Norfolk and Norwich University Hospitals NHS Foundation Trust

Henderson Unit

Quality Report

Julian Hospital
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Norfolk
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Website:

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Medical care	Good

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care	Good 	Services at the Henderson unit were rated as good overall. Safety was rated as requires improvement , with effective, caring, responsive and well led all rated as good. Onsite medical support was minimal (two days a week) and had the potential of being compromised out of hours. This was an outstanding concern raised during our previous inspection in March 2015, which had been identified as part of the unit action plan, but was not due to be reviewed unitl February 2016. Due to the minimal medical provision on site, medications could be prescribed without a patient review by a clinician. Monitoring of DNACPR and capacity decisions was not robustly monitored and there was limited access to certain additional training opportunities for staff such as phlebotomy training and last offices. Gaps in documentation from governance meetings meant that there was a risk that issues were not being appropriately monitored and progressed and therefore governance arrangements should be reviewed to ensure robust process, documentation and tracking of issues identified Certain items of equipment and the environment required updating. There was a shortage of profiling beds and pressure relieving mattresses. Incidents were reported and learning identified and shared with staff. Staffing levels were appropriate for the acuity of patients and agency use was minimal. There was strong team cohesiveness with all members of the multidisciplinary team having input into patient care. Patients were encouraged and actively involved in their care and discharge plans. There was a full and comprehensive list of scheduled activities to support individual reablement programmes. There were plans underway to convert the large defunct bathroom into a toilet/shower-room and storage areas, although this was in the early stages of planning and funding had not yet been approved.

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Background to Henderson Unit

The Henderson Unit is a 24 bedded health and social care reablement unit to help patients recover after a period of ill health. The unit provides an intermediate facility that provides a direct link to community services. The unit is run in partnership with other statutory authorities and is therapy led.

The unit is based on the Julian Hospital site at Bowthorpe road in Norwich and provides a "stepping stone" service for patients that are medically fit to leave hospital but need further support to return home safely. The unit admits patients over the age of 18 that have been discharged from the Norfolk and Norwich University hospital. Patients are encouraged towards independence through occupational therapy, physiotherapy and the use of daily tasks and activities. Henderson is an intensive model with a maximum two-week length of stay.

This was an unannounced inspection undertaken as part of a comprehensive inspection of Norfolk and Norwich University Hospitals NHS Foundation Trust.

Our inspection team

This inspection was carried out by two Inspection Managers.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

Why we carried out this inspection

We undertook an unannounced inspection on the 25 November 2015 at the Henderson Unit as part of a comprehensive inspection of Norfolk and Norwich University Hospitals NHS Foundation Trust between the 10 and 13 November 2015.

This organisation has two other main locations:

- Norfolk and Norwich University Hospital, a large acute hospital comprising all acute services.
- Cromer Hospital which offers surgical and outpatients' services.

Detailed findings

These were also inspected and have been reported on separately.

The Henderson unit is a 24 bedded reablement service, based at the Julian Hospital Site, that opened in December 2014 as an action to improve capacity and reduce delayed transfers of care at the Norfolk and Norwich University hospital

How we carried out this inspection

During the visit, we observed the environment, spoke with a range of staff at the unit, including nurses, occupational and physiotherapists and administrative and clerical staff.

We talked with patients and observed how people were being cared for, talked with carers and/or relatives and reviewed patients' records of personal care and treatment.

We also reviewed information provided to us by the provider.

Facts and data about Henderson Unit

The Henderson Unit is a 24 bedded health and social care reablement unit to help patients recover after a period of ill health The unit admits patients over the age of 18 that have been discharged from the Norfolk and Norwich University hospital and declared as medically fit but may need some additional support prior to discharge home.

Patients are encouraged towards independence through occupational therapy, physiotherapy and the use of daily tasks and activities. Henderson is an intensive model with a maximum two-week length of stay. Average length of stay being 10 days. Since opening in December 2014 there had been over 500 patients admitted.

At the time of inspection the unit consisted of two six bedded female bays, one six bedded male bay and six side rooms, one with an ensuite bathroom that was used if a patient required isolation if there was a risk from infection . At the time of inspection, there was only one shower and one bathroom functional.

There was commitment from the Norfolk and Norwich University hospitals Trust for ongoing funding for the foreseeable future. Staff had plans to convert one of the larger side rooms into a two-bedded room and for a second studio apartment but this was only at discussion stage and no business case had been developed.

During this inspection, we spoke with six staff, both therapy and nursing staff and seven patients. We observed care and some interactional therapy groups. We reviewed six sets of medical records and reviewed information requested by us and provided from the Trust.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

Medical care

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The Henderson Unit is a 24 bedded health and social care reablement unit to help patients recover after a period of ill health The unit admits patients over the age of 18 that have been discharged from the Norfolk and Norwich University hospital and declared as medically fit but may need some additional support prior to discharge home.

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Summary of findings

Services at the Henderson unit were rated as good overall. Safety was rated as requires improvement , with effective, caring, responsive and well led all rated as good.

Onsite medical support was minimal (two days a week) and had the potential of being compromised out of hours. This was an outstanding concern raised during our previous inspection in March 2015, which had been identified as part of the unit action plan, but was not due to be reviewed unitl February 2016.

Due to the minimal medical provision on site, medications could be prescribed without a patient review by a clinician. Monitoring of DNACPR and capacity decisions was not robustly monitored and there was limited access to certain additional training opportunities for staff such as phlebotomy training and last offices.

Gaps in documentation from governance meetings meant that there was a risk that issues were not being appropriately monitored and progressed and therefore governance arrangements should be reviewed to ensure robust process, documentation and tracking of issues identified

Certain items of equipment and the environment required updating. There was a shortage of profiling beds and pressure relieving mattresses.

Medical care

Incidents were reported and learning identified and shared with staff. Staffing levels were appropriate for the acuity of patients and agency use was minimal. There was strong team cohesiveness with all members of the multidisciplinary team having input into patient care. Patients were encouraged and actively involved in their care and discharge plans. There was a full and comprehensive list of scheduled activities to support individual reablement programmes.

There were plans underway to convert the large defunct bathroom into a toilet/shower-room and storage areas, although this was in the early stages of planning and funding had not yet been approved.

Are medical care services safe?

Requires improvement

Services at the Henderson unit were rated as requires improvement for safe because:

- There was a mix of old and new equipment which could be reviewed and updated. The majority of beds were non-profiling and there was a lack of pressure relieving mattresses.
- Onsite medical support was minimal (two days a week) and though an inpatient service, the unit was reliant on out of hours community medical services overnight and weekends. This was an outstanding concern from our previous inspection in March 2015.
- Due to the minimal medical provision on site, medications could be prescribed without a patient review by a clinician.
- Staffing levels for nursing and therapy staff were appropriate to current patient acuity and there was minimal use of agency however there was no flexibility within the staffing numbers to cover staffing changes or if patient acuity altered.

However:

- There was a process in place to report incidents and learnings were communicated.
- There were infection control processes in place and regular audit to ensure standards were maintained.
- Process for storage and monitoring of medication was in place.
- Patient documentation and record management was good.

Incidents

- A system and process for reporting of incidents was in place. Staff understood the mechanism of reporting incidents, this was confirmed verbally, both at junior and senior level. The incident reporting form was accessible via an electronic online system.Staff stated that they received feedback from incidents.
- There had been 105 incidents reported on the electronic data system between June and November 2015. 46 of these had been categorised as low / minimal harm where patients required minor treatment or additional

observations. The remainder were categorised as no harm. Themes identified were patient falls, which were the majority, medication incidents, staffing and pressure ulcers.
- Learnings were shared across the organisation by organisational wide learning (OWL) alerts. The safer use of insulin alert was displayed in the staff room to provide information to all members of the team.

Safety thermometer

- The quality and safety dashboard data was visible on notice boards in the main corridor. The dashboard data is a tool to provide staff with information to improve quality of patient care. Information includes data such as pressure ulcer occurrence, falls data and infection control.
- Data displayed showed that there had been no hospital acquired pressure ulcers (HAPU) in November, the last one being October 2015 which had been a grade II. The unit does not accept admission of patients that have a pressure ulcer above a grade II. The lack of pressure relieving mattresses had been identified as a risk, this had been discussed at the trust and seven mattresses were due to be identified and provided from the trust to the unit in January 2016.
- Falls data recorded for 2015 showed that there had been 96 falls between January and October 2015, 41 of which had been unwitnessed, 16 witnessed, 19 falls from bed and 20 assisted falls.

Cleanliness, infection control and hygiene

- The Henderson unit patient areas were visibly clean and uncluttered. “I am clean” stickers were visible on equipment, such as Zimmer frames, step block and physiotherapy plinth, to indicate that equipment was clean and prepared ready for patient use.
- There was a record in place to flush the water system by running taps daily in non-functioning rooms in order to reduce the risk of **Legionella** bacteria.
- Staff adhered to trust policies and guidance on the use of personal protective equipment (PPE), and to 'bare below the elbow' guidance, to help prevent the spread of infection. There was adequate provision of gloves, aprons and visors throughout.
- Staff ensured hand hygiene occurred between patient contact. Data displayed on the main corridor notice board, stated that compliance from the recent hand hygiene audit was 100%.
- The commode and bedpan audit for September and October 2015 showed that compliance was 100%.

Environment and equipment

- There was adequate space around each bed area in the six-bedded bays to allow patient movement safely. There was a large lounge area that was utilised for group activities and patio doors gave access to an outside space consisting of a patio area and garden.
- There was a range of old and new equipment. There were only five profiling beds and 19 non-profiling beds which meant that the majority of beds were not equipped to allow patients to easily alter their position.
- There was a range of mobility supporting equipment and therapy aides available for patients to utilise.
- The majority of equipment had electrical testing stickers indicating that PAT testing had taken place and were in date. The microwave in the therapy kitchen was blank; this was brought to the attention of staff to ensure testing took place prior to the next use.
- There was a lack of pressure relieving mattresses that had been reported as a risk on the risk register. There were repose mattresses available to help mitigate the risk to patients and actions were in place to resolve this issue by January 2016.
- A process for monitoring and recording the temperature of the food fridges within the therapy kitchen were in place however, there was no indication of the acceptable parameters of temperature and staff were not aware of this detail to ensure appropriate temperatures were maintained.
- There were plans in place to convert the large defunct bathroom into a toilet/shower-room and storage areas. This had been included on the unit action plan and quotes were in the process of being obtained prior to submission to senior management for funding
- The emergency defibrillator was in date for electrical testing.

Medicines

- Certain medications are required to be stored within specific temperatures to maintain their integrity. Drug fridges temperatures were monitored and recorded daily. Information recorded at time of inspection indicated temperatures had remained within acceptable limits.

Medical care

- The ambient room temperature in the clinic room where medications were stored was also monored and recorded to ensure optimum conditions were maintained.
- Dressings and medications were stored appropriately and securely to maintain patient safety. The clinic room door was kept locked and was only accessed by staff.
- Medications reviewed were within their expiry date and therefore safe for patient use.
- We reviewed three medication charts and these were completed appropriately, there were no missed does and allergies were clearly noted.
- Staff contacted medical staff via the bleep system for medication and prescription requests that occurred when there was no doctor on site. The prescription request would then be forwarded to the pharmacy department and the drugs sent over to the unit once prepared. This meant that decisions for medications occurred following a verbal handover and without the patient being seen by a doctor which could increase the risk to patient safety due to an incomplete assessment of clinical condition.

Records

- There was a system in place of coloured stickers to denote the role of the staff member writing in the notes. For example, the registered nurses, occupational therapists, physiotherapists and medical staff used a different colour. This meant that tracking under specialty was easy to do and there was clarity to the person recording the entry.
- We reviewed six sets of medical records. Entries were legible and accurate. Records were fully completed and included a full triage assessment completed prior to admission that identified any potential concerns, discharge letter from the trust, entries from all of the multidisciplinary team and daily living and occupational therapy activity assessment.
- There were regular audits of documentation to monitor standards of completion. Evidence recorded in the November 2015 governance meeting minutes showed that six records had been audited, four were 80% complete and two were 100% complete.
- During the daily multidisciplinary team (MDT) meeting the door was closed to ensure patient confidentiality during discussions. There was a confidential waste bin available in the MDT meeting room to allow appropriate disposal of confidential waste.

Assessing and responding to patient risk

- When a patient became unwell, staff stated that they would call 999 and the patient would be transferred to the Norfolk and Norwich University hospital. Incident forms were not completed when patients were transferred back to Staff stated that incident forms were completed for anything outside process, however transfer was within process, which meant that these were not incident reported.
- Concern regarding the level of medical cover had been included in our previous report following inspection in March 2015. Medical provision, consisting of two vists per week, remained the same and therefore we had continued concerns that this level of medical provision may not be sufficient to ensure timely review of patients with complex rehabilitation needs. This had been identified as part of the unit action plan but was not due to be reviewed unitl February 2016.
- To reduce the risk of inappropriate admission there was a clear exclusion criteria outlined. Included in this were patients with complex wound care, complex medical needs, bariatric and end of life care. This meant that there was management to reduce the admission of those patients with conditions that were likely to deteriorate.

Nursing staffing

- The current staffing establishment consisted of three physiotherapists, three occupational therapists and 11 registered nurses and healthcare assistants.
- The unit was not staffed to full establishment. At the time of inspection there was 1.8 whole time equivalent (WTE) vacancies and with one staff member leaving this was due to increase to 2.8 by the end of January 2016. There was a rolling recruitment advertisement in place.
- Normal staffing numbers were two registered nurses per shift and two health care assistants for 24 patients. Bank staff were utilised to ensure this level was maintained however there were occasions when issues arose due to bank staff not attending for a booked shift.
- The level of nursing agency usage was minimal at 17% for the sixth month period up to inspection (June-November 2015). Staffing rota showed that on average there were seven or eight bank shifts booked a month.

Medical staffing

Medical care

- An Associate Specialist in Older Peoples Medicine (OPM) provided medical cover to the unit twice a week, on Tuesday and Fridays. At these visits, any patients that the team were concerned about or any patient that had asked to see the doctor would be reviewed. Cover for annual leave was provided by a registrar.
- Between the hours of 8am and 5 pm, advice can be sought from the same associate specialist or staff would contact the OPM clinical director. Medical cover was provided by a bleep system from the Norfolk and Norwich University hospital. Outside of these hours, i.e. evening, overnight and at weekends, staff contact the GP out of hour's service. There had been occasions on bank holidays and weekends where GP had not responded to a call out request.
- Medical support can be compromised at times due to medical staffing vacancies at the trust. There was an incident at the weekend following a patient death where no doctor was available to attend to certify the body. Practice standard should be that certification take place within four hours. Medical cover review was noted on the units action plan to be undertaken by February 2016.

Are medical care services effective?

Good

Effectiveness of services were rated as good because:

- There was an active local audit programme to ensure continuing improvement.
- Patient outcomes reflected that 88% of patients were discharged home, and only 7% were readmitted to the Trust.
- Average length of stay was 10.5 days.
- There was a cohesive multidisciplinary team and daily review of patients.

However:

- Monitoring of DNACPR and capacity decisions was not robustly monitored.
- There was limited access to certain additional training opportunities.

Evidence-based care and treatment

- Local audit activity to ensure best practice was evident. Audits included documentation, infection prevention and control, cleaning and hand hygiene audits. The Henderson unit audit results were also reviewed as part of the Quality Assurance Audit Programme at the Trust.
- Actions had been identified from the October hand hygiene audit (results were 90%) with recommended actions and a re-audit date planned. This had been effective as audit results on 2 November 2015 showed improvement and were 100%

Nutrition and hydration

- There was a large dining room area and patients were encouraged to walk down to the dining area at meal times. Tables and chairs were arranged in a dining room fashion to seat four people at each to enable interactions and create a homely setting. There were two sittings for meals to ensure patients could be seated safely.
- Breakfast was organised by placing a selection of cereals on a sideboard and patients were encouraged to select and carry their items to the table if appropriate, similar to a bed and breakfast scenario.
- There were two caters on site that prepared the meals and involved patients in choosing the menu.
- There was a large white board in the dining area and a sticker system in place to indicate patients with specific dietary needs. A red sticker indicated those patients that required assistance with feeding, FC indicated a food chart was in use and DD diabetic diet. This meant that staff were all aware of specific patients' needs.
- There was a therapy kitchen that was used to undertake patient assessment prior to discharge

Patient outcomes

- Information provided from the Henderson unit data report, February to December 2015, showed that 89% bed occupancy had been achieved. Average length of stay had been 10.5 days.
- Out of 592 discharges, 360 (60%) had occurred before 11am. 521 patients were discharged home (88%), 23 (3%) had placement with ongoing care and 43 (7%) were readmitted to the trust.
- 174 patients (29%) received home based therapy support services following discharge, 8 (1%) received private care but the majority, 410 patients (69%) were discharged requiring no ongoing care with support from family members.

Medical care

Competent staff

- Regular training was organised by the unit manager for staff to updated skills. There was a schedule for training in October and November 2015 for the following topics: dementia training falls training, mental capacity act and deprivation of liberty training.
- There was a practice educator link nurse in place on site to support staff.
- However, the manager stated that there was an ongoing struggle to obtain access to certain training such as last offices training for the staff.
- Staff stated that they received an induction on joining the unit and that they were kept up to date through regular staff meetings; however, there were some delays with availability of certain additional training. One member of the team was awaiting phlebotomy training and was not certain when this might occur.
- At the time of inspection, all staff had received an appraisal or had the date booked for this to be completed.

Multidisciplinary working

- The therapy staff, physiotherapist and occupational therapists worked closely with the nursing and medical staff. A multidisciplinary meeting took place daily, at 11am, with all staff contributing to the update of patient care.
- There were five volunteers that worked alongside the nursing and therapy teams and provided assistance with patient activities, such as manicures and hand massage.
- Staff from social services had an office on the unit and were involved and included with patient care packages and discharge plans.

Access to information

- On discharge from the unit, patient information was provided to the patients' general practitioner (GP) to ensure continuity of care. This clinical letter is sent electronically, to GPs, to update them on a patients progress and included details of remaining issues and changes to medications.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a lack of support to the unit in relation to patients with mental health and dementia. Support to the trust from local mental health teams and the dementia intensive support team could be delayed and caused frustration to staff and increased the risk to patient safety.
- Recording of "do not attempt cardiopulmonary resuscitation order (DNACPR) was not consistent and was not robustly monitored. In one of the six records reviewed, there was a record of DNACPR recorded in the transfer of care record however there was no form in place. We raised this with the unit manager and were informed that this had been raised at the multidisciplinary team meeting the week before and noted for the doctor to review on the Tuesday, however this had not taken place and was still pending. This meant that there was a risk that appropriate actions might not be undertaken should the patient arrest.

Are medical care services caring?

Good

Services at the Henderson unit were rated as good for caring because:

- Patients were treated with dignity and respect
- Patients and relatives were positively encouraged to participate in therapy activities.
- Patients and relatives were included in decision of care and discharge planning

Compassionate care

- Friends and family data results in October 2015 were 100%. The unit had a service user feedback questionnaire that patients were encouraged to complete to provide information for staff. Response was varied results for September showed that only eight completed cards were completed and 63% patient satisfaction was achieved.
- Patients were overwhelmingly positive about the staff and environment in the unit. One patient stated, "staff are so helpful and attentive although I can't wait to go home". Another patient said " I could stay here forever, the food is excellent and so are the staff although they make us work hard"

Medical care

- There were positive interactions observed between staff and patients. There was a clear level of rapport and use of humour to promote conversation with positive, appropriate body language.
- Patients in side rooms were easily visible to staff for safety and monitoring purposes but there were also curtains fitted to enable privacy.

Understanding and involvement of patients and those close to them

- During group activities, each individual was referred to by name and the activity was altered to the needs and abilities of the individual. For example one armchair exercise involved a beach ball being thrown to a patient and the patient returning the ball to the member of staff. Those that required upper body exercises did this by a catch and throw method, those that required lower limb exercises did so by kicking the ball. There were nine participants in this activity and all were smiling, clapping and actively interacting.
- Another group activity that was observed was a quiz that provided mental stimulation to those participating.
- There was a patient being discharged during the inspection. Staff were attentive and provided plenty of information. The staff reiterated what was going to happen when the patient went home and provided contact numbers to them for the support services.
- Another patient confirmed that they also had been fully informed and involved with their discharge plans.
- Consideration of family members, for example a spouses confidence to cope when their husband / wife came home, was included in discussions at the MDT meetings to ensure that support and ongoing concerns were included as part of discharge planning.
- There was a poster to identify the coloured uniforms and denominations of staff, on the main corridor notice board, to allow relatives to easily identify different members of the team.

Emotional support

- A Chaplaincy service was in place via weekly visits, by a chaplain, to the unit to provide emotional support to any patients, or staff that may benefit from this. Outside of the scheduled visits staff could contact the service at any time should the need arise. Staff were aware of the process and numbers to call to do so.

Are medical care services responsive?

Good

Responsiveness of services were rated as good because:

- There was a clear criteria for admission inclusion and exclusion
- There was a clear process for discharge planning, initiated in the first 24 hours of admission. With support and information for the patient throughout.
- Activities were organised to ensure patient involvement and encourage participation and socialisation as well as clinical need.
- There was a proactive approach to learning from complaints

Service planning and delivery to meet the needs of local people

- The Henderson unit is a 24 bedded reablement service, supported by multiagencies, that opened in December 2014 as an action to improve capacity by reducing the number of delayed transfers of care at the Norfolk and Norwich University hospital. The aim of the unit is to help patients recover after a period of ill health. The unit provides an intermediate facility that provides a direct link to community services.
- There was a clear admission criteria document in place that outlined both inclusion and exclusion criteria for reference when considering referral for admission. This meant that patients with the appropriate acuity level should be admitted. It was noted that this document did not include a footer denoting author, date or review date.

Access and flow

- The unit was intended to be an intense therapy unit with the maximum stay of two weeks. The average length of staff was ten days. However, there was on occasion exception to this timeframe. At the time of inspection, one patient had been on the unit since August 2015.
- Since opening in December 2014, the unit had admitted over 500 patients. On average 7% of patients were readmitted to the Trust from the unit. This information was monitored and tracked on a database to allow senior staff to identify themes to help reduce the risk.

- On discharge, staff provided information to patients regarding available groups and activities that may be local to continue an interest they may have had during admission. This meant that patients that had enjoyed socialisation and being involved in a group activity were helped to maintain this post discharge which helped reduce the risk of self-neglect
- The discharge co-ordinator worked four days out of seven and enabled direct contact with the community services to promote timely discharge. They provided assistance with all aspects of discharge such as transport, heating and non-clinical liaison with families. Discharge was aimed before 11am to allow beds to be vacant in a timely manner for other admissions within daytime hours.
- The discharge process was set within 24hours of patient admission, and included two days planning, checking of transport and arrangement of medication to take home the day before discharge.
- Status of care for each patient and discharge plans were discussed at the daily multidisciplinary meeting. There was a RAG rating (red, amber, green) given for medication and mobility aspects of care. An electronic white board was used to update a patient's progress and care plans were updated during the meeting.

Meeting people's individual needs

- There was a range of activities organised to encourage participation and socialisation of patients to help prepare them for discharge. The activities were timetabled and included seated exercises, mental agility quiz, and bingo. Knitting and yarn crafts, art, hand massage and a nail bar.
- Clocks within the unit had a therapy focus. The clock in the dining room was large to enable patients with some visual impairment to be able to read it and had the date included to encourage cognitive awareness.
- The large communal area had a range of chairs to accommodate for the varying needs of patients. This include chairs with varying seat heights to encourage patient's own mobility and reduce the risk of dislocation following total hip replacement.

Learning from complaints and concerns

- Communication of complaints was via discussion at the unit meeting and information placed in the communication file in the staff room. The last complaint, prior to our inspection in November, was In June 2015, from a relative and involved discharge without a care package however the package had been refused by the patient.
- One family had raised concerns regarding patient assessment for discharge and had felt that the questions and assessment had taken place to early. Staff had reflected as a group how the assessment questions were undertaken and the family were invited to join in a patient and public involvement forum in order for learnings to continue.
- The notice board in the main corridor displayed examples of "you said, we did". An example was provided of incontinence pads being provided on discharge, once this had been highlighted.

Are medical care services well-led?

Good

Services were rated as good for well led because:

- Staff were aware of the vision and values for the service.
- There was good local leadership and all staff felt supported and involved.
- The unit manager was aware of current risks which were included on the trust risk register
- There was active communication between all memebrs of the multidiscipilanry team
- There was support in place from the trust with weekly meetings from the divisional operational manager

However:

- Gaps in documentation from governance meetings meant that there was a risk that issues were not being appropriately monitored and progressed.

Vision and strategy for this service

- Staff were aware of the Trusts vision and values. There were posters displayed on the wall of the staff room that stated the vision of the trust to provide every patient with the care we want for those we love the most and the values of the trust which were PRIDE (people focused, respect, integrity, dedication and excellence).

Governance, risk management and quality measurement

- There was a local governance structure in place which consisted of monthly operational meetings. Information provided indicated that the format of these meetings had changed. In June and July 2015, the operational meeting minutes were headlines of topics discussed only with no individual actions identified or review of previous meeting points.
- From August 2015 to November 2015, the minutes were recorded using the trust template for Directorate & Divisional Governance Meetings. This format included sections for safety issues, clinical and non-clinical, patient experience, capacity, information governance, workforce, complaints and quality performance measures. It also allowed for recording of matters arising and action points from previous meetings however, these section were all blank which meant that we could not be assured that issues were appropriately monitored and progressed in a timely manner.
- The unit manager could identify current risks, the top two being lack of pressure relieving mattresses and staffing. Risks were reported centrally via a risk report for inclusion on the trust risk register. The lack of mattresses was reported on 6th November 2015 with actions identified to lower the risk.
- Staff had pocket cards that contained information about basic processes such as actions to follow should a patient fall. Staff felt this was helpful and gave immediate information. It had been discussed that this innovation may be adapted and utilised at the trust.
- The level of medical cover for the unit had been identified during our inspection In March 2015. Despite being on the unit action plan it was not due for review until February 2016 which meant that the response from the Trust to risks identified was not managed in a timely manner. It was not clearly identified how the unit governance structure and meetings fed into the Trust governance structure.

Leadership of service

- Leadership at the unit was supportive and the manager was visible. The manager undertook one night shift each month to participate, support staff and maintain clinical competence.
- Staff said they felt included and worked as part of the team. This included the administration and catering staff. Email communications and notice boards in the staff room were used to keep staff updated.
- There were staff monthly unit meetings, the minutes of which were available in a folder in the staff room for staff to review. Between March and November 2015, the only month where the meeting had not taken place was April.
- There was the potential of isolation and support issues initially when the unit opened hindered by the off-site location however, these had improved. The unit was visited by the operational manager weekly.
- There was a monthly meeting and supervision in place for the manager of the unit. This took place at the Norfolk and Norwich university hospital and meant that there was a regular opportunity for sharing of information and updates from the Trust. The manager had also attended a viewpoint meeting held by the Chief Executive to be updated on changes within the Trust.

Culture within the service

- Staff were all very positive about working within the unit. They felt supported and included in the care provided. One staff member stated that they enjoyed the additional time that they could spend with the patient, which was in contrast to their previous experience at the Trust.
- All staff felt confident in being able to raise a concern or complaint without fear of retribution. They stated that the manager provided time with staff and would listen to ideas. Regular monthly unit meeting took place to provide a route for communication.

Public and Staff engagement

- The unit had initiated a twice-yearly patient and public involvement forum meeting and the next meeting was scheduled for 15 January 2016. There were plans in place to instigate an External Public Auditor Programme. An initial visit had taken place from individuals within the Patient Experience Working Group with the next steps to develop the programme and goals for this.
- The unit produced weekly communication circulars that included general news, clinical news, events, training and education and a topic for staff to have their say. Quarterly staff surveys had taken place since the unit had opened and from September 2015, this was to become monthly to capture recent information.

Medical care

- The unit, as part of the Norfolk and Norwich University Hospitals NHS Foundation Trust was participating in the National Staff Survey to gain feedback from staff. The closing date for 2015 was 26th November and therefore results were pending. However, learning would be restricted as this survey did not allow individual areas to be identified and therefore would be limited in its use to the unit itself.

Outstanding practice and areas for improvement

Outstanding practice

- Multidisciplinary working and communication between all staff to ensure complete and holistic care for each patient.

Areas for improvement

Action the hospital SHOULD take to improve

- Review governance arrangements and ensure documentation and tracking of issues identified.
- Review medical cover for the unit out of hours and weekends to ensure clear process and safe practice.
- Ensure a robust process for ensuring DNACPR and capacity assessments is in place.
- Review staff training and availability to additional training requirements such as phlebotomy and last offices.