# The Royal Wolverhampton NHS Trust

RL4

# Community health inpatient services

## Quality Report

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# Summary of findings

## Locations inspected

| Location ID | Name of CQC registered location | Name of service (e.g. ward/ unit/team) | Postcode of service (ward/ unit/ team) |
|---|---|---|---|
| RL4X1 | West Park Rehabilitation Hospital | | |

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

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

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

# Summary of findings

## Ratings

| | |
|---|---|
| Overall rating for the service | Good |
| Are services safe? | Requires improvement |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Good |

# Summary of findings

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# Summary of findings

## Overall summary

The Royal Wolverhampton NHS Trust provided community in-patient services at West Park Hospital which offered 88 beds across four wards at the time of our inspection.

The hospital consisted of four wards. The Neuro Rehabilitation ward provided 10 specialists beds for patients living with or recovering from neurological conditions such as stroke, Parkinson's and multiple sclerosis. Ward One was a mixed sex stroke ward, ward Two provided beds for mainly elderly, frail, male patients and ward Three mainly provided beds for elderly, frail, female patients.

Security and fire procedures was a concern of staff and senior managers and was present on the West Park Hospital's risk register for over 12 months.

The knowledge of duty of candour and safeguarding awareness was imbedded across all four wards. We saw all wards were experiencing long-term nursing vacancies which were proving difficult to fill. Despite this, outcomes for patients and patient satisfaction was high.

Policies and procedures had been developed in line with national guidance and there was an excellent stroke care pathways in place for patients.

Delayed transfer of care meant 20 out of 88 patients were ready for discharge but remained at West Park Hospital due to external social service delays.

Patients told us they felt well looked after by doctors, nurses and therapists and staff communicated well with patients and their relatives and supported them to be as independent as possible. Patients felt informed about their day to day care and discharge arrangements.

The therapy care provided across all wards was very good particularly with patients at the Neuro Rehabilitation ward.

The majority of community inpatient staff had faith in their local leaders, senior managers and executive team to lead the trust and shared the vision of the future direction. Ward staff felt able to raise issues with managers if required and felt well supported by their line managers and were proud of the service they worked in.

# Summary of findings

## Background to the service

West Park Hospital mainly provided rehabilitation care for patients registered with a Wolverhampton based GP. Referrals came from New Cross Hospital, Cannock Chase Hospital, community teams and GP's and referrals were also accepted from out of area for patients with specific rehabilitation needs.

Care was delivered by nurses and therapists with support staff across all four wards and each ward provided specific care depending on the patient's condition upon assessment.

The therapy team consisted of approximately 35 physiotherapists and 24 occupational therapists made up of bands 5, 6 , 7 and 8a's, who worked across all four wards and also covered clinics such as: outpatients, falls, domiciliary therapy and community based therapy classes. Nursing and healthcare assistants totalled 108 across the four wards. Staff worked in designated wards unless asked to assist in other wards where they needed support due to low staffing or increase patient dependency.

Each ward had a ward sister who worked in a supervisory capacity However, on occasions where bank nurses were not available to cover shifts, ward sisters covered these shifts instead.

During the inspection, we spoke with 85 staff, including consultants, nurses, medical, therapy and healthcare assistants, administrative and domestic staff. We talked with 40 patients across four wards. We observed interactions between patients and staff and we reviewed 28 sets of nursing notes, medical records and related medication charts.

## Our inspection team

Our inspection team was led by:

**Chair:** Karen Proctor, Director of Nursing Guy's and St Thomas' Hospital NHS Foundation Trust

**Team Leader:** Tim Cooper, Head of Hospital Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialists: who were a Medical Director, an Executive Director of Nursing & Quality, a Designated Nurse for Child Safeguarding, a Consultant Physician in Diabetes & Endocrinology, a Consultant in Clinical Oncology, a Outpatients Doctor, a Consultant in Palliative Medicine, a Consultant Orthopaedic Surgeon, a Consultant, formerly Emergency medicine, a Consultant Obstetrician & Gynaecologist, a Consultant in Intensive Care & Associate Medical Director, a Paediatrician and a FY2 (Junior Doctor), a Clinical Nurse Specialist Older People, a Staff Nurse - End of Life Care & Oncology, a Renal Specialist Nurse, a Principal Radiographer Head of Imaging and Equipment Services, a Surgery Nurse Midwifery, a Senior Staff Nurse Senior management / Nurse - Paediatrics and child health and a student nurse.

The specialists advisors who worked with our community teams had experience: Community Children's Nurse, a Senior Health Advisor for Looked after Children, a Registered Nurse - Nursing and clinical care both acute and primary care, leadership/management & governance systems, a Service Manager District nursing and two Nurses Palliative Care.

There were three experts by experience who were part of the team, they had experience of using services and caring for a person who used services.

## Why we carried out this inspection

We undertook this inspection as part of our commitment to review all acute and integrated trusts by March 2016. This service was scheduled sooner because it had

# Summary of findings

incorporated services from the now dissolved Mid Staffordshire Trust and we wanted to assess the impact of that. It had previously been part of the initial wave of inspections which was pre ratings which was also an consideration in scheduling this inspection.

## How we carried out this inspection

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

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

'Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 02, 03, 04 and 05 June 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists and non-clinical staff. We talked with people who use services both on the day and prior to the inspection during advertised listening events. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced between the dates of 08 to 19 June 2015.

## What people who use the provider say

"The therapists here are wonderful, so kind and caring, they really made a difference to my recovery after my stroke, life would have been unbearable without their help".

"Nurses are kind and always pleasant they always go out of their way to make sure my mum gets what she's needs".

"It's a good hospital but it's very boring during the day, there's nothing to do, I suppose everyone is just so busy"

## Good practice

The stroke care pathway which included rehabilitation care and therapy at West Park Hospital provided excellent support, advice and treatment to all patients in Wolverhampton who had suffered a stroke or a TIA (trans ischemic attack).

Staff provided all aspects of support and advice to include physical, psychological and financial. They were regarded by patients and fellow ward staff as a source of expertise to refer and signpost patients onto the most appropriate health care professionals to assist patients in their stroke recovery.

They had recently qualified as independent prescribers which enabled them to prescribe a range of items such as continence aids and equipment necessary to aid a patient's health and well-being. They recently employed a stroke care support worker who took on the support of carers and provided a signposting service to ensure carers were also well supported.

# Summary of findings

## Areas for improvement

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

**Must:**

- The trust must review the fire policy and procedures at West Park Hospital particularly providing effective communication systems.
- Improved door exit systems in the event of an emergency.

**Should:**

- The trust should improve specialist disease specific training for nursing staff i.e.: MS, Parkinson's, Epilepsy, Diabetes, Dementia and Brain Injury across at West Park Hospital.
- The trust should continue with its Registered Nursing recruitment process
- The trust should consider introducing a menu of ward based activities for patients at West Park Hospital.
- The trust should ensure that the frail and elderly did not become bored and that some stimulating activities are available to them.

The Royal Wolverhampton NHS Trust

# Community health inpatient services

**Detailed findings from this inspection**

Requires improvement

## Are services safe?

By safe, we mean that people are protected from abuse

**Summary**

The overall safety of the service at West Park Hospital required improvement. There was an increased risk that patients and staff may be harmed as some safety concerns had not been addressed. For example absence of security at night time, absence of an effective communication system in the event of an emergency and the need to review fire procedures relating to insufficient break glass panels in situ. We also noted that the

Incident reporting and recording was encouraged and embedded across the service. There was a robust process in place for staff to learn from lessons to minimise future risks to patients.

There was good use of safety quality dashboards to monitor performance in key areas of patient safety.

Recruitment to fill nursing vacancies was slow and this was an item on the risk register, however this did not affect patient outcomes or overall patient satisfaction.

Infection control procedures were imbedded across all wards and the cleanliness of clinical and communal areas was consistently better than the trusts infection control targets.

Risks to patients were effectively assessed and managed and clinical practice was reviewed regularly to improve patient care.

**Incident reporting, learning and improvement**

- Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were zero Never Events registered at West Park Hospital.
- From April 2014 to March 2015 there were 169 incidents reported by staff at West Park hospital, 94.7% of incidents reported resulted in no harm. There were five pressure ulcers, two of which were grade three pressure ulcers reported by inpatient therapy services and ward three and required investigation and six falls with harm.
- The numbers of catheters with urinary tract infections (C.UTIs) generally remained between 0 and 3 per month, however there was six reported in March 2014 and eight

reported in September 2014. We were told by senior management there had been no investigation into this increase and all of the patients had been admitted from the acute hospital with catheters in place.

- Staff across all four wards were encouraged to report incidents and were able to access the trust's electronic incident-reporting system.
- Staff were made aware of incidents from other services within the trust in various forms, for example, through weekly team meetings, monthly governance meetings and emails disseminated from line managers to share lessons learned.
- We talked to senior nurses and saw that serious incidents were managed swiftly. For example ward One reported a grade three pressure ulcer post March 2015. The investigation process was robust and included a 48 hour initial ward action plan to be submitted to the governance committee. Followed by a root cause analysis (RCA). Actions agreed by the investigating officer was shared at ward level during their weekly team meeting and fed back to the governance committee held once per month. They were further discussed at weekly matrons meeting to share lessons learned and ensure new practice improvements were imbedded. For example, ward One identified through their RCA that poor skin inspection regime was a contributory factor to the development of the grade three pressure ulcer. The senior matron had put in place a new bedside handover which held nurses to account before they went off duty to ensure all documentation was completed and skin inspections had been carried out at regular intervals throughout the day. This was being rolled out across all four wards.

**Duty of Candour**

- Staff told us they were confident about reporting incidents and were aware they needed to be open and transparent with patients and their relatives if anything went wrong with their care.
- The Ward one sister told us of a serious incident involving the development of an avoidable grade three pressure ulcer within the past 6 weeks. The patient and their relative were invited to a meeting whereby a full explanation was given together with an apology and a promise to keep the patient and relative updated on a weekly basis. This was recorded in the patient's medical notes.
- Staff told us if they witnessed poor practice they would have no reservation to whistle blow and escalate their concerns to either: the senior manager, the safeguarding lead, the social worker or the care quality commission.
- Staff were aware of and knew how to access the trusts' whistleblowing policy and we saw the trust had created a staff leaflet explaining the New Duty of Candour regulation 2014, outlining the responsibility for staff. To include openness and honesty with patients especially if things go wrong. This leaflet was available across all wards.

**Safeguarding**

- Staff demonstrated a good knowledge of the trust's safeguarding policy and the processes involved for raising an alert.
- Staff received safeguarding training at induction and at regular intervals and this was well-attended we saw safeguarding training figures was 100% .
- Staff knew the name of the trust safeguarding lead.
- They told us they were well-supported and would seek advice if they had safeguarding concerns.
- We saw that safeguarding alerts were completed within the recommended 24-hour timeframe and were relayed verbally during staff handover times to ensure that all staff were aware of patients' safeguarding issues.

**Medicines management**

- All four wards had appropriate storage facilities for medicines and safe systems for the handling and disposal of medication appropriately.
- All ward-based staff reported an excellent service from the pharmacy team who visited the ward daily.
- The trust had a pharmacist acting as controlled drugs Accountable Officer.
- There were suitable arrangements in place to store and administer controlled drugs. Stock balances of controlled drugs were correct and two nurses checked the dosages and identification of the patient before medicines were given to the patient and regular checks of controlled drugs balances were recorded.
- We saw records that fridge temperatures were regularly checked, recorded and adjusted as appropriate.
- Patients across all four wards were prescribed and administered medication as per their prescription charts. We talked to 40 patients and relatives across four wards who told us the patient received their medication on time.

Requires improvement

# Are services safe?

### Safety of equipment

- Records demonstrated that resuscitation trolleys on each ward had been checked and signed daily. Equipment was in date, appropriately packaged and ready for use.
- Pressure-relieving mattresses and cushions for people at risk of pressure damage were in place. The trust had a central equipment bank for pressure-relieving equipment and an effective process for issuing, returning and cleaning the equipment.
- All wards had a good supply of manual handling equipment such as hoists, slings, sliding sheets and condition-specific equipment such as nebulisers, syringe drivers and monitors, which were well maintained, cleaned and had a label saying " I am clean" when stored ready for use.

### Records and management

- We looked at 28 patient records across four wards and saw records were well maintained and updated at timely intervals. Patient records were held in nursing and medical paper-based notes. Nursing notes were located at the foot of each patient's bed to allow quick and easy access for staff to refer and update patient details.
- Risk assessments were completed weekly for: manual handling, falls, nutrition and pressure ulcer damage. This included fluid balanced charts, comfort rounds and repositioning charts.
- The skin inspection and assessment tool and pressure ulcer prevention plan contained a body map, initial wound assessment and daily inspection record.
- We saw comprehensive and well-documented wound management plans. These showed that wounds were assessed; treatment records were in place and evaluated to show progress of healing.
- Nursing records in most medical wards were updated regularly and included care plans. However we saw each ward had access to 75 pre-printed care plans. We looked at 28 nursing records and saw in the majority of cases care plans were not individualised to the patient. For example, one patient complained of a mouth ulcer, one nurse told us it was probably due to friction from their loose bottom dentures, however, the dentures remained in place and continued to cause pain. We brought this to the attention of the ward sister. The oral care plan did not contain this information. Another patient following a stroke needed staff to communicate slowly in short sentences. Their communication care plan did not contain this information, it was not recorded in their medical notes or included on the handover sheet and therefore staff were reliant on their individual knowledge of each patient and not a detailed care plan for all staff to read and follow. The senior matron was aware care plans were not personalised and told us this was an area for improvement.

### Cleanliness, infection control and hygiene

- All the staff we spoke with were aware of current infection prevention and control guidelines and there was sufficient hand-washing facilities at the entrance to and inside all wards.
- All other clinical and communal wards looked clean and in a good state of repair.
- We observed staff consistently following hand hygiene practice and 'bare below the elbow' guidance.
- Aprons and gloves were readily available in all areas.
- Each ward used colour coded aprons to indicate the task being carried out. For instance, red aprons signified personal hygiene care, green aprons signified assisting with mealtimes, yellow aprons signified barrier nursing and blue aprons signified general care. We saw on two occasions that the wrong colour apron was worn, both staff explained they had forgot to change aprons in-between tasks.
- The infection prevention society audit results showed in October 2014 wards One and Three scored 95%, ward One scored 94% and the Neuro Rehabilitation ward in July 2014 scored 95%.
- There had been one episode of increased incidence for Clostridium Difficile on ward Two, involving three patients recorded in December 2014 and one outbreak of norovirus on the same ward from 23 February 2015 to the 5 March 2015. We were told by the senior staff both incidents were due to a patient being unknowingly admitted to ward two with the condition which then spread.
- Side rooms were used where possible as isolation rooms for patients identified as an increased infection control risk (for example, patients with MRSA). There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room.
- West Park Hospital scored the best possible score for both cleanliness and condition, appearance and

maintenance comparable with other wards across the two main acute sites of New Cross Hospital and Cannock Chase and scored 100% in the June 2014 PLACE (patient led assessment of the care environment) inspection.
- Housekeepers were employed by the trust and conducted a deep clean at each ward twice per year.
- We saw each bay on each of the four wards was cleaned three times per week. Patients were escorted to the day rooms whilst their beds, lockers, curtains, flooring and shelving was cleaned.
- We saw documentary evidence that commodes were cleaned three times per day at 8am, 2pm and again at 6.30pm. We saw commodes were turned upside down and wheels wiped thoroughly and any soiled commodes were cleaned by nursing staff.
- Infection control monthly audits results were displayed at the entrance of all four wards. We saw in the month of April all four wards scored more than 95% and ward one scored the highest 99.2%.

**Mandatory training**

- Mandatory training covered 35 skill areas and attendance figures were recorded as a collective percentage across all four wards to include admin staff, senior managers, nursing staff and untrained staff.
- Staff attendance target was achieved in most areas. For example within the last 12 months, fire safety achieved 99.4%. Safeguarding adults achieved 100%. Manual handling people achieved 90%, Tissue Viability achieved 89% and VTE risk assessment training achieved 99%.
- The lowest score for attendance was blood transfusion training at 61%. The Senior Matron explained patients at West Park Hospital rarely required a blood transfusion. If this treatment was required patients would be transferred to New Cross Hospital.

**Assessing and responding to patient risk**

- Patients' individual risk assessments were completed weekly or sooner if their condition deteriorated.
- Staff used ViEWS (vital early warning score) a standardised warning system tool to alert if a patient's health deteriorated; this was monitored at regular intervals throughout the day. Nurses demonstrated a good understanding of how to use the tool and when to request a medical assessment for patients with a deteriorating condition.
- Patients were usually seen by their consultant within the first 24 hours of their admission and had access to a doctor daily if required.
- Nursing staff told us, should a medical assessment be required for a deteriorating patient, attendance to the ward between 8am and 7pm was swift and assessments were thorough, any requests for doctors after 7pm came from Prime Care GP service.
- Patients who were transferred from New Cross or Cannock Chase hospital out of hours such as after 7pm or at weekends to West Park Hospital had to have a ViEWS score of zero. This was to ensure the admission was safe and the patient presented with minimal risks whilst there was no doctor on duty at the West Park site.
- Handovers took place at the beginning of every shift change. Patient information sheets were given to each member of staff and alert symbols were placed on the bed boards to identify patients at risk such as patients living with dementia, at risk of falls, reduced mobility and required assistance to eat.

**Staffing levels and caseload**

- Therapy staffing levels across all four wards were well-organised. Rotas were planned in advance and the staff skills mix was appropriate to adequately meet patients' needs.
- However there were nursing vacancies across all wards, for example ward two has two nursing vacancies, ward three had three vacancies and the Neuro Rehabilitation ward had 3.8 nursing vacancies.
- The West Park Hospital incidents register showed within a 12 week period nurses had reported 35 instances of poor staffing levels which had affected patient care delivery. For example nurses complained they were unable to complete necessary paperwork, provide one to one care for vulnerable patients and attend patients' needs when requested to do so.
- The senior matron told us they had an ongoing recruitment drive but vacancies were difficult to fill as nursing candidates did not always meet the required standards set out by the hospital.
- We were told and we saw from staff rotas that any unfilled nursing shifts were always filled by a health care assistant. Senior staff were aware this was not ideal and had placed this concern on the risk register.
- There are no national guidelines for community inpatient nurse staffing levels. The national staffing requirements for acute wards are one registered nurse

for every eight patients. We were told by senior nurses and we saw from the staffing rota that the Neuro Rehabilitation ward had only one nurse on duty at night to care for 10 patients who was supported by one healthcare assistant. Nursing staff told us they often have to prioritise care, however if they required an extra healthcare assistant, they were always supplied. We saw wards One, Two and Three had two nurses on duty at night. We were told they felt "stretched" at times, however there was always an ample supply of healthcare assistants which helped ease the pressure.

- Nursing handovers occurred every morning, afternoon and night time. Each ward manager was supernumerary, however due to nurse vacancies across all wards ward sisters often stepped in to backfill vacant shifts. We saw this occurred one to two times per week on ward one and ward three.
- There were adequate staffing levels of doctors and consultants across all four wards ensuring that patient assessments, care and treatment were conducted in a timely manner.
- There was a Neuro-Rehabilitation Consultant on site each day Monday-Friday; a Care of the Elderly Consultant on site each day Monday-Friday and a Stroke consultant visited Ward One daily to facilitate daily ward rounds.
- There was a staff grade doctor on each ward 9-5 Monday-Friday.

From 5pm to 7pm one doctor covered all four wards, 88 patients in total. If a patient required a medical assessment after 7pm, the nurse would contact the on call consultant at New Cross hospital for initial telephone advice. Should the patient require a medical assessment the community out of hours Prime Care GP would be called or 999 in an emergency.

### Managing anticipated risks

- West Park Hospital risk register identified the following areas at risks: nurse staffing vacancies, this was partially mitigated by the ongoing recruitment programme, using bank staff to cover shifts.
- West Park Hospital did not have any security from 8pm to 7am. This contract had been stopped over one year ago and not replaced. There had been several security breaches reported within the past 12 months, involving an intruder attempting to gain access to the back doors of the premises and reports of soliciting in the carpark. During focus groups and interviews staff told us they felt vulnerable and the security risk to patients and staff was real and ongoing.
- Senior managers told us security provision at West Park hospital was being reconsidered, however no new contracts had been agreed.
- In the event of fire or major incident, there was no effective form of communication between the senior on call nurse and ward fire marshals. Senior management told us they needed hand held radios to facilitate instructions, however there was no other method to communicate other than landlines. Following the inspection the trust informed us that they had ordered handheld radios for key staff.
- Not all fire doors within West Park Hospital premises with green push buttons had break glass panels next to them, this meant staff or patients could not override fire doors locking mechanism in the event of an emergency and exit safely. Following the inspection the trust confirmed that they were aware of this risk and it was due to be addressed September 2015.
- We saw each ward identified a daily designated fire marshal and there was an on call bleep holder each night, however we saw they were counted in the rota and were not supernumerary, there was a risk that if the ward was short staffed and the bleep holder was the only qualified nurse on duty, they would be unable to respond to an emergency and for instance support the wards to evacuate in the event of a fire.
- We saw the West Park Hospital had a Fire Response Procedure and a Fire Evacuation Plan, we saw the procedure identified security as one of four key personal during a fire, however there is no hospital security on duty at night.
- The trust's risk register highlighted West Park Hospital Fire procedure as high risk and stated "If a fire were to occur at West Park Hospital there is a very high probability that this could result in injury or loss of life due to a failure to comply with national and statutory standards".

### Major incident awareness and training

- The Business Continuity plan was in place and included what actions to take in the event of an unplanned major incident at West Park Hospital such as fire or flood.
- The plan was two months out of date and due for renewal on 1 April 2015.

Requires improvement

# Are services safe?

- Staff were aware of the plan and confident that their respective area managers understood their roles in protecting patients and staff.

Good

# Are services effective?

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

**Summary**

The effectiveness of the service was good. Patients' pain, nutrition and hydration were well managed. Therapy competency frameworks and evidence of specialised training was in place, however specialised training for nurses was not as robust.

Care delivery was underpinned by evidence-based practice and followed recognised and approved national guidance. Multidisciplinary working both internally and externally was evident to achieve the best possible patient outcomes were demonstrated across all wards especially the Neuro Rehabilitation ward.

Discharge, transfer and transitions between the acute services and West Park Hospital wards were planned in advance and involved holistic assessment of patient's needs; this includes working with other agencies to assess, plan and coordinate care, however, external social service delays resulted in nearly 25% of patients across all wards were medically fit for discharge, however there was no discharge date in place. We saw that the trust interacted with local authorities to try and improve the social provision with the community.

Staff had access to information and we saw staff gaining patients consent with each nursing and therapy intervention.

**Evidence based care and treatment**

- All medical services delivered evidence-based practice and followed recognised and approved national guidance across West Park hospital.
- Staff understood their roles and clinicians worked within their scope of practice in accordance with their professional governing bodies.
- Nurses and therapists made timely internal and external referrals to other healthcare professionals to ensure that patients were seen by the right person at the right time.
- Hospital policies and procedures were developed in line with national guidance; they were available electronically and we saw staff access policies freely via the trust's intranet.
- We saw evidence that the National Institute for Health and Care Excellence (NICE) guidance, such as the clinical guidance on the prevention and management of pressure ulcers was followed across all four wards.

**Pain relief**

- Patients were administered pain relief according to their individual prescriptions and nursing staff were vigilant when monitoring patients' pain levels.
- Patients pain levels were discussed at bedside handover however, there was no recognised pain care plan or tool used to record patients pain levels.
- We saw one nurse took time to explain to a patient the importance of taking their pain relief medication even though they were not experiencing pain at the time. The patient was reassured and agreed to take their medication.

**Nutrition and hydration**

- A Malnutrition Universal Screening Tool (MUST) was completed on admission and at regular intervals to monitor patients' nutritional status.
- Referrals to the dietician were carried out promptly when required and patients' weight was recorded weekly on wards One, Two and the Neurorehabilitation ward. However there were some gaps in weight recordings on ward Three, which was highlighted to the nursing staff, who told us, weights may sometimes be missed if the patient was unavailable or asleep. We were reassured any missed weights would be addressed as a priority. The majority of patients told us that the food was tasty and enjoyable and portion sizes were adequate.
- We saw patients could eat without interruption and that staff were available to support them when it was required in a relaxed and dignified manner and ward staff upheld protected mealtimes.
- Hot and cold drinks were offered to patients at regular intervals and fluid balance charts were recorded appropriately.
- We saw snacks were offered to patients in between mealtimes such as biscuits, cakes and fruit.

Good

# Are services effective?

**Approach to monitoring quality and people's outcomes**

- Individual wards held performance data to measure the quality of care and the documentation for each patient via the clinical dashboard.
- Therapists explained that each patient had individualised rehabilitation goals depending on their personal targets and needs. For instance one patient's goals was to be discharged home and walk from the living room to the bathroom. Another patient's goal was to stand and sit unaided. All patent's goals were discussed at the weekly MDT meeting and progress was monitored and recorded in the patient's medical notes and discussed verbally with each patient.
- The neuro rehab ward held MSAS (mobility scale for acute stroke) outcome measures. The scale was completed at the start and the end of each patient's therapy intervention, From February to May 2015, 23 patients had been admitted and discharged to the ward, 22 patients had improved MSAS and one patient's mobility had stayed the same. This showed an overall improvement of 96%.
- The baseline assessment tool for NICE guidelines on stroke rehabilitation made 119 recommendations. The trust which included figures taken from West Park Hospital wards met 115 of them scoring 97%. The senior matron maintained a monthly ward performance record for each ward which included up to 59 areas of audit. These areas covered: needle stick injury, calls bells in easy reach, pressure relieving equipment in place, bed rail assessment completed, medication errors and the patient looks comfortable and well kept. The results for April 2015 showed the neuro rehab ward performed the best by achieving a green rating in 57 out of 59 areas. Ward One and Three both achieved a green rating in 56 out of 59 areas and ward two achieved a green rating in 35 out of 59 audited areas. Action plans were put in place for areas that underachieved and were rated as red and their performance was monitored closely by the ward sister and senior matron.

**Competent staff**

- Therapy staff demonstrated good rehabilitation competencies of the older adult and especially skilled and knowledgeable with patients with neurological needs such as stroke, multiple sclerosis and brain injury. Therapists were supported by a competency framework related to these areas and attended specialist training to ensure they were equipped to deliver specialised rehabilitation care.
- We saw nursing competencies in areas of blood transfusion, female and male catheterisation. However there was minimal training and competency records to support condition specific diseases such as dementia, stroke, multiple sclerosis, brain injury, Parkinson's or epilepsy.
- We were told by nurses they acquired their knowledge and skills through 'on the job training' and learning from their peers and that there was limited specialised training available. We talked to ward sisters and senior management who told us plans were in place to look at ongoing training for disease specific training.

**Multi-disciplinary working and coordination of care pathways**

- Staff demonstrated good internal multidisciplinary working across all four wards and demonstrated a wider team knowledge, which enabled them to refer patients in a timely manner to other specialist areas such as the resource centre and the wheelchair services.
- There was an obvious professional respect between doctors, consultant nurses and therapists which made communication of patient information at handovers, ward rounds and multidisciplinary team meetings effective and efficient.
- We saw a case study of where the MDT had worked together to admit a patient from home who spent 24 hours in bed having suffered a stroke and family were struggling to cope. The patient was admitted into West Park Hospital for intensive rehabilitation therapy. The team together with the patient and their family set short and long term goals which was achieved and the patient was discharged home able to stand, mobilise and was independent with personal care.
- Another patient's family was struggling to cope and the ward offered to emulate a package of care four times a day. This involved allowing the family open visiting times and at designated times of the day, ward staff assisted the family to care for the patient as a care agency would if they were at home. This enabled the family the opportunity to trial the virtual care package in a safe environment and learn how to move the patient safely with confidence. This resulted in a safe and successful discharge.

Good

# Are services effective?

- The stroke care pathway included rehabilitation care at West Park Hospital and included nurses doctors, therapists and specialist nurses. The MDT worked in partnership with the patient and family to achieve goals and meet patient's needs. Patients who had suffered a stroke started their stroke care at the A& E department, once stabilised they were usually admitted to West Park Hospital ward one, however, services available in the pathway had been offered to patients admitted onto the neuro rehab ward also.
- We saw intensive rehabilitation therapy being carried out with five patients in the rehab gym and we saw other rehab groups available to patients at West Park Hospital such as: cycling group using adapted trikes, model railway group, art group and gardening group in a specially designed garden on the hospital grounds. Patients remained on the stroke pathway for one year post initial stroke and patients were encouraged to continue their rehab when they were discharged home.
- We talked to the Occupational therapist and the stroke care specialist team who confirmed community classes for fishing, swimming and gym, ladies at lunch and quiz groups were well attended and promoted individual coordination and social interaction.

**Referral, transfer, discharge and transition**

- Referrals into West Park Hospital wards came from New Cross Hospital, Cannock Chase Hospital and GP's.
- Home assessments for patients, for example to assess their mobility in their own environment prior to discharge, was undertaken by a member of the therapy staff when required. This process ensured any equipment or additional support could be arranged prior to their discharge.
- Patients were referred appropriately to community services, for example community nursing teams to ensure their needs continued to be met.
- Referrals to clinical nurse specialists such as tissue viability nurse, speech and language therapist, falls lead and dietician were available and provided an in-reach service to wards on request and staff told us the referral process was easy to use.
- We saw 20 out of 88 patients were medically fit for discharge, however there was no set discharge date and not all patients had received a social work assessment.
- We were told the average length of stay was approximately four to six weeks, however we saw several patients across four wards had stayed more than three months and one patient with complex housing needs had been waiting for more than six months.

**Availability of information**

- Patients arriving from the acute hospitals were accompanied with paper records which detailed their recent care and treatment.
- Staff had access to patients' records for those patients who arrived from the community and community staff also provided a verbal handover to ward staff to aid patients' admission.
- We saw the paper records for patients on the unit. They included medical records, diagnostic results and nursing notes this enabled staff to care for patients safely.
  - Discharge summaries were produced for patients discharged home, this included rehabilitation goals met and outstanding ones, current condition, list of medication and follow on appointments.

**Consent**

- We saw staff involved patients in their care and they obtained verbal consent before carrying out any personal care or treatment.
- We saw therapy staff were thorough in recording 'consent obtained' for each therapy intervention.
- On wards two and three we saw patients who were living with dementia or were suffering confusion due to infections. Two staff we spoke with were unsure of when they should determine a patient's mental capacity as mental capacity assessments were carried out by social workers and staff rarely were involved.
- Senior staff were aware of capacity and consent, but more junior staff lacked an understanding of their role in this. The managers of the service acknowledged more training was needed in this area.

Good

# Are services caring?

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

**Summary**

Staff treated patients and their relatives with dignity and respect. Patients felt looked after and staff responded quickly and compassionately to patients in pain or discomfort.

Nursing and therapy staff included patients in all aspects of their care and treatment and we observed caring interactions between staff and patients at the bedside and especially during one to one therapy sessions in the rehabilitation gym.

Nursing and therapy staff promoted and supported patients' independence throughout their stay and provided emotional support to patients and relatives alike.

**Dignity, respect and compassionate care**

- Interactions we observed across all four wards between staff and patients were undertaken in a quiet, dignified and compassionate way. For example, on ward one we saw a patient living with dementia calling out, the nurse attended to them quickly. The nurse knelt down beside them, held their hand and reassured them making the patient laugh before they gave them a drink and left them comfortable and calm.
- We talked to 40 patients across 4 wards and generally patients spoke highly of staff as did their loved ones who visited them.
- The recent PLACE results for June 2014 showed all four wards scored a combined total of 94.2% for privacy, dignity and wellbeing of patients.

**Patient understanding and involvement**

- A large part of a patients care at West Park Hospital was to engage in rehabilitation therapy to regain activities of daily living skills or achieve individual optimal levels of independence following long term illness or acute stroke.
- Patients were involved in their care by joint discussion and agreements with the therapists at the first assessment, reassessments and evaluation and upon discharge. We saw clear records to support this.
- We observed therapy staff working with patients to achieve their individual therapy goals in the gym on a one to one or two staff to one patient ratio. Staff explained the reason for specific activities to aid patient's understanding and gain trust. For example, we saw two therapists working with a patient to improve their posture and balance following a stroke. The therapist explained what was going to happen and how the patient may feel to prepare them. They talked to the patient through the process, stopped when the patent asked them to and provided reassurance from beginning to end of the intervention. Another patient was being supported by a therapist with a building activity, the therapist provided a full explanation of the activity, and involved the patient by reinforcing the benefits of the activity ie: to strengthen coordination and concentration.
- We saw evidence to support patients were involved in their care through the monthly performance monitoring audit for matrons. This looked at areas such as: are patients aware of risk of falls, patients has been made aware of the expected date of discharge, the patient is aware of the discharge plan and the patient is aware of their drugs when discharged and how to take them. In April 2015, all four wards achieved a green rating in all of these areas which meant t they had achieved the required target.

**Emotional support**

- We spent time on all four wards and observed interactions between patients and staff. Staff engaged with patients and comforted them if they were distressed. For example during bedside hand over we heard how one patient who was confused due to an infection became upset and physically aggressive. The nurse took time to find out why and ascertained it was because they wanted a morning shower. The patient was reassured and a shower was given and this was handed over to staff to ensure this would become part of the patients personal hygiene plan.
- Relatives were welcomed when they visited the wards and we saw one relative who was obviously distressed being consoled by a nurse, who offered to go into a room to talk privately.

Good

# Are services caring?

- We saw examples of 'thank you' cards, expressing the gratitude of patients and relatives for the care and support they had received whilst an in-patient or visiting the units.
- A chaplain was available for patients or their relatives and staff could also access

leaders of other faiths if required.

**Promotion of self-care**

- The majority of patients across all four wards were encouraged to wear day clothes. We were told this was to promote a sense of normal daily living in preparation for discharge.
- We saw patients were encouraged to be as independent as possible and we saw staff give patients support and time when mobilising to and from the bathroom, self-dressing and grooming and engaging in therapy activities.
- Vulnerable or frail patients who required extra support were appropriately assisted.

Good

# Are services responsive to people's needs?

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

**Summary**

Staff were aware of the referral criteria for each ward to ensure the patient received the right care by the right team promoting optimal level of care to meet patient's needs.

Patients and relatives concerns were listened to and acted upon swiftly by staff. Vulnerable patients were identified on admission and staff provided individualised care to meet their needs.

Staff communicated well with patients and relatives and involved them in their nursing and therapy care plans, referrals and discharge plans. Patients told us they felt well informed.

**Planning and delivering services which meet people's needs**

- West Park Hospital was divided into four wards providing 88 beds in total. The Neuro Rehabilitation ward provided 10 beds, ward one, stroke ward had 22 beds, ward two provided 28 elderly frail male beds and ward three provided 28 elderly frail female beds.
- The majority of patients were referred from the acute hospitals of New Cross and Cannock Chase. All patients were assessed prior to admission to ascertain which ward would suit the patient's needs best.
- Patients who had suffered a stroke were placed on the stroke care pathway and were admitted to either the Neuro Rehabilitation ward or ward one, the stroke ward.

**Equality and diversity**

- Equality and diversity training was delivered to staff as an on-line module as part of their mandatory training.
- Staff informed us interpreting services were available for patients when they were required although we did not meet with any non-English speaking patients during our inspection.
- Patients with special food requirements to meet cultural and religious needs were catered for on request, for example Halal or Kosher.

**Meeting the needs of people in vulnerable services**

- The trust's 'about me' documentation for patients living with dementia was used and completed appropriately across all four wards, this enabled staff to read patients family and social history and their needs and preferences. However, this was not reflected in the care plans.
- The butterfly symbol was used and displayed above patient's bed boards to indicate they were living with dementia, were vulnerable and required extra support.
- Staff we talked to were very aware of the individual needs of their patients, for example their likes and dislikes.
- However, there was no provision for patients to take part in ward activities. One patient told us they were very bored because there was nothing to do. We talked to the matron who told us activities such as arts and crafts and a reminiscence group to keep patients stimulated used to be led by volunteers however all the volunteers had left and there was no one available to lead on activities. We were told this was an area being looked into.

**Access to the right care at the right time**

- All patients received medical assessments upon admission and had access to medical care on a daily basis when required.
- There were no stroke outlier patients identified during the inspection and all patients requiring specialist Neuro Rehabilitation were appropriately placed on the neuro ward.
- We talked to a senior nurse who told us not all patients received specialist care and treatment to meet their needs at the right time. For example two out of ten patients required regular and intensive psychotherapy. However the contract with Wolverhampton University allowed only one session per week which was insufficient to meet their specific needs and staff told us this hampered their overall rehabilitation progress.
- We were told social service assessments were delayed due to recent social worker redundancy and also as social workers were trialling six day working to include Saturdays. Nurses and therapists told us social workers working on Saturdays was ineffective as assessments and referrals were carried out Monday to Friday. This had a negative impact on the average length of stay for patients.

Good

# Are services responsive to people's needs?

**Complaints handling (for this service) and learning from feedback**

- Staff we talked to were aware of and knew how to access the trusts complaints policy.
- We saw PALS (patient and liaison service) stickers were displayed on patient's bedside lockers and complaint information leaflets were available on each ward. However this information was not available in languages other than English.
- Staff were aware how to resolve local complaints and when to escalate to senior management.
- We talked to 40 patients across four wards including some relatives, the majority of patients were very happy with the care and treatment provided. One patient and their family was unhappy and told us they attempted to complain about the lack of basic care but their concerns had not been taken seriously. During the inspection the patient's concerns had been listened to and resolved appropriately.

Good

# Are services well-led?

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

**Summary**

Staff shared in the trusts' vision and the majority of staff were very happy to work at West Park Hospital. Governance arrangements to monitor and measure ward performance was robust and local leaders took a proactive approach to improve care and the patients experience as a whole.

Staff were well supported by local and senior leaders and felt the executive board had the right skill set and experience to take the service forward.

Staff across West Park Hospital were committed and compassionate in delivering quality care to patients and often pulled together across wards to fill vacant nursing shifts.

Results from the Friends and Family Test showed significant improvements across all four wards over a short period and the NHS staff survey results was better than the national average in areas of communication with managers and opportunities for staff learning development.

Staff were encouraged to be innovative in practice and introduced a new bedside handover, therapists offered external activity programmes for stroke patients and the Practice Education team provided extensive support and advice to all pre and post registration staff and had an excellent reputation trust wide.

**Service vision and strategy**

- Staff at West Park Hospital shared in the trust's future vision and strategy which was to continually strive to improve patients' experiences and outcomes.
  - Staff from all disciplines described themselves as "fortunate' and "privileged" to work at West Park Hospital and the majority of staff were proud to work in what they considered to be a winning team.
  - Staff were enthusiastic and encouraged and supported by the senior matron, ward sisters and therapy managers.
- This was displayed by all staff we talked to individually and in staff focus groups.

**Governance, risk management and quality measurement**

- The quality of care was measured using clinical performance dashboards and comparable ward performance was discussed and measured at monthly governance meetings, minutes taken and shared among ward staff to encourage improvements in practice.
- Under-performing wards were monitored closely by ward sisters, senior matron and group managers and plans put in place for remedial action.
- The trusts risk register had been reviewed in June 2015 and highlighted several areas of concern relating to West Park Hospital: nursing staffing levels, fire procedure and security. Actions by the trust in response to these risks involved the senior matron submitting a report and discussing each risk at the monthly governance meeting.

**Leadership of this service**

- Staff told us their immediate line managers and key members of the executive team for example the chief nurse and the chief executive were visible, accessible and approachable, and described them as caring leaders with good support systems in place.
- Strong local leadership was evident across all four wards , however we saw this was especially evident at ward One and the Neuro Rehabilitation ward this was largely due to the multidisciplinary working between nursing and therapy staff. These services were well-organised and strong team working was encouraged, resulting in good patient outcomes.
- Ward sisters met regularly with matrons and group managers to discuss performance and quality and incidents and complaints were dealt with swiftly and sensitively.
- Staff were supported to attend mandatory training and therapists were actively encouraged to attend specialist training. However, the opportunity for nurses to attend specialist training for disease specific conditions such as Epilepsy, Parkinson's, Dementia and brain injury was limited. The matron told us this was an area for improvement.

Good

# Are services well-led?

### Culture within this service

- In general, we found the culture of care delivered by staff across all four wards was dedicated and compassionate and strongly supported at executive, divisional and ward level.
- Staff were hard-working and committed to providing the best care possible to their patients on a daily basis despite nursing vacancies on each ward.
- Staff from all disciplines spoke with passion about their work and conveyed how happy they were to be working at West Park Hospital.
- Throughout the hospital we saw staff greeted each other, patients and visitors in a friendly manner and staff looked happy working at West Park Hospital.
- Staff told us they had confidence that the executive team had the skills, knowledge and experience to lead them now and into the future and told us they thought they were doing a good job.
- Through one to one interviews with managers and through staff focus groups we were told the executive team were honest and open with staff and this was demonstrated through the recent transition to include Cannock Chase Hospital as part of the trust.
- Staff told us the executive team worked with integrity to promote an open and communicative approach to ensure the transition went smoothly with the least amount of disruption to new staff at Cannock Chase, existing staff at New Cross and patients in general.

### Public and staff engagement

- Results for the NHS Friends and Family test which asks patients and their families if they would recommend the hospital to others showed a significant improvement for wards one and three at West Park Hospital. For example, ward one previously scored 70% in April 2014 achieved 95% in June 2014. Ward three scored 75% in April 2014, achieved 100% in June 2014. The most significant improvement was the Neuro Rehabilitation ward which scored 66% in April 2014 and achieved 100% in June 2014 and ward two remained stable at around 94% in April and June 2014.
- Patient feedback was not routinely gathered for individual wards. Patients were asked verbally about their care and treatment, however this was recorded and measured. However the Stroke Care Specialist team carried out an annual patient survey. In 2014, out of 25 questionnaires, 15 were returned. All 15 patients felt involved in their care and treatment and all 15 patients felt they were listened to, 11 patients felt the service met all of their needs and four patients felt the service met most of their needs. Fifteen patients rated the service as excellent.
- The same team held stroke service user group meetings. The minutes from April 2015 showed patients attended and shared their experiences of the service and discussed with the therapists and group manager how services could be improved. For example, patients suggested the stroke leaflet could be improved by adding contact details to the back page and also ensuring that all patients at West Park hospital who had suffered a stroke received a booklet on discharge as this was not always the case.
- We were told all suggestions were acted upon which helped to shape and improve stroke services with the stroke care pathway including West Park hospital.
- West Park Hospital staff took part in the 'Chat Back' staff questionnaire in August 2014 which asked staff 31 questions about how they felt to work in the trust. For example, "are you satisfied with your job", "are you satisfied with the quality of care you deliver". The trusts' overall response rate was 22%. We saw wards One, Two and Three scored very positive results and achieved an overall green rating, however the Neuro Rehabilitation ward provided less than satisfied answers and scored an overall rating of red.

### Innovation, improvement and sustainability

- The senior matron of West Park Hospital had introduced new improvement in practice for example, ward one were trialling the bedside handover to improve communication, documentation and nursing accountability, we saw this worked well and plans were in place to roll this out to all four wards.
- The therapy team provided a range of activities such as gardening, cycling, fishing, ladies at lunch club and model railway group for patients living with or recovering from neurological conditions, this reduced patient's social isolation, one patient recovering from a stroke told us, " I love coming to the garden club, its gets me out the house and I've made some very special friends, its speeded up my recovery"
- The practice education team provided trust wide support to pre-registration and post registration staff. They linked in with Wolverhampton University and staff from all four wards described them as "nurturing" and a

Good

# Are services well-led?

"source of excellence". Staff told them they were visible, accessible and very helpful with learning and development of student nurses, newly qualified staff, staff with development needs and substantive staff who were new to West Park Hospital.

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 |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Management of supply of blood and blood derived products<br>Nursing care<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br>How the regulation was not being met:<br>People who use the services and others were not protected against the risks associated with unsafe or unsuitable premises because of insufficient measures in relation to night time security West Park Hospital. Also, inadequate operations of the premises for safe door exiting systems at West Park Hospital in the event of an emergency. |