

The Mid Yorkshire Hospitals NHS Trust

RXF

Community health inpatient services

Quality Report

The Mid Yorkshire Hospitals NHS Trust, Trust
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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)
RXFX3	Queen Elizabeth House	Queen Elizabeth House	WF1 4AA
RXF14	Monument House	Monument House	WF8 2AY
RXF05	Pinderfields Hospital	Ward A1	WF1 4DG







This report describes our judgement of the quality of care provided within this core service by The Mid Yorkshire Hospitals 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 Mid Yorkshire Hospitals NHS Trust and these are brought together to inform our overall judgement of The Mid Yorkshire Hospitals NHS Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall we rated safe and well-led as inadequate and effective, caring and responsive as requires improvement.

When we inspected this service in July 2014 we rated the service overall as requires improvement and the safe, effective and well-led domains as requires improvement. We asked the provider to make improvements. We went back on this visit to check whether these improvements had been made. The inspection was announced and was carried out on the 23, 24 and 25 June 2015.

At the time of the inspection community inpatients at The Mid Yorkshire Hospitals NHS Trust (the trust) was providing accommodation and nursing care for patients in three units; Queen Elizabeth House (QEH), ward A1 at Pinderfields General Hospital and the Kingsdale Unit via a contract with BUPA. We did not visit the Kingsdale Unit as part of this inspection.

Before this visit we had received information of concern about staffing levels at the units, especially at night, staff training and people's care, treatment and support needs not being met. During our visit we found evidence to support this information.

During the inspection we used different methods to help us understand the experiences of patients using the community inpatients service at the trust. We directly observed how patients were being cared for at both locations, including an evening visit to QEH. We spoke with 14 patients and seven relatives / visitors / family members, who shared their views and experiences of the service with us. We also observed three mealtimes; two lunches (one at each site) and one breakfast (QEH) and attended an early morning handover at each site.

We looked around the premises, including people's bedrooms, bathrooms, toilets, communal areas, sluice rooms, the kitchen (at QEH) and outside areas. Eleven people's care records were used to pathway track patients' care. We observed two medication rounds and reviewed 44 medication records. Management records were also looked at, these included; nine staff personal files, policies, procedures, risk registers, audits, accident and incident reports, complaints, staff training records, staff rotas and monitoring charts.

We spoke with 24 staff including two matrons, two team leaders, 11 nurses, seven support workers and therapy staff. We also met with the management team.

During the inspection we found all of the available beds in the units were occupied; there were 26 inpatients at QEH and 18 inpatients on ward A1.

We found care and treatment was not person-centred and did not always meet patients' needs or reflect their preferences. Patients and relatives told us they had not been involved in planning their care and were not given choices about the activities of daily living; these included mealtimes, access to snacks and drinks outside mealtimes, what time they went to bed and got up and when they could have a bath or shower.

Patients were not always treated with dignity and respect and were not supported to be independent. We observed incidents during the inspection at QEH which did not ensure the privacy and dignity of patients. At the last inspection it was noted that the toilet facilities not designated same sex. This did not comply with the government's requirement of Dignity in Care. At this inspection we found no changes had been made to the designation of toilets as female or male at QEH. We also found patients were not supported to self-medicate during their stay at the units, to prepare them for discharge.

We did not find any evidence to show that patients had given consent to their care and treatment and patients confirmed they had not been asked to give their consent. Mental capacity assessments were in place in care records, but the service had not complied with the requirements of the Mental Capacity Act 2005 in obtaining consent for those patients who lacked capacity.

We found systems and processes to keep patients safe were unsafe. There were no major incident or business continuity plans in place and staff were unaware of the procedures to follow in the event of an emergency. Fire documents requested were not available, out of date or incorrect. The fire risk assessment provided for inspectors to review at QEH was for Monument House and there were no fire evacuation plans, fire drills, fire safety training or fire risk assessment available on site at QEH. Staff were unable to tell us what they would do in the

Summary of findings

event of a fire, apart from ring 999. When we asked senior nursing staff about this they were unaware of the problem. Following our inspection we referred our concerns to the West Yorkshire Fire Service for investigation.

We found the call bells at QEH were not always accessible to patients. This meant patients were unable to summon assistance when they needed it. We also found patients at QEH waited a long time for call bells to be answered; one of our inspection team pressed a call bell with a patient in their room and it took longer than 10 minutes for staff to attend the room. Four patients told us it regularly took at least 30 minutes for staff to respond when they pressed their call bell.

We found patients at QEH were being deprived of their liberty of movement by physical means without lawful authority in that the doors to the unit and the garden gates were kept locked. One patient at QEH had a deprivation of liberty authorisation in place but none of the patients could leave the unit without staff assistance.

The nutrition and hydration needs of patients were not always being met. Patients were identified at QEH who were at risk of malnutrition and/or dehydration. We saw care plans which documented that food and fluid charts were required to monitor patient's food and fluid intake. However, we found 15 out of 19 food and fluid charts at QEH had not been completed. One patient identified as at risk of dehydration did not have a food and fluid chart in place. They had also lost weight recently and had not been referred to a dietician.

Premises and equipment used by the service at QEH were not suitable for the purpose for which they were being used and were not properly maintained. The design, layout and lack of maintenance of the QEH premises did not promote people's wellbeing. For example, the lift at QEH was in a poor state of repair, with frequent breakdowns reported. Seven of the 26 patients resident at QEH during the inspection required at least two staff to hoist them and 19 of the 26 bedrooms were on the first floor. There was also not enough room in the lift at QEH for a bed or stretcher. This meant the premises were not fit for the purpose of caring for frail elderly patients with mobility problems.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records relevant to the management of the service were not maintained. A large number of documents were found not to be up to date or were absent. These included policies and procedures, management records, meeting minutes, accident and incident reports, supervision and appraisal records, risk registers, risk assessments and complaints.

We had significant concerns about the assessment and monitoring of the quality of the service provided and the issues we found during the inspection had not been identified by the service's own management team. There was little evidence of follow up of audits and satisfaction surveys or any systems or processes in place to demonstrate to us the units had an effective quality management system.

There was not enough qualified, skilled and experienced staff to meet patient's needs safely and in a timely manner. The service used a high proportion of non-permanent staff to fill the frequent gaps in the rotas. These included agency staff and staff from other areas of the trust. The service did not use a dependency or acuity tool to determine what the minimum staffing levels should be based on the dependency needs of the patients.

Training for temporary, new and existing staff required improvement to ensure they had the skills and knowledge required to carry out their duties. Staff did not receive appropriate professional development, supervision and appraisal. We found a significant number of examples which showed that patient care and treatment was affected by the shortages and lack of consistency of staff.

The service did not act in an open and transparent way when a notifiable safety incident resulting in moderate harm had occurred. The problems we found with compliance with the requirements of the duty of candour breached Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the report.

Summary of findings

Background to the service

At the time of the inspection intermediate care community beds at The Mid Yorkshire Hospitals NHS Trust (the trust) were being provided at Queen Elizabeth House (QEH), ward A1 at the Pinderfields Hospital site and the Kingsdale Unit via a contract with BUPA. We did not visit the Kingsdale Unit as part of this inspection.

QEH had 26 beds in use and ward A1 had 18 beds. Patients from Monument House (MH) in Pontefract, which had 24 beds, had been relocated to ward A1 at Pinderfields General Hospital (PGH) on the 4 June 2015 due to an influenza outbreak. The community inpatient service at the trust was nurse led.

The service provided intermediate care including rehabilitation and step down for patients, prior to discharge home and those waiting for nursing home care.

The service had 64 staff across the two units visited. At QEH there were two teams, each was responsible for half of the patients there. Occupational therapists and physiotherapists were co-located on the same sites and worked alongside nursing and support staff in a multidisciplinary way caring for patients who used the service.

Patients using the service were mainly elderly, many had fallen and some had fractures. Both units were fully occupied at the time of the inspection. We were told that between 20 and 30 people would be patients at QEH in a month and between 15 and 22 people would be patients at MH in a month, prior to the recent transfer of patients from MH to ward A1.

Our inspection team

Our inspection team was led by:

Chair: Dr Bill Cunliffe

Head of Delivery: Adam Brown, Care Quality Commission

The community inpatients inspection team was made up of two inspectors, a specialist advisor (who was a community staff nurse), and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Why we carried out this inspection

We inspected this core service as part of a focussed inspection of The Mid Yorkshire Hospitals NHS Trust. This inspection was to follow up on issues identified at the last comprehensive inspection of services at the trust, in July 2014.

How we carried out this inspection

To get to the heart of patients' experiences of care, we routinely ask the following five questions of services and the provider:

- Is it safe?
- Is it effective?

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

Prior to the announced inspection, we reviewed a range of information that we held and asked other

Summary of findings

organisations to share what they knew about the trust. These included the clinical commissioning

groups (CCG), trust Development Authority, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), and the local Healthwatch organisations.

We carried out the announced inspection visit between 23 and 25 June 2015. During the inspection we held focus groups and drop-in sessions with a range of staff including nurses, junior doctors, consultants, allied health professionals (including physiotherapists and occupational therapists) and administration and support staff. We also spoke with staff individually as requested. We talked with patients and staff from ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We used different methods to help us understand the experiences of people who used the community inpatients service. We directly observed how patients were being cared for at both locations during the inspection, including an evening visit to the QEH unit. We spoke with 14 patients who used the service and seven relatives / visitors / family members, who shared their views and experiences of the core service. We also observed three mealtimes; two lunches (one at each site) and one breakfast (QEH) and attended an early morning handover at each site. We spoke with 24 staff including two matrons, two team leaders, 11 nurses, seven support workers and therapy staff. We also met with the management team.

We reviewed care and treatment records of 11 patients who used the service, 44 medication records, nine staff files, staff training records and other records relating to the management of the service, such as audits and the risk register.

What people who use the provider say

QEH

"All the staff are lovely."

"The meals are good and nothing's too much trouble."

"Staff are very stretched in the mornings."

"We get well-looked after."

"They need extra staff."

"I love it here, I feel very safe and the staff are very good."

"Staff work in a very haphazard manner; no-one takes the lead."

"I do feel safe but I am very unhappy here, I have no idea when I am going home."

"Tomorrow it will be a different set up altogether (referring to staff team)."

Ward A1

"There's no activities we just sit here and look at each other."

"These physios here are the best; they're wonderful."

"We get plenty of drinks, day and night."

"Sometimes we have to wait a wee while."

"I don't know when I am going home."

"I think they've got enough staff, everyone's nice."

"This is one of the best teams I've worked on. We've got a lovely team."

"The patients here get good care."

"Staff morale is better than it has been, it has been poor."

Summary of findings

Areas for improvement

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

- Ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.
- The trust must ensure robust major incident and business continuity plans are in place and understood by staff. This must include fire safety at QEH.
- The trust must strengthen the systems in place to regularly assess and monitor the quality of care provided to patients.
- The trust must ensure where actions are implemented to reduce risks these are monitored and sustained.
- The trust must ensure there are improvements in the monitoring and assessment of patient's nutrition and hydration needs to ensure patients' needs are adequately met.
- The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.
- The trust must continue to strengthen staff knowledge and training in relation to the mental capacity act and deprivation of liberty safeguards.

- The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines.
- The trust must ensure in all services resuscitation and emergency equipment is checked on a daily basis in order to ensure the safety of service users and to meet their needs.

In addition the trust should:

- The trust should ensure staff are involved and informed of service changes and re-design.
- The trust should ensure in community inpatient services there is a referral criteria for the service and in-reach assessments are carried out consistently to improve the admission and referral process.
- The trust should ensure toilet facilities in community inpatient services are designated same sex, in order to comply with the government's requirement of Dignity in Care.
- The trust should ensure care and treatment of service users is only provided with the consent of the relevant person.
- The trust should ensure patients receive person-centred care and are treated with dignity and respect.
- The trust should ensure the equipment and premises are suitable for the purpose for which they are being used and are appropriately maintained.

The Mid Yorkshire Hospitals NHS Trust

Community health inpatient services

Detailed findings from this inspection

Inadequate 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Overall we rated community inpatients services as inadequate for safety.

When we inspected this service in July 2014 we rated the safe domain as requires improvement. We asked the provider to make improvements following that inspection. The trust had been told across services they must ensure safe staffing levels to meet the needs of the patients. There was no system in place to record the dependency levels of the patients to determine minimum staffing levels and 17% of shifts were below minimum staffing levels. Risk assessments within patients' care records were not always completed and there was inconsistency across sites. We went back on this visit to check whether these improvements had been made.

The trust's safety thermometer data showed there had been improvement in harm free care at Monument House/ward A1 for the three months from March to May 2015. The harm free care figures for QEH showed little or no change over the past 12 months.

Incident reporting was inconsistent; we found evidence of under reporting of incidents and of serious incidents not being consistently followed up. Staff knowledge about the duty of candour requirements was poor and there was a lack of evidence of lessons learned from incidents.

Medicines were generally well managed and the environment, including communal areas and bedrooms in the two units, were visibly clean. However, at QEH we found items of equipment which were either not clean and/or not fit for purpose and there was also a lack of equipment available.

We found the trust had not taken steps to provide care in an environment that was adequately maintained at QEH. The design, layout and lack of maintenance of the QEH premises did not promote patient's safety, health and wellbeing. A high proportion of the patients at QEH had mobility problems, which made the premises unsuitable for its current purpose. For example, the majority of the bedrooms were on the first floor and the lift was in a poor

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state of repair, with frequent breakdowns reported. There was also not enough room in the lift at QEH for a bed or stretcher which meant if a patient deteriorated, they would not be able to be moved downstairs using the lift.

Records relating to the management of the units required improvement to ensure they contained up to date information and were fit for purpose. Patients' care and nursing records were accurate and up to date and included appropriate risk assessments.

There was not enough qualified, skilled and experienced staff to meet patient's needs safely and in a timely manner. The service was not using a dependency or acuity tool and there was no system in place to record the dependency levels of the patients to determine the appropriate minimum staffing levels to deliver care safely. The service used a high proportion of agency staff and staff from other areas of the trust to fill gaps in the rotas. The services had vacancies which they found it was difficult to recruit to and there were high levels of staff sickness. Recruitment to the vacancies was on going and staff based in the community were working on the inpatient units to cover the shifts.

Mandatory training was not up to date, for example resuscitation and fire training. This meant staff did not have the training to assess and respond to patient risk appropriately.

Following our inspection, we referred our concerns to the West Yorkshire Fire Service for investigation.

Safety performance

- Harm free care focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE). The trust's safety thermometer data showed there had been improvement in harm free care at Monument House/ward A1 during the three months from March to May 2015. The harm free care figures for QEH were static. We saw that all harms reported in April 2015 were at QEH; where five out of 26 patients had experienced harm.
- We saw the incidence of harm free care at QEH each month from April 2014 to May 2015 had never been below 8% (two patients out of 25b affected) and was 30.77% (eight patients out of 26 affected) in October 2014.

- The service had reported a number of falls and pressure ulcers. For example during 2014 the service had reported five avoidable pressure ulcers at QEH and four at MH and in January 2015 5 patients out of 24 at MH had developed a new pressure ulcer.
- In 2014- 2015 there had been 69 falls at QEH up to the end of March. Senior staff told us the service was working with the corporate nursing team to reduce the number of falls within the unit.
- We saw that safety performance information was on display at both units. For example, in the QEH reception there was a 'safety cross' with dates of the current month and whether any falls had occurred on that date. We saw there had been two falls at QEH in the month of June up to the date of our visit.

Incident reporting, learning and improvement

- Staff all told us they knew how to report incidents on the trust's electronic incident reporting system (Datix). The matron told us the numbers of incidents reported at QEH was 'quite high.' For example in 2015 there had been 18 in January, 15 in February, 9 in March and 6 in April. They told us falls had reduced recently and that there had been two at QEH in June 2015 to date.
- The matron said that there would be a joint root cause analysis and a joint action plan put in place for any patients who had fallen and transferred to the service from the acute trust.
- We looked at the incidents that had been reported and found the main themes from these incidents for both sites involved staffing, pressure ulcers and falls.
- We also found incident reporting was inconsistent and there was a lack of evidence of lessons learned. For example, there had been two never events at the trust involving methotrexate. We asked staff about never events that had occurred in the trust, including senior nursing staff and the management team. They were not able to tell us about these incidents. From the service's incident records we identified one serious notifiable incident from 22 November 2014 at QEH, where a piece of equipment failed during the transfer of a patient and significant harm had been caused to the patient. This had not been followed up in a timely manner and the Datix records for this incident were incomplete. Senior nursing staff and the management team were unable to

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tell us what had happened following this incident. This incident had also not been being followed up appropriately with the patient to comply with the Duty of Candour requirements.

- There was also a lack of awareness among staff and senior managers of the Duty of Candour requirements. This requires the service to act in an open and transparent way after a notifiable safety incident has occurred.
- Incidents had been completed for lift breakdowns at QEH and MH, but they had not consistently been reported. Datix records showed one lift breakdown incident had been reported in 2015. The team leader confirmed that there would have been more lift breakdowns than this. Data submitted by the trust showed there had been nine lift breakdowns at QEH in 2015 to date. This lack of datix records for these additional lift breakdowns meant there was evidence of under-reporting of incidents within the service.

Medicines

- When we inspected this service in July 2014 we found there were no warning notices displayed prohibiting smoking or naked flames where oxygen cylinders were stored. On this visit we found warning notices on oxygen cylinders were now in place.
- Medicines were well-managed overall at both QEH and Ward A1. We observed two medication rounds and reviewed 44 medication administration records (MAR) at the two sites.
- However, we found QEH medication administration records where staff had recorded the time on all patient records as 10pm. This indicated that night time medications had been given to all 26 patients at 10pm. This meant the time medication given was not being recorded accurately by nursing staff administering the medication round at night.
- Staff deployment, especially at QEH, seemed disorganised. For example, we observed the medications round at QEH on the morning of 25 June 2015 was being carried out at 10am outside the dining room, at the same time as the patients were eating their breakfast.

Environment and equipment

- The environment at QEH was dated and not well-maintained. Accommodation was provided in 28 single rooms, 26 of which were in use. Two rooms were being used for storage. None of the rooms had ensuite facilities; toilets and bathrooms were separate and 19 of the 26 bedrooms were on the first floor. Commodes were used in bedrooms for patients that needed them.
- Staff, patients and relatives told us the lifts frequently broke down on both the QEH and MH sites. However, lift breakdown records for the lift at QEH were not kept on site and were not available for the inspection team to look at during the inspection. We also observed that the lift at QEH was not fit for purpose, as there was no room for a bed or stretcher. This meant the premises were not fit for the purpose as patients who deteriorated would need to be transferred on a bed or a stretcher. The environment on ward A1 was well-maintained and fit for purpose. Patients were accommodated in three five-bedded bays and three individual cubicles. Staff told us the accommodation at MH was all in single rooms. We observed the lounge and dining area on ward A1 to be cluttered with mobility equipment, with a limited number of chairs. This meant this space in this area could not easily accommodate patients, staff and visitors and there were trip hazards. There were no private areas on the ward for patients to see their visitors.
- Equipment at QEH was not always available and/or fit for purpose. For example, not every toilet at QEH had a raised seat and there were not enough recliner chairs for the number of patients that needed them. One person told us their chair was not suitable for them and said, "My legs get trapped."
- We saw dining room chairs at QEH which were not fit for purpose for the patients there. For example 12 out of 27 (44%) patient chairs had loose or wobbly backs and 7 out of 27 (26%) did not have arms for patients to use to assist them when sitting down or standing up.
- All of the wheelchairs at QEH were old and broken and we saw many had footplates missing. We observed wheelchairs at QEH being used to transport patients inappropriately; for example we saw one patient with both feet on one footplate.
- At QEH on 25 June 2015 we heard staff telling a patient being transported in a wheelchair with no foot plates

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that they would have to keep their feet up. When we asked senior nursing staff about this they told us they had reported this problem repeatedly but no action had been taken.

- The resuscitation trolley at Queen Elizabeth House was located behind the reception desk in the entrance. Records showed the trolley had not been checked on four days in the previous month - the resuscitation equipment had been checked daily 94% (113 out of 120) of the time over the previous four months (February to May 2015).
- The resuscitation equipment at ward A1 / MH had been checked daily 78% (84 out of 120) of the time over the previous four months (February to June 2015). This meant patients may be at risk in the event of a medical emergency.

Quality of records

- When we inspected the service in July 2014 we found patients' care plans did not always have all of the appropriate risk assessments completed. We were told at that visit that this was an area where a considerable amount of work was being implemented to improve cross-site consistency.
- During this inspection we looked at 11 sets of care records, five on ward A1 and six at QEH. We found the record keeping to be accurate with appropriate risk assessments in place and completed. Nursing documentation was detailed, dated and signed.

Cleanliness, infection control and hygiene

- The environment at both care facilities was visibly clean, including bedrooms and communal areas. Housekeeping staff were employed to maintain a clean environment. The sluices at both units were clean and equipment was stored appropriately.
- Hand gel and hand washing technique posters were available at each location. Staff adhered to the trust policy of bare below the elbows. Staff had access to personal protective equipment such as aprons and gloves.
- Sixteen pieces of equipment were checked at QEH, 56% (9 out of 16) were identified as having been cleaned

appropriately. However, we found all of the wheelchairs, pressure cushions and stand-aids were not clean. We observed that patients shared wheelchairs and that these were not cleaned between uses.

- The infection prevention and control (IPC) team told us they worked closely with the CCG and used the example of the recent influenza outbreak at MH. An outbreak meeting was held and a quick decision made to close the unit as 20 patients were affected and 14 staff. All patients were relocated to ward A1. Ward A1 had been closed to visitors during the outbreak and reopened on 15 June 2015 when the outbreak had been declared over.

Mandatory training

- Staff mandatory training was not up to date, this included fire safety, manual handling, safeguarding and resuscitation. For example, records showed 3 registered nurses (RN) and 6 healthcare support workers (HCSW) at MH were out of date with their safeguarding level 2 training and eight staff had no date recorded for this training. Two RNs at MH also had no date recorded for resuscitation training.
- Moving and handling training at MH showed on the trust summary training record as being 100%. However, individual staff records showed 1 RN and 2 HCSWs were out of date for moving and handling training and 1 RN and 2 HCSWs had no date recorded for moving and handling training. This showed that the trust summary records were not accurate and meant patients who needed moving and handling could be put at risk, as staff had not all had the appropriate training.
- Fire training was being undertaken by staff during our inspection on ward A1 as the staff had recently undertaken a change in environment.

Assessing and responding to patient risk

- Information of concern received prior to the inspection and evidence gathered during the inspection indicated that the service did not always assess and respond to patient risk appropriately.
- For example, on 24 June 2015 we found a patient with a grade 3 or 4 pressure ulcer on A1 who had been sitting out on a chair in the lounge for three and a half hours. They told us they were in a lot of pain. When we looked at this patient's care plan we found they should only be

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sitting out for 1 hour at a time. We also identified that the alarm for the pressure relieving cushion this patient was sitting on had been sounding for two hours but no action had been taken. Staff were not following current NICE guidance or the patients care plan for the use of bed rest and pressure relieving equipment in patients with pressure sores.

- We also identified that the instructions entered in patients' care records by the tissue viability nurses (TVNs), relating to how long patients should sit out, for staff to follow was not always clear. This showed that communication of care needs between staff on the ward and specialist nurses could be improved.
- Staff on ward A1 told us sensor mats and bed rails assessments were completed every night. They also told us falls assessments were always updated straight away following a fall and falls risk assessments were carried out on the day of admission.
- At QEH there was a call bell system, bed sensors and chair sensors for patients identified as being at high risk of falls.
- We observed that the resuscitation trolley at QEH was located on the ground floor and 19 of the 26 bedrooms (73%) were on the first floor. There was no resuscitation trolley on the first floor. This meant there was a risk of a delay in accessing resuscitation equipment in the event of a medical emergency. There was no risk assessment available for the resuscitation trolley. Staff told us they had not had a situation when the resuscitation trolley was needed on the first floor at a time when the lift had broken down.
- The resuscitation trolley at QEH was located behind the reception desk in the entrance; we observed that the reception desk was not always staffed. The drawers of the trolley were not locked and they contained medication and sharp items such as needles. There were patients living with dementia or other mental health problem at QEH. This meant there was a risk of harm to these patients as items in the trolley were not secure.
- When we asked senior nursing staff about this they told us the trolley location, its contents and it being unlocked had been assessed by the trust resuscitation team, who had not raised any concerns.

- We observed soup which was boiling being served to patients at lunchtime in the dining room at QEH; however, we did not hear staff on duty tell patients that the soup was very hot. This meant there was a risk that patients could burn themselves when they ate this soup.

Staffing levels and caseload

- The previous report identified that the trust must take action to improve staffing levels and ensure staffing levels were safe to meet the needs of patients. At this visit we found the staffing levels at the service were worse than at the last inspection in July 2014.
- Registered nurses (RNs) and healthcare support workers (HCSWs) at the service worked 12 hour shifts, day and night on both sites. Cleaning staff at QEH worked 8am to 6pm seven days a week.
- Agreed minimum staffing on ward A1 for 18 patients was 2 RNs + 2 HCSW during the day and 2 RNs + 2 HCSW at night, however there was often only one HCSW at night.
- Staffing at QEH was meant to be 2 RNs + 4 HCSW in the day and 2 RNs + 2 HCSW at night. This meant RN to patient ratios was 1 to 12 at MH/A1 and 1 to 13 at QEH.
- Similar to the last visit, we found the service was still not using an appropriate dependency or acuity tool or assessing the dependency levels of patients. When we asked senior nursing staff about this, we were told, "No work has been done to look at the dependency of patients in the unit or at skill mix."
- Senior staff told us the nursing establishment on both units was based on historic figures. They were unable to tell us what the current staff establishment for the service was. We were told there was to be a full service review, which would include identifying the staffing establishment required. However, we were not shown any evidence to confirm this. When we asked the matron about using an acuity tool they confirmed, "There isn't one." They told us the service needed to look at skill mix and clinical skills of staff, such as using advanced nurse practitioners (ANPs) that could prescribe medication.
- The recent move from MH to ward A1 meant staff to patient ratios at the time of the visit had improved from 1 to 12 to 1 to 9, as there were 24 beds at MH and 18 beds on ward A1. Staff told us this had improved the care that patients on ward A1 were receiving.

Are services safe?

- Senior nursing staff told us the trust was using the 'safer nursing care' tool, but that this was designed for use in acute services. Community inpatient units were recording red flag incidents (such as shortages of staff on shift, leading to the use of agency staff). Senior nursing staff told us the service had not achieved 100% compliance since this monitoring tool had been introduced.
 - The service used a high proportion of agency / bank and community staff. For example, staff rotas showed that 96% of shifts in a four week period (18 May 2015 to 28 June 2015), across both sites, used at least one non-permanent member of staff (from agency, bank or community). Two shifts were identified in this period where only one RN was on duty. This meant the nurse to patient ratio on those shifts would be one to 24 (at MH) or one to 26 (at QEH).

The staff rotas also showed that out of the 28 days there were only two days when both sites were staffed entirely by permanent staff employed by the service.

The team leaders had been told to fill in incident reports whenever non-permanent staff were used to cover shifts; however, this had only been in place for two weeks at the time of the visit.
 - We found there had been two agency staff on the night shift at QEH on the Saturday prior to our inspection (19 June 2015). One patient told us, "They did not know the building or the patients." We were also told that on the Sunday night prior to the inspection (20 June 2015) there were no nursing staff for the night shift at QEH at the 7pm handover and only one HCSW. Two nurses from other sites and a HCSW were brought in to cover the unfilled shifts at QEH and were all on site by 9pm. This confirmed the concerns which had been raised with us; that patients were regularly being cared for by staff who were unfamiliar with their care and treatment needs.
 - The majority of staff we spoke with throughout the inspection visit, told us, "Sorry I don't usually work here" or "I'm just filling in." Other staff told us they felt they had only been moved to work in the community inpatients units because of the inspection visit.
 - The inspection team attended two 7am handovers, one at each site, and found both were well structured and professional. These were attended by the nurses and support workers.
 - We found a significant number of examples of when care was delayed due to staffing levels during our visit, for example:-
 - On one occasion, patients sat waiting for 45 minutes in the dining room at QEH before lunch was served.
 - We observed staff pushing wheelchairs and carrying walking aids at the same time as assisting patients to bed. Each patient required assistance from at least one member of staff and this took between 10 and 20 minutes each to complete.
 - Nurses on the night shift told us, and we observed, that they had to help the support workers to put patients to bed at QEH as so many needed to be hoisted or aided with their mobility. Other staff told us the service was taking more highly dependent patients, many of whom needed hoisting.
 - On the first day of the inspection (23 June 2015) we found seven out of the 26 patients at QEH needed hoisting with 2 staff, one of these seven needed 4 staff to hoist them.
 - There were unfilled vacancies at both units. There were 3.21 WTE band 5 vacancies at QEH which were going out to advert and a 1.0 WTE RN at MH/ward A1 which had been recruited to and they were awaiting a start date. Staff told us a RN at QEH was leaving and this would only leave four permanent RN staff on the rota for that site.
 - At MH two HCSWs had been recruited and at QEH two HCSWs had been advertised for and shortlisting was in progress. The matron told us it had been difficult to recruit to vacant posts in the service and applicants were often not of the required standard.
 - They also told us both units had high sickness rates compared with the trust target of 4.5%. Sickness at QEH was 11.26% and sickness at MH was 11.67%.
 - Feedback via the friends and family test and feedback from relatives, patients and staff was that there was not enough staff to meet patient's needs. One patient at QEH told us, "Most of the time they (the staff) are rushed off their feet; we just have to wait for help."
- Major incident awareness and training (only include at core service level if variation or specific concerns)**

Are services safe?

- There were no major incident or business continuity plans in place and staff were unaware of the procedures to follow in the event of an emergency.
- The management team told us they had identified that there was no evacuation plan for the two inpatient units during the move from MH to ward A1 when the influenza B outbreak occurred earlier in June.
- Staff at QEH told us that in the event of a medical query out of hours they would call Local Care Direct. The service was not linked to the crash team, so staff would ring 999 in a medical emergency. Ward A1
- Estates checked the fire alarms at QEH every Thursday. However, fire documents requested were not available, out of date or incorrect. The fire risk assessment provided for inspectors to review at QEH was for MH and there were no fire evacuation plans, fire drills, fire safety training or fire risk assessment available on site. Staff were unable to tell us what they would do in the event of a fire, apart from ring 999. When we asked senior nursing staff about this they were unaware of the problem.
- Records submitted by the trust following the inspection showed 14 staff had undertaken fire safety training at QEH on 3 February 2015. Seven of these were therapy staff, three were HCSWs and three were registered nurses; including the team leader and sister.
- We observed ski pad emergency evacuation slides were available on the first floor at QEH. However, none of the staff we spoke with had been trained to use these. This showed the service had not considered the fire safety training needs of the agency and community staff working at QEH who were unfamiliar with the environment.
- Following our inspection we referred our concerns to the West Yorkshire Fire Service for investigation.

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

Overall we rated the service as requires improvement for the effective domain.

When we inspected the service in July 2014 we rated the effective domain as requires improvement. This was because the inspection team found there were:-

- no evidence based care pathways
- 6 out of 12 weight charts reviewed were incomplete
- the rate of readmission to hospital in February 2014 was 23.4% against a trust target of 5%
- the rate of delayed discharges was 11.6% against a trust target of less than 10%.

The trust was also told they should take steps to ensure that the inpatient facilities referral criteria were applied consistently (this was reported under the responsive domain in the previous report).

We asked the provider to make improvements following that inspection. We went back on this visit to check whether these improvements had been made.

We found patients at QEH were not protected from the risks of inadequate nutrition and dehydration. The systems and processes for ensuring patients received adequate nutrition and hydration were not robust and were not always followed by staff. Nutrition and hydration for patients on ward A1 was good.

A significant number of staff appraisals were out of date, some by more than three years. Appraisal records reviewed were found to be brief and not fit for purpose.

Data submitted by the trust prior to the inspection showed readmission rates at both units were significantly worse than in July 2014. For example, in the six months from October 2014 to March 2015 the readmission rates for QEH and MH were 29.0% and 26.5% respectively, compared with 23.4% in February 2014.

There was good evidence of multidisciplinary team (MDT) working and coordinated care pathways and on ward A1 they had introduced clinical champions in medicines, IPC and tissue viability.

We found the service's referral criteria was very broad. The management team told us the purpose of the service was that 'all people leaving acute hospital care should be given the opportunity to benefit from rehabilitation and recuperation and for their needs to be assessed in a setting other than an acute hospital ward'. This meant patients were at risk of being inappropriately referred to the service and may not benefit from intensive rehabilitation. The system for in-reach assessment of patients was not being applied consistently.

We found the doors at QEH were kept locked and the gates to the garden were locked. When we asked staff about this they said some patients could go out and they would let them out, but they would not give them the keypad code. It was not clear from staff discussions if individuals had been assessed and decisions made as to why they couldn't have the key code pad or whether there was a "blanket" policy for the unit. We saw no evidence in patient information or a sign which highlighted to patients informing them to ask staff so they could leave the premises.

The service was carrying out mental capacity assessments and patients with DoLS authorisations in place had good documentation to support this. Staff knew which patients in their care had a DoLS in place.

There was no evidence of consent to care and treatment in the 11 care records reviewed. This meant there were no systems in place to demonstrate that the service had gained and reviewed consent from patients. Where patients did not have the capacity to consent, the service did not act in accordance with legal requirements.

Nutrition and hydration (always include for Adults, Inpatients and EoLC, include for others is applicable)

Are services effective?

- We observed three mealtimes during the visit, two lunches (one at each site) and one breakfast (QEH). We saw there was ample food available and it looked appealing.
- Patient's nutritional and hydration needs were generally being met. We saw menus offered limited variety and choice and patients with specific nutritional needs, such as soft or pureed diets were catered for. However, one member of staff felt the service did not cater well for patients on special diets. Information we received from a relative prior to our inspection informed us of difficulties they had accessing a special diet at QEH. Patients and relatives' feedback about food and drink was mixed.
- Mealtimes at QEH were close together; breakfast at 8.30am, lunch at 12 noon and tea at 4.30pm. Patients told us it was "always soup and sandwiches" at 4.30pm and they were offered drinks around 8pm, but "nothing after that."
- On 25 June 2015 we visited QEH in the morning and found patients having breakfast in the dining room when we arrived on site at 9.50am. We observed lunchtime on the same day; lunch was served at 12.45pm once all the patients had been assisted to the dining room.
- We spoke with the cook at QEH who told us the food was not cooked on site; all the meals were chilled and all the vegetables were frozen. Soup was made up from packets. They said fruit was never directly offered to patients but might be available on a platter.
- Hydration and nutrition was excellent on ward A1; patients were choosing food from the trust menu. However, at QEH we found systems and processes to ensure patients received adequate hydration and nutrition was poor. For example, we found 15 out of the 19 food and fluid charts were incomplete.
- Of the five care records reviewed at QEH we found only one out had a MUST assessment in place and the patient had been weighed weekly. Two patients were recorded as "Patient hoisted, unable to weigh or undertake MUST." There was no evidence to show these patients had undertaken a MUST by arm measurement and there was no evidence of referral to the dietician. This meant staff were not identifying patients who may be at risk of inadequate nutrition and/or hydration.
- Care records reviewed at QEH showed that two patients whose care plans documented they should be weighed on a weekly basis were not being weighed every week as required. This meant change in these patients' weights may not be identified in a timely manner.
- At QEH during breakfast on the 25 June 2015, we observed at least two patients that needed assistance to eat and drink but staff were not helping them. Staff that were available was busy with other duties, such as administering medication or assisting patients to move to and from the dining room. This meant these patients were at risk of inadequate nutrition and/or hydration.
- Food and fluid charts not completed; staff told us they were "just too busy" to fill them in and they were not conveniently located (in the dining room). Staff said they had to leave patients unattended to collect the food and fluid charts or go and fill them in.
- At QEH we identified a patient who had been admitted following dehydration but did not have food and fluid monitoring in place. At breakfast time we saw they needed prompting with eating and drinking and was drowsy. We reviewed this patient's care and found their care record said food monitoring only. We saw they had also lost 5% of their body weight in the previous month. Their risk assessment and care plan indicated they should have had a food and fluid chart. We were unable to locate a chart for this person and when we asked staff about this a new chart was completed immediately. When another member of the inspection team asked to see this chart a few hours later it took more than 15 minutes for staff to locate it. We also checked the handover sheet and found this patient was not identified on there as being at risk of dehydration. This meant the systems in place for ensuring patients received adequate nutrition and hydration were not robust and were not always followed by staff.

Patient outcomes

- When we inspected the service in July 2014 we found the rate of readmission to hospital in February 2014 was 23.4%, the trust target was 5%. It had been identified that more specific audits would be needed to ascertain where the problems were and what actions needed to be taken.
- Data submitted by the trust prior to the inspection showed readmission rates were worse than at the last

Are services effective?

visit. For example, in the six months from October 2014 to March 2015 the readmission rates for QEH and MH were 29.0% and 26.5% respectively. We saw that in March 2015 the readmission rate at MH was 44.4% and in April 2015 the readmission rate at QEH was 45.2%. When we asked the matron about this they said this was due to the complex needs of the patients admitted to the service.

- An audit of readmission rates had been carried out by managers; we saw that the coding was robust. There was no pattern to readmissions (which were expected to be in first two days due to being transferred to units too early). It was a complex cohort of patients and no themes had been identified; leaders within the division told us they planned to complete further work on this.
- When we inspected this service in July 2014 we found the specific outcome measures could not be specified for the individual service locations. We found the service was now using specific therapy outcome measures and more general outcome measures such as length of stay and functional abilities at discharge, compared to the patient's preadmission abilities. There were no other audits carried out which related to patient outcomes.

Competent staff

- Appraisals had not been carried out consistently at either unit. Data submitted prior to the inspection showed 28 out of 32 staff at MH (82%) and 12 out of 32 staff at QEH (35%) had undergone an appraisal in the previous 12 months. The trust target was 85%. The 12 staff at QEH that had an up to date appraisal were all support staff; the team leader, sister and seven registered nurses were out of date.
- A high proportion of the staff we spoke with told us their appraisals were either out of date or overdue. Nursing staff told us they had never had clinical supervision. We did not find any evidence of supervisions or one-to-one meetings with staff. Staff on A1 told us the new team leader was planning to introduce these.
- We were told that new nursing staff, from the community teams, participated in a two-week induction working in the inpatient units and existing community staff completed an induction pack prior to working on the unit. However, one member of staff (a community HCSW) who was working on ward A1 told us they had not completed an induction prior to working on there.

- We reviewed nine staff records for MH staff (now on A1); eight of these were generally up to date. However, some staff appraisals were up to three years out of date.
- On ward A1 they had introduced clinical champions in medicines, IPC and tissue viability. Staff told us they felt this was a positive change on the unit.

Multi-disciplinary working and coordinated care pathways

- Care records reviewed showed patients were being appropriately referred to the mental health team for mental health assessments.
- There was good evidence of multidisciplinary team (MDT) working. For example, all care records reviewed had notes of MDT meetings and records of associated actions.
- All care records reviewed at QEH showed a full therapy assessment and a full nursing assessment had been carried out within 24 hours of admission; this was in line with the draft admission policy we were shown. All patients had also been reviewed by a clinician on the day of admission.
- The team leader at QEH told us a consultant from Pinderfields Hospital (PGH) visited the home on Monday and Friday mornings and a registrar visited on Wednesday mornings. If medical input was required outside these times then staff could ring for assistance.
- On ward A1 a geriatrician from Pontefract General Infirmary (PGI) visited three times a week.
- Community matrons and integrated care staff, including occupational therapists and physiotherapists, attended the twice weekly MDT meetings at the units. Staff on ward A1 told us the social worker visited twice a week and also attended the MDT meetings. There was also a lead therapist responsible for therapy on the community inpatient units.

Referral, transfer, discharge and transition

- When we inspected this service in July 2014 we found the referral criteria for QEH and MH were not being adhered to because of demand on the acute hospital beds. This meant the patients being admitted to those units were not always those who would benefit from intensive rehabilitation. There was also a risk that staff were not able to meet patients' needs.

Are services effective?

- We found that patients were still being admitted who may not benefit from intensive rehabilitation. We found the referral criteria that the service used was very broad, and did not exclude many patients from being referred to the units. We reviewed a document which stated the referral criteria was:
 - Over 18
 - Wakefield GP
 - Medically stable
 - No challenging behaviour
 - Staff told us patients who used the service were often very complex cases. We received inconsistent information from staff regarding the referral criteria and whether the units were rehabilitation units or intermediate care units. The difference between these terms was not well understood among staff.
 - There had been work on in-reach from the community nurses into the acute wards in the trust. This meant community nurses visited acute wards in the trust to assess and support discharge of patients. Senior staff told us there was an informal process for in-reach assessment for referral to the inpatient units. This meant that the lead therapist visited the acute trust to assess the suitability of patients prior to transfer. This was carried out by therapy staff, however we found this was inconsistently applied at the time of our inspection.
 - Staff on A1 told us the in-reach service for referrals had improved the referral process. When we visited ward A1 we found 89% (16 out of 18) of patients were participating in active rehabilitation.
 - Expected dates of discharge were on display on both units, next to patient's beds. Patients and relatives we spoke with told us these were new and had been put in place immediately prior to our inspection. Several patients and relatives said they had concerns about the lack of information and planning for discharge, which they had not had the opportunity to discuss.
 - Patients we spoke with told us they had experienced problems being discharged from the service when they had been told they were fit to go home. This was generally due to a lack of equipment or appropriate care package being in place.
 - The service at both sites was available seven days a week and senior nursing staff told us other services within the trust, such as the hospital pharmacy, supported this. The discharge team worked weekends and there was full nursing cover at weekends. Staff told us at MH the pharmacy had only visited once a week, now on ward A1 there was seven day pharmacy availability.
 - Patients were admitted to and discharged from the service over the weekends; the deadline for admissions to the units in the evenings was 8pm.
 - The average length of stay on the two units was 22.6 days; this was significantly lower than the national average for 2014 which had been audited at 28 days.
- Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)**
- Patients care records had Mental Capacity Act (MCA) assessments in place; these had been carried out by a clinician or the acute hospital liaison nurse. Staff told us the DoLS representative from the trust had trained the registered nurses to carry these out.
 - We saw one person at QEH and one person on ward A1 had DoLS authorisations in place. The associated documentation for these DoLS authorisations was of a good standard. All staff questioned were aware of which patients had a DoLS in place. This showed us the provider was aware of their responsibilities to protect patients using this legislation.
 - The Deprivation of Liberty Safeguards (DoLS) provide a legal framework to ensure that patients are only deprived of their liberty when there is no other way to care for them or safely provide treatment and to ensure that patient's human rights are protected.
 - We found the doors at QEH were kept locked and the gates to the garden were locked. When we asked staff about this they said some patients could go out and they would let them out, but they would not give them the keypad code. It was not clear from staff discussions if individuals had been assessed and decisions made as to why they couldn't have the key code pad or whether

Are services effective?

there was a “blanket” policy for the unit. We saw no evidence in patient information or a sign which highlighted to patients informing them to ask staff so they could leave the premises.

- We did not find any evidence of consent in any of the 11 care records examined. Two of the five care records reviewed on ward A1 contained consent forms, but these were unsigned.
- A high proportion of staff had never had MCA training. For example, records submitted showed nine RNs and a HCSW at MH had never had MCA training. Trust records

also indicated that staff had not been trained in consent; the records showed this as ‘not applicable.’ When we asked the matron about this they explained that they thought this was because consent training was for staff caring for patients undergoing surgery.

- There were no systems in place to record that the service had obtained and reviewed consent from patients. Where patients did not have the capacity to consent, the service did not act in accordance with legal requirements.

Are services caring?

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

Summary

Overall, we found the service required improvement for being caring. This domain was rated as good at the last inspection in July 2014.

This domain has been included in this report because of concerns identified during the focussed inspection visit.

Staff interactions with patients were generally caring, friendly and respectful. However, patient's privacy, dignity and independence were not always respected.

Feedback from patients and relatives via the 'friends and family test' was generally positive at both units. These surveys were given to patients when they were being discharged. This meant patients did not have the opportunity to give formal feedback about their care at the service until they were leaving it.

The feedback in the friends and family test results appeared to be more positive than the feedback the inspection team received from patients and their relatives during this inspection.

We found patient's views and experiences were not taken into account in the way the service was provided and delivered in relation to their care. Patients told us they had not been involved in their care and treatment planning and most did not know when they would be going home.

Three mealtimes were observed and these were found to be sociable experiences. However, patients told us they did not get a choice about mealtimes or about when they preferred to go to bed and get up.

Relatives told us communication was poor and it was difficult to get through on the phone.

There were limited activities on offer for patients at both units, apart from watching television. This meant the service was not meeting patient's social and emotional needs.

Compassionate care

- We observed how staff interacted with patients during the three days of our inspection. At both locations, we saw and heard staff were generally caring in their

approach and spoke with and supported patients in a compassionate and respectful way. However, we did hear staff discussing a patient's treatment in front of a visitor and another patient.

- We observed three mealtimes during the three days and found these to be a sociable experience.
- Feedback from patients and relatives about staff was generally positive. One patient at QEH told us they needed to go to the toilet more often due to a medical condition and one staff member had refused to take them as, "They said I had already been, they were very nasty."
- Patients told us that care offered was variable because the staff were "So inconsistent." For example, one patient told us some staff would offer biscuits with a drink and other staff would refuse. We observed this to be the case in the lounge at QEH; when one of the inspection team asked staff about providing biscuits with drinks they found their attitude was unhelpful and brusque.
- One patient told us they had arrived at QEH at 4.30pm on their date of admission and no-one introduced themselves. They were left in a wheelchair in the lounge, and all their bags were left in the reception area, until they were transferred to their bedroom at 10pm.
- Several patients at QEH told us they had frequently moved rooms during their stay. Staff explained that this was because the less mobile patients were accommodated in the ground floor bedrooms where possible.
- Friends and family test results were generally positive, for example in May 2015 22 patients (55%) at QEH had responded and 100% said they were likely or extremely likely to recommend the service. We were told there were between 20 and 30 inpatients at QEH each month.
- Patients we spoke with told us they had not been asked to complete a survey. Staff told us this was because these were given out when patients were discharged. This meant patients did not have the opportunity to give formal feedback about their care at the service until they were leaving it.

Are services caring?

- We observed examples when the service did not always respect patient's privacy and dignity. For example, we observed one patient at QEH whose catheter bag had leaked onto the floor in the lounge. Staff did not ask the patient if they wanted to go somewhere private, they put up screens and changed their catheter bag in the lounge at QEH on the Tuesday and the Thursday. We also observed a female patient with a full catheter bag strapped to their leg, which was visible, as it was below the level of their skirt.
- Patients at QEH told us they were not able to access baths and showers as often as they would like. One patient told us they had not had a shower since they came in two weeks ago and another said they had, "Only had bed baths." A third patient told us their relative came in every day to give them a strip wash.
- Patients at ward A1 told us they could usually access a shower when they requested one, one patient said, "Depending on how many staff are on."

Understanding and involvement of patients and those close to them

- Patients we spoke with told us had not been consulted or had any input about their expected dates of discharge (EDD), most were unaware of their EDD and had not been involved. One patient, who had been in QEH since 25 May 2015 said, "I have no idea when I am going home."
- All of the patients and/or their relatives we asked told us patients had not been involved in their care planning. This was confirmed when we looked at patient's care records; we did not see any evidence of involvement in 10 out of the 11 care records reviewed.
- We did see very good records of discussions about a DoLS with a patient's family in one care record at QEH; this had been completed by the acute hospital liaison nurse.
- Staff on ward A1 told us relatives were kept informed "about everything that happens." However, when we asked patients and relatives at both units whether the risks and options relating to their care and treatment had been explained to them they all told us this had not been discussed.
- Patients and relatives told us communication was generally very poor; phone calls were not answered or, if they were, staff on duty were unable to give them updates. One relative said, "I get a different answer every time." One patient, who had been in Pinderfields Hospital, told us, "They never told me I was being transferred here."
- Patients told us, and we observed that patients were not given a choice about when to go to bed and when to get up. For example, patients at QEH told us they were taken to bed from 8pm and had no choice about this. This confirmed our observations at QEH on 23 June 2015, when all four staff on duty were busy taking patients to their bedrooms from 8pm to 10pm. Another patient at QEH told us they were woken up at 8am in the mornings and told it was time to get up.
- Patients we spoke with told us they would prefer more choice about when they had their meals. Some told us they got hungry through the night and it was a long time between tea one day and breakfast the next. One patient at QEH said they would like a cup of tea before breakfast; staff had got them up at 7am that morning and they didn't get a drink until breakfast time, at around 9.30am.
- A patient on ward A1 told us "We get a cup of tea three times a day and a variety of drinks at bedtime." They told us they were not able to, "just get a cup of tea." This meant people's choices and preferences were not being considered and acted upon.
- We found that the visiting times had changed when patients were moved from MH to ward A1 and that relatives and carers had not been informed. Visitors we spoke with confirmed this had been a problem. Staff on A1 told us they had acted quickly to revert to the MH visiting times, rather than adopting the visiting times of the acute hospital site.
- The trust had a policy and procedures for supporting self-medication by patients. However, we found this was not being used for patients cared for at the two community inpatient locations. We found there were no resources to allow patients with capacity to self-medicate prior to discharge. We did not see any plans or evidence to suggest patients were enabled to self-medicate at either unit. This did not promote patients' independence and meant staff could not assess the patient's ability to administer their own medications when they returned home.

Are services caring?

Emotional support

- Patients, relatives and staff told us there were no activities offered or provided at the units. Some patients told us they amused themselves by reading, chatting or watching television, others told us it was “boring” and “a long day and even longer nights.” This meant the service was not meeting patient’s social and emotional needs.
- When we asked senior nursing staff about activities, they told us therapy staff did exercise sessions in the lounge at QEH and a therapy dog came in on Sunday afternoons.
- On ward A1, we saw there was an outside area next to the lounge and dining area. Staff told us it was difficult to access this area, as security staff had to come and open the doors for them and they could not leave them a key. They explained this was due to the nature of the PFI (Private Finance Initiative) agreement, because the building did not belong to the trust.

Are services responsive to people's needs?

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

Summary

Overall we found the service was not always responsive to people's needs. This domain was rated as good at the last inspection in July 2014.

This domain has been included in this report because of concerns identified during the focussed inspection visit.

In the last report it was noted that the toilet facilities had not been designated as same sex use. This did not comply with the government's requirement of Dignity in Care. This was reported under 'Use of equipment and facilities' in the effective domain in the last report.

Patients told us they waited a long time for their call bells to be answered. Several patients at QEH told us it regularly took over 30 minutes for staff to come when they pressed their call bells. There were no call bells in the lounge areas at QEH, hand bells were available on side tables but not all patients could reach them. Other patients were observed without a call bell within reach. This meant not all patients could summon assistance from staff when they needed it.

Baths and showers were not always available, due to staff shortages. One person told us they had been in QEH for two weeks and had not had a shower. Patients on ward A1 said they could usually get a shower.

Toilet facilities were not designated as same sex at QEH or MH; this was identified as an issue at the last inspection and no changes had been made since then. This meant the service was breaching the government's requirement of Dignity in Care. Since the transfer of patients to ward A1 patients were accommodated in same sex bays or single cubicles with their own toilets and showers.

The environment at both units was not dementia friendly and patients were not encouraged to self-medicate prior to discharge home. This meant the service was not meeting the needs of people in vulnerable circumstances.

A complaints system was in place. Formal complaints were investigated but verbal complaints were not. People making formal complaints were not asked whether they were satisfied with the outcome of their complaint and there was limited verbal evidence to demonstrate whether lessons were learnt and shared with staff.

Planning and delivering services which meet people's needs

- At QEH on 25 June 2015 patients were sitting in the dining room from 11.45am and lunch was still not finished at 1.30pm. At 4.30pm on 23 June 2015 we observed patients lining up to go into the dining room for the tea time meal. One patient told us they usually had their tea in the lounge, where they liked to watch a favourite television programme. They said, "We were told we had to eat in the dining room because CQC were here, it was just a farce."
- The cook at QEH told us they had asked for a blender as there was a patient whose jaw had locked. They were told it would take six weeks to get one. One patient at QEH had been identified as needing a bariatric wheelchair. Staff at QEH told us there was a five to six week wait for the patient just to be measured for the wheelchair. This meant the service was not able to be responsive to meeting patient's individual needs.
- Several family members told us it took a long time for staff to answer the telephone, especially on ward A1. One relative told us they regularly waited 15 minutes for a phone call to be answered; they added that they frequently were cut off and had to start again.
- Patients and relatives told us they often had to wait a long time for buzzers to be answered. Others told us they could not access assistance, for example one patient told us, "I can't get to the bell, it's over on the wall." Four patients at QEH told us they regularly waited at least 30 minutes for assistance. We saw there were no call bells available in the lounges at QEH, instead there were hand bells placed around the room on side tables. One person told us, "Room 8 is a problem," they said staff could not hear the buzzer when it went off in that room. Staff we spoke with confirmed this; they were unable to tell us of any actions that had been put in place to mitigate the risk to patients. This meant not all patients could summon assistance from staff when they needed it.
- We pressed a buzzer in one of the upstairs bedrooms during the visit to QEH and found staff did not respond to it for over 10 minutes. When we asked senior nursing

Are services responsive to people's needs?

staff at QEH whether they could monitor call response times they told us the call bell system was old and they did not think this was possible. The management team confirmed that call bell response times were not monitored.

- The team leader told us there was always a member of staff in the lounge area at QEH. However, we observed occasions during the three days of the visit when there were no staff in that area. This meant patients who required assistance to walk from staff could be at risk of un-witnessed falls or other un-witnessed incidents when there was no member of staff in the room.

Equality and diversity

- When we last visited this service we found the toilet facilities were not designated as same sex; female and male patients used all of the toilets available. This did not comply with the Government's requirement of Dignity in Care.
- On this visit we found toilets at QEH were still not designated according to same sex use and we witnessed patients of both sexes using the facilities independently. When we asked senior nursing staff about this they told us it had been decided that it was too difficult to introduce same sex toilets in the service. On ward A1 there were male and female bays and patients were cared for separately with toilet and shower facilities in each bay. Staff on ward A1 told us that the toilet and bathroom facilities at MH were still used by both sexes prior to the move.

Meeting the needs of people in vulnerable circumstances

- The environment at both units was not dementia friendly. We found there were three patients with dementia at QEH and two patients with dementia on ward A1 at the time of the visit. The matron confirmed that the service had not been 'passed' as being dementia-friendly.
- Staff on ward A1 told us dementia screening was carried out on all of the patients admitted to the ward. All staff were trained in the 'forget me not' dementia process. There were also two link nurses for dementia.

Learning from complaints and concerns

- We did not view any complaints records during the inspection as these were not available. Records submitted following the inspection showed there had been four formal complaints since September 2014, two at QEH and two at MH. The complaints we reviewed were about the standard of care given to patients by staff. These showed there was a complaints system available and formal complaints people made were responded to.
- However we did not find any evidence of sharing lessons learnt or evidence to confirm that the complainants were satisfied with the outcome. The service was also not logging or investigating verbal complaints.
- Staff we spoke with on ward A1 told us complaints were well documented and the team leader gave feedback to staff. However, we did not see any written evidence to support this.

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

Overall we rated the service as inadequate for well-led. This domain was rated as requires improvement at the last visit due to deficiencies in risk management and the risk register, interim positions in the management team, poor levels of staff satisfaction and high levels of workplace stress.

The trust was also told they should take action to review the interim management appointments to minimise the effect on the stability and the sustainability of the improvements. We asked the trust to make improvements following that inspection. We went back on this visit to check whether these improvements had been made.

We found there were fewer interim management posts compared with the last visit. However, we found the service did not have a clear vision and strategy and there was no clear definition of what the service was for. The service was not well integrated, effective or efficient.

Systems and processes to keep patients safe were not safe. For example, fire safety management at QEH was inadequate and staff were unaware of the procedures to follow in the event of a fire.

The service did not have effective systems in place to regularly assess and monitor the quality of service that patients received. Assessment and monitoring of the quality of the service, which was carried out, was limited or inadequate and we were concerned that the service's own management team had not identified the issues we found during this inspection

There was limited evidence of follow up of audits, action plans and satisfaction surveys or any systems or processes in place to demonstrate to us the service had an effective quality management system. There was no evidence of continuous quality improvement or any strategy to introduce or sustain improvements.

The management team seemed disconnected from the service being provided and had not put robust plans in place to address the issues identified at the last inspection visit.

There was a lack of evidence of engagement with patients and relatives. This meant there were limited opportunities for patients and relatives to give feedback about the care and treatment they received at the service. Feedback surveys were given out to patient when they were being discharged.

There was little or no evidence of staff engagement within the service. There had been no improvements in this area since the last visit despite the fact that poor staff satisfaction and morale was identified as an issue at the last inspection.

We were told that the recent influenza outbreak at MH had been well-managed.

Service vision and strategy

- The report from the last inspection identified that the vision for the unit was to have an in-reach assessment so that patients could be appropriately selected and thus rehabilitated more effectively. We found the in reach assessment of patients was inconsistent; staff told us they felt that in-reach assessments by the lead therapist resulted in improved application of the referral criteria and selection of patients.
- There was little evidence of a vision and strategy for the community inpatient units during the inspection. The management team were able to describe a planned service review that was to be undertaken. A draft strategy document for intermediate care services in the community (2015-2018) outlining this review was submitted following the inspection. The review incorporated the trust's strategy 'striving for excellence' and acknowledged that the current intermediate care services were not well integrated, effective or efficient.
- There was no clear definition of what the service was for, as it was working on a model commissioned in 2010. Since that time there had been significant changes to long term conditions and the patient group using the service. We were told there was a plan to review the service with the Clinical Commissioning Group (CCG)

Are services well-led?

and local authority. However, the managers were unable to give us a timescale of when this work would begin. We did not see any evidence of this during the inspection.

- Following the visit an Integrated Care Development Plan document was submitted which identified work streams such as safe administration of medication and staffing levels. The document showed that none of the 11 work streams identified had been completed. Timescales were given e.g. May-15 and Jun-15; but it was unclear whether these were start dates or target dates for completion.
- Managers agreed that the specification and model of care was out of date and the cohort of patients using the service had changed. They told us they had looked at other services for ideas and guidance. They said it was difficult to benchmark nationally due to the complexity and differing needs of patients.

Governance, risk management and quality measurement

- Information submitted by the trust, for example meeting minutes and service review documents did not demonstrate a functional quality management system, governance framework or evidence of continuous quality improvement. For example, we found many of the management records relevant to the service were not readily available. Records were found to be either out of date or absent; records which were provided were often incomplete. These included supervision and appraisal records, policies and procedures and meeting minutes.
- Staff were not aware of NICE requirement to record medications near misses and, as a result, the service had not been reporting these. This was confirmed by the team leader and matron at QEH.
- Senior nursing staff were unable to confirm what would constitute a medication error and how they would be categorised (low / medium / high). Incidents were signed off by the matron who was also unable to tell us what would constitute a medication error and how such errors would be graded.

- The last report identified that the risk register in place for the services needed further work to ensure risks were clearly identified, recorded and risk-rated so they could be managed appropriately.
- We were told the risk register was reviewed and challenged monthly at the governance meeting. The two risks on the risk register for each site related to staffing and lift breakdowns. There was no evidence of on going monitoring, the risks had not been given a severity score, there were no on going actions recorded and no severity score post-mitigation. This meant risks continued to not be appropriately recorded or managed.
- Breakdowns of the lifts at QEH and MH had been on the service's risk register since December 2013. This was identified by the governance committee as a major failure which was non-compliant with current guidance and legislation. There was no evidence to show that any actions had been taken to mitigate this risk, apart from periodic insurance inspections and monthly maintenance visits.
- Medication and care records audits on ward A1 were reviewed and found to be good.

Leadership of this service

- At the last visit, a number of the managerial appointments were interim. The trust was told they should review the interim managerial appointments to minimise the effect of the instability and sustainability of improvements. Concerns were raised by staff at that inspection that further managerial changes could affect the sustainability of the improvements.
- We found there were fewer interim management posts compared with the last visit. For example, the new team leader on A1 had been in post for five weeks and the team lead at QEH (on secondment at the time of the previous inspection) told us their post was now substantive.
- The matron talked to us about review of skill mix and using ANPs and generic support workers but we were not shown any documentary evidence to confirm this.
- The two matrons both told us they were supported with external leadership training and senior staff were encouraged to complete internal leadership training.

Are services well-led?

- The management team seemed to be unaware of the issues the service had. From our discussions at the management team meeting it appeared the management team didn't understand the issues with quality identified at the last inspection and the actions needed to address them.
- Actions from the last visit had not been followed up and no-one had taken ownership for dealing with the concerns identified. We were shown an action plan which had been written three months prior to the focussed inspection, however there was limited evidence of progress in those three months.
- Staff told us the transfer of patients to ward A1 had been well-organised and achieved with 24 hours' notice. The outbreak which led to the transfer was under investigation as a serious incident at the time of the inspection.
- At the last visit we found patients and relatives filled in the 'friends and family test' and no other formal feedback surveys were available from patients or their relatives. We found no other systems and processes had been introduced at the service since the last inspection.
- We were told in the meeting with the management team that the service planned to launch the Big Conversation with service users as part of a 'listening into action' scheme. A date had not been set for this at the time of our inspection.

Staff engagement

Culture within this service

- Most staff told us morale was low and there was a high turnover rate. They told us it was difficult to cope working with staff they had never met before and patients who complained that they were being kept waiting. However, some staff on ward A1 told us they felt morale was improving.
- Staff on ward A1 spoke highly of the new team leader. They told us the new team leader was effective and approachable, with high standards. They said they felt valued by them and had faith in them.
- Most staff told us did not feel valued and respected; especially the staff at QEH. Some told us they were very dissatisfied with their overall experience of working for the trust.
- Staff felt their well-being was not a priority; following the 2013 staff survey one of the action points was to offer a more varied shift pattern to improve work/life balance. During the 2014 inspection, we found this had been discussed in a team meeting. Staff said there had been no further discussions about changing shift patterns or other options for flexible working.
- Some staff told us they felt certain senior nursing staff working within the service were rude, abrupt and not supportive.
- The report from the last inspection identified levels of staff satisfaction in the service were very poor and action plans with time scales were in place to support improvement in staff satisfaction. One of the action points was to offer a more varied shift pattern to improve work/life balance for those staff who wished for a change.
- Staff told us they had never been consulted about whether they were happy about 12 hour shifts and there had been no discussion about options for changing their shift patterns. They said 12 hour shifts were mentally and physically draining. Staff we spoke with was also unaware of flexible working options. This meant there was no evidence of staff engagement about working patterns or improvements made since the last visit.
- When we asked the team leader at QEH about this they said these discussions had been started but had 'fizzled out' due to staff not taking ownership. The matron told us none of the staff had come forward to say they wanted to work differently. They told us this should be discussed in one-to-ones with staff. However, we found one-to-ones with staff were not taking place. This meant staff did not get the opportunity to discuss their working patterns with their managers.
- Managers and senior nursing staff acknowledged that no work has been done to improve the work life balance for staff since the last inspection; they expected staff to take responsibility for this.
- Staff working at the service that had been transferred in from other areas, such as community teams, were not happy, as they had not been consulted about working in the community inpatient units.

Public engagement

Are services well-led?

- The 'Big Conversation' had been taking place with other staff across the acute trust and had taken place at QEH two weeks prior to the visit. This had not been carried out on ward A1 at the time of the visit and the results from QEH were still to be analysed.
- The matron told us there had not been many staff meetings held in the previous six months at QEH. This was confirmed when we looked at the staff meeting minutes available. These showed the most recent meetings had been on 16 Feb 2015, 20 Nov 2014 and 11 June 2014.
- On ward A1 staff told us there had not been a staff meeting at MH for over a year, and the previous team leader had never held a staff meeting. They said there had been a staff meeting with the new team leader on ward A1 in the month prior to the visit.
- Staff told us the e-rostering was a problem as you could get given too many shifts together, at the end of one rota and the beginning of the next. Annual leave requests and allocation was also an issue; staff felt there were not enough staff to allow annual leave to be taken throughout the year. These issues also affected the work life balance for staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines and that oxygen is prescribed in line with national guidance.

The trust must ensure that infection control procedures are followed in relation to hand hygiene, the use of personal protective equipment and cleaning of equipment.

The trust must ensure all patients identified at risk of falls have appropriate assessment of their needs and appropriate levels of care are implemented and documented.

The trust must ensure there are improvements in referral to treatment times and accident and emergency performance indicators to meet national standards to protect patients from the risks of delayed treatment and care. The trust must also ensure ambulance handover target times are achieved to lessen the detrimental impact on patients.

The trust must ensure there are improvements in the number of Fractured Neck of Femur patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours.

The trust must improve the discharge process for patients who may be entering a terminal phase of illness with only a short prognosis.

The trust must ensure in all services resuscitation and emergency equipment is checked on a daily basis in order to ensure the safety of service users and to meet their needs.

This section is primarily information for the provider

Requirement notices

The trust must ensure staff follow the trust's policy and best practice guidance on DNA CPR decisions when the patient's condition changes or on the transfer of medical responsibility.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

The trust must ensure there are improvements in the monitoring and assessment of patient's nutrition and hydration needs to ensure patients' needs are met.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The trust must strengthen the systems in place to regularly assess and monitor the quality of care provided to patients.

The trust must ensure where actions are implemented to reduce risks these are monitored and sustained.

The trust must be able to demonstrate they follow and adhere to the ten expectations from the national quality board.

The trust must ensure policies and procedures to monitor safe staffing levels are understood and followed.

The trust must ensure robust major incident and business continuity plans are in place and understood by staff. This must include fire safety at QEH.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing
Ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.

This section is primarily information for the provider

Requirement notices

The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.

The trust must continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards.