

Sussex Community NHS Trust

RDR

Community health inpatient services

Quality Report

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This report describes our judgement of the quality of care provided within this core service by Sussex Community NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Sussex Community NHS Trust and these are brought together to inform our overall judgement of Sussex Community NHS Trust

Summary of findings

Ratings

Overall rating for Community health inpatient services

Good



Are Community health inpatient services safe?

Requires Improvement



Are Community health inpatient services effective?

Good



Are Community health inpatient services caring?

Good



Are Community health inpatient services responsive?

Good



Are Community health inpatient services well-led?

Good



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	4
Background to the service	6
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	6
What people who use the provider say	7
Good practice	7
Areas for improvement	7

Detailed findings from this inspection

Findings by our five questions	9
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Summary of findings

Overall summary

The trust has nine hospitals providing community inpatient services and during our inspection we visited seven of these services. To help us understand and judge the quality of care in the hospitals we used a variety of methods to gather evidence. We observed care and the environment and looked at records, including patient care records. We attended staff handover meetings, multidisciplinary meetings and looked at a wide range of documents, including audit results, action plans, policies, and management information reports. We spoke with approximately 59 patients and five relatives. We spoke with in excess of 60 staff including operational managers, ward sisters, matrons, doctors, staff nurses, nurses, healthcare assistants, facilities staff, chaplains, volunteers, therapists and support staff.

Overall we judged community in-patient services to be effective, caring, responsive and well led. However, we considered that some elements of safety required improvement.

We found that some aspects of medicine management needed improvement, however patients received their medicines safely when they were prescribed.

Patient records generally contained the information required to ensure safe levels of patient care although they were not consistent across all hospitals and not easy to navigate. We had concerns that care support plans were of a generic nature and did not reflect, evaluate or sufficiently record the needs and treatment of individuals. Therefore, this meant that information was not easily accessible for staff to maintain appropriate levels of care to individual patients. We found that confidential patient nursing records were not stored securely in some ward areas. Forms concerning information relating to patient's wishes regarding resuscitation were not always completed correctly.

The inpatient facilities were clean and well maintained and staff recognised and practiced infection control procedures. There were adequate numbers of suitably qualified and experienced staff to meet patients' needs and to keep them safe with the exception of therapy staff.

This meant that in some hospitals patients were waiting longer for therapeutic interventions to aid their rehabilitation. In some instances this resulted in cancelled therapy sessions and delayed discharges.

We found that opportunities for ensuring that hospital environments were suitable for people living with dementia had not been instigated and some therapy rehabilitation facilities were not conducive for the rehabilitation of bariatric patients particularly at The Kleinwort Centre.

Robust systems for assessing and mitigating risks were in place and when incidents did occur there was evidence to show that staff understood how to report them. We saw that incidents were appropriately investigated with changes made to practice to reflect lessons learnt, both at local level and across the trust.

Patients received care that followed the latest published guidance and best practice with outcomes that were generally in line with national averages. Patients received adequate pain relief, although we were unable to see that there was a universal use of pain management assessment tools. Patients were supported to eat and drink suitable food in sufficient quantities and in line with their dietary and cultural preferences.

Staff received adequate training to safely undertake their roles and participated in performance appraisals. Patients received their care from a multi-disciplinary team who worked cohesively to deliver the best care to meet their needs.

Patients were positive about their care experience and told us they received compassionate care that respected their privacy and dignity and we observed care being delivered in a kind and respectful way. Patients told us they felt involved in decision making about their care. Where patients lacked capacity to make decisions for themselves, staff acted in accordance with legal requirements.

The geographical locations of the hospitals was well placed to meet the diverse needs of patients and was

Summary of findings

committed to providing care as close to patients homes as possible. The environment in all of the inpatient hospitals would benefit from being made more dementia friendly.

Admissions to the inpatient service were generally well managed to minimise risk to patients and to maximise the rehabilitation experience. Discharge from the service was well planned and co-ordinated to ensure that the needs of patients would continue to be met.

There was a shared vision and philosophy of care in the service with a strong rehabilitate ethos and we observed a caring and positive culture. Staff expressed confidence in their leaders, who were visible and said they felt supported to do their job well. All staff were aware of the trust vision and strove to demonstrate this through their daily work and there were arrangements to ensure they were engaged in the running and development of the service.

Summary of findings

Background to the service

Sussex Community Trust provides community in-patient services in nine locations throughout the county of West Sussex. These are Crawley Hospital, Horsham Hospital, Bognor War Memorial Hospital, Arundel Hospital, Zachary Merton Hospital, The Kleinwort Centre, Midhurst Community Hospital, Salvington Lodge and Chailey Heritage Clinical Services. Inpatient services provided vary from location to location but include intermediate care, palliative care and rehabilitation. The regulated activities carried out across the hospitals are diagnostic and screening procedures and treatment of diseases and

disorder and injury. In some locations the additional regulated activities of surgical procedures and accommodation for persons requiring nursing care are carried on. Patients are admitted to community in-patient services from their own homes or from acute hospitals. At Bognor Hospital care is consultant led, at Midhurst Salvington, Arundel, and Zachary Merton Centre are medically led by local GPs and Crawley Hospital, Horsham Hospital and Kleinwort Centre are medically led by GPs employed by Sussex Community Trust.

Our inspection team

Our inspection team was led by:

Chair: Frank Sims, Chief Executive, Hounslow and Richmond Community NHS Trust

Team Leader: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists: including, a director of nursing, a school nurse, a GP, district nurses, palliative care nurse specialist, physiotherapists, a dentist, a health visitor and 3 people with experience of using services or caring for someone using services

Why we carried out this inspection

We inspected this provider as part of our comprehensive community health services inspection programme.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 8th and 11th of December 2014. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists and administration staff. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who

use services. We met with people who use services and carers, who shared their views and experiences of the services. We carried out an unannounced visit on 21st December 2014.'

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

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

Summary of findings

What people who use the provider say

- “Amazing staff, amazing care” and . “Thank you to all the staff for just going the extra mile”.
- “After many re-organisations, the Trust mission is at last wonderfully simple – it reflects what we have always tried to do anyway”.
- “after five years of being in an out of hospitals no one has ever asked me what I would like to eat – marvellous”.
- “I don’t mind if they call me face ache, as long as they are kind!”
- “Staff work very hard to make sure the ward is clean, this hospital has a high standard of cleanliness”. Another reported “Everywhere is beautifully clean”.
- “staff work very hard to keep it spotless”.
- “I wouldn’t be where I am now without the nurses and healthcare assistants helping with my goals”.
- “The staff are wonderful I am being thoroughly spoilt and they are just being so very kind to me”.
- “Now that’s what you call caring”.
- “Nothing is too much trouble”
- “If I ring for assistance they come very quickly”
- “The staff are the hospitals greatest strength”
- “The quality of staff is wonderful, The ward is excellently run”
- I’ve spent 54 years across the UK and never seen this type of care anywhere like it is here- everyone cares”.

Good practice

Our inspection team highlighted the following areas of good practice:

- At Arundel Hospital we saw how a wall sized patient journey board had been designed reflecting all aspects of the patient journey and care needs. We saw how all members of the multi-disciplinary team used the board to ensure that the most up to date information was displayed. Staff told us that it was a ‘great aid’ to making sure all staff were aware of each individual’s health status and care requirements. We saw how following a handover meeting this board was again updated.
- We found an exemplary example of good practice at Arundel Hospital with a “Major Incident Box” which was stored in a prominent position within the staff room and contained everything staff would require to manage an incident. The Ward Manager told us that this had been developed with the involvement of all levels of staff.
- A proportion of mandatory training was moving towards e Learning modules. Some older staff expressed concern they did not have the information technology (IT) skills to make the most of this opportunity. However, at Arundel hospital we were given examples of how individuals had been supported to undertake e learning in a group environment, affording them support and opportunities to discuss the learning further. Staff commented that this not only helped them but made the training more participative and fun.

Areas for improvement

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

The Trust should take action to review record keeping and ensure that all records are well maintained, up to date and personalised to meet patients’ needs

The Trust should undertake an audit of medicines administration and documents relating to this to ensure that patients receive the correct medicines at the correct time.

Summary of findings

The Trust should review its processes for pain assessment and evaluation.

The Trust should ensure that all appropriate staff have access to and attend dementia training.

Sussex Community NHS Trust

Community health inpatient services

Detailed findings from this inspection

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

Requires Improvement



Are Community health inpatient services safe?

By safe, we mean that people are protected from abuse

Incident reporting, learning and improvement

- During the period 12th March 2013 to 12th September 2014, there were 19 serious incidents reported in the Trust.
- More than a third of the serious incidents reported (42.1%) were for fractures. The Trust also reported four incidents of infectious disease. These related to an admitted patient reporting that they had swine flu, a suspected influenza outbreak on Don Baines Ward at Bognor Hospital, a Patient transferred from the acute Trust to Crawley Hospital with Group A Streptococcus, and a patient who had been diagnosed with C-Difficile on Ferring Ward at Salvington Lodge.
- Trust policy stated that incidents should be reported through a commercial software system that enabled incident reports to be submitted from wards and departments. We saw a breakdown of incidents by category and date that allowed trends to be identified and action taken to address any concerns.
- Staff completed an incident form which once submitted went to their line manager who reviewed the incident and reported on the actions that they had taken to mitigate a reoccurrence of the incident. Once submitted by the manager the incident was then reviewed by the Hospital Matron who also added any actions that they had taken with respect to the incident. The feedback section of the form was then filled in and any local learning taken as a result of the incident would be fed back to staff.
- We were shown that staff would receive an email following the reporting of an incident which told them about any actions that had been taken as a result of them reporting the incident. Ward managers would also talk to staff members to ensure that they communicated any actions or learning from the incident to the individual.
- We saw that root cause analysis (RCA) investigations were performed for serious incidents. We looked at examples of these investigations and saw they were

comprehensive and detailed with associated action plans. We followed up on an RCA action plan and found that the action plans had been implemented and found that staff were made aware of the incident and the associated learning. For example, On Caravelle Ward at Crawley Hospital we were given an example of learning following a patient fall. The fall had occurred whilst the patient was in the X-Ray department. As a result of the incident the Trust put in place an escort policy, and improvements were made to the 'Falls Bundle' documentation.

- All four Band six sisters on the Horizon Unit had attended regular 'Safety Express' meetings with the patient safety team. During these meetings they discussed incidents that had occurred and ways to mitigate further occurrences of these incidents. In recent meetings they had concentrated on falls, pressure injuries, and medication errors. Two of these sisters had also attended patient safety and risk management training.
- On the Horizon Unit we saw that incident record numbers were recorded in patients care plans to ensure that staff had an easy reference system to incidents that had occurred.
- The North of the region (Horsham Hospital, Kleinwort and Crawley Hospital) met monthly for a Sisters meeting. During this meeting incidents would be discussed and the Sisters would share any learning from incidents which would be disseminated to staff.
- Staff told us they now had a system in place to ensure they received feedback when they reported an incident. We looked at minutes of staff meetings and noted that there was a standing agenda item where reported incidents and their outcomes were discussed with ward based teams. We saw initiatives that had been introduced in many of the hospitals including pictorial signs above patient beds showing their levels of mobility. At Kleinwort we saw that staff had identified falls as a concern and had formulated an action group, introduced night care charts, purchased new assistive technology for beds and chairs and involved therapy staff in working night shifts. They described how this had reduced the number of falls and how this was an ongoing project involving all members of the staff team.
- Managers told us that they received regular reports of incidents and this enabled them to identify themes and trends and take corrective actions accordingly.

Safeguarding

- Staff received training in protecting vulnerable people which was part of the mandatory training programme. Training rates for adult safeguarding across hospitals was 37.38% with The Horizon unit at 68.09% and the lowest at Midhurst Hospital with 16.67%.
- Staff we spoke with were aware of the principles of safeguarding and we saw safeguarding policies agreed with the local authorities were available for staff to reference.
- Temporary staff including agency staff were made aware of safeguarding procedures as part of their familiarisation and induction to the ward. Staff we spoke with demonstrated an understanding of the principles of safeguarding and could describe the steps they would take if they had concerns or suspected abuse. We saw that information including contact numbers to report concerns was prominently displayed in ward areas. The trust had dedicated safeguarding leads and staff knew who these were. This meant staff were aware of their responsibilities in relation the safeguarding of adults at risk.
- Staff described safeguarding referrals they had made and showed that they had been engaged in the procedures. We were given examples of safeguarding referrals and the sequence of events that followed to ensure people were protected from abuse. Social care staff we spoke with praised the engagement of community in-patient service staff in safeguarding procedures. This demonstrated that staff worked collaboratively with social care colleagues to protect people at risk of abuse.
- Patients we spoke with told us they felt safe.
- The trust whistleblowing policy with associated procedures was available for staff displayed on staff notice boards and on the trust intranet. Staff told us they were aware of the procedures and comfortable about raising any issues or concerns.

Medicines management

- Overall we found that there were adequate systems in place for the safe supply, storage, administration and disposal of patients' medications, although we found some issues that required improvement.
- Community in-patients were served by a pharmacy service with registered pharmacy services and pharmacy technicians visiting the hospitals and wards.

Records were available to confirm that pharmacy technicians visited at least weekly to ensure that stock levels were maintained and provided advice regarding medicines management to both staff and patients. Registered pharmacists also visited the wards and provided a clinical pharmacy service that ensured patients' medicines use was optimised. This meant that community in-patient services had access to a comprehensive pharmacy service.

- We saw that generally the supply of medications was prompt but that staff reported issues with obtaining pharmacy supplies from St. Richards. A member of staff told us "If they don't have something in stock that we ordered they will forget to send it when it is in stock so we have to consistently chase them which is very time consuming".
- We saw drug charts that showed medicines given were generally signed for. However, we found incidents on both wards at Bognor where medication charts had not been signed to indicate medicine had been administered. An example was that on one ward there had been nine unsigned boxes received in November, 2014. We asked the Ward Manager if this had been reported as an incident and were told that it had not as they would usually check the charts and then speak to staff immediately. This meant that there was no robust audit trail of missed medication.
- Medicines were stored securely in locked cabinets or trolleys. We tested medicine cabinets and trolleys on all wards during our inspection and found them to be locked. We found that prescription pads were stored within locked cabinets and that access to all medication keys was controlled by the nurse in charge.
- We found that where medications were stored the ambient temperature was checked. Medicines that required it were stored in designated refrigerators which were locked with the temperatures checked and recorded appropriately. This meant that patients' medications were stored at the correct temperatures to avoid deterioration that would affect their effectiveness.
- We observed nurses administering medication and found that they complied with "Standards for medicines management" issued by the Nursing and Midwifery Council (NMC).
- We saw that information was available for patients regarding their medications. Patients told us that nursing staff and the pharmacist were always happy to explain what medications were for.
- There were systems to prevent patients being given medicines to which they were allergic. Allergies were recorded on treatment charts. We saw there was a system of identifying stickers identifying product allergies such as gluten.
- We observed that oxygen was prescribed, in line with the NPSA/2009/RRR006 for when it was required by patients.
- Throughout our inspection we found discrepancies in the majority of patients' medication charts that we viewed. For example at Salvington Lodge we looked at three patient medication charts and found two with unaccounted missed doses. At Kleinwort we reviewed four medication charts and found all had omissions. One of the omissions related to a critical medicine as defined by "NPSA/2010/RRR009: Reducing harm from omitted and delayed medicines in hospital". We found that the relevant sections on the medicine charts had not been signed and there was no indication why the medicines had not been given. At Arundel Hospital four medication charts were checked with significant omissions, one with 13 instances and the other with 15 omissions, two of which were warfarin, another critical medicine. At each location we brought this to the attention of the Ward Managers and Matrons. It was unclear if either of these incidents had been reported. This meant there was no record to demonstrate why a patients' medicine was not given as prescribed.
- There was an event reported at Bognor War Memorial Hospital concerning drug administration. This concerned a diabetic patient who was given additional insulin. We saw how the incident had been recorded, managed and how staff competency training had been undertaken with learning disseminated to staff at ward/team meetings.
- We observed that there were adequate arrangements for the disposal of unused or unwanted medicines. Medicines for disposal were stored in designated bins with distinctive lids while awaiting collection by the relevant waste contractor. Staff were able to describe the system they would follow and the records required to record disposal information.
- We found that the ordering and storage of controlled drugs met with legal requirements. We sampled controlled drug registers and found there were no stock discrepancies. Controlled Drugs (CD's) are medicines which are subject to additional controls as they are liable to be mis-used. We saw that the ordering and

delivery systems for CD's met legal requirements, that the registers were accurately maintained and that CD's were stored appropriately with balances being regularly checked and recorded. Unwanted CD's were destroyed with a member of pharmacy staff using de-naturing kits which we saw available.

- The Medicines Management Team had completed a medications audit during one visit to each inpatient unit during the audit period September to November. The audit data was collected from a sample of 10 Medicine charts in each unit. The first 10 Medicine charts seen which had been in use for at least five days and had at least five regular items prescribed. At Horsham Hospital where results were displayed on information board the audit showed that the medication charts had been 100% accurate in the recording of 'as required' medication (PRN) and patients who had a correctly filled in name band in situ. The audit results were separated into the three ward areas and some areas had received lower audit scores than others. For example, blank boxes being left on medication charts where one ward area scored 90%, one 50% and one 40%.
- A new Sussex Community prescription and administration chart was introduced to all bedded units at the end of 2013. As a part of this process 61 doctors, nurses, and pharmacy staff were trained on the use of the chart and also the prescribing standards for inpatient prescription charts.

Safety of equipment

- We found that in each of the in-patient ward areas emergency equipment was located and was easily accessible to staff and ready for use. This included items such as defibrillators and emergency medicines. We saw completed checklists that demonstrated this equipment was checked daily to ensure that it remained ready for immediate use. Staff told us they felt competent and confident to use the equipment available in the community hospitals.
- Patient Led Assessments of the Clinical Environment (PLACE) earlier in 2014 awarded scores in 'Condition, appearance and maintenance' with a range of 84.4% at Horsham Hospital up to 96.1% at Salvington Lodge. The organisational average for this area was 90.0% which is slightly higher than the national average for community organisations which is 89.1%.
- Staff received Health and Safety training as part of the mandatory training programme. Compliance levels across the hospitals was 98.7%.
- Staff described the system for reporting faults with equipment or the environment and reported that maintenance staff responded in a timely and appropriate manner. We saw records that showed items such as hoists were maintained according to manufacturers' instructions. We saw that small electrical items had been subject to portable appliance testing in the past year.
- The trust operated different systems for equipment in the north and south of the region. In the south equipment such as beds was on a hired basis with the north purchasing these items. We were told that this presented problems with obtaining replacements in the event of breakdown. For example at Arundel hospital an incident referral had to be raised in order to replace three beds urgently to prevent admissions being affected.
- We found there were arrangements for checking mattresses to ensure they remained fit for purpose and did not increase the risk of cross infection or pressure damage to patients. We saw checklists that showed mattresses were checked regularly, subject to cleaning regimes and removed from use if found to be inadequate.
- We asked staff to describe how Electrical Medical Equipment (EME) was checked and maintained by the trust's EME department. They told us that any faults or concerns were responded to quickly.
- We saw staff induction records which showed that new staff were trained in, and competency assessed, in the use of equipment found in their work area. In each area staff had access to a current, site-specific 'Management of Medical Devices Manual' for reference. This meant staff were able to use equipment safely.
- We found that medical gas cylinders were stored safely and on transportation trolleys in accordance with current Health and Safety Executive (2013) guidelines.
- We found that generally items and substances that presented a risk to health were stored in line with guidance for "The Control of Substances Hazardous to Health Regulations 2002." However, at Bognor hospital, on both wards we found hazardous items stored in sluice rooms in unlocked cupboards.
- We were told during a focus group with staff that there was an ongoing problem with the night security access

door at Bognor Hospital. During the inspection we were unable to locate any records relating to this with the facilities or estates departments but when we raised the concerns with the Head of Facilities the matter was dealt with swiftly and effectively.

- We found that the only radiography imaging facilities directly managed by the Trust, were located at Bognor Hospital. Senior staff were able to provide assurance that radiography services were compliant with the requirements of the “Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).” Staff told us that they were able to access timely diagnostics for in-patients and there were good integrated working arrangements.

Records and management

- We looked at training records which showed 77.7% of staff across the hospitals had received training in Information Governance.
- We found that confidential patient nursing records were not stored securely in some ward areas, for example in the Rheumatology Ward at Bognor Hospital we observed that confidential patient records were stored in open plastic crates in a decommissioned clinical room and record storage cabinets were found to be open and unlocked. Entry to this room was by key code but all levels of staff were able to obtain access. This meant that unauthorised access to these records was possible.
- In all other locations we found patient identifiable records were locked in secure cabinets or trollies. Only staff who needed to access records were able to do so.
- In Zachary Merton Hospital where the Nurses station was in a public accessible area, the patient information board closed when staff were not using it which meant that patient information could not be viewed by people visiting the ward. The patient information boards at Horsham Hospital were in an office behind the nurses station. We noted that staff locked the door of this office when it wasn't in use. This showed that staff had considered patient confidentiality and data protection in the running of their departments.
- Medical records accompanied patients when they transferred from acute care. Staff told us that old patient notes could be obtained when they were required.
- Although nursing care records were comprehensive and current they did not contain evaluation of any care and were not easy to navigate. However, in Horsham

Hospital staff had looked at the organisation of documentation folders as part of their Productive Ward work and we found records here were organised logically and information was easy to access as a result.

- When we looked at a selection of nursing records throughout all hospitals, we found that in some hospitals they were not always consistently completed. For example we saw repositioning charts, food charts and personal care round records were not completed on every occasion. We saw an example of hydration/fluid charts that contained no indication of what constituted “to maintain a fluid intake” i.e. no amount identified. This meant that they did not always contain all the information required to support the delivery of safe care.
- We saw that nursing documentation contained a range of risk assessments that covered the major risks to which patients were subject. We saw that there were standardised risk assessments covering risk of pressure damage, risks of falls and use of bed-rails. We noted that these were not always evaluated or updated when required. For example we found a patient at Bognor Hospital had been admitted with Grade 4 sacral sore but this had not been identified or recorded on the initial nursing assessment. When we reviewed the care of this patient we found that a pressure ulcer care plan identified wound dressings used initially but there was no evidence to support that this had been updated as the wound dressings changed. We were able to see that the Tissue Viability Nurse's expertise had been sought and documented with the wound assessment tool completed but then the progress notes were inconsistent regarding the evaluation of the wound. There was no information recorded to demonstrate that following the initial probing and measurement of the wound there had been any further analysis of the size of the wound. This meant that the records were unable to support the effectiveness of care received.
- We viewed patient records at all locations and, overall, found them to be complete, current, accurate and fit for purpose. However, we had some minor concerns relating to some specific records such as pain management. There was no consistency in the use of a pain assessment tool and we were unable to ascertain from patient records the nature or site of pain or the effectiveness of any medication administered. There was no indication in notes to confirm that any re-

valuation had taken place. However, as part of the comfort round systems, patients were routinely checked to ensure they were comfortable and told us that their pain was adequately managed.

- We had concerns that care plans were of a generic nature and were therefore, not individualised or personalised. In some cases handwritten notes were scribbled on the generic form but this meant that information was not always easily accessible to ensure the correct levels of care were available for staff to access. For example on one set of patient notes we found the care plan did not identify the intervention of oxygen or the reason why the patient was receiving it. The evaluation sheet recorded that care should be continued with oxygen but there was no requirement for oxygen saturation monitoring to be instigated. Another example was a urinary care plan that did not identify type/size of pad required. Evaluation of care recorded that the incontinent pad had been changed but there was no evidence of whether urine was contained in the pad. We found no additional information on the care plan to support that specific interventions had been instigated to promote continence. Another elimination urine care plan contained no evaluation of urine colour/ odour just stated “good fluid intake” but no evidence to support what was good.
- We looked at "Do Not Attempt Resuscitation" (DNAR) decisions in all hospitals and found that they were not always consistently completed. For example we viewed four at Salvington Lodge and found that one was not completed correctly. We looked at four at The Kleinwort Centre and found that one only contained initials for a signature from the medical consultant. At Arundel hospital we found that one form had accompanied the patient from the acute hospital and had been incorrectly completed but no review or follow up had been instigated in the community hospital setting. This meant that the omission remained unchecked or corrected. We reviewed four at Bognor Hospital and found that one form had been signed without capturing any conversation with the patients family just contained the comment “to be discussed”. This meant that patient wishes were not always recorded appropriately.
- However, at Crawley, Horsham and Zachary Merton Hospital where we also viewed four DNAR documentation we found that paperwork had been completed comprehensively. We found that decisions had been discussed with the patient and their family

members where appropriate, and these conversations had been recorded in patient health records. Where patients did not have capacity to make decisions we saw that capacity assessments were recorded along with the reasons for the decision for the DNAR and the discussions that had been held with the patients relatives recorded.

- Therapy records were generally well maintained and we found that patients therapy goals were recorded and agreed with the individual. However, there was no consistency in the recording of reviews or planned review dates.
- We looked at medical records and found that these were maintained contemporaneously. They were comprehensive and complete.
- During our discussions with the Matrons we heard how the organisation had recognised the need to standardise the patient records and saw that a Document Review Group and an Organisational Nursing Documentation Committee had been established to undertake a review of all community in-patient documentation. Staff told us that the aim of this group was to standardise all documentation within the hospitals. We saw minutes of these groups which demonstrated that to date the admissions documentation had been reviewed with the next priority being individualising care plans.
- Other records relevant to the running of the service were maintained, and could be produced when requested. These records were current and fit for purpose.

Cleanliness, infection control and hygiene

- We judged that The Department of Health’s, “Code of Practice” on the prevention and control of infections and related guidance” was being followed in all the hospitals that we visited.
- During our inspection we found all ward areas to be exceptionally clean and patients told us that “staff work very hard to keep it spotless”.
- We saw that an annual infection control audit was undertaken by the trust. Actions arising from the audit were disseminated to each hospital with an associated action plan. We saw that the progress of the action plans were monitored at governance level.
- Staff working in the inpatient areas had a good understanding of their responsibilities in relation to cleaning and infection prevention and control.

- The trust employed a team of specialist infection control nurses who were appropriately trained. Ward staff told us they knew how to contact these staff and that they visited regularly and attended team meetings. They also told us they valued their input. Additionally there was a link-worker scheme for ward staff and we saw that these link workers received support and training to undertake this role.
- Patient Led Assessments of the Clinical Environment (PLACE) assessments earlier in 2014 awarded scores in cleanliness ranging between Horsham Hospital at 98.1% and Crawley and Zachary Merton Hospital at 99.8%. The average score across all inpatient sites for cleanliness was 99.1% which is above the national average for Community Organisations which is 96.3%.
- We found the ward areas to be clean, with attention paid to both high and low surfaces. Clinical areas were monitored for cleanliness by the facilities team. We looked at three months cleaning audit scores. Each area had a target score and an actual score for the day that it was audited. Expected scores were graded in line with expected standards laid out by The National Specifications for Cleanliness in the NHS (April 2007). We found that cleaning audits were completed correctly and consistently met with, or exceeded the levels of cleanliness required.
- We spoke with facilities staff across all sites who all demonstrated a clear understanding of their role. Cleaning staff were able to discuss the audit scores for their area and describe to us how they managed corrective actions where any part of the audit of their area did not meet with requirements. We saw examples of corrective action documentation for all the inpatient areas and found that staff had completed corrective actions within the timeframe required.
- Nursing staff were responsible for cleaning clinical equipment. Where equipment had been cleaned this was indicated using Green labels which were dated and signed by the member of staff who had cleaned the equipment. We noted good levels of compliance with clinical equipment cleanliness across all of the Wards we visited.
- The staff we observed were complying with the Trust policies and guidance on the use of personal protective equipment (PPE) and were bare below the elbows.
- There were hand hygiene, 'Bare below the Elbow' audits undertaken which demonstrated staff were compliant

with best practice guidance. These were done for each clinical area, and documented in the annual clinical governance report. Results of these audits were displayed on each Ward area we visited.

- We observed staff on the Wards washing their hands in accordance with the guidance published in the Five Moments for Hand Hygiene published by the World Health Organisation (WHO 2014).
- There were procedures for the management, storage and disposal of clinical waste. We observed that clinical waste was segregated and 'sharps' waste was handled appropriately in line with Guidance from the Health and Safety Executive issued in 2013.
- We saw where water temperatures had been checked monthly and appropriate measures were in place to reduce the risk of Legionella contamination.
- Feedback regarding cleanliness from patients was good and one said "Staff work very hard to make sure the ward is clean, this hospital has a high standard of cleanliness". Another reported "Everywhere is beautifully clean".

Mandatory training

- There was a programme of mandatory training and most staff told us they were up-to-date with this. We saw ward managers retained accurate local training records and showed us plans to ensure that essential training was updated when required. Training rates for the percentage of staff across the inpatient hospitals who were up to date with their mandatory training ranged from fire 79.40%, Infection Control 80.22%, Information Governance 80.22%, Health and Safety 91.87%, Equality and Diversity 38.21%, Safeguarding Vulnerable Adults/ MCA and Dols 37.38% and resuscitation 65.74%. Midhurst Hospital had consistently low numbers of staff up to date in all areas. This meant that not all staff had fully participated in mandatory training requirements.
- The Trust reported that they have had a national problem with the e-Learning package which has meant that staff had been largely unable to access the training. Therefore, delivery methods had recently been reviewed and face to face training delivery and also workbooks have been added so that staff had a wider choice of how they accessed the training. This has resulted in an increase in compliance not reflected in the data that had been submitted as this reflects the last 6 months (May – October 2014) and the new delivery methods

were introduced from November when the new Equality and Diversity lead came into post. A similar problem had been encountered with safeguarding training and resuscitation training with new training leads now in post.

- A proportion of mandatory training was moving towards e Learning modules. Some older staff expressed concern they did not have the information technology (IT) skills to make the most of this opportunity. However, at Arundel hospital we were given examples of how individuals had been supported to undertake e learning in a group environment, affording them support and opportunities to discuss the learning further. Staff commented that this not only helped them but made the training more participative and fun.
- Staff told us they could access training, including accredited training at institutes of higher education as part of their professional development plan. We saw examples of staff being supported to complete degree level studies such as mentorship and palliative care.
- We were also shown examples where staff had been identified as lacking the required competency to fulfil their role. We found that these cases were managed using appropriate human resources policies and procedures.
- We saw that temporary staff received an induction when they first worked in a community hospital to ensure they worked safely and competently. The trust had contractual arrangements with the agencies they used to be assured that staff supplied possessed the relevant clinical competencies.

Assessing and responding to patient risk

- A central Risk Register was held by the Trust. This register included risks, what actions are being taken and what date this would be reviewed. The risk register was regularly reviewed by The Senior Management Team.
- One example of how these risks were managed by the Trust was where staffing levels had been raised as a risk. The senior team had discussed this risk and had closed a ward as a result. This meant that staff were redistributed to make staffing levels safer. This had been reviewed regularly and the ward had been reopened when staffing levels had increased to do so safely.

- Local risks were recorded on Health and Safety Registers within departments and wards. The Health and Safety Manager attended the Heads of Department meetings which took place every two months in the Trust and we viewed a sample of minutes for these meetings.
- On The Horizon Unit we were shown an example of an analysis of incidents which had highlighted an increase in patient falls. The unit had looked at this as a patient safety issue and had changed practice as a result. They had completed this by looking in depth at patient factors in the incidents reported for example, neuro diagnosis and capacity. By identifying what time of day falls were prevalent the ward had changed staff working patterns to ensure that more staff were on the floor at this time. The Ward had also purchased a further three motion sensors for patients with dementia and improved the falls assessment documentation. The ward had also rolled out falls training in the form of a workbook to staff.
- The Band six physiotherapist on the Ward was responsible for falls data collection and analysis. The physiotherapist then fed back the learning from this through the Productive Ward meetings. The matron for the unit presented a paper outlining the work that the unit had done on falls and presented it to the trust wide Clinical Governance Group.

Staffing levels and caseload

- Staffing levels were acknowledged throughout our inspection as a challenge for the Trust. This was evident on all of the Wards that we visited. The Trust had been working hard to recruit to their permanent and bank staff as a result. However, staff reported that due to the length of time spent in processing applications and undertaking suitability checks by Human Resources, many applicants became frustrated and secured positions in other organisations.
- A report outlining the issues was presented at a public board meeting on 26th June 2014. The report highlighted national guidance requirements for NHS Trusts and presented actions that the Trust had taken to date. The report laid out a new 'Safe Staffing' template which provided staffing levels and skill mix to deliver safe, effective care to a patient group demonstrating increasing frailty, complexity and dependency. In addition, the uplift in the Registered Nurse template provided for supernumerary status for new starters to ensure appropriate orientation and competency, whilst

supporting staff retention. 'The Safe Staffing template' provided for greater resilience in terms of quality and continuity of care and operational delivery, and included a supernumerary Band seven ward manager and accommodated a 22% uplift to cover annual leave entitlement, sickness and statutory training.

- We found that the wards were mainly staffing to their agreed staffing levels but were reliant on substantive staff doing overtime, bank and agency staff to meet this demand.
- We found that the only band seven ward manager working super-nummery across all of their shifts was the ward manager on the Horizon unit at Horsham Hospital. As a result of this we saw far greater compliance on this ward with initiatives such as Productive Ward, Dementia friendly initiatives such as the Butterfly scheme, and innovation from ward staff.
- On other ward areas we found the levels of super-nummery shifts for ward managers varied with most reporting that even when super-nummery shifts were rostered they found themselves working clinically due to the demands placed on them by fulfilling expected staffing levels on the wards.
- The Trust has set an initial internal threshold of 85% fill rate for day and night shifts. The final staff template recommendation acknowledges that the template does not align with the national RCN Benchmarking of one Registered Nurse (RN) to eight patients. However, this benchmark was set for acute inpatient settings and not for community hospital environments.
- The Trust has set a minimum staffing level for Registered Nurses of two registered nurses per shift as follows - Early Shift: Between 3-4 patients per staff member, Late Shift: Between 4.4-5.6 patients per staff member and Night Shift: Between 5.6-7 patients per staff member. With some specific wards having exception staffing; For example, The Stroke Rehabilitation ward and wards with all single rooms such as Salvington Lodge.
- Currently, the vacancy for Registered Nurses in the inpatient units is Coastal Hospitals 23.5 (26%) and Hospitals in the North of the region 41.28 (44%).
- This represents recruiting to 100% of the total template which includes the 22% uplift to provide cover for annual leave, sickness and training. If this was

calculated without the uplift, the total vacancies would be lower, however the mechanism for providing staffing cover would need to be supported by recruitment to the staff Bank.

- Horsham hospital had recently had two further trained nurse posts approved. The Ward Manager described raising an issue regarding staffing with the Chief Nurse at a meeting and having the Ward Posts agreed by her the following day. They told us that they felt this was a good example of how supported they were by senior managers with staffing.
- Staff told us that they felt supported and involved when staffing issues were affecting or predicted to affect safe levels of patient care. We were told how at Salvington Lodge staff had identified this and were involved with senior trust personnel to explore options and solutions. The decision to close one ward was made and delivered collaboratively with senior personnel and staff told us this demonstrated that the trust responded to their concerns in a timely and inclusive manner.
- Crawley hospital had also just had funding approved for a further four trained nurses and five Health Care Assistants (HCA) posts. Because Crawley Hospital had three Wards they were also able to swap staff between Wards where needed.
- We identified concerns regarding the availability of therapy services throughout the hospitals. Staff reported that at Salvington Lodge patients had been unable to access any therapy services for a three week period due to lack of therapy services. This resulted in patient outcomes and length of stay being compromised. Patients told us that they used to participate in activity groups but this had been frequently cancelled due to therapy staffing issues.
- At Horsham hospital the Band 6 physiotherapist was the highest grade physiotherapist and was in their first role as a band 6 physiotherapist. There was no cover for them when they were on leave or training. They told us that if they needed professional support they would go to physiotherapy leads at other hospitals in the Trust. However there was a Band 7 lead occupational therapist in the unit and they could access professional advice for the physios.
- Concerns were identified regarding the medical cover at The Kleinwort Centre with a salaried GP contracted to work Tuesday to Friday during the hours of nine and five, with additional locum cover on a Monday. Staff

expressed concerns as to the level of sickness cover that does not always afford them the levels of support needed and as the current GP post holder is due to take maternity leave in March staff were not confident that appropriate cover would be in place.

- We discussed the availability of therapy staff at Bognor hospital and were told that there were generally adequate staff to meet the needs of the patients. However, we were told that shortages of staff within the Musculoskeletal service, outpatients and other specialities often resulted in staff being asked to cover and left the team feeling pressured and not able to fully meet the needs of all patients on the inpatient wards.

Managing anticipated risks

- In addition to the overarching trust risk register each hospital maintained its own local risk register and we saw examples of these. We noted that these were current and complete. Staff told us that they felt confident in raising concerns or risks with managers for inclusion on risk registers both at local and organisational level.
- All managers we spoke with were able to clearly articulate the risks for their area of responsibility. During focus groups held with staff they were able to describe risks particularly pertinent to their working environment.
- There were robust arrangements for disseminating national safety alerts. Staff we spoke with were aware of the system and we saw minutes of team meetings where safety alerts had been discussed. We saw records of safety alerts retained in ward areas.
- The Department Manager at the Radiology department at Bognor Hospital told us how they had addressed concerns regarding the age of the x-ray equipment which was now 18 years old. In response to concern they had identified anticipated risks concerning the age of this equipment and were able to demonstrate that they had explored these risks, amended maintenance checks, updated risk registers and amended protocols for breakdown and monitoring the equipment and advised staff of their responsibilities.
- Staff in all hospitals had been involved in mock fire evacuation exercises. We looked in particular at an evacuation exercise undertaken at the Horizon unit and found evidence to support that staff learned from this and practice was changed as a result.

- The Horizon Unit within Horsham Hospital had also had cardiac arrest situations simulated twice a year as a minimum. We were able to see the debrief following this and the learning from this.
- The entrance to the Horizon unit had been changed a few days before our inspection which caused some confusion on the day with visitors still trying to use the previous entrance. We were told that the reason for the change was that nurses could monitor now who was arriving on the ward which they were not able to do previously. This had improved security on the ward.

Major incident awareness and training

- The Trust had a Business Continuity Plan in place to manage situations such as electrical failure, flooding, and severe weather. We saw that these plans were updated annually.
- The hospitals in the North of the region had escalation plans in place to take patients from the local Acute Trust during a major Incident.
- The Matron at Zachary Merton demonstrated a knowledge of where staff lived so that they could be redirected to their nearest place of work in the event of snow or severe weather. The Trust also had a 'Four wheel Drive Contract' in the event of snow in order to move staff around the area. At The Kleinwort Centre the business continuity plan reflected concerns that the GP providing medical care lived some way from the unit which would present problems in the event of bad weather. Staff described how the trust emergency planning team had received and considered this feedback.
- The Trust had recently undergone a 'Snow day test' to check the effectiveness of the plan.
- We were told how there had been a fire at Crawley Hospital where staff had needed to evacuate patients. Staff had managed the situation well, and staff told us that this was a demonstration of how important their fire training had been. Following this incident, the department heads had met to debrief the incident and The Head of facilities talked us through the learning from this event.
- Horsham Hospital had recently undergone a mock fire evacuation. We were shown the report outlining how staff had managed the evacuation. The fire at Crawley Hospital had been started deliberately by a member of the public who then stole hospital property whilst staff were busy evacuating patients. During the Horsham

mock fire evacuation a member of Trust security staff had entered the ward area and had removed equipment. Staff had challenged them and they were detained by staff whilst they were dealing with the evacuation. At Salvington Lodge staff told us how the governance team and health and safety personnel had supported them during an exercise by participating as actors.

- We found an exemplary example of good practice at Arundel Hospital with a “Major Incident Box” which was stored in a prominent position within the staff room and contained everything staff would require to manage an incident. The Ward Manager told us that this had been developed with the involvement of all levels of staff.

Are Community health inpatient services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Evidence based care and treatment

- We found there was a system for reviewing latest guidance from National Institute for Health and Care Excellence (NICE). NICE guidelines were available on the Trust's intranet systems and staff demonstrated that they were able to access these. Each ward team had link nurses who were responsible for keeping updated with current practice in their area and disseminating this to other members of staff. Link nurses had roles in areas such as infection control, palliative care, wound care, dementia and nutrition.
- We saw examples in ward meeting minutes where such guidance was discussed and the implications for local practice was considered. We were shown documents that demonstrated that the actions resulting from audits were tracked to ensure progress was made, actions were clearly set out with the person responsible and it was confirmed when they were completed.
- We saw examples of national guidance being implemented. For example in the area of nutrition we saw that guidance from NICE relating to screening for malnutrition was in place.
- We viewed records that demonstrated patients' needs were assessed when they entered the service and those assessments were regularly reviewed. We saw that patients had a range of standardised, validated risk assessments using recognised risk assessment tools. These included assessments for falls risk, manual handling and Waterlow score (used to determine the risk of pressure damage). We noted that these were completed and updated as required.
- At Crawley we saw a stroke pathway in use and when we reviewed a sample of patient records we saw how multidisciplinary teams had been involved including therapists, stroke nurses, and discharge co-ordinators. This meant that patients received care using evidence based treatment pathways.
- We found that staff and managers could clearly describe robust, systematic arrangements for disseminating and reviewing new guidance, for assessing the impact of new guidance on clinical practice, and for monitoring required change. Some audits of care and treatment

effectiveness had been performed at an organisational level that included community in-patient services. We saw an example of the impact of the falls reduction initiatives being monitored through audit methodology in a number of the hospitals.

- We found that patients all had a care and rehabilitation plan devised to meet their needs. Therapy goals and milestones had been identified but review dates were not always evident and because currently all hospitals used pre-printed care plans these were often insufficiently personalised to the needs of individual patients.

Pain relief

- Patients told us that their pain was adequately controlled. They said pain relief was provided regularly or as needed. They told us they could request pain relief when they needed it. One patient said, "They always ask me if I am comfortable or if I'm in any pain". We looked at medicines administration records which confirmed patients received pain relief as prescribed on both a regular and as prescribed basis.
- We did not see any evidence of non-pharmacological approaches to pain relief, and staff told us these techniques were not routinely used.
- We checked evaluation records after we saw that as required pain relief had been given, and saw that an evaluation of its effectiveness was rarely included. As part of the comfort round systems, patients were routinely checked to ensure they were comfortable and their pain was adequately managed. For example at The Kleinwort Centre we tracked the entries on the comfort round that was taken during our visit and found that nine entries recorded that pain had been noted but did not contain any indication of site, nature or intensity. However, when we looked at the patient progress notes we found that three of the nine entries contained no evidence of any evaluation of pain relief administered.

Are Community health inpatient services effective?

Nutrition and hydration

- We observed that patients were served a choice of foods and that therapeutic diets were managed well. Patients were assessed by a dietician when screening suggested a risk of malnutrition, or if there were medical problems that compromised patients' nutrition.
- Dietary supplements were given to people when prescribed.
- Patient Led Assessments of the Clinical Environment (PLACE) assessments in 2014 awarded scores averaging 96.6% which is above the national average for small community organisations of 91.4%.
- There was the facility to order food off-menu if this was required at the hospitals. Patients also told us that they were encouraged to drink adequate fluids and that hot drinks were available throughout the day and night.
- We observed patients being helped to eat and drink. The wards operated a protected mealtime policy and this was advertised on the ward, but in practice this was only partially implemented. For example we saw medicines rounds that clashed with mealtimes, and not all staff were focussed on making sure patients drinks were within reach. We saw various systems that identified those who required special help with feeding to staff, for example a knife and fork symbol on patient doors. We did not see any pictorial menus to help those with dementia or learning difficulties make food choices.
- We saw that adapted cutlery and crockery was available for patients that needed it and at Arundel Hospital meal monitors had been appointed to ensure that patients were using the appropriate aids to promote their independence.
- The community hospitals had access to advice from dieticians and speech and language therapists. Dieticians visited each hospital weekly and were also available to give telephone advice.
- Menus were planned by the catering teams with input from the dieticians to ensure that nutritional guidelines were met. Feedback was sought from patients and we saw examples of changes being made in the light of patients' comments.
- We saw evidence of menus to accommodate patients with specialist dietary needs. An example of this was a range of gluten free diets at Bognor with a designated toaster and separate storage area for gluten free items that could be accessed for snacks.

- Food that met people's special cultural and religious needs was available.

Approach to monitoring quality and people's outcomes

- The community in-patient services all participated in the National Patient Safety Thermometer scheme, and this demonstrated that the patient outcome measures were in line with national averages.
- The wards all took part in auditing Hand hygiene, and catheter care. They monitored the numbers of urinary tract infections (UTI's) in patients with an indwelling catheters. Results of these audits were displayed on notice boards in ward areas. The staff that we spoke with were aware of their progress with these audits.
- We saw that the performance information included staffing levels, incidences of harm such as falls and pressure areas and patient feedback and this was displayed in all hospitals.

Competent staff

- We found there were systems to ensure that qualified staff remained registered with the Nursing and Midwifery Council, or the Health Professions Council.
- Health Care Assistant competencies on The Horizon Unit were assessed and recorded by trained nurses. These included tasks such as taking a patient's blood pressure.
- On The Horizon Unit at Horsham Hospital and at the Kleinwort Centre 100% of staff had received their annual appraisal. All other hospitals reported that between 90% and 100% of staff had participated in an annual appraisal.
- Staff at Crawley hospital told us how each member of staff had a supervisor who they had a documented one to one meeting with every eight weeks..
- New members of staff including bank staff received a two week induction by the Trust. Their induction and training would be signed off by senior staff before they worked unsupervised.
- Within the community in patient service although appraisal were completed annually, formal clinical supervision had not been universally implemented. We saw that at some hospitals individual supervision was complimented with group supervisions, including at Arundel Hospital where a newly formed healthcare assistants group therapy session had been introduced. However there was not a consistent approach.

Are Community health inpatient services effective?

- We were told that some Ward Managers and sisters did not always have time to provide formal supervision to staff as they were needed to work clinical shifts due to staffing pressures.
- Leadership skills courses were available.
- Staff reported that the trust showed a “commitment to developing staff” and told us that they were encouraged to access training with no boundaries for staff to participate in development opportunities.
- A common theme when we spoke with staff about accessing training was the need for it to be made more localised.
- Facilities staff were encouraged to participate in NVQ level 2 qualifications and we heard how the trust was considering the implementation of a dedicated apprenticeship course for cleaning staff. We were told by staff that this “makes us feel appreciated and a valued part of the care team”.

Multi-disciplinary working and coordination of care pathways

- Within community hospitals we identified that there was a strong commitment to multi-disciplinary working. Each ward area had a multi-disciplinary team meeting on at least a weekly basis to plan the needs of patients with complex needs. We saw documentary evidence of a multi-disciplinary approach to discharge planning.
- Generally we saw that patients had timetables detailing when each therapist would be treating them that week. This ensured that patients, their families and nursing staff were aware what and when planned therapy sessions there would be.
- At Arundel Hospital we saw how a wall sized patient journey board had been designed reflecting all aspects of the patient journey and care needs. We saw how all members of the multi-disciplinary team used the board to ensure that the most up to date information was displayed. Staff told us that it was a ‘great aid’ to making sure all staff were aware of each individual’s health status and care requirements. We saw how following a handover meeting this board was again updated.
- Ward teams told us they had access to mental health services from a mental health trust. Psychiatric assessments were carried out as a result of referrals.
- The therapist at Crawley Hospital had recently started to work over the weekend. They told us that this had been a success and that seven day working had assisted them

to provide consistent therapy treatments. They said that they found weekends had been a good time to take patients on home visits as their relatives often preferred this at weekends.

- On the Stroke rehabilitation Ward at Crawley Hospital relatives/carers were invited in three days after a patients admission to have a meeting with members of the MDT. During these meetings basic goals are set and an understanding of patients expectations are discussed.
- A traffic light system was being used on the stroke rehabilitation ward at Crawley Hospital. This was a visual aid to guide staff in relation to each patients discharge status.
- In the north of the region therapy staff were expected to assist nurses over mealtimes. This gave them opportunities for assistance rehabilitation along with ensuring that as many staff as possible were available to assist patients who required help when eating.
- We observed that staff worked in a cohesive team and they demonstrated a strong commitment to multi-disciplinary working. Staff demonstrated a sound understanding of each others roles, and staff commented that all staff were treated with respect.
- Therapy staff praised the skills of nursing staff and health care assistants in relation to meeting the continual needs of rehabilitation therapy for patients. They described how they worked together to ensure that during weekends patients’ therapy needs were maintained. And we saw how training sessions had been arranged to support staff.
- We saw from the National Staff Survey results for 2013 that staff reported team working rated highly and was above the national average.

Referral, transfer, discharge and transition

- We found there were systems in place to manage referrals and ensure that the services were effectively utilised for the benefit of the local population.
- We found that there was an appropriate emphasis on discharge planning and observed good practice in this area. Patients, their families, and outside agencies were engaged in discharge planning processes. This meant patients were discharged safely and their needs continued to be met after they left the hospital.
- We observed the handover of a patient to the transport ambulance crew and saw how a checklist was used to

Are Community health inpatient services effective?

ensure that the patient was transported comfortably in line with their needs. The patient was being transferred to another location. The relevant referral documentation was included in the transfer and the patient told us “I don’t want to leave as they really look after you here”.

- We saw evidence that demonstrated staff were aware of the availability of NHS Continuing Care Funding and the process for ensuring people were assessed for this as part of their discharge planning. We were assured that, when appropriate, patients were referred and received an assessment to establish their eligibility for this funding.
- There were some delayed transfers of care, and staff told us that this was usually due to awaiting NHS funded continuing healthcare assessments, awaiting local authority funding or a lack of local availability in care homes. These situations are beyond the control of the trust, but remain within their sphere of influence and we found that staff worked to minimise any delays.
- We found that patients were referred to appropriate community services to ensure their needs continued to be met in their own homes. This included referral to community rehabilitation teams to ensure patients’ rehabilitation continued post-discharge and that they were supported to achieve their full rehabilitation potential.

Availability of information

- We spoke to clinical staff who told us they had access to current medical records and diagnostic results such as blood results and imaging to support them to care safely for patients. We were told that patients’ old notes were retrieved from the hospital archives when required without delay.

- We reviewed the discharge summaries produced for patients including those sent electronically to GP’s. We found they contained all the key information about the patient’s care and treatment and therapy needs that would allow this to continue in the community setting.
- There were systems to keep all ward staff informed of the current hospital bed situation via information in the ward office or at the nurses’ station. These contained information about the numbers of patients awaiting discharge and admission in real time and assisted staff to prioritise workload. The system also kept a track on outstanding actions for patients on the ward such as the completion of key risk assessments, therapy needs and screening activities.

Consent

- Training in the MCA and DoLS formed part of the mandatory training programme.
- Staff we spoke with were able to talk about their responsibilities under the mental capacity act. They could name the safeguarding matron who led on matters relating to the MCA and gave examples of how they use their expertise.
- We sampled patient records throughout our inspection and found that the appropriate consent of patients was obtained during admission and throughout each episode of care.
- We saw evidence that where required, formal best interests meetings were held to establish capacity and determine best interests in line with the Department of Health Code of Practice for the implementation of the MCA. Records were available to us to demonstrate that these meetings had been documented.
- Staff understood the concept of deprivation of liberties and could give examples of where the safeguards had been applied or considered.

Are Community health inpatient services caring?

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

Dignity, respect and compassionate care

- During our inspection we observed that patients were treated kindly and with respect. During conversations with each other staff talked positively and respectfully about patients and their circumstances.
- Patient Led Assessments of the Clinical Environment (PLACE) assessments in 2014 awarded scores averaging 90.1% which was above the national average for small community organisations of 85.3%.
- The community in-patient services administered the 'Friends and Family' test to gauge patient satisfaction. Average percentage scores averaged 89%. However, caution is required in interpreting these results as often sample sizes were small.
- Patients were overwhelmingly positive about their experience. Typical comments received were, "Amazing staff, amazing care" and "Thank you to all the staff for just going the extra mile".
- We saw a patient at The Kleinwort Centre who had suffered sudden hearing loss and was only able to communicate using a pad and pen. Staff had devised a list of prompts for the patient to use to ensure that they were able to make any of their care needs known quickly and with minimal fuss. The patient told us that they had been extremely frightened and distressed but that staff had been extremely caring, understanding and considerate and could not praise them enough for their kindness. They said "The staff are wonderful I am being thoroughly spoilt and they are just being so very kind to me".
- We observed that on all of the wards we visited staff completed 'Intentional Comfort Rounding', when at regular intervals, nursing and health care assistants checked that patients were comfortable. This information was documented and included whether patients were in pain, needed support to go to the toilet, or were hungry or thirsty.

Patient understanding and involvement

- Patients told us they were involved in planning their care and understood what was happening to them. Patient comments included, "I've been told about my treatment and how long I'm going to be here".

- We saw that each hospital had patient information packs available both in booklet format and on the trust website. Staff told us that patients received a copy on admission.
- We saw many examples of how staff had introduced initiatives to support patients, their supporters and family. Examples of this were the regular Matrons surgery for relatives to help their understanding at Salvington Lodge and the patient and family meetings on admission introduced at Zachary Merton Hospital.

Emotional support

- Patients told us they felt emotionally supported by the hospital staff.
- Within patient notes we saw mood assessments/care plans
- Staff could refer patients to a mental health liaison service. Staff were clear about how to access these services and how important such a referral would be if they detected a patient needed an appropriate mental health assessment to be performed.
- We found that patients could access a range of specialist nurses, for example in palliative care, stroke and diabetes care and that these staff offered appropriate support to patients and their families in relation to their psychological needs.
- Throughout the community hospitals a hospital chaplaincy service was available and staff were aware of how to contact spiritual advisors from major world faiths in order to meet the spiritual needs of patients and their families.

Promotion of self-care

- We observed that there was a strong ethos of promoting independence and rehabilitation throughout the service. We saw that staff encouraged patients with patience and kindness to undertake tasks for themselves where this would aid their recovery.
- We saw that therapy was designed to support patients towards independent living when they were discharged.

Are Community health inpatient services caring?

However, we did have concerns that the lack of therapy staff in some of the hospitals had resulted in cancelled sessions and this precluded patients from receiving continuity of therapy and delayed discharge.

- In all of the hospitals patients were encouraged to eat in the communal dining area and maintain social links with other patients. We saw patients being encouraged to help and support each other during the lunch time.

- Of particular note was the programme of activities provided by staff and volunteers at Arundel Hospital for patients to access. This included entertainment evenings, bingo afternoons, keep fit exercise classes and regular reminiscence sessions.
- At Horsham Hospital we spoke with a patient being cared for in the independent living flat, which was an area of the ward designed for patients who were testing an environment similar to the one they would live in on their discharge.

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

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

Planning and delivering services which meet people's needs

- The musculoskeletal service at Crawley was collecting data on patients not attending clinics, appointments not being filled, and cancelled appointments in order to make improvements to the service. The demand on the service had increased with non-urgent appointments having a waiting time of 14 weeks. The department had a high level of patients not taking up the appointments offered to them. For example, between September 2013 – July 2014 the service had received 110 referrals 68 of which had come from General Practitioners (GPs) 48 of these referrals had not taken the appointments that the service offered to them. We were told that the service on average had 29 missed appointments over a four week period. Staff felt that the reasons for this were patients not being prepared to wait, patients not receiving appointment letters, and the high volume of calls to the service which meant patients said that they struggled to get through to talk to staff.

Equality and diversity

- Staff received training in equality and diversity as part of the mandatory training programme.
- There were arrangements to communication needs of people for whom English was not their first language, or used British Sign Language. We saw posters advising that interpreting services were available for patients. Staff we spoke with were aware of how to arrange these. We noted that patient information leaflets were available in large print and displayed in languages other than English.

Meeting the needs of vulnerable people in services

- We found there were facilities and resources available to meet the diverse needs of patients. This included the provision of adaptive equipment, mobility aids, bariatric equipment and interpreting services. We saw that some hospitals had introduced specific measures to meet the needs of people living with dementia, but observed that generally the ward environments were not dementia

friendly as defined by best practice guidance. We were told that there had been environmental audits of the ward areas regarding dementia friendliness and initiatives were being introduced.

- There was an arrangement with the local NHS mental health services to provide a liaison service for people with learning disabilities. Staff reported they were responsive and happy to accept telephone referrals at all times. We noted that staff appeared familiar with the service and demonstrated an awareness of the "Care Passport" scheme where patients with a learning disability brought a document outlining their care needs, preferences and other useful information in with them for staff to reference. There were no patients who needed to use these during our visit.
- Staff in all areas were aware of the lead for learning disabilities in the trust and knew how to contact them. We were given an example in Zachary Merton of how they had supported a patient with learning difficulties with the assistance and advice from the Trust lead. Staff were able to access communication tools to assist them with communicating where this was needed.
- Staff received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of the mandatory training programme.
- All staff we spoke with were aware of their responsibilities in relation to the Mental Capacity Act 2005 and we saw evidence that where people did not have the capacity to consent, the provider acted in accordance with legal requirements.
- We viewed 'Do not attempt cardio-pulmonary resuscitation' orders that had an integral capacity assessment completed and were compliant with the requirements of the MCA.
- Staff were able to describe how they would organise a best interest meeting if needed, and gave us examples of such meetings being held and their outcomes. We saw from patient records that these meetings had been appropriately recorded.
- We saw information available about an advocacy organisation that provided Independent Mental capacity Advocates (IMCA) to the community in-patient services displayed.

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

Access to the right care at the right time

- The north and south of the region used different processes for accepting admission into their services from the two local acute trusts. The North of the region was able to evidence a robust system where discharge teams in the acute Trusts acted as gatekeepers for admissions to ensure that admissions were appropriate for the rehabilitation and environment that the wards were offering. In the South of the region this was managed by 'One Call' staff in the South had experienced problems with patients being admitted to the wards who were not suitable for rehabilitation.

Meeting the needs of individuals

- In-patient services are implementing the "Butterfly" scheme, however there were inconsistencies in the approach. For example:

On The Horizon Unit staff had worked hard to promote dementia friendly care. The environment of the unit was limiting for staff with only one patient being visible from the nurses station. However, the ward manager had worked hard to put in place the butterfly scheme to assist staff to recognise patients who required extra support during their stay. The unit was using 'This is me' documentation which staff encouraged families and friends to complete.

At the Zachary Merton Hospital staff faced similar challenges in terms of environment. Staff there had not considered ways to assist patients with dementia and neither the 'butterfly scheme' or 'This is me' documentation were being used.

- Dementia training was not part of the mandatory programme. However, the dementia action plan contained a strategy to ensure that all trust staff received dementia training appropriate to their role.
- We found that individual hospitals had adopted initiatives for supporting people living with dementia. An example of this was at Salvington Lodge where a weekly "Reminiscence Group" was provided for patients by volunteers.
- Individual hospitals had systems for identifying people with hearing or visual impairments. Some wards highlighted these on their hand-over sheets, and others used discreet symbols on patient status whiteboards.

- Bariatric equipment was available throughout all in-patient facilities on a hire basis. Staff reported that there were no issues with the availability of this equipment.
- At the Kleinwort Centre we were told how the increase of younger patients with traumatic amputations had prompted the need to make the garden area more accessible to wheelchairs. We saw that doors and paths had been adapted to promote independent access to the garden area.
- Throughout our inspection we observed that patient call bells and requests for help were responded to appropriately. Patients said if they used the call bell, staff responded promptly.
- We saw that there was much relevant patient literature displayed in each hospital, both in reception areas and on wards. This included disease specific information, health advice and general information relating to health and social care and services available locally. We noted that some patient information leaflets were displayed in languages other than English.
- Horsham Hospital staff had completed a patient survey on 'Terms of Endearment in clinical practice' and had displayed the results of the survey. The survey showed that 90% of patients preferred staff to use their first name only. Patients had been asked whether they found terms of endearment an acceptable way to be addressed, 80% of patients felt that terms of endearment were an acceptable form of communication

Complaints handling and learning from feedback

- We found there were clear procedures for receiving, handling, investigating and responding to complaints.
- We saw literature and posters were displayed advising patients and their supporters how they could raise a concern or complaint formally or informally. Patients told us they all knew how to raise a concern and were confident that their concerns would be acted upon.
- We saw minutes of meetings that showed concerns, complaints and plaudits were discussed at team meetings, and that action plans were formulated and implemented in response to these. We saw how the learning from complaints was shared at staff meetings and clinical governance meetings.
- Ward areas displayed 'You said we did' information. An example of this was at Arundel Hospital, where family

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

meetings had been introduced as soon after admission to ensure that patients and their relatives could be assured of continuity of care when arriving from acute hospitals.

- All staff told us that wherever and whenever possible day to day complaints from patients were dealt with immediately.

- Staff we spoke with told us that they made sure that patients' carers knew who to contact to raise a concern or make a complaint.
- Information was displayed in all hospitals advising patients how to access advocacy services and the Patient Advice and Liaison Service (PALS).

Are Community health inpatient services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Service vision and strategy

- We observed that the trust corporate mission statement was prominently displayed in all hospitals and on all wards. Staff we spoke with showed an awareness of these values in our discussion with them.
- We saw that Individual hospitals and wards had developed their own philosophies of care to compliment the corporate trust mission. These were displayed in prominent positions and staff told us they had been involved in their formulation. We noted that the values described dealings with patients and their families being “conducted with courtesy, professionalism, integrity, openness and respect”. During our inspection we saw that staff worked to put these values into everyday practice. We spoke with staff who told us they understood and contributed to the hospital/ward vision and could describe the contents. This showed that the in-patient services had a vision and sense of common purpose that helped ensure patients received quality care.

Governance, risk management and quality measurement

- At community in-patient service level we found there were robust governance arrangements. We saw minutes of ward meetings where there was a standing agenda that covered areas such as risks, incidents, complaints and audits. Clear actions were described and previous actions were evaluated. Staff were able to access these minutes and they were displayed on staff notice boards.
- We were also told about the Quality Risk Panel meeting which ensure that quality and safety matters received due consideration, and that actions were agreed and progress monitored.
- The pharmacy technician on The Horizon Unit was involved in the Productive Ward work going on in the department. As a part of this work they had produced medication audits which had changed the way that medication was dispensed on the unit.

- In Crawley Hospital staff had completed monthly audits patient care charts such as prescription charts, comfort round charts, and nutrition documentation. Learning from these audits was shared with staff during handovers and ward meetings.
- At the Kleinwort Centre a newly formed continence action group for the ward had been instigated at the request of healthcare assistants and involved nursing staff and the ward manager.

Leadership of this service

- The Chief Executive’s weekly message was generally well-received and staff appreciated the opportunity to be kept up to date with organisational developments.
- Staff told us that it would not be unusual for a member of the executive team to visit their hospital in the evening and have had a night visit from the chief executive.
- Throughout all of the hospitals we saw examples of very proactive Ward Managers and Matrons who spoke highly of their teams. We saw minutes of formal and informal team meetings and a selection of team newsletters that had been developed to involve and inform staff.
- The leadership at Arundel and The Kleinwort Hospital where of note, staff gave us many examples of how the Matron and Ward Manager motivated them and continuously acknowledged their efforts, both individually and as part of their teams.
- Nurses and their managers all told us that they had met the Chief Executive and members of the board during unannounced walkabouts that the board did regularly. Other wards told us that the Chief Nurse had worked alongside them on the wards. The general feeling from staff was that they felt supported by their managers and by the senior leaders within the Trust.
- We spoke with a number of band six and band seven Sisters who all expressed that they were supported by their matrons. The sisters were enthusiastic when talking about their staff who they described as dedicated, going beyond what was expected of them, hard working and striving to deliver the best care that they could.

Are Community health inpatient services well-led?

- Facilities staff were all able to discuss their management structure and were positive about the support that they received from them.

Culture within this service

- We found that staff were passionate about their work and the difference it made to patients. They displayed positive attitudes and said they were supported by their managers to provide excellent care and services. There was a commitment to a multi-disciplinary approach to care and an ethos that promoted autonomy and independence.
- Staff we spoke with told us they felt the matrons and Ward Managers provided strong leadership that focussed on the needs of patients. They were visible in the hospital wards and when we spoke to patients they told us could recognise them and knew what their roles were.
- We were told that the trust Chief Executive and members of the executive team held meetings in the localities and were approachable and interested in their roles and showed a keen interest in their work.
- We were informed that the Trust Finance Director regularly covered a shift as part of the compliment of HCA's at Arundel Hospital and staff commented on how beneficial this was.
- We found that the leaders encouraged collaborative working across the community in-patient facilities. For example, we saw how matrons, ward managers and therapists worked towards establishing uniform practice across the trust and how their contribution was valued.
- Staff told us that the organisation worked towards a common aim of providing excellent care.

Public and staff engagement

- We saw minutes that confirmed that site team meetings took place which afforded staff the opportunity to

discuss both local and wider organisational issues, and to be kept updated with trust initiatives and service developments. We noted these meetings provided a forum for communication to flow up and down through the various levels within the organisation.

- We saw that each site had an active 'Friends' organisation and staff could tell us about the financial support they received to purchase equipment and to improve facilities. We saw advertising materials about the Friends organisations displayed throughout the service.

Innovation, improvement and sustainability

- Staff told us that as yet there had been no negative impact from any cost improvement plans or efficiency saving programmes.
- Staff throughout the community in-patient facilities were very positive about the inspection and we saw how the Ward Manager at Arundel had used the opportunity to maximum benefit, creating an improvement and positive attitude notice board. The main focus of the board was to highlight and involve staff in identifying all the benefits of a CQC visit giving them an opportunity to "shine at what you do best – looking after patients".
- Staff on the Horizon Unit had embraced the challenges of productive Ward and its impact was seen in all areas. For example, the staff had designed magnets which were displayed on boards behind each patient's bed. The magnets were symbols and pictures which told staff important information about the patient. For example, A red 'F' magnet indicated that the patient was at risk of falling.
- At Salvington Lodge a member of staff had developed a door sticker with a knife and fork symbol to prompt people to remember the patient required assistance with eating.