clinical observations such as blood pressure, temperature, heart rate and respirations were recorded and entered into the clinical computer system. If the observations indicated that a patient may have sepsis (a serious blood infection), an alert appeared on the screen so that sepsis screening could be carried out. This complied with guidelines produced by National Institute for Health and Care Excellence (NICE).

Staff had been trained in the use of the national early warning system (NEWS) and the paediatric early warning system (PEWS). This was a quick and systematic way of identifying patients whose clinical condition was at risk of deteriorating. Patients records showed that these were used when necessary.

The service had access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Mental health nurses were based at another hospital but were readily available by phone. They would speak to the patient causing concern and would arrange ongoing care for them.

Staff shared key information to keep patients safe when handing over their care to others. Patients who left the department and required further investigation or treatment received a copy of their patient notes to take with them to facilitate safe handover and transfer of care. Shift changes and handovers included all necessary key information to keep patients safe.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough staff to keep patients safe. The unit was staffed by emergency nurse practitioners (ENPs), emergency care practitioners (ECPs) and qualified nurses. (ENPs are experienced and specially trained nurses who are qualified to diagnose and treat minor injuries. ECPs are experienced and specially trained paramedics who are qualified to diagnose and treat minor injuries). We reviewed the staff rota for the last four weeks and found that there were sufficient staff with the right skills at all times.

The department manager could adjust staffing levels daily according to the needs of patients. Shift patterns were flexible to meet the needs of staff and patient activity.

The number of staff almost matched the planned numbers. There was a part-time vacancy for an ENP. One member of staff was undertaking a further qualification in order to fill the vacancy.

The service had low and reducing vacancy rates and turnover rates. Sickness rates were reducing following a period of long-term sick leave.

The service had low rates of bank and agency nurses. Managers limited their use of bank and agency staff and requested staff familiar with the service. They made sure all bank and agency staff had a full induction. Temporary staff were supervised until their induction was complete.

Good

Community urgent care service

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Patient records were computer-based and were password protected. We looked at nine sets of records and found that information regarding the patient's care and treatment was clear and well documented. There was appropriate information to understand the diagnosis and treatment delivered.

When patients transferred to a new team, there were no delays in staff accessing their records. If patients needed to transfer to another hospital a copy of their record was given to them. Discharge summaries were sent to the patient's GP, and when required to health visitors or other professionals.

Records were stored securely. Access to patient records was controlled by individual smartcards and passwords. Screens were situated so they could not be viewed by unauthorised personnel.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Most of the emergency nurse practitioners had qualified as nurse prescribers. Those that were not qualified as nurse prescribers, administered selected medicines under guidance, known as patient group directions. These were up-to-date and had been completed according to national guidance.

Staff completed medicines records accurately and kept them up-to-date. Medicines administered in the unit were recorded on the clinical computer system.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in locked cupboards and fridges. Fridge and room temperatures were regularly checked and temperatures recorded. We found that all temperatures were within a safe range.

Staff stored prescription pads securely in a locked cupboard and recorded the serial numbers and issuing prescriber, so that all forms could be tracked throughout the unit.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them.Incidents and accidents were reported using an electronic system and were graded in severity from low or no harm to moderate or severe. Staff raised concerns and reported incidents and near misses in line with hospital policy.

Good

Community urgent care service

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The clinical lead was sent an automatic alert when an incident was reported and had been trained in the investigation of incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. They met to discuss feedback and look at improvements to patient care. For example, frailty scores had been introduced when assessing injuries that had resulted from falls.

Are Community urgent care service effective?

Good

We rated effective as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Clinical guidelines contained information from the National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM) standards.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. They showed a good knowledge of Mental Health Act legislation and legal frameworks. They were confident regarding the person they could contact for additional support if they needed it.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Patients were rarely in the unit for more than four hours and so meals were not provided. A variety of drinks and snacks were available via vending machines in the waiting room.

Pain relief

Staff assessed and monitored patients to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The unit used a pain score of one to ten to identify the severity of a patient's pain. For non-verbal children a pictorial scale was used. Not all patient records had a pain score recorded but pain relief was still given rapidly when needed.

Good

Community urgent care service

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for patients were positive, consistent and met expectations, such as national standards. There were quarterly prescribing audits, environmental audits and hand hygiene audits and a yearly audit of safeguarding procedures. Aldo treatment audits for conditions such as animal bites and sore throats. Result showed patient assessment and diagnosis complied with national standards. Auditing of x-ray requests and results was continuous.

There were plans to recommence the audit of patient records which had been suspended during the pandemic. A member of staff had taken responsibility for this and the audit was due to start in September 2022.

Managers and staff used the results to improve patients' outcomes. A pre-emptive audit, designed by the senior clinical team, was taking place to establish the potential benefits of introducing a new medicine. A new wound cleaning gel, which had local anaesthetic and antiseptic properties, had recently been produced. The audit was aimed at establishing how many wounds were likely to benefit from the gel and the current outcomes of the wounds. If the new gel was introduced, a further audit was planned to compare the results of wound outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. A repeat prescribing audit carried out by the pharmacy team showed improved knowledge of antibiotics used for resistant infections.

The service had a low rate of patient re-attendance for the same injury. Monthly records showed that 2% of patients returned within seven days of their original attendance. Rates varied from 0% to 4% from July 2021 to June 2022.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers had access to a computerised learning and development dashboard. It was colour coded to highlight staff who had outstanding training requirements, so managers could more easily monitor training compliance.

Two thirds of the service's emergency nurse practitioners (ENPs) were also nurse prescribers. Nurse prescribers had completed a specialist prescribing course recognised by the Nursing and Midwifery Council.

Managers recognised that there was a national shortage of ENPs, which meant that recruiting was challenging. To combat this, managers had recently seconded existing nurses onto a training programme to progress to the ENP role.

Clinical staff attended additional training in deteriorating patients and sepsis awareness, radiation protection training relating to the onsite x-ray department, fracture identification training, advanced child and adult safeguarding, and domestic abuse awareness training. Group supervision sessions were held for clinical staff to support their practice.

Managers gave all new staff a full induction tailored to their role before they started work. This took between two and four weeks depending on prior experience. New staff were directly supervised until they were assessed as fully competent.

Managers supported staff to develop through yearly, constructive appraisals of their work. Records showed that all staff who had been in post for the last year had received an appraisal Staff told us they found the appraisal reviews to be a positive experience.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Appraisals included a learning review where opportunities were identified for further development. Staff told us that any requests for further training were fully supported by managers. Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Multidisciplinary working

Nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. There were good working relationships with community services, the emergency department at a neighbouring hospital and with local GPs. The clinical lead had also developed a strong relationship with acute specialties at the neighbouring hospital. This meant that patients could be referred directly to them without being re-assessed by the emergency department or a GP. For example, a patient with a severe jaw injury was referred directly to a specialist facial surgeon without the need for further investigations by other doctors.

Staff could rapidly discuss complicated X-rays with specialist imaging doctors via a digital network. We observed the X-ray of a patient with shoulder pain being discussed in this way. The specialist thought that the abnormality was a sign of a more widespread problem and advised a chest X-ray as well. This also showed an abnormality which needed urgent investigation. In conjunction with the patient's GP the investigations were arranged so that treatment could follow in a timely fashion.

There were effective links with other services such as health visitors, district nurses and local authority social work teams.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. There were good working relationships with the crisis mental health team so that patients with acute mental health problems could be effectively assessed.

Seven-day services

Not all key services were available seven days a week to support timely patient care.

The X-ray department was staffed by a neighbouring hospital and was only open from Monday to Friday and from 9am to 5pm. If staff suspected a fracture outside of these hours, they had two options. If the fracture was likely to be minor, they immobilised it and advised the patient to return the next day for an X-ray. If the injury was more serious, or if there was going to be a two or three day wait for the department to open, patients were advised to travel to the nearest emergency department which had a continuous X-ray service.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, seven days a week. Apart from the X-ray service, staff could contact on-call specialists whenever necessary.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

Good

Community urgent care service

The service had relevant information promoting healthy lifestyles and support. There were leaflets in the waiting room giving information about smoking cessation, weight reduction, and drug and alcohol misuse.

Staff assessed each patient's health when they attended and provided support for people to live a healthier lifestyle. They gave practical advice on self-care and how to look after wounds to patients. If the opportunity arose, staff would discuss aspects of a patient's lifestyle during their assessment. We observed them using humour and empathy to give suggestions and provide information about local services that could support with healthy eating and weight loss.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. This was clearly recorded in the patients' records

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. They were aware of the legal guidelines which meant children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so. Otherwise, consent would be sought from the child's parent or guardian. If a child attended without a person who was able to provide consent, staff would attempt to contact an appropriate adult.

Are Community urgent care service caring?

Good

We rated caring as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. They were unfailingly courteous to patients and their families and took individual circumstances into account when deciding on treatment.

Patients said staff treated them well and with kindness. We spoke with three patients all of whom were complimentary about the kindness they had received. The clinical lead monitored written expressions of thanks from patients. Descriptions of the service from recent patient feedback included words such as "Great", "Amazing" and "First-class care".

Good

Community urgent care service

Staff followed policy to keep patient care and treatment confidential. Confidentiality was maintained at the reception desk by means of signs asking people to stand back from the desk, when someone was being registered. Examination and treatment took place in individual treatment rooms. We observed staff knocking before entering in order to maintain privacy.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed staff discussing a patient with autism. They displayed a good understanding of the patient's needs and the help that the family may find useful.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. They took time to reassure patients emotionally, as well as treating their physical injuries. One patient told us hoe concerned they were on attending the unit, but how staff patience and kindness helped them to feel better.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. They undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We observed a member of staff discussing the results of investigations that were worse than expected. They spoke slowly and checked the patient's understanding before continuing their explanation. A plan of action was suggested and agreed with the patient and they were assured that they could telephone the unit later if they had any further questions.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed staff involving children and their families in discussions about treatment options.

Staff talked to patients in a way they could understand, using communication aids where necessary. We observed staff adjusting explanations of treatment depending on patients' level of understanding. They used pictures and computer images to aid understanding.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service used to take part in the Friends and Family NHS survey. Despite information about this being displayed in the unit there were few responses. Recently the clinical lead started a formal record of the verbal and electronic feedback they received. There were plans to monitor themes, report these to staff and use the information to improve future services but these had not yet been implemented. We reviewed recent feedback, all of which was positive.

Are Community urgent care service responsive?

Good

We rated responsive as good

Good

Community urgent care service

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. The clinical lead was working with the local ambulance service to inform them of the facilities and treatment options that were available in the unit. In this way, they hoped that more patients could be brought to the minor injuries unit (MIU) rather than waiting for long periods in an emergency department.

Staff in the unit were conscious of the difficulties some patients faced when there was no x-ray service available. They were working with two other MIUs in the area to employ a radiographer who would rotate between the units to provide a degree of service at the weekends.

The unit was working closely with a neighbouring emergency department to reduce the number of patients who had to wait there overnight with minor injuries. If there was a long wait to see a doctor or practitioner in the emergency department, and if an experienced nurse considered it safe for the patient to be seen the next day, the patient would be given a choice of waiting in the emergency department or going to the MIU. First aid and advice would be given to the patient and the nurse would e-mail the patients notes to the MIU so that they were expecting them. This new arrangement was being carefully monitored but early indications were positive.

Staff could access emergency mental health support seven days a week for patients with mental health problems, learning disabilities and dementia. There were good working relationships with the mental health crisis team so that patients with acute mental health problems could assess support in a timely fashion.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. They understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Staff could describe how they adapted their approach to practice and communication when caring for patients living with dementia, a learning disability or sensory loss. They had developed skills from dementia training courses they had attended. Dementia friendly signs were displayed throughout the unit.

The service had information leaflets available in languages spoken by the patients and local community. Although the leaflets on display were in English, staff told us that they could print them out in different languages if necessary.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. There was a telephone translation service available whenever the unit was open.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Good

Community urgent care service

Managers monitored waiting times and made sure patients could access urgent care services when needed, and received treatment within agreed timeframes and national targets. The national standard for minor injuries units is to admit, transfer or discharge 95% of patients within four hours of arrival at the unit. We reviewed monthly data from August 2021 to June 2022 and found the unit achieved this target. Results varied from 95.4% to 100%. The average (median) for the year was 98%.

Managers did not routinely monitor the time patients waited to see a practitioner for treatment.

Managers and staff worked to make sure patients did not stay longer than they needed to. We observed that all staff were patient focused and understood there may be other urgent priorities as well as their injury. For example, they paid special attention to a mother who needed to leave by a certain time to collect her child from school.

The number of patients leaving the service before being seen for treatment was low. During the year ending June 2022 an average of 1% of patients left without being seen with monthly figures varying from 0.5% to 2%.

Staff supported patients when they were referred or transferred between services. When the x-ray department was closed in the evenings and at weekends patients had to go to the x-ray department at a neighbouring emergency department. Staff at the MIU were able to directly refer patients for the appropriate investigation. They had electronic links with the neighbouring x-ray department so that they could view the x-rays on their clinical computer system. Once they had viewed the x-ray, they would phone the patient and tell them the results. If the patient could be treated at the MIU they returned, if they needed specialist treatment they were referred directly to specialists at the neighbouring hospital. This meant the patient did not have to make an extra journey to the MIU for their results.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff told us that if a patient made a verbal complaint, they would try and resolve the concern at the time. However, they always gave patients the option of a formal written complaint.

Managers investigated complaints and identified themes. The clinical lead phoned patients as soon as a complaint was received. This enabled them to give an early apology and to gain more details and understanding of the issues involved. Complaints were investigated methodically and a clear and courteous response was sent within three weeks.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, information given to patients via the website had changed as a result of a complaint.

Good

Community urgent care service

Are Community urgent care service well-led?

Good

We rated Well-led as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The minor injuries unit (MIU) was managed by the clinical lead who was visible across the unit. We saw them carrying out clinical duties and giving advice to other staff. This meant they had a good awareness of the issues that mattered to staff and patients. Staff we spoke with told us that the clinical lead had the skills, knowledge, experience and integrity to lead the service.

The clinical lead reported to the head of community hospitals and, via two other layers of management, to the managing director. Staff knew the senior managers by name as they regularly visited the unit. They told us that they trusted the leadership team and knew that they would be listened to if they raised concerns.

Several staff had been supported to develop their skills and there were plans to introduce an apprenticeship scheme as another route for staff development.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The vision for the service was to provide a minor illness service in addition to the treatment of minor injuries. This would relieve pressure on local GPs and improve access to treatment for the local population. Staff were aware of the vision and the strategy for achieving it. They were in the process of calculating the training, staffing and environmental factors needed to achieve their aim.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff that we spoke with told us they enjoyed working at the MIU. They felt that they were supported by their peers and other departments within the hospital. They told us that the small numbers of staff in the unit produced a good sense of teamwork and that there was a 'no blame' culture' that made it easier to admit any mistakes and to learn from them.

The clinical lead had a strong commitment to easing staffing issues and creating workforce stability. The staff rota was a flexible one with a variety of working patterns. This produced a strong work-life balance for staff and enabled them to work around the other priorities in their lives.

Good

Community urgent care service

It was apparent that staff shared the same professional values. The main one being "The patient comes first". Throughout the inspection we saw this value informing the actions taken by staff.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The clinical lead was a member of the hospital's quality and safety group which informed the governance of the unit. The group met monthly and reviewed items such as incident reports, audit results, infection control, policy updates and national clinical guidelines. As many decisions as possible were made at the meeting but further advice could be sought as needed from the regional governance group.

Information from the quality and safety group was discussed at monthly MIU meetings. Minutes were circulated to all staff. New information that staff needed quickly was sent via email and discussed at staff handovers. For example, guidance about a recent outbreak of monkeypox, including recognition of symptoms and initial treatment pathways.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The unit had a risk register which was reviewed monthly. Risks had been given a score depending on the degree and likelihood of harm resulting from the risk. If a new risk was added to the register, it was discussed with the regional health, safety and risk manager to agree a risk score. Measures to reduce the risk were recorded and monitored. The service had a business continuity plan which gave guidance to staff should unexpected events such as power cuts or floods take place.

At the start of the COVID-19 pandemic staff were redeployed to other parts of the organisation and the unit had to close for several weeks. Concerned about the lack of service for local people, the clinical lead developed a protocol for a "virtual MIU". As staff gradually returned to the MIU, patients could telephone for advice and either be re-directed to a relevant service or given an appointment at the MIU. In this way, patients could access treatment for minor injuries while maintaining maximum social distancing, thus reducing the risk of infection for patients and staff. The new protocol proved to be successful and was later adopted by other MIUs.

The clinical lead monitored and reviewed performance, both on a day-to-day basis and monthly to identify any trends. Aspects of performance that were monitored included; time patients spent in the department, age range of patients, deprivation scores (based on postcode), the number of ambulance conveyances and unplanned re-attendances. However, the service did not monitor any delays for the initial assessment of patients and so could not be certain that any risk to newly arrived patients was minimised.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Good

Community urgent care service

The unit had effective information systems, which provided real-time and retrospective reporting of performance, safety, risk and quality, and patient data. Information was regularly reviewed and used to support continuous improvement.

Attendance and performance data was used when looking at staffing levels and any changes within the department.

There were effective information governance processes and safeguards. Staff received information governance training and understood their responsibility to safeguard confidential data.

IT equipment, including access to electronic patient records, was protected by individual smartcards and passwords.

Engagement

Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

There were monthly staff meetings which were guided by a standard agenda to ensure that key issues were not forgotten. The meetings were well attended and accurate records were kept. Actions identified at previous meetings were addressed.

There was information in the patient area encouraging feedback and also a section on the website for patients to provide feedback.

The clinical lead was part of an NHS 111-service working group and a same day emergency care (SDEC) working group. Both groups were supported by the local clinical commissioning group and aimed to improve timely treatment for patients at the most appropriate clinical service.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff recognised that clinical practice was constantly evolving and wanted to ensure that practice within the MIU was as up-to-date as possible. They had therefore organised regular presentations by clinical experts on subjects such as hand examination and elbow injuries.

The clinical lead had been following a research project carried out at a neighbouring emergency department. It showed that outcomes of injuries to ligaments and tendons was much improved if they were seen immediately by a physiotherapist. Funding had been gained for a trial of immediate physiotherapy intervention at the MIU. The physiotherapist would be present for two days a week and patient outcomes would be studied to identify the benefits of the new practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The community inpatients service must ensure records provide sufficient information and detail to enable staff to support patients. Assessment tools must be completed according to guidance and include evidence of escalation where risks were identified. Patients preferences on how their needs are to be met must be sought. Care plans must be developed from assessments, provide guidance to staff on how to consistently meet the identified needs and reviewed to determine the progress made on the action plans and where appropriate adjust the plan.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The community inpatients service must ensure medicine systems are safe. The service must ensure they have assurances that patients have medicines as prescribed. Prescription charts must detail the reasons for not administering medicines. Equipment checks of the resuscitation trolley must be robust.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service must ensure that community inpatients staff attend mandatory training including basic life support, to ensure the safety of patients and their needs are met.