

HCRG Care Services Ltd

Sittingbourne Memorial Hospital

Inspection report

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

Ratings

Overall rating for this location

Good



Are services safe?

Requires Improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Overall summary

We rated this location as good because:

- Staff understood how to protect patients from abuse, and managed safety well. All patients that we spoke with told us that they felt safe.
- Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Managers and staff gave us examples of recent lessons learnt from incidents and changes that had been made to prevent this from happening in the future.
- Staff across the services controlled infection risk well.
- The teams used systems and processes to safely prescribe and store medicines.
- Staff provided good care and treatment and gave them pain relief when they needed it. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. The patients we spoke with were happy with their care; one patient described the service as “excellent”.
- The provider planned care to meet the needs of local people and took account of patients’ individual needs. Patients we spoke to told us they felt confident to raise concerns about the care received.
- Leaders ran services well and staff felt respected and supported. They were focused on the needs of patients receiving care and clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However;

- Staff did not always ensure they kept up to date with their mandatory training. Some teams such as the community nursing teams, and speech and language therapy teams were not keeping up to date with their basic life support and anaphylaxis training.
- Team leaders across the core services did not always record clinical supervisions with staff. Although all staff we spoke to said they met regularly with their clinical supervisors and training and development educators, and these met their needs. Staff from the inpatient services told us they received one-to-one meetings with their managers on an ad-hoc basis, and clinical supervision was being carried out. We saw that one staff member had not received clinical supervision for over a year.
- Not all staff were fully compliant with the essential safety modules of fire safety and evacuation which fell below the service’s target and not all staff had attended fire evacuation drills in line with the provider’s policy in the inpatient services. The service did provide an action plan which showed that the remaining staff had been booked onto a training session.
- There were staff vacancies across all core services. Some community health services teams were reporting they were quite stretched. On the inpatient units, we saw that shifts were covered by bank or agency staff who did not always know the patients well.
- The ward environment in the Kestrel ward was not dementia friendly so patients could not always orientate themselves. The wards did not have dementia assistive aids in place.
- Some services such as the podiatry service and speech and language therapy had a high waiting list, which meant that people might not always be able to access the services when they needed them.

Summary of findings

- On the Community inpatients wards, we saw that staff did not ensure that patients' maximum dosage for medicines were stated on their medication chart. For example, we saw that there had been no indication for eight different medications on one patient record. For another patient with a low weight, no maximum dosage was shown for paracetamol.
- The continence team did not have a bladder scanner. Although staff informed us that there was a purchase order for a bladder scanner, the teams have been without a bladder scanner for over two months.
- Some services such as the podiatry service and speech and language therapy had a high waiting list, which meant that people might not always be able to access the services when they needed them.
- Patients we spoke who were receiving care from the community health services for audits teams reported that staff did not routinely collect feedback and the provider was not actively engaging with patients and carers to plan and deliver services.
- The phlebotomy clinic was quite small with two patient chairs next to each other. This impacted on dignity and privacy. Although staff told us they could draw the curtains, people in the room could still overhear the conversations of others.

Summary of findings

Our judgements about each of the main services

Service

Community health inpatient services

Rating

Good



Summary of each main service

We rated it as good because:

- Staff understood how to protect patients from abuse, and managed safety well. All patients that we spoke with told us that they felt safe on the wards.
- Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Managers and staff gave us examples of recent lessons learnt from incidents and changes that had been made to prevent this from happening in the future.
- The service controlled infection risk well. Staff followed national guidance for the use of personal protective equipment (PPE) and the ward had a hand hygiene station at the entrance to enable all staff and visitors entering the ward to utilise this and reduce the risk of spreading COVID-19. The service had a recent hand hygiene survey which was 100% compliant.
- The service used systems and processes to safely prescribe and store medicines.
- Staff provided good care and treatment and gave them pain relief when they needed it. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. The patients we spoke with were happy with their care; one patient described the service as “excellent”.
- The service planned care to meet the needs of local people and took account of patients’ individual needs. People could access the service when they

Summary of findings

needed it and received the right care in a timely way. It was easy for people to give feedback and patients we spoke to told us they felt confident to raise concerns about the care received.

- Leaders ran services well and staff felt respected and supported. They were focused on the needs of patients receiving care and clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Not all staff were fully compliant with the essential safety training modules of fire safety and evacuation which fell below the service's target and not all staff had attended fire evacuation drills in line with the provider's policy. The service did provide an action plan which showed that the remaining staff had been booked onto a training date.
- The ward environment did not provide enough space for the safe storage of large equipment, such as hoists, which were stored on a corridor within the ward and created both a trip and evacuation hazard for any patients located in the side rooms off this corridor.
- There were some vacancies on the ward and shifts were covered by staff taking on overtime, or bank and agency staff who were not always experienced.
- Patient notes were not always secure as they were stored in a cabinet which had locks broken.
- Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Although, patient feedback on the food was entirely negative around both the quality and quantity.
- The ward environment was not entirely dementia friendly so patients could not always orientate themselves. There were no explicit aids in place within the environment to assist these patients in orientating themselves
- Staff told us they received one-to-one meetings with their managers on an ad-hoc basis, and clinical

Summary of findings

supervision was being carried out, although for one staff member, they had not received clinical supervision for over a year. Managers did not routinely record clinical supervision with staff.

- Senior leaders were not present or visible on the wards and some staff felt that they did not always manage issues escalated to them.
- Staff did not ensure that patients' maximum dosage for medicines were stated on their medication chart. For example, we saw that there had been no indication for eight different medications on one patient record. For another patient with a low weight, no maximum dosage was shown for paracetamol.
- There was not always enough nursing and support staff on to cover shifts. Some staff told us that they often worked extra hours to cover, and some of the agency staff who worked on the wards did not have the requisite skills and experience which increased the workload of regular staff.

Community health services for adults

Good



We rated the service as good because:

- The service controlled infection risk well. The environments where staff cared for patients were clean and well maintained.
- Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Staff ensured that care plans were detailed and supported patient treatment and recovery. They ensured patients who were at the end of their lives received timely pain relief.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Summary of findings

- The service planned care to meet the needs of local people and took account of patients' individual needs.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However:

- Staff did not always ensure they kept up to date with their mandatory training. Some teams such as the community nursing teams, and speech and language therapy teams were not up to date with their basic life support and anaphylaxis training.
 - The continence team did not have a bladder scanner. Although staff informed us that there was a purchase order for a bladder scanner, the teams have been without a bladder scanner for over two months.
 - Some services such as the podiatry service and speech and language therapy had a high waiting list, which meant that people might not always be able to access the services when they needed them.
 - Patients reported that staff did not routinely collect feedback and the provider was not actively engaging with patients and carers to plan and deliver services.
 - Team leaders did not always record clinical supervision with staff.
 - The phlebotomy clinic was quite small with two patient chairs next to each other. This impacted on dignity and privacy. Although staff told us they could draw the curtains, people in the room could still overhear the conversations of others.
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Summary of findings

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Summary of this inspection

Background to Sittingbourne Memorial Hospital

Sittingbourne Memorial Hospital is one of four locations within the North Kent business unit under HCRG Care Services Limited, who are an independent healthcare provider with over 5,000 staff nationally working in partnership with the NHS and local authorities.

Sittingbourne Memorial Hospital provides community adults services across the Swale boroughs in Kent, which align with the local Health and Care Partnership. After more than 10 years as part of the Virgin Group, Virgin Care rebranded as HCRG Care Services Limited in 2021 and was acquired by Twenty20 Capital.

The service registered with the Care Quality Commission in 2016. They are registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Nursing care

Sittingbourne Memorial Hospital provides the following core services:

- Community health services for adults
- Community inpatient service

The community health services for adults operated across the whole of Swale area. They provided care and treatment for patients in their own homes and in clinics.

The teams at Sittingbourne Memorial Hospital consist of:

- Community cardiology service based at Kent Science Park worked Mondays to Fridays 8.30am to 4.30pm, and held clinics at the Sittingbourne Memorial Hospital, Sheppey Community Hospital, Castle Connections (Charity) in Queensborough and King George's Pavilion (Park Avenue) on different days of the week.
- Community Matrons services based at the Kent Science Park, worked Mondays to Fridays 9am to 5pm. They also provided out of hours cover from 5pm to 8pm seven days of the week.
- Community Nursing teams worked from 8am to 8pm seven days of the week and held daily handover meetings between 1.30 and 3pm.
- Multidisciplinary Coordinator Service worked Mondays to Fridays 9am to 5pm across sites.
- Tissue Viability Service (TVN) and Wound Medicine Centre (WMC) worked seven days of the week with clinics on weekdays between 9am and 5pm.
- Community Diabetes Service based in Kent Science Park held clinics in Sittingbourne Memorial Hospital on Wednesday afternoons and Diabetes Education on some evenings.
- Community Respiratory Service based at Kent Science Park held clinics at the Sittingbourne Memorial Hospital on Mondays.
- Phlebotomy Clinic at Sittingbourne Memorial Hospital operated from 8am to 2pm Mondays to Fridays.
- Podiatry service based at Sittingbourne Memorial Hospital worked Monday to Friday 8.30am to 2.30pm.
- Speech and Language Therapy (SALT) teams worked virtually or in the community and clinics were held on demand. The service was available from 8.30am to 4.30pm Mondays to Fridays.
- Continence Service based at Kent Science Park worked virtually and provided continence service from 8am to 4pm Monday to Friday.

Summary of this inspection

The community inpatient service, Kestrel ward, is a 22-bed rehabilitation ward. At the time of the inspection the ward had 17 patients. The ward had beds for patients with progressive and non-progressive neurological conditions who need more rehabilitation following discharge from an acute hospital. This may be following a stroke.

Rehabilitation is also provided for patients who are medically stable but need support to improve their independence. The service provided therapy, education and support enabling patients and their carers to achieve the best possible quality of life.

Kestrel ward worked on improving mobility, strength, independence in personal and domestic care tasks, cognitive ability, communication and language.

At the time of this inspection the service did not have a registered manager but they had submitted an application.

We had not inspected this location before.

What people who use the service say

Community health services for adults:

Patients and carers were very positive about the service, staff and the care and support they received. Patients told us the staff were very knowledgeable and experienced and they felt the care they provided was safe. Patients reported that staff were very kind and respectful and always addressed them by their preferred name. Some patients reported that they felt the staff were going over and above in the way they cared for them. While a majority of patients reported that the care and treatment met their needs, one patient told us they did not feel their needs were being met as the physiotherapy sessions often left them in pains days later

Community inpatient service:

People who used the service were positive about the care they received and the staff. They told us that they felt safe, that they were being helped to get better, that they were always treated with dignity and respect and that they felt involved in their care. They told us that staff were very responsive and friendly and they appreciated staff taking the time to spend with them. They told us that the cleanliness level of the ward was always very high. However, they gave negative feedback around the quality and quantity of food they received on the ward.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Summary of this inspection

Is it well-led?

Before the inspection visit, we reviewed information that we held about the service. We announced this comprehensive inspection 48-hours prior to the inspection visit. Due to the service providing services throughout England, we announced the inspection so that the service could arrange interviews.

Community health services for adults:

During the inspection, the team:

- Visited outpatient clinics where care and treatment were provided
- Attended two home visits with staff
- Spoke with 15 members of staff including managers, service leads, community matrons, specialist nursing teams, therapists, phlebotomists, allied health professionals and health care assistants. These were carried out via onsite interviews as well as virtual staff focus groups for staff we could not speak to onsite
- Spoke with 18 patients and two relatives
- Reviewed five patient care and treatment records
- Observed a handover meeting
- Looked at a range of policies, procedures and other documents related to the running of the service.

Community inpatient service:

During the inspection, the team:

- Visited and had a tour of the ward and clinic/ treatment rooms
- Spoke with 9 staff including the ward manager, ward matron, physiotherapist, occupational therapist, registered nurses, and healthcare assistants. These were carried out via onsite interviews as well as virtual staff focus groups where staff could join and give feedback on the service
- Spoke with five patients who were using services and five of their relatives
- Reviewed four patient care and treatment records
- Reviewed four medication charts
- Observed a weekly multidisciplinary discharge meeting
- Observed staff providing care to patients on the ward
- Looked at a range of policies, procedures and other documents related to the running of the service.

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

Outstanding practice

We found the following outstanding practice:

Community health services for adults:

- The community nursing teams were sending bereavement cards and flowers to families and relatives following the death of patients. This demonstrated compassion and kindness.

Summary of this inspection

- There was a water crisis on the Isle of Sheppey in July 2022 where the whole of the island was without water due to burst mains water pipe leading to the island. Staff coordinated with the water company to ensure that all patients had access to water. Staff stayed long past their shifts into the night to deliver water bottles to patients around the island and also worked with people in the community to identify vulnerable families who needed water urgently.
- The provider had recently put in a business case with the commissioners to purchase a Hoverjack – a piece of moving and handling equipment that enabled the safe and transfer of palliative/ end of life patients. The provider informed us that the equipment had led to reduced visits from clinical staff as hoist and sling assessment were no longer required. The provider also informed us that the use of the equipment had improved comfort and dignity for patients during transfers.

Areas for improvement

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

Action the service MUST take to improve:

Community health services for adults:

- The provider must ensure that staff complete their mandatory and statutory training. (Regulation 18. Staffing)

Community inpatient service:

- The service must ensure that all equipment stored on the ward is stored safely to reduce environmental health and safety risks, particularly to prevent evacuation difficulties, in line with their policy. [Regulation 12 (2) (b) Safe care and treatment]
- The service must ensure that all ward staff attend fire training and evacuation practices on a regular basis to improve confidence and familiarity in the event of an emergency evacuation, in line with their policy. [Regulation 12 (2) (b) Safe care and treatment]

Action the service SHOULD take to improve:

Community health services for adults:

- The provider should ensure that the teams have access to specialist equipment to carry out their jobs effectively.
- The provider should continue its work towards reducing the waiting list across the services to ensure people are getting timely care and treatment.
- The provider should ensure that it is actively engaging with patients and carers in the planning and delivery of services.
- The provider should ensure that staff are routinely collecting feedback from patients about their care and treatment.
- The provider should ensure that team leaders are recording clinical supervision in line with the providers policy.
- The provider should consider improving the dignity and privacy of patients visiting the phlebotomy clinic.
- The provider should continue to recruit to the vacant positions across the services.

Community inpatient service:

Summary of this inspection

- The service should ensure that all agency staff employed to work on the ward have appropriate training and experience to do so.
- The service should ensure that patient notes and information are stored securely.
- The service should ensure that staff have access to dementia training.
- The service should ensure that the environment is dementia friendly so that patients can orientate themselves.
- The service should consider making improvements to the food provision on the ward.
- The service should ensure that all staff are receiving consistent and accessible clinical supervision.
- The service should ensure that managers record when staff receive clinical supervision.
- The service should ensure that senior leaders are more present on the ward and are actively listening to staff.
- The provider should ensure that staff record maximum dosage for all patient's medication in their medication chart in line with best practice.
- There was not always enough nursing and support staff on to cover shifts. Some staff told us that they often worked extra hours to cover, and some of the agency staff who worked on the wards did not have the requisite skills and experience which increased the workload of regular staff.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Requires Improvement	Good	Good	Good	Good	Good
Community health services for adults	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Community health inpatient services

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

Are Community health inpatient services safe?

Requires Improvement 

Mandatory training

The service provided mandatory training in key skills to all staff and made sure most staff completed it. However, the compliance with some essential safety courses fell below the service's target and was not in line with the providers policy.

At the time of the inspection, 93.5% of staff had completed their mandatory training across all the required training, which was above the service's target of 85%.

However, fire awareness and evacuation training was one of two courses which fell below the service target as only 63.6% of staff had completed this. Managers showed an action plan designed to address where training was below the compliance target, and this evidenced that outstanding staff were booked on to complete this in the next few months.

The service also recorded fire drill training which aimed to familiarise staff with actions to be taken in the event of a fire alarm and evacuation. The provider's fire management policy identified that whilst an annual fire drill was standard, this needed to be more frequent where staff turnover was high or evacuation strategy was complex.

The service provided records that showed that the last three fire drills had been carried out in April 2022, November 2021 and June 2020. On the recent April training, 12 members of staff had attended this fire drill training and reported how beneficial they had found this. However, some staff told us that they had never completed this training despite having worked at the service for several years and at times worked night shifts where the staffing levels were considerably lower which increased responsibility on these staff members in the event of a fire. The impact of this meant that patients were likely being cared for by staff on shift who were not always familiar or confident with the evacuation processes.

The service had recently employed a new Practice Development Nurse (PDN) who was focused on reviewing compliance and identifying gaps in staff training and learning. The PDN was offering staff additional training in modules including learning disability, autism, diabetes, Parkinson's and dementia. Although, these were not part of the mandatory training package for staff working on the wards and staff told us that they were not always able to attend these due to work demands or the travel required to get to the training locations.

Community health inpatient services

Managers had access to a training matrix to identify when training was due, and they sent reminders out to staff.

Safeguarding

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

The service had a dedicated safeguarding lead that staff could access for advice. Staff spoke highly of the support they received from the safeguarding lead in being able to talk through any concerns and receive support in making referrals. The safeguarding lead also held a recent safeguarding debrief with staff regarding a recent safeguarding referral made against them by the local ambulance service. Despite this being an unfounded safeguarding allegation, they identified some gaps and areas where action could be taken to improve care.

Staff completed the appropriate safeguarding training for their role with a current average compliance rate of 98% across all four safeguarding modules. Staff said they felt confident raising safeguarding concerns and understood their role in the process. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Senior staff told us they discussed safeguarding incidents in monthly quality governance meetings and then this cascaded down to the team through their monthly team meetings and a safeguarding newsletter which was shared via email. Team meeting and staff briefing agendas had safeguarding as a standing agenda item, so this meant that information was shared effectively with staff. The service also provided safeguarding supervision and followed a safeguarding policy.

Cleanliness, infection control and hygiene

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

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date which demonstrated that all areas were cleaned regularly. Cleaning audits showed an average compliance rate of 98% for the period of May to July 2022.

Staff knew how to prevent infection and had received training in infection prevention and control (IPC). The current compliance for this training was 90.91%. Staff followed national guidance for the use of personal protective equipment (PPE) and the ward had a hand hygiene station at the entrance to enable all staff and visitors entering the ward to utilise this and reduce the risk of spreading COVID-19. The service had completed a recent hand hygiene survey which was 100% compliant. Managers and staff told us that the service did have a COVID-19 outbreak a few months ago.

We observed that staff cleaned equipment after use. Although the ward had four side rooms, these did not have en-suites and therefore they were not always able to isolate patients appropriately to ensure strict IPC practices and control infection.

The service had an infection control lead responsible for ensuring audits were completed. The recent 2021 IPC audit showed 100% for general IPC questions and 70% for the environmental audit. Comments and actions plans were evidenced throughout which showed how the provider made clear where improvements could be made.

Community health inpatient services

Environment and equipment

Staff were trained to use equipment. Staff managed clinical waste well. However, the use of facilities and premises did not always keep people safe.

The design of the environment followed national guidance. There were no mixed gender bays and some patients had their own rooms which maintained their privacy and dignity. Although, the ward was tired and in need of redecoration with paint chipping from the walls and marked skirting. Also, they had a total of five toilets and one bathroom for all 17 patients. There was a shower room though this was not currently in use due to a leak and a step which made it difficult for immobile patients to access.

Patients could reach call bells and we observed staff responding quickly when called. We reviewed the call bell system and saw that most call bells had been responded to within five minutes which meant that patients were not left waiting for long when they needed staff. During inspection we observed a call bell being responded to within three minutes.

Staff disposed of clinical waste safely.

Patients had access to specialist equipment to aid their rehabilitation and meet their needs including use of a dedicated kitchen and day room. The kitchen was used for visitors if they wanted privacy during their visit. The day room was open planned and comfortable with a television and books available for patients to use. Although, the chairs around the dining room table, which were also in the day room, were standard dining room chairs and did not offer appropriate support for elderly patients.

Staff carried out daily safety checks of specialist equipment. Staff had easy access to an emergency resuscitation trolley which had equipment including a defibrillator, oxygen and suction. The equipment was in date and checked regularly.

The service had suitable equipment to help them safely care for patients, for example hoists, wheelchairs and pressure relieving mattresses. However, the ward had challenges in respect of available storage space and excessive equipment. For example, there were two hoists, three stand aids, three dynamaps, all of which is equipment used to assist and care for patients, yet it took up the entire space of one of the linking corridors. The service had decommissioned one of the ward side rooms to enable storage of commodes, of which there were 14. In a laundry cupboard there were seven unused pressure relieving mattresses and in another area of the ward there were two bariatric wheelchairs despite excluding admissions for bariatric patients because of the wider fire evacuation complexities. The impact of this lack of space meant that equipment was being stored along corridors which would hamper swift evacuation of patients in the side rooms off these corridors. The provider's fire management policy identified that "means of escape must never be blocked or partially blocked by storage of furniture, equipment, waste or other materials".

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Care records we looked at showed appropriate use of risk assessment tools such as Waterlow scoring for pressure ulcer assessments and use of the National Early Warning Score (NEWS2) carried out three times a day. We saw evidence of one patient

Community health inpatient services

whose haemoglobin levels were low, so they arranged a transfer to the local acute hospital for a blood transfusion before the patient returned to the ward for continued care where frequent monitoring remained in place. In addition, when the service experienced its COVID-19 outbreak in June, five out of eight patients deteriorated within 24 hours and this triggered transfer to the local acute hospital.

Staff completed risk assessments for each patient on admission and reviewed these regularly, including after incidents. Staff made assessments of the appropriate moving and handling needed for the patient, dementia assessments, as well as whether patients were at risk of falls, including bed rail assessments, and kitchen assessments.

Patients assessed as at risk of slips, trips and falls were observed closely by staff and placed into easily observable rooms. The service also used a wristband scheme to easily identify patients at risk of falls. Patients wearing red wristbands enabled staff to easily identify who required assistance to mobilise. A yellow wristband meant patients required supervision, and green wristbands meant that patients had been assessed as independent.

Staff knew about and dealt with any specific risk issues. Staff checked skin daily for patients identified with a pressure ulcer or deteriorating health. We saw that the SSKIN (Surface, Skin, Keep Moving, Incontinence, Nutrition) care bundle was completed for patients at risk of pressure ulcers.

The service printed off electronic handover sheets which were updated by the nurse in charge on day and night shifts, and staff carried out bedside huddles at the start of each shift to share key information on patients care. Shift change handovers included all necessary key information to keep patients safe, including infection risk, food charts, safeguarding concerns, ability to mobilise and falls risks, as well as updates on their discharges. Staff found that this type of handover was more efficient use of their time and ensured that they had a copy of the information they needed for daily care.

Staff referred patients for specialist mental health support and assessments if they were concerned about a patient's mental health, including emergency support from the CRISIS team where needed.

The service did not have piped oxygen on the ward. This meant that patients who required oxygen were not able to receive this at their bedside immediately due to a need to retrieve a cylinder from the ward storage. This was on the service risk register and staff mitigated the risk of this by storing it in the main corridor with masks attached ready for use. Staff also completed checks to ensure available supplies.

As the service was on the first floor of the hospital building, there was no direct access to outdoor space for the patients.

The recent annual fire risk assessment was assessed as high and evacuation routes from the ward were via use of a lift override and a staircase and included strategies for immobile patients of commodes, wheelchairs, hospital beds and ski sheets which were fitted to every bed. A ski sheet is an evacuation aid used to transfer patients in an emergency. The service had a ward specific and an overall hospital fire evacuation plan.

Although the service had a guidance flow chart which detailed the procedures for an emergency evacuation of patients in the critical event of an emergency such as a fire, not all staff had attended the fire evacuation drill as required. However, staff ensured that patients had personal emergency evacuation plans (PEEPS) in place. A PEEP provides those who cannot get themselves out of a building unaided with the necessary information and assistance to be able to manage their escape to a place of safety and ensures that staff are aware and ensure that the correct level of assistance is always available.

Community health inpatient services

Staffing

The service did not always have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Although, the service did not always have enough nursing and support staff to keep patients safe. Some staff told us that they often worked extra hours to cover. To mitigate risk, the service used bank and agency staff to cover unfilled shifts and all bank and agency staff had a full ward induction. Although, staff told us that contracted agency care staff did not always have the necessary experience or skills, with some having never previously worked on a ward, and most arrived late for shifts. Due to this, all staff told us that they had to support agency staff to carry out tasks on the ward which doubled their own workload.

The service had a contract in place with an agency which sourced agency staff. Managers told us that they provided the job descriptions to the agency to match the staff resource prior to potential staff CVs being sent to the service to check for suitability. They told us that they accept agency staff based upon the agency being able to evidence suitability in line with the job description, ensuring that they have the relevant experience and knowledge to carry out the requested duties.

The service had an induction checklist for agency workers, which included orientation around fire safety and procedures, deteriorating patient and location of emergency equipment. This was signed off by the identified nurse or health professional in charge who were responsible for ensuring the temporary worker was fully briefed and had all relevant information to enable them to carry out their work professionally and safely.

Managers sought feedback on agency workers and avoided further bookings when there were identified concerns, as well as escalating these to an internal contract and performance manager who dealt with any concerns raised by the team in respect of agency workers.

The service used an electronic system which automated the staff roster in advance to ensure the ward had an appropriate mix of skilled staff on shift and gave a RAG rating to identify where compliance was not met. The data provided to us by the service showed that within the recent four-week period between July and August 2022, the service had five unfilled shifts for registered nurses and thirteen unfilled shifts for unregistered staff. These included a mixture of nights, early and late shifts. They had a temporary staffing list which showed that most of the shifts covered by this staffing group were mostly night shifts.

At the time of our inspection there were three full time equivalent (FTE) registered nurse posts vacant. There were also two healthcare assistant posts. Managers told us that they were currently onboarding two healthcare assistants and one registered nurse onto their bank.

Staff sickness on the ward was at a total of 2.98% for the past 12-months. 0.33% of this was long term sickness and the most significant reasons for absence were COVID-19 and headaches and migraines. The provider also separately recorded the number of stress related absences which was two and stress/ depression/ anxiety was the fifth reason for absence amongst staff.

Community health inpatient services

Some staff we spoke with told us that there had been several staff who had left the ward, and that retention was one of the biggest issues. Although, the data provided by the service showed the staff turnover rate for the ward was 0% for the past 12-months, showing that there had been no leavers in the last year.

Medical staffing

At the time of our inspection, the ward had medical cover from a locum agency doctor. Managers told us that the previous substantive doctor had left in April 2022 and the post had not been put back out to recruitment as the service were reconsidering their medical model to become nurse led, with a plan for the development of advanced nurse practitioners and nurse prescribers. Although, this had not yet been put in place. During times without medical cover, they relied on a doctor from another ward who responded to any requests for discharge letters or take out medication requests. The lack of ward doctor featured on the service risk register.

Staff told us that during periods where they had no medical cover, they sent patients to the local acute hospital for assessment. Out of hours staff could access medical support via the local urgent treatment centre run by a neighbouring community healthcare company. In an emergency, staff contacted the emergency services.

Quality of records

Staff kept detailed records of patients' care and treatment. Records were up-to-date and easily available to all staff providing care. Although, these were not always stored securely.

Patient notes were thorough, and all staff could access these easily. We looked at four patient care records which were comprehensive and person-centred.

All records, including patient risk assessments, routine patient observations, food and fluid charts and pressure care assessments were paper based and stored in a cabinet at the ward clerk's desk. Managers told us that some of the locks were broken on these cabinets which had been escalated to the engineers. This meant that records were not kept securely.

Medicines

The service used systems and processes to safely prescribe and store medicines. Although, the medication records did not always provide indications of medication and the maximum dosage was not always stated on the charts.

Staff followed systems and processes to prescribe and administer medicines safely. Medication rounds took place three times a day on the ward. Medicines were supplied by a local independent community pharmacy. The service was supported by the organisation's lead pharmacist who worked across all four locations within the business unit and who visited the ward once a week.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. We saw evidence that the pharmacist completed a drug reconciliation process on admission of all patients.

Community health inpatient services

Staff completed accurate medicines records and kept them up-to-date. The service kept a log of controlled drugs prescribed for individual patients which was double signed, and the recording of stock for controlled drugs was accurate. Any discrepancies were reported via the incident reporting system.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

However, some medication administration records (MAR) did not always provide indications of medication and the maximum dosage was not always stated on the chart. For example, we saw that there had been no indication for eight different medications on one patient record. For another patient with a low weight, no maximum dosage was shown for paracetamol. As best practice, any patient under 50 kilograms should have the amount of paracetamol reduced and a maximum set.

Emergency drugs were stored in a labelled box in the clinic room and checked weekly. Clinic rooms were locked with a keypad.

The fridge and room temperature were checked daily to ensure medicines required to be kept at a certain temperature remained intact.

Safety performance

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Staff monitored and recorded an appropriate range of safety performance indicators. These included recognising patients at risk of physical health deterioration and using a routine physical health monitoring tool.

The service displayed a safety thermometer board on the ward, which showed visitors the number of falls and pressure ulcers during the month. At the time of inspection, there had been one fall and no medication errors or acquired pressure ulcers recorded for the month.

Falls and pressure injuries were reported on and reviewed at specified harm reduction groups where staff could identify any themes or trends. This information was fed back during monthly quality governance meetings.

The service made appropriate changes to care for patients with complex needs after identifying potential safety concerns. For example, one-to-one nursing and observations when required to help mitigate the risk of falls.

Incidents

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

All staff we spoke with knew what incidents to report and how to report them in line with the service's policy. Falls and pressure ulcers were the most commonly reported incidents.

Community health inpatient services

Senior managers attended monthly incident review panel meetings where specific incidents were discussed and lessons learnt identified which were then shared with the team during team meetings, ward meetings, and handovers.

There was evidence that changes had been made as a result of feedback. For example, following a fall to fracture incident which occurred the service adopted an escalation plan around patients which included introduction of wristbands to easily identify patients at risk of falls, with patients wearing red wristbands easily identified as those who required assistance to mobilise. They also carried out a daily mobility update with all staff to clarify whether the staff numbers required when moving and handling had changed, with this information also documented on the chart above the patient's bed. There was a board in the main corridor which provided staff with clarity over identified acronyms and terminology. The service also carried out a post falls training update which all staff were required to attend.

Staff received feedback from investigation of incidents across community services and met to discuss the feedback and look at improvements to patient care through monthly 'learning events' which all staff could attend.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Staff told us that managers debriefed and supported them after any serious incident.

Are Community health inpatient services effective?

Evidence-based care and treatment

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

Staff kept up to date with and followed relevant National Institute for Health and Care Excellence (NICE) guidelines to plan and deliver quality care according to best practice.

Staff had access to policies on the staff Intranet and knew where to find them. Leaders told us they checked to make sure staff followed guidance through individual supervision and team meetings.

The service discussed audit outcomes during monthly quality governance meetings. Identified risks featured on the corporate risk register.

At the time of our inspection, the service had no patients subject to detention under the Mental Health Act 1983.

Staff protected the rights of patients in their care and worked with patients to develop rehabilitation goals. These included increasing independence, improving mobility and activities of daily living. Occupational therapists and

Community health inpatient services

physiotherapists produced joint rehabilitation plans for patients. Staff did tell us that pre COVID-19 there were a lot more group activities which took place on the ward. They told us that the day room was being used more frequently by patients and how they would like to increase the group activities on the ward. We saw patients using the day room during the inspection.

The therapy team also completed home visits to ensure that patients' home environments were suitable to meet their needs once discharged, such as providing extra equipment.

Nutrition and hydration

Staff gave patients food and drink to meet their needs and improve their health, although the quality and amount of food was not always adequate. The service used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff used a Malnutrition Universal Screening Tool (MUST) in line with professional guidance to assess and improve nutritional care. Patients' weight was recorded weekly as a minimum, with each bay or room being allocated a weigh day.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff recorded patients' dietary requirements, including allergies, on a white board outside the patient kitchen. The ward also had a "red" system which meant that if a patient was given food on a red tray or if they had a red beaker, this alerted all staff not to remove the food or drink until what had been consumed by the patient had had been recorded.

Patients were referred to a dietitian or speech and language therapist if they needed support with their nutrition or hydration. Managers told us that speech and language therapists attended the ward when referred to, and a dietitian employed by a neighbouring community trust attended the ward once a week.

The food was supplied by an offsite canteen three times a week and brought to the ward where it was stored frozen. Staff provided patients with three options the day before so that they could choose their meals in advance. On the day, care staff put the choices into the oven, temperature probed and distributed this to patients. Any special needs were identified, and the canteen notified. For example, allergies, soft choice, energy dense, healthy eating, vegetarian, gluten free or diabetic menus. Although, staff told us that sometimes if they had admissions on that day, they did not always have the right amount of food. They also told us that feedback from patients about the food was not always positive. All patients that we spoke with were negative about the food. One told us that vegetables were "burnt" and that it was not "appetising at all", and another's relative told us that it was "terrible" and that her loved one could not eat the food that was being given to her so family brought in food for her.

Pain relief

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

Community health inpatient services

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used the Wong-Baker faces pain rating scale which was a pain scale comprised of smiley and unhappy face cards which they could relate to and explain their pain based on these. All patients we spoke with told us that they were comfortable and felt that their pain was controlled.

Staff prescribed, administered and recorded pain relief accurately. Trained nurses were able to administer paracetamol without a doctor's prescription for temporary pain relief.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. These included audits on falls, MUST assessments, admission paperwork, safeguarding, record keeping, and IPC environment.

Managers and staff used the results to improve patients' outcomes. For example, a recent audit carried out on the cleanliness of commodes was 80%. In order to improve this, the infection prevention and control link staff member delivered training to staff and sent out communications via email. Managers also set out an action plan and discussed at a ward meeting. The audit was repeated the following week and was assessed as 100% compliant as significant improvements had been made.

Managers made sure staff understood information from the audits and this was shared in local teams meetings and on the staff Intranet.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Although, one staff member did not attend regular clinical supervision groups.

Overall staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service had recently employed a practice development nurse (PDN) to support the learning and development needs of staff as they recognised that there was a lack of full clinical competencies in place for both registered and unregistered staff. At the time of our inspection, the PDN was undergoing a review of the team's competencies to identify all outstanding clinical competency requirements. Some staff had received core competency work booklets and the service was carrying out refresher training for relevant updates on use of medical devices, NEWS2, MUST, aseptic techniques, documentation and communication. Although staff acknowledged the amount of additional training on offer, some reported issues with the accessibility of this training.

Newer staff were now receiving a full induction programme which was spread over five weeks and included various training inputs and clinical competency sign off.

Managers told us that every staff member was trained before they came onto the ward. Although, some staff told us that some of the agency staff lacked the appropriate experience and skills.

Community health inpatient services

Staff reported feeling well supported from their direct line management and described that they received informal supervision with their manager who had an “open door” policy. Managers told us that they always tried to have informal one to one sessions with staff on a regular basis, and that they were always available when on the ward.

Staff were also supported in their clinical practice through clinical practice supervision groups which had been set up across the business unit and enabled constructive and reflective peer discussions. Some staff told us that they had not had one in over a year due to cancellations and leave. The provider’s policy stated that staff should be attending these at least four times a year, although, managers did not always keep clear records of the attendance of these.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop through yearly appraisals. At the time of our inspection 95.5% of staff had received constructive appraisals of their work. Managers told us that these took place between May and July, with additional “how are you” catch ups taking place in October and November. Appraisals gave staff and managers the opportunity to discuss any relevant concerns or issues with poor performance and put in place plans to support staff to improve.

Managers made sure staff attended monthly ward meetings or had access to full notes when they could not attend as these were emailed to staff. Information was disseminated to the team via email, during daily shift handovers and posted on the Intranet.

Multidisciplinary working and coordinated care pathways

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

All staff we spoke with felt that they worked well together as part of a multidisciplinary team (MDT). Staff described good opportunities for joint working, learning from each other and being able to challenge decisions constructively with colleagues.

Staff held weekly and daily multidisciplinary meetings to discuss patients and improve their care. For example, the ward had an MDT board meeting daily to identify actions for each member of the MDT with regards to preparing a patient for discharge. We also observed a weekly MDT discharge meeting attended by the nursing team, therapy team and a discharge coordinator where staff gave updates on patients’ current situation and identified any outstanding actions required to facilitate discharge, as well as any reasons for a delay. Where there were delays, we observed that actions were escalated to address this.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw that patients had been referred on to other specialist teams as needed.

Staff reported good working relationships with professionals visiting the ward and other community providers. Staff worked with colleagues in adult social care when planning a discharge package of care for patients.

Health promotion

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

Community health inpatient services

The service had relevant information promoting healthy lifestyles and support on the ward. Staff assessed each patient's health when admitted and identified who may need additional support due to frailty or cognitive issues. Staff gave advice about health conditions, treatment and outcomes. Patients we spoke with felt that the ward was helping them to get better.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training was covered within the mandatory adult safeguarding training. The safeguarding lead also carried out additional training for staff to improve confidence. We saw evidence in a patient's notes that they had recorded capacity assessments.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, considered their wishes, and recorded this in the patients' records.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. We observed discussion around patients' mental capacity during the weekly MDT discharge meeting.

We found that 'do not attempt cardiopulmonary resuscitation' (DNACPR) records were appropriately maintained and easily accessible at the front of patient notes so that staff could find them quickly in an emergency.

Are Community health inpatient services caring?

Compassionate care

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

Staff were passionate about delivering care and were discreet and responsive when caring for patients. All patients we spoke with told us that they were treated in a compassionate and caring way by staff and that staff respected their dignity and privacy. We observed positive and compassionate interactions between staff and patients on the ward.

We spoke with five patients and five relatives during the inspection. All patients and carers spoken to felt happy with the care they or their loved one had received and told us staff treated them well and with kindness. One patient told us that staff were "excellent", and a relative told us that their loved one was "well looked after".

Community health inpatient services

The ward had several thank you cards displayed at reception from patients and relatives thanking them for their kindness and compassion during their stay.

Most staff took time to interact with patients and those close to them in a respectful and considerate way. Most patients told us that staff would have conversations with them when they could. Although one patient told us that sometimes agency staff “shouted” at them when they called their bell because they were busy and that on occasion, they were waiting 10-15 minutes for their call bell to be answered. Though they had said that most staff were good.

Staff followed policy to keep patient care and treatment confidential. They understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Managers gave examples of how they supported families to bring in specific food for patients who wanted this for cultural reasons.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for and discussing patients. At discharge meetings, staff discussed the psychological and emotional needs of patients, their relatives and carers, as well as practical considerations.

Emotional support

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us they took extra time to listen to patients to support with their emotional wellbeing and this was reflected in the patient feedback as both patients and relatives described staff as kind and friendly. Staff told us that when patients were coming up for discharge, they were often anxious which was when they would spend more time reassuring them.

Staff supported patient's relatives, particularly in understanding their complex health conditions. Feedback from patients and their relatives was that staff discussed with them plans for treatment and care, both on the ward and for discharge.

Understanding and involvement of patients and those close to them

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

Staff supported and involved patients and those close to them. Patients and relatives told us that they were both involved in their care and treatment. Staff told us that they personalised care plans and ensured, where possible, patients read and signed their care plans.

Staff contacted relatives to update them on patient care. Managers told us that after the MDT meetings they would update relatives. Some families also preferred to speak to staff during their visits to the ward.

The service allowed visitors each day for three hours within two allocated visiting slots. The service did not have a specific visitor's room on the ward but enabled the therapy kitchen to be used for any visits or multiagency visits where privacy was required. Staff also provided phones for patients to use to keep in touch with their relatives when needed.

Community health inpatient services

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw a feedback box located at reception and posters advertising the ways in which patients and families could provide feedback. The service had also restarted 'tea with matron' which was being held monthly and gave patients the opportunity to discuss any concerns or share compliments informally with the ward matron.

Relatives were able to complete the friends and family test (FFT) feedback form and patients could complete the reported outcome measures (PREMS) prior to discharge. The business unit received an average positive score of 96.29% in the last 12 months of FFT responses.

Are Community health inpatient services responsive?

Good 

Planning and delivering services that meet people's needs

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

Managers planned and organised services, so they met the changing needs of the local population. The service kept open bed space specifically for community patients who were no longer safe to be independent at home in order to avoid their admission into acute hospitals.

The service had systems to help care for patients in need of additional support or specialist intervention.

Therapy staff tailored patients' therapy sessions to meet their individual needs and involved care staff in the delivery of recommendations, as they then motivated and supported patients daily to engage in activities as part of their rehabilitation, such as those of daily living.

Staff discussed patients' progress at daily handover meetings and daily MDT board huddles, as well as weekly MDT discharge meetings. We saw evidence of multi-agency working in patient care records, particularly around discharge planning.

Staff supported patients to attend any required follow-up appointments at the acute hospital and transport was arranged for this. Staff could also arrange for some diagnostic appointments to take place within the hospital location so that patients did not need to travel for these.

Meeting the needs of people in vulnerable circumstances

The service made reasonable adjustments to help patients access services and coordinated care with other services and providers.

Staff had access to communication aids to help patients become partners in their care and treatment. For example, the service could use large print, braille or audio tools for those who had visual impairment. Staff also told us that for patients who struggled to communicate verbally they used communication cards to assist with this. Staff also used whiteboards and markers to communicate with those with hearing difficulties.

Community health inpatient services

Staff used translators via telephone for patients whose first language was not English and information could be provided to patients in languages other than English.

Patients were supported with their cultural and religious preferences, and the service welcomed religious leaders onto the ward to visit when patients requested this.

Staff facilitated contact with relatives for patients during COVID-19 outbreaks when visiting was restricted on the ward. Staff used mobile devices to set up video and telephone calls for patients and relatives.

Although, considering that the ward often had patients with dementia and cognitive impairments, we did not see any explicit aids in place within the environment to assist these patients in orientating themselves.

Access to the right care at the right time

People could access the service when they needed it and received the right care promptly.

Managers and staff worked to make sure patients did not stay longer than they needed to. Managers monitored admissions and discharges, as well as patients that spent more than 25 days on the ward which they reported to the clinical governance group. Managers told us that waiting lists were managed by the discharge coordinator and that once a patient was discharged, they would always receive a further referral.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The service worked closely with adult social services for any required care packages which were sourced by an independent provider. Managers monitored the number of patients whose discharge was delayed and took action to reduce them. At the time of the inspection, managers told us that the service had two patients experiencing delayed discharge as they were both waiting for assessment beds and packages of care.

The service moved patients only when there was a clear medical reason or in their best interest. For example, there were some instances where patients had been moved back to the acute hospital when their physical health had deteriorated.

Staff supported patients when they were referred or transferred between services.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns and staff understood the policy on complaints and knew how to handle them.

The service clearly displayed information about how to raise a concern in patient and visitor areas. We observed a feedback box located at the reception desk and staff told us patients were asked if they would like to fill in the friends and family test (FFT) form and patient reported experience measure (PREM), prior to discharge to give their feedback. Although, none of the patients or relatives that we spoke with had been asked for feedback from the service. The service also displayed a 'you said we did' poster on the ward to encourage ideas and feedback from patients and relatives.

Community health inpatient services

In the last 12 months, the service had not received any formal complaints, with all concerns or issues dealt with at ward level. The service identified themes from any informal concerns. The recent ones had been around food and the delays in receiving packages of care to enable discharge. Managers told us that although packages of care were not the responsibility of the service, they still invited families onto the ward to be part of any discussions and made sure patients and relatives were kept updated and understood the processes involved with these. They also directed patients and families towards advocacy.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw that complaints were routinely discussed as a standing agenda item during team meetings. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

The service also received compliments and shared these with staff.

Are Community health inpatient services well-led?

Good 

Leadership

Leaders had the skills and abilities to run the service and understood the priorities and issues the service faced.

Staff described the ward managers and matrons as accessible and approachable. Staff told us ward managers and matrons supported them on the ward clinically with patient care as needed. The matron prioritised their time between two locations, and feedback from staff was that they were responsive and visible when on site.

Most staff we spoke with told us that it was not common to see members of the senior leadership team on site at Kestrel ward and most did not know who they were as there had been some changes within the business unit. Staff told us that there was a chain of delegation where all issues escalated up from the ward went to the ward manager and matron in the first instance, before being taken to the senior leaders. Although, some staff felt that when issues were raised, these were not always actioned by senior leaders. For example, the lack of medical cover on the ward was something that had been raised though they have seen no further action taken around this. Staff told us that they had to manage patient expectations when they asked to speak to a doctor. In addition, some staff told us that they felt unsafe with the expectations around a fire evacuation, especially when working at night. Some staff also felt that they would like more support to develop and attend additional training.

Vision and Strategy

The service had a clear vision of what they wanted to achieve and the strategy to turn it into action. Staff understood the vision and strategy of the service.

The North Kent business unit had a vision for what it wanted to achieve under HCRG Care Services Limited following the rebranding from Virgin Care in 2021, and a strategy to turn it into action developed with all relevant stakeholders.

Community health inpatient services

HCRG in North Kent was focused on sustainability of services and aligned to local plans within the wider health economy. The strategic plan for 2022 to 2025 identified priorities to be delivered including meeting the expectations of people accessing care; being a responsive provider by driving quality outcomes for patients; investing in their employees to develop, attract and retain a high performing and sustainable workforce, adding social value to the communities they serve; and maintaining financial sustainability.

Most staff we spoke with explained that the rebranding of the service had come in suddenly, and some staff felt that there had been a lack of communication from seniors prior to this happening. Some staff told us that they felt the new business were budget orientated and that finances were a barrier within the service. For example, initially overtime was not being paid to staff who worked extra hours to cover staff shortage. Although, this has since been resolved with staff being registered on flexible bank and claiming payment through this.

Despite the rebranding, all staff told us that there had been no change in the delivery of their general day to day work. Staff described wanting to provide the best possible care for the needs of patients, and the utmost support for their colleagues.

Culture

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

Staff we interviewed both individually and in the focus groups felt respected, and supported within the team. They described good team support and a positive atmosphere. Staff felt able to approach their line manager if they wanted to provide feedback.

The service had an open culture where staff felt able to raise concerns without fear. Staff were supported to learn lessons when things went wrong without being made to feel blamed. Managers addressed any issues within the team through one to one feedback and supported staff with grievance processes if necessary.

The service promoted equality and diversity in daily work. Managers and staff told us how policies were in place to protect staff against any discrimination. Leaders also gathered workforce data in relation to diversity, equality and inclusion.

Although, some staff raised a discrepancy with the different staff contracts. For example, some legacy staff remained on previous NHS payment structures whereas those who joined under the private company had different entitlements, including lower hourly rates and sick pay. Staff described how this had an impact on the morale of the team, especially when they were needed to cover extra shifts or work longer hours.

The service had a staff wellbeing board on the ward and a wellbeing internal webpage where staff were able to access information and wellbeing support. Staff were encouraged to speak about concerns.

Governance

Leaders operated effective governance processes throughout the service and with partner organisations. The service improved service quality with monthly quality governance meetings and monthly operational meetings attended by

Community health inpatient services

service managers. The service had action plans to address specific risks which were discussed during focused meetings, for example harm reduction meetings which monitored pressure ulcers and falls. The service held meetings twice weekly for clinical leads and service managers to share learning across teams and the senior leadership and quality team met weekly to discuss significant events.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service, as well as to feedback into any changes on the ward. The service had regular team meetings which enabled sharing of information. These were recorded and sent out so that staff who were unable to attend received the same information.

Management of risk, issues and performance

The service identified and escalated relevant risks and issues. The organisation had an overall corporate risk register which applied across the business unit and a separate risk register which outlined specific risks for Kestrel ward. Leaders logged actions to reduce their impact and improve the service for patients, and each risk was assigned to an individual staff member. We saw evidence that this was regularly reviewed and updated.

Information Management

The service collected reliable data and analysed it.

Staff knew how to access key information such as policies on the Intranet. Managers made staff aware when policies had been updated.

The service submitted notifications to external bodies, such as the CQC, as required. Staff had submitted two notifications to CQC in the six months prior to the inspection relating to two serious incidents.

Engagement

Leaders actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. The service worked closely with colleagues from the local acute hospital as well as with wider system partners.

The service held regular formal and informal team meetings which demonstrated that line managers updated their staff with information such as but not limited to, service updates, incident reports, audits and outcomes, compliments and complaints and lessons learnt. Staff were encouraged to attend monthly learning events. The service sent out monthly newsletters to staff to share good news/good practice and any other relevant updates.

The service had a staff survey to provide staff the opportunity to give feedback. Managers told us that they had an 'open door' approach and encouraged staff to bring up any issues to discuss. They also had "have your say", informal one to ones and appraisals as platforms to be able to feedback.

Learning, continuous improvement and innovation






All staff were committed to learning and improving the service. The role of the practice development nurse was to help with this by focusing on inducting new starters, training, and reviewing competencies of staff. They had a good understanding of quality improvement methods and the skills to use them.

Community health inpatient services

Leaders encouraged innovation. The service felt proud of its innovative working of the electronic handover sheets, which they felt improved efficiency of information sharing, and the daily MDT board meetings which helped to focus on the areas of need in order to facilitate a patient's discharge. Managers told us that innovation on the ward was a team effort.

The service delivered learning events for all staff to provide a venue to support shared learning across HCRG in North Kent. Staff told us these events were time protected for wider sharing of learning to take place from events and incidents, promoting good practices and lessons learnt.

Community health services for adults

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

Are Community health services for adults safe?

Requires Improvement 

Mandatory Training

While the service provided mandatory training in key skills to all staff, we saw that some staff did not always complete their mandatory training.

The provider had a 90% mandatory training target for the teams. On this inspection, we saw that the mandatory training rates for some teams were below the provider's target. For example, the speech and language therapists and community nursing teams training rates for basic life support and anaphylaxis were 40% and 65.2% respectively. The training rates for other modules such as conflict resolution, fire training and moving and handling were below the providers target for the community nursing teams. However, we saw that some teams such as the community matrons kept up to date with all of their mandatory training.

The mandatory training was comprehensive, and staff felt it met their needs and provided them with the skills and knowledge they needed to care for patients.

Managers told us they monitored mandatory training and reminded staff to complete their training such as during team meetings and one to one discussion. Managers informed us that some of the training that had not been completed was face to face training which needed to be rescheduled due to lack of availability of trainers.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to recognise and report abuse.

Staff knew how to make safeguarding referrals and who to contact if they had concerns. The North Kent business unit had a designated safeguarding lead who was responsible for reviewing all safeguarding referrals and ensuring that appropriate actions were taken. The teams also had a safeguarding champion.

Staff told us there was safeguarding supervision for all staff which was facilitated by the safeguarding lead up to four times a year. The safeguarding audit showed that there had been four safeguarding referrals in the last 6 months.

Community health services for adults

Staff discussed safeguarding robustly during handovers and in team meetings. Staff ensured that safeguarding risks were identified as part of patient's initial assessment. If there were any safeguarding concerns, this was highlighted on the system so that everyone was aware. The team leads ensured that bank and agency staff were aware if there were any safeguarding concerns on allocation of patients.

Managers kept staff informed of the outcomes of safeguarding investigations. For example, we observed during handover the team lead providing an update on a safeguarding referral that was raised by a staff member.

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

The service provided safeguarding training as part of their mandatory training. Staff told us that all qualified staff and managers, were required to complete level three safeguarding training, while non-qualified staff were required to complete level two safeguarding training. However, we saw that some teams were not consistently completing their safeguarding training. For example, only 54% of the community nursing teams had completed their adult level 3 safeguarding training, and only 69% of this staff group had completed their self-neglect training.

Cleanliness, infection control and hygiene

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

All clinics we visited were visibly clean and the furnishings were well maintained. The phlebotomy department was clean and cleaning records were up to date and demonstrated that all areas were cleaned regularly.

The service generally performed well for cleanliness. The cleaning audit for the Sittingbourne Memorial Hospital was consistently above the provider's target of 95% for the last three months.

Sharps waste was disposed of appropriately and bins were not overfilled. The phlebotomy department at Sittingbourne Memorial Hospital had a wash sink and hand sanitisers around the department.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. For example, we observed the phlebotomy staff wiping down patient chairs with antimicrobial wipes after each patient use. We also saw that staff disposed of single use items between patients, such as gloves and aprons.

While we saw that staff followed infection control principles including the use of personal protective equipment (PPE) for all clinics we observed, records showed some staff were not up to date on their donning and doffing training. For example, only 56% of the community nursing teams had completed the donning and doffing training.

Environment and equipment

The design, maintenance and use of facilities and premises kept people safe. Staff managed clinical waste well.

Most teams had access to equipment to help them provide safe care for patients. However, the continence team did not have a bladder scanner, as the bladder scanner had been broken for some time. Staff reported that the provider was in process of procuring a new bladder scanner for the team.

Staff carried out daily safety checks of specialist equipment.

Community health services for adults

The provider carried out regular equipment audits. Managers informed us there was an ongoing programme to replace some of the old equipment in the next year.

The premises that the service used for outpatient clinics were safe and well maintained. The service had suitable facilities to meet the needs of patients' families.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

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

Staff completed risk assessments for each patient and reviewed patients risks regularly. The community nursing teams completed assessments for patients using a Malnutrition Universal Screening tool (MUST). Staff completed a Waterlow risk assessment for patients. This assessed the risk of pressure ulcers developing.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The community nursing and rapid response staff told us they regularly assessed and monitored patients to ensure their health was not deteriorating using the national early warning score 2 (NEWS2). One patient reported staff weighed them regularly to ensure they were maintaining a healthy weight which could have an impact on their condition.

Staff knew about and dealt with any specific risk issues. Staff ensured that patients who were at risk of falls had the right equipment in place, such as a walking frame. The tissue viability nurses ensured that patients who were bed bound had a comprehensive care plan in place to manage patients pressure areas. One patient told us that the speech and language therapists (SALT) had advised them of the food they should avoid which could lead to choking.

Staff could refer to the mental health liaison and specialist mental health teams, if they were concerned about a patient's mental health. Staff told us if they had concerns that a patient was at risk of self-harming or suicide, they would raise an urgent safeguarding and escalate this appropriately.

Staff shared key information to keep patients safe when handing over their care to others. We observed a handover meeting with the community nursing teams and saw that staff discussed patients risks and any changes to their risks. The handover meetings were held daily, and it included all key information to keep people safe.

Staffing

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Team leaders regularly reviewed staffing levels and skill mix, and prepared staff rotas three month months in advance to ensure all gaps were well covered. For example, the diabetic team told us that they could get additional staff to manage increasing demand and that there were good cover arrangements if anything changed.

The service had a pool of bank of locum staff that they could call at short notice. Managers told us that the teams rarely used agency staff. The only team that used agency staff on a regularly was the rapid response team. Staff told us that the agency staff were regular agency staff, who knew the service and the patients well.

Community health services for adults

The service was reporting a number of vacancies across the teams. For example, there were six vacancies across all staff bands for the community nursing teams in Sittingbourne. There was one band five vacancy for the podiatrist and four vacant positions for the wound management teams. While we saw that the provider was actively recruiting for these roles and some staff were onboarding, some of these positions had been vacant for a long time. For example, the podiatrist vacancy had been vacant for 530 days. The podiatry teams told us that they have a very busy workload and staffing was quite stretched.

The provider was reporting 19 vacancies for the rapid response team. Senior leaders informed us that the reason why the vacancy rate was high was because they had received extra funding from the commissioners to recruit more staff and increase care provisions, which meant an increase in the number of staff they were actively recruiting to. They had successfully recruited around nine staff to the vacant positions who were awaiting their pre-employment checks at the time of our inspection.

The turnover rate for all staff bands and teams was about 12% including voluntary and involuntary exit in the last 12 months. One staff member was dismissed, and four members of staff wanted a better work life balance. The provider collected feedback from all staff that left the service and analysed the information in order to improve recruitment and retention.

The sickness and absence rates were generally quite low across the services.

Records

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

Patient notes were comprehensive, and all staff could access them easily. It was easy for agency and bank staff to access patient records in order to provide care and treatment.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. All staff had individual log in credentials to access patient records.

Medicines

The service did not prescribe any medicines. Two members of staff were currently on the non-medical prescriber course. All medicine prescriptions were done by the patient's GP.

Staff followed best practice to check that patients had the correct medicines when they were admitted. Staff told us they regularly did a stock check of patients' medication to ensure they were taking them as required, and any side effects they might have.

Staff had epinephrine kits which were all in date and the teams were required to carry them on visits. However, we saw that some staff had not completed their epinephrine administration training which was part of the basic life support training. We were concerned that staff may not know the side effects of epinephrine administration especially for patients with an underlying heart condition.

Community health services for adults

Incidents

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

The service had an online incident reporting system. Staff knew what incidents to report and how to report them, using the online system and in line with the provider's policy. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff discussed recent incidents and lessons learned during team meetings, handover meetings and during learning and development training sessions.

Staff understood the duty of candour. They told us it was about being open and honest and giving patients and their families a full explanation when things went wrong.

We reviewed four incident reports across the service and saw that incidents were thoroughly investigated, staff were given feedback and lessons were learned following investigation of incidents.

Team leaders supported staff after a serious incident, and team leaders debriefed and supported staff after any serious incidents.

Are Community health services for adults effective?

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service had practice development nurses who supported the nurses with training and development, ensuring that staff were up to date with current clinical practice.

Managers told us they checked to make sure staff followed national guidance through individual managerial supervision, peer group supervision and one to one sessions, and each patient's care and treatment was discussed during daily handover meetings.

Staff told us they always ensured they were up to date NICE guidelines, and they completed risk assessments and care plans in line with best practice. The community nurses completed care plans depending on individual assessed needs and adapted the plans as required. For example, the diabetic nurses told us they would always amend oral medication in line with British National Formulary (BNF) and NICE guidelines.

Community health services for adults

The service leads told us they were relaunching the patient care plans with a more detailed, holistic and personalised plan with a focus on patients' views of what they wanted to achieve. They told us that they were waiting for approval from senior leaders to implement the new care plan.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff told us they did a malnutrition assessment for all patients using the Malnutrition Universal Screening tool.

Patients told us that staff offered to make them drinks and gave advice about their food and fluid intake.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Staff told us they always monitored patients for pains using verbal and non-verbal techniques. For patients who could not verbalise, they monitored them for signs of pain or discomfort. Staff told us when a patient expressed pain or discomfort, they immediately contacted their GP for a pain relieving medication.

Staff ensured that patients who were at the end of their life and on syringe drivers for symptom control were seen daily.

The service had a system in place for monitoring and reporting pain medication for patients who were at the end of their life.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service carried out a number of audits including the number of patient attendances and discharges.

Staff told us that there had been increased numbers of referrals across the different specialisms since the COVID-19 lockdown eased. Managers informed us that the service audits allowed them to plan and align their services to improve care and treatment outcomes for patients. For example, the service was carrying out falls, pressure sore and pressure ulcer audits. The audits allowed the provider to submit a business case to the commissioners to purchase new equipment and recruit more staff.

Outcomes for patients were positive, consistent and met expectations, such as national standards. For example, the provider audited the number of safeguarding referrals and actions taken to ensure that people were protected from harm and abuse. Results from the last three months indicated that the teams were performing very highly in responding to safeguarding concerns.

Managers and staff used the results from audits to improve patient outcomes.

Community health services for adults

Patients reported that they generally received good care and treatment outcomes from the service. One patient told us the treatment programme the physiotherapists put in place was very effective as it had helped stabilise their balance.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

The service has a robust induction programme for all new staff. Managers told us that the induction programme was developed in collaboration with staff to ensure they were getting the best out of the induction. Staff told us that they found the induction very useful and it had prepared them for their roles. The induction was a four week programme which included mandatory and statutory training, as well as staff reading and understanding the provider's policies and procedures.

Staff across the specialisms were vastly experienced, and they had the right skills and knowledge to meet the needs of patients. The qualified staff told us they kept up to date with their clinical practice through continuous professional development (CPD), and with support from the clinical educators.

The clinical educators supported the learning and development needs of staff. Staff told us the teams had regular in-service training events. For example, the physiotherapy lead had recently carried out a neck collar (a device used to support neck bones and ligaments and reduce any movement that may cause further damage to the cervical spine/ neck injury sustained) training for the team. The sessions resulted from gaps in knowledge identified by the team.

We saw another example of the community nursing teams undertaking workshops and training with the occupational therapy (OT) teams for National Early Warning Score 2 (NEWS2). The OTs now have the application on their work mobile phones. The rapid response nursing teams had also undertaken end of life training with the OTs.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had a six monthly performance review and annual appraisal.

All staff we spoke to said they had regular one to one discussion with their line manager, and these met their needs. However, while we saw that senior managers undertook and recorded clinical supervision with the band seven staff, we saw that staff supervision was not always recorded for all staff below band six grade in line with the provider's policy.

Managers told us that they ensured staff received specialist training for their roles. For example, the community nursing teams had undertaken training on how to care for end of life and palliative care patients. Staff told us there was training available for them on how to deliver sensitive news for terminally ill patients. However, some staff reported that the provider could do more to support them to access other external specialist training.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

The service consisted of teams across different specialisms who worked together to benefit patients. The teams worked with other healthcare professionals including GPs and mental health services to ensure people's holistic needs were being met.

Community health services for adults

Staff worked across health care disciplines and with other agencies when required to care for patients. Managers and staff reported they generally had a good working relationship with other healthcare professionals, social services and other specialist services. For example, the diabetic nurses received clinical support as well as worked in collaboration with other diabetic services including a transition service for 18 to 20 year olds. Staff from the respiratory teams told us they worked closely with the acute hospital to manage patients with respiratory conditions, including those who required oxygen daily.

Staff reported that some GPs were very responsive and supportive in ensuring patients received timely care and support such as medication reviews, while some GPs were not very responsive, resulting in delays in patient care. The MDT coordination teams were now working with GP practice nurses to identify and provide early intervention for frailty patients.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There was a monthly meeting across all specialisms. The MDT coordination teams met weekly to review patients on wards to facilitate discharge, ensuring that issues that could cause delayed discharge, such as housing and care packages, were addressed.

Staff referred patients for mental health assessments when they showed signs of mental ill health such as depression.

Seven-day services

Key services were available seven days a week to support timely patient care.

The rapid response teams provided a 24 hour, 7 days a week service.

Staff told us they could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Where required, staff could admit patients to the inpatient wards.

Health promotion

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

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The service had relevant information promoting healthy lifestyles and support.

Staff offered training for patients on how they could manage their own health and condition. For example, one patient told us that they have recently undertaken a diabetic training course which they found very useful, with support from staff. The patient told us the training helped them understand what they can and cannot eat and how to manage their dietary needs. Other patients we spoke to also told us that staff had recommended training courses to them to improve their health and wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff told us that they would always presume a patient had capacity to make their own decisions.

Community health services for adults

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patient records we reviewed showed that staff sought consent before undertaking care.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available. Staff gave us an example of a patient who was not complying with their treatment; however, the patient was assessed to have capacity. Staff ensured that all documentation was completed accurately, and the patient was required to sign that they understood the risks of not accepting treatment.

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act.

Staff could describe and knew how to access policy and get accurate advice on the Mental Capacity Act.

Are Community health services for adults caring?

Good 

Compassionate care

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

All patients we spoke to said staff were kind and caring. They said staff treated them well, cared for them kindly, reassured them and always ensured they were comfortable.

Patients said staff took time to interact with them in a kind, considerate and respectful way. Patients and their carers told us staff took time to address any concerns they had. Staff took time to care for patients and patients said they never felt rushed.

Patients described staff as thoughtful, understanding and professional in the way they carried out their duties. Two patients we spoke to said that when they cancelled their visit at short notice, staff were very understanding and accommodating, and they ensured they booked another visit as soon as possible.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, we saw that staff were considerate when they arranged appointments to ensure they did not conflict with people's schedule.

Community health services for adults

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. One patient reported they were anxious when they got a clinic appointment, but staff provided assurance and eased their anxiety. The patient described their clinic session as very relaxed and informative.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. There were screens in some clinics to protect people's privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. One patient who had been waiting for a diagnosis of their condition from their GP told us how a staff member followed this up. Staff explained to them what their condition was, their treatment options and supported them to access other services.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

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

Patient told us that staff involved them in decisions about their care and treatment. All patients we spoke to told us that staff provided them with information on their first visit and regularly gave them information leaflets about their condition, the service and how to get further help and support with their health.

Staff informed patients promptly about visits and clinic appointments. Patients told us that staff usually rang them to schedule an appointment or visited at a time that was convenient for them.

Patients told us staff asked them if they understood the information and discussed their options, giving patients the opportunity to make informed decisions about their care. One patient told us that the physiotherapists went over a list of things they wanted to achieve and put a programme in place and adjusted when it felt too difficult, but they thought it was too hard. However, the patient felt they could have been more involved in the decisions.

While some patients and their families told us they have given feedback about the service, others told us that staff did not routinely ask them for feedback. Patients generally gave positive feedback about the service.

Staff supported patients to make advanced decisions about their care.

Community health services for adults

Are Community health services for adults responsive?

Good 

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

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

Managers planned and organised services, so they met the changing needs of the local population. For example, there was a podiatry clinic in Isle of Sheppey and Sittingbourne Mondays to Fridays. Staff told us that the clinics were planned a month in advance and were flexible depending on where the demands were highest.

The service had a multidisciplinary coordination team that worked with other stakeholders such as GPs, the inpatient wards, care homes and social services to support patients with complex care and help prevent hospital admission. Every week the MDT met with the other teams to review up to 10 patients to identify any barriers to care including whether the patients have a package of care, housing, benefits and carer support.

The MDT also worked with local charities to provide mental health support to patients. There were frailty nurses attached to GP surgeries who carried out initial patient visits and assessed their status and home environment. They fed back to the MDT, who then coordinated the patient care.

Facilities and premises that were used for most of the outpatient clinics were appropriate for the services being delivered. The phlebotomy walk in clinic at Sittingbourne Memorial Hospital was fully equipped. However, we saw that the phlebotomy clinic room was very small with two patient chairs next to each other which impacted on patients' dignity and privacy. Although staff told us that they could pull the curtains if the patient wanted some privacy, other people in the room could still hear the conversations. We saw that there was an extra area in the clinic which was also used for children and offered more privacy and dignity. In addition, the signage to the clinic was not very clear. We directed patients to staff that were wandering in the corridor during the inspection.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia via the MDT coordination teams. The service also worked with a mental health charity to ensure that people who required mental health services got the required help and support they needed.

The service had systems to help care for patients in need of additional support or specialist intervention.

Managers monitored and took action to minimise missed appointments. All patients we spoke to said that their appointments were rarely cancelled. Some patients told us that when staff cancelled, they called them to explain the reason, for example due to staff shortage, and apologised. The community nurses told us all patients were red, amber, green (RAG) rated and before a visit was cancelled it was always risk assessed. Staff ensured that the patient visits missed were always scheduled for next day.

Staff ensured that patients who did not attend clinic appointments were contacted. Patients told us that staff were always happy to rebook a time that is convenient for the patients.

Community health services for adults

The service relieved pressure on other departments when they could treat patients in a day. The rapid response team were required to see patients within two hours to avoid hospital admission.

Meeting people's individual needs

Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The services were accessible for patients with mobility problems. Staff told us that the outpatient clinics were designed to accommodate wheelchair users. Managers informed us there was a holistic approach to care to ensure all patients needs are met. For example, the podiatrists informed us that there was a weekly home visit to housebound patients to provide care and treatment to them.

The service supported other services to ensure people's care and treatment needs were met. For example, the diabetic nursing teams provided education to care homes. There was also training for GPs and practice nurses which was updated regularly.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff were aware of the Accessible Information Standard (AIS). The Standard sets out a consistent approach to identifying, recording, flagging and sharing the communication needs of patients.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. The service used a third party interpreting and translation service that was available 24 hours of the day.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff showed us picture cards and signs which they used to communicate with patients who had communication difficulties.

Most patients we spoke to felt the service was inclusive and took account of their individual needs and preferences. For example, a patient told us that the fitness programme the physiotherapist put in place was very useful and prepared them for their operation. However, one patient told us that the physiotherapy sessions did not meet their needs. They felt staff did not fully understand their condition. The patient reported they usually experienced a significant amount of pain for days following the physiotherapy sessions.

The provider had a range of information leaflets for patients about how they could access other services.

Staff made sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet all their needs.

Staff took account of patients' hydration and nutritional needs when they planned their care. The speech and language therapist informed us they always took account of people's cultural and religious needs when they recommend certain foods.

Access and flow

People could generally access services when they needed it. However, some services such as the podiatrists were reporting high waiting times from referral to treatment.

Community health services for adults

The service had a clear criterion for who they would offer a service. The community nursing teams carried out home visits only for patients who were housebound. All patients that were ambulatory (able to mobilise and get into a car) were seen in an outpatient clinic which was held up to three times a week.

All referrals to the service came through a single point of contact known as the Care Coordination Centre. Referrals came from GPs, consultants, care homes, hospices, practice nurses and people could also self-refer.

The service used a red, amber, green (RAG) rating system to triage all referrals. Patients that needed to be seen urgently were rated red and referred to the rapid response team. The rapid response team were required to see patients who were referred to them as urgent within two hours of referral. Staff told us that if a referral was triaged and found to be inappropriate for the service, they would refer back to the referrer with a suggestion of care.

Some services had key performance targets which were set by the provider and reported to the commissioners. This included the waiting times for referral to treatment, serious incident reporting such as pressure ulcers and safeguarding. Most of the specialist services had an 18-week target for referral to treatment for routine patients.

The podiatry teams were reporting a high waiting list. Managers told us that Covid-19 had played a huge part in the increased numbers of patients on the waiting list compared to previous years, because some services were stopped at the peak of the Covid-19 pandemic in order to support more urgent referrals. Managers told us they have been working really hard to reduce the waiting list. There were about 800 patients on the waiting list in March 2022 and by July 2022 the numbers had reduced to less than 100. Managers told us they have taken time to review all of the referrals and ensured that patients who needed urgent treatment were seen promptly. Managers told us they also ensured that they followed safe discharge for those that no longer required their services.

While most patients told us it was relatively easy for them to access services, and had a swift initial appointment, some reported that they were waiting a long time before they were seen. One patient who needed treatment for their mobility problems told us they were on the waiting list for about two years before they were seen. Another patient told us they had waited a year for their initial assessment by the speech and language therapists. The patient also told us that the service they had been receiving from the team was exceptional and was full praise for the team.

Managers monitored cancelled visits and clinics. Staff told us that visits and clinics were rarely cancelled. However, in the exceptional circumstance that planned visits or clinics were cancelled, patients were always informed, and staff rescheduled the visits or clinics for when it suited them.

Most of the clinics were relatively easy to access, for example, those at the acute hospital site. However, we did see that the signage to the phlebotomy department was not very clear. Patients reported they sometimes missed the signs. During our inspection, we had to direct two patients to the phlebotomy waiting room and to staff.

Learning from complaints and concerns

People knew to raise concerns about the care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients told us they knew how to complain or raise concerns although they have not needed to because they have been receiving a good service.

Community health services for adults

Staff had a patient information booklet that they handed out on initial visits which contained details of how to contact the service and also how to raise a concern or make a formal complaint.

Staff understood the policy on complaints and knew how to handle them. Staff told us that they would always try to resolve any concern with the patient or carers initially, and if they wanted to make a formal complaint, they would support them to do so.

Managers investigated complaints and identified themes.

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

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice. For example, some patients and locals had raised a concern previously about the long queues outside the hospital for the phlebotomy clinic. Staff told us that this was during Covid-19 and that patients needed to maintain a two metre distance. However, they have now implemented a ticketing system which allowed staff to plan more effectively for the number of patients they could attend to during opening hours.

Two patients we spoke to said staff have never asked them for feedback. Although both patients were very complimentary of the services they received.

Are Community health services for adults well-led?

Good 

Leadership

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

Staff spoke very positively of the guidance and support they received from their managers. Staff reported that the training and support they received from their leaders gave them the confidence to do their jobs.

Leaders supported staff's professional and career development. We saw several examples where the leadership team had supported staff members professional development such as supporting staff through a nursing apprenticeship programme, creating more job roles so that staff members could move to a higher band with managerial opportunities and experience and also allowing study time and financial support to staff who were undertaking their prescribing courses.

The provider made reasonable adjustments for staff who needed them. Managers supported staff who had been off work for extended periods to slowly get back into work. Managers worked with staff to identify other job roles which would suit their situation or condition with opportunities to grow and develop.

Community health services for adults

Although some team leaders reported they had not received formal managerial training, they felt there were good opportunities to grow in their role and they were getting adequate support from senior leaders including shadowing them.

Vision and Strategy

The provider had a clear vision which was to work collaboratively with health and care commissioners and communities to transform services with a focus on experience, efficiency and improved outcomes for service users.

Each service had a clear strategy of how they would achieve the providers vision and we saw that they were patient and staff focused. Leaders and staff knew what the strategy was, how they would apply it and monitor progress. For example, we saw that some teams were collecting regular data to measure their performance via different matrices including referral to treatment times.

The provider had a programme to grow its own staff. Managers were supporting a staff member to undertake an apprenticeship programme with the open university. Staff told us there were career development opportunities. Two members of the nursing staff were training to become non-medical prescribers.

Culture

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

Staff reported that their managers made them feel valued. They could approach them with any concerns around work and wellbeing and they felt managers addressed them. For example, some staff reported that their workload was high due to the number of patients they saw daily. Managers told us they were reviewing caseload and staffing daily to ensure there was an adequate number of staff with the right skills to provide care and support for patients.

Staff said that they always pulled together as a team and supported one another. For example, we saw that due to the increased volume of referrals to the rapid response teams, the intermediate care team were offering support to see patients who needed to be seen urgently. Although some members of staff expressed concerns about the impact the increased workload was having on them.

The provider had a freedom to speak up guardian who staff could contact if they had any concerns, and staff knew how to contact them. Staff we spoke to said they have not needed to contact the freedom to speak up guardian because they felt they were getting adequate support from their line managers. Staff felt there was always someone to listen if they had concerns.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. There was a clear reporting structure which fed into clinical governance.

The provider held monthly clinical governance meetings where service leads met to discuss and review performance. The team's performance was reported to the senior leadership team and monitored via a quality reporting dashboard.

Community health services for adults

The service had an annual schedule of audits in place which provided assurance to the board. HCRG North Kent business unit patient safety and quality committee carried out regular audits and oversaw six key areas including infection prevention and control, safeguarding, health and safety, information governance, regulations and maintenance.

The results for the last three months showed that the teams were performing well across all the matrices.

There were staff meetings and managers meetings where issues affecting staff and patients were discussed. This was escalated to the clinical governance meeting through the team leaders and service managers. Outcomes of governance meetings were fed back to the teams via their managers. Staff told us they could access the minutes of clinical governance meetings on the intranet, and they were also sent regular newsletters and updates.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Each team maintained a register of risks which fed into the overall risk register and this was monitored and reviewed at monthly clinical governance meetings.

The service RAG rated the risks for the likelihood and impact of risks occurring. For example, the speech and language therapists rated the risk of patients with swallowing difficulties developing chest infections as high. The service put controls in place to mitigate the risk which included prioritising patients most in need.

Leaders used a system of audits to monitor the service performance. The provider had just completed a NICE guidance audit to ensure that the service was working in line with current best practice and national guidelines.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Staff collected and analysed data about outcomes and performance and engaged actively in local quality improvement activities.

The service used electronic systems for managing patient care records. Patients also had a copy of their personal management plan in their own homes.

Incidents, safeguarding and complaints were reported via an incident management system which was monitored by managers.

All staff had individual laptops and mobile phones and they could access patient records on their laptops. Staff kept patient records up to date. Staff told us that there were usually no delays in updating patient records.

The service consistently submitted information and notifications to external organisations such as the CQC, Health and Safety Executive and the CCGs as required.

Community health services for adults

Engagement

Leaders and staff were working towards increasing patient engagement activities. Managers told us some patient engagement activities had been suspended temporarily due to pressures and demands resulting from the Covid-19 pandemic. Senior leaders told us that relaunching patient and carer engagement was one of the organisational objectives for the financial year.

The provider was engaging with staff via several platforms including staff surveys, “you said, we did” and “feel the difference programme” where staff could give feedback about the service. Senior leaders told us the extra funding for the new induction programme was as a result of staff feedback.

Managers and staff felt the provider treated them as partners in the planning and delivery of the services. However, some teams felt they could have been consulted before the provider purchased new specialist equipment.

Learning, continuous improvement and innovation

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

The service was providing an educational programme for type 1 and type 2 diabetes over a six week period, including on weekends, for patients and staff.

The community nursing teams told us they have introduced a new initiative such as sending bereavement cards to relatives when they lose a dear one.

The provider had recently put in a business case with the commissioners to purchase a Hoverjack – a piece of moving and handling equipment that enabled the safe and transfer of palliative/ end of life patients. The provider informed us that the equipment had led to reduced visits from clinical staff as hoist and sling assessment were no longer required. The provider also informed us that the use of the equipment had improved comfort and dignity for patients during transfers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Community inpatient service: <ul style="list-style-type: none">• The service must ensure that all equipment stored on the ward is stored safely to reduce environmental health and safety risks, particularly to prevent evacuation difficulties, in line with their policy. [Regulation 12 (2) (b) Safe care and treatment]• The service must ensure that all ward staff attend fire training and evacuation practices on a regular basis to improve confidence and familiarity in the event of an emergency evacuation, in line with their policy. [Regulation 12 (2) (b) Safe care and treatment]

Regulated activity	Regulation
Treatment of disease, disorder or injury Nursing care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider must ensure that staff complete their mandatory and statutory training. [Regulation 18. Staffing]