Somerset Partnership NHS Foundation Trust

RH5

Community health inpatient services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RH5K6	Bridgwater Community Hospital		TA6 4GU
RH5F8	West Mendip Community Hospital		BA6 8JD
RH5X5	Dene Barton Community Hospital		TA4 1DD
RH5X9	Wellington Community Hospital		TA21 8QQ
RH5G2	Wincanton Community Hospital		BA9 9DQ
RH5G5	Frome Community Hospital		BA11 2FH
RH5X2	Burnham On Sea War Memorial Hospital		TA8 1ED
RH5Y8	South Petherton Community Hospital		TA13 5EF
RH5W6	Chard Community Hospital		TA20 1NF
RH5X7	Williton Community Hospital		TA4 4RA
RH5F7	Shepton Mallet Community Hospital		BA4 4PG
RH5Y4	Minehead Community Hospital	<Placeholder text>	TA24 6DF
RH5X4	Crewkerne Community Hospital		TA18 8BG

This report describes our judgement of the quality of care provided within this core service by Somerset Partnership NHS Foundation 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

Somerset Partnership NHS Foundation Trust

and these are brought together to inform our overall judgement of

Somerset Partnership NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Overall summary

During our inspection a team of inspectors, specialist advisors, and an expert by experience visited all of the community hospitals. Eleven were visited during the announced inspection (8th to 11th of September 2015); two were visited during the unannounced element of the inspection on 24 September 2015. Our Pharmacist looked at medicines management in six community hospitals. We spoke with 94 staff (including managers, nurses, health care assistants and therapists) and 40 patients, relatives and carers. We also spoke with five volunteers and reviewed 29 medical records and seven care records.

We rated safety in the community inpatients as requires improvement. We found that where serious incidents were reported they were investigated thoroughly using a robust investigation methodology. However, we found the threshold of what was reported as an incident was high, particularly where there were medication errors, which meant that opportunities for learning were limited. Since the inspection an action plan had been introduced. We looked at 27 prescription and administration records across six community hospital inpatient wards. We saw 22 gaps in the administration records. Staff had not recorded they had given the medicine and had not recorded the reason if it had been omitted. We found there was a sharp contrast in the environments which people were cared for. In the community hospitals that were new or newly refurbished we found light bright environments with consideration for dementia awareness in their design. However, we found that hospitals such as Chard Community Hospital had safety concerns around access to fire escapes training of emergency equipment in the event of a fire. We also found that at Dene Barton Community Hospital the day room was small and cramped and did not allow easy access by patients. Staffing was recognised as a significant risk for the community hospitals, with 40% registered general nurse vacancy rates. Although many shifts were being filled by bank and agency staff there were a high number of shifts which did not meet safer staffing guidelines. As a result of this the trust agreed with the clinical commissioning group to reduce the number of beds provided by the trust. At the time of our inspection 61 beds were closed with an additional 20 beds in use by a local acute NHS trust.

We judged the effectiveness to be good. We saw good examples of where evidence base and audit results were having a positive effect on care and treatment and found that best practice guidance was being followed. However, where there was good practice, this was not effectively shared and used throughout all of the hospitals. Patient outcomes collected were limited to length of stay and audit results which reduced the understanding of how effective the treatments they were giving were. Staff we spoke with all had appraisals and competency training and were being given opportunities to develop further in their careers. Staff were recognising when a patient required pain relief and patients' nutrition and hydration needs were met. Consent processes were followed appropriately and staff had a good understanding of the mental capacity act. Flow through the hospital was being affected by delays with social services which were outside of the control of the trust. This resulted in regular and extended delays in discharge. However, where there were extended delays the divisional managers worked with the community hospital staff, the trust board, the local clinical commissioning group and social services to resolve the problems.

We judged care provided by staff to be good. We observed compassionate care from all of the staff at the community hospitals and patients were complimentary about the care being given. Patient led assessments of care rated the hospitals to be better than the national average. When talking to patients and staff we were given multiple positive examples of how staff were working with compassion, were involving the patient's relatives and carers and were providing emotional support. The therapies teams (occupational therapists and physiotherapists) were highly regarded by the patients and we observed good care when watching interactions with patients. We spoke with volunteers who work at the community hospitals. Their interactions with patients were having a positive effect on patients wellbeing. If patients didn't have visitors volunteers would go and sit with them and have conversation or do puzzles or play games with them.

We rated the responsiveness of the service as requires improvement. We found that where there were active and affluent league of friends there was a vast array of

Summary of findings

activities available to patients for stimulation (for example at Williton Community Hospital and South Petherton Community Hospital). However, we found that in other community hospitals there were none for example Chard Community Hospital and Dene Barton Community Hospital. We also found that personalised care was only applied to those who most needed it and not everyone. We found that services were planned and delivered to meet people's needs with access to in reach services. There was flexibility in how patients were managed and the Primary Link Service always tried their best to place patients at their preferred choice of location. We found that if a complaint was received through patient advice and liaison service thorough investigations were done with learning shared between community hospitals. However, if a complaint or concern was raised in a community hospital every effort was taken to resolve the issue locally. This restricted the level of learning taken from the incident and didn't allow staff to pick up on, monitor, or introduce mitigating actions from these incidents.

We judged the inpatients service as requires improvement in its leadership. We found that the governance systems and practices were not providing effective governance, risk management and quality measurement and did not allow effective communication between different community hospitals or to different levels in the organisation. Risk management was reactive when an incident occurred rather than proactive in mitigating potential risk. Understanding of governance varied between the community hospital matrons. One matron discussed having items on the risk register to keep external contractors available to quickly fix infrastructural issues and another said that risks were managed locally without recording them. The leadership and culture of the service varied greatly between the community hospitals. Innovation wasn't shared effectively and there was little understanding from the divisional leads of issues, risks and concerns in the community hospitals. Matrons felt well supported with any issues that arose by senior staff and staff in the community hospitals felt well supported by their matrons and ward sisters.

Summary of findings

Background to the service

Somerset Partnership NHS Foundation Trust provides community inpatient services with 252 beds in 13 community hospitals spread out across the county of Somerset. At time of our inspection 61 of these beds were closed with an additional 20 being used by a local acute trust.

These hospitals were run all nurse led and have access to medical support either from local GP services or directly employed doctors. Therapies such as occupational therapy, dietetics, physiotherapy and speech and language therapy attended the wards to manage rehabilitation and end of life care.

There had recently been a structural change in senior management which meant the recent recruitment of one of the two divisional leads. The day to day running and the continual strategy for the service was influenced by the local clinical commissioning group, two local acute trusts and social services in Somerset.

Our inspection team

Our inspection team was led by:

Chair: Kevan Taylor, Chief Executive Sheffield Health and Social Care NHS Foundation Trust

Team Leader: Karen Bennett-Wilson, Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

The team included CQC inspection managers, inspectors, pharmacists, an analyst and inspection planners.

There were also specialist advisors from a variety of community health service backgrounds, including consultants in community health services, senior nurses and social workers.

In addition, the team included experts by experience who had personal experience of using community health services or caring for someone who had used these services.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health and community services inspection programme.

How we carried out this inspection

We always ask the following five questions of every service and provider:

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

Before the visit, the inspection team:

- reviewed information that we hold on the trust
- requested information from the trust and reviewed that information
- asked a range of other organisations that the trust works in partnership with for feedback these included NHS England, Somerset clinical commissioning group, Monitor, Healthwatch, overview and scrutiny committees,professional bodies and user and carer groups

Summary of findings

- held three listening events before theinspection to hear the views of local people

reviewed information from patients, carers and other groups received through our website.

What people who use the provider say

- "Staff are very kind to me, marvellous. I feel like they are old friends."
- " I have a fear of falling and they do try to give you confidence but you have to take some risks"
- They listen and take on board what you're saying."
- "Yes they are very sensitive and this morning we had a long chat with Consultant and the occupational therapist."
- "I have been in here over three weeks after having a fall. No one told me exactly which bone I had broken. My wife had to tell me three days ago"
- "excellent at answering difficult questions"
- "if I am worried I will tell them and they do comfort and reassure me"

Good practice

- The new community hospitals and newly refurbished community hospitals embraced the needs of people living with dementia and incorporated best practice around this in the design of the hospitals.
- Activities at some of the community hospitals which were run by the league of friends were imaginative and innovative and were tailored to the patient's needs.
- The primary link service managed the needs for patients both being discharged and admitted to the community hospitals and always worked hard to put patients in their preferred hospital.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider must ensure that there is suitable access to fire escapes and training for emergency equipment to all at Chard Community Hospital.
- The provider must ensure that risk is properly assessed at the community hospitals and that this is recorded and escalated appropriately.

Action the provider COULD take to improve

- The provider should improve the availability of activities to patients at the community hospitals and ensure they are better engaged.
- The provider should work to improve staffing levels in the community hospitals.

Somerset Partnership NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safety in the community inpatients to require improvement. We found that where serious incidents were reported they were investigated thoroughly using a robust investigation methodology. However, we found the threshold of what was reported as an incident was high, particularly where there were medication errors, which meant that opportunities for learning were limited. We looked at 27 prescription and administration records across six community hospital inpatient wards. We saw 22 gaps in the administration records. Staff had not recorded they had given the medicine and had not recorded the reason if it had been omitted.

We found there was a sharp contrast in the environments which people were cared for. In the community hospitals that were new or newly refurbished we found light bright environments with consideration for dementia awareness in their design. However, we found that hospitals such as Chard Community Hospital had safety concerns around access to fire escapes training of emergency equipment in the event of a fire. We also found that at Dene Barton Community Hospital the day room was small and cramped and did not allow easy access by patients.

Staffing was recognised as a significant risk for the community hospitals, with 40% registered general nurse vacancy rates. Although many shifts were being filled by bank and agency staff there were a high number of shifts which did not meet safer staffing guidelines. As a result of this the trust agreed with the clinical commissioning group to reduce the number of beds provided by the trust. At the time of our inspection 61 beds were closed with an additional 20 beds in use by the local acute trust.

Safety performance

- The National Safety Thermometer was displayed in all hospitals for patients and visitors to see. This is a national prevalence audit which allows us to establish a baseline against which we can track improvement.

Requires improvement

Are services safe?

There are four key measures as part of the safety thermometer which included falls, pressure ulcers, venous thromboembolism (VTE) and urinary tract infections (UTI's) in patients with catheters.

- The amount of recorded falls which resulted in harm fluctuated over the thirteen months prior to the inspection and were generally low numbers. There were no falls with harm during July 2014, August 2014, April 2015 and May 2015. However, September 2015 saw a peak of 12 falls which resulted in harm.
- The number of new pressure ulcers fluctuated over the thirteen months prior to the inspection reaching a high of four for five of the months which is a low number. There were no new pressure ulcers in July 2014. Some hospital sites such as Wincanton Community Hospital, Shepton Mallet Community Hospital, Frome Community Hospital, Burnham-on-Sea War Memorial Hospital, Chard Community Hospital and Bridgwater Community Hospital had been free from acquired pressure ulcers over 12 months. West Mendip Community Hospital had no new pressure ulcers for 936 days prior to the inspection.
- The amount of recorded catheter and new urinary tract infections has varied throughout the year. The highest recorded values were six in June 2014, five in February 2014 and four in September 2014 which is low.

Incident reporting, learning and improvement

- In the twelve month period between June 2014 and July 2015 there has been 10 serious incidents requiring investigation. Of these incidents five had been grade 3 pressure ulcers, three slips, trips and falls, one grade 4 pressure ulcer and one unexpected death. These were fully investigated and learning shared between staff. When asked staff could describe the learning of incidents which had been shared between sites.
- We were given examples of where investigations had taken place as a result of an incident. A serious fall had happened earlier this year at Bridgwater Community Hospital resulting in serious injury. An investigation had taken place by an independent Matron and a Falls Specialist Nurse. The investigation identified gaps in the assessment of a patient's falls risk assessment and record keeping. Staff followed duty of candour and met with the family, apologised, and discussed this incident and the learning that had taken place. At West Mendip Community Hospital trends were identified when an incident occurred and informal peer review was used to encourage best practice. We were not shown any records of peer review taking place.
- Staff we spoke with were clear about how they reported incidents and said they were encouraged to report incidents and near misses. Staff told us they received feedback about incidents they had reported. Ward sisters and matrons described how they managed incidents. They fed back to staff individually or via staff meetings about any learning that could be taken forward to improve practice. At Dene Barton Community Hospital the matron said they were enthusiastic incident reporters and good at reporting incidents, however, sometimes failed follow up incidents with investigations or look at the learning from an incident. This meant that not all incidents were reported.
- Managers were confident that falls were being reported appropriately. This was due to a good awareness culture of reporting incidents. Incident reports, weekly falls reports are received by the divisional lead who presented falls at board meetings. A monthly fall local action group (FLAG) with membership consisting of three to four representatives from the ward, and a therapist was in place. Falls incidents were discussed in detail at the FLAG meeting, and learning shared. Falls incidents, at the time of our inspection, were decreasing. Monthly falls local action groups were also in place at Chard and Williton Community Hospitals. A falls information board was also displayed at Williton Community Hospital where there was also a trial of yellow wristbands. This aim of the trial was to support prompt identification, by all staff, of a patient who may be at risk of a fall.
- An example of learning from incidents was given when there was an unplanned transfer to an acute provider (where a patient was too unwell to be at a community hospital). A 72 hour report of a patient's record would be analysed to see if anything could have been undertaken differently. This resulted in an increase in the frequency of recording a patient's observations, so deterioration in a patient's condition identified earlier, and appropriate action taken. Further monitoring of any unplanned transfers to the district hospitals was continuing. This action was not shared between community hospitals.

Requires improvement

Are services safe?

- Duty of Candour sets out what providers must do to make sure they are open and honest with patients and their families when something goes wrong with their care and treatment. The matrons were aware of duty of candour and knew the principles of it based on guidance in the nursing handbook. However, none of them had received any formal training in the regulations implementation. There was no platform to record actions as a result of duty of candour in incident forms. However, comments were made in the patient's notes as to its implementation. We were given examples of where duty of candour had been implemented. Actions included apologising to patients, families and carers and arranging meetings to support them and to discuss learning.

Safeguarding

- Staff, of all grades, at all community hospitals were able to talk confidently about recognising safeguarding issues and how to report any concerns they had. We were told the safeguarding e-learning had recently been introduced and some staff said they found it interesting and challenging.
- We saw in staff handover meetings safeguarding alerts concerning patients being discussed with the team to ensure all appropriate staff were informed.

Medicines

- The community hospitals had systems in place to order medicines from a local acute hospital. We were told by staff that medicines were delivered to inpatient wards once a day (Monday to Saturday). Systems were in place to order medicines outside of the standard working hours if required. This meant that patients did not have delays in receiving their medicines.
- A pharmacy technician visited the wards once a week and checked patient's prescription and administration records. Staff told us they were happy with the service provided and had the pharmacy support they needed.
- The medicine storage areas were secure, clean and tidy. The room temperatures in the medicine storage areas were not recorded. This did not follow the trust medicines policy. Staff could not assure themselves that medicines were always stored at a suitable temperature and would be safe to use. Staff recorded the temperature of medicine refrigerators daily, to check they were in the safe range for storing medicines. The date of opening was not recorded on the liquid medicines. This included one medicine which had an expiry date of 90 days after opening. This increased the risk that patients may be given medicines which were not safe for use.
- The ordering, receipt, storage, administration and disposal of controlled drugs were in accordance with current legislation. Ward staff made regular checks of controlled drugs. The results were sent to the medicines management team for monitoring. The pharmacy team carried out a check every three months. The standard operating procedures for controlled drugs had been updated in November 2014. Incidents involving these medicines were reported to, and investigated by, the Accountable Officer for controlled drugs.
- We spoke to six patients about their medicines. Five of the patients said that they had been told about their medicines and had enough information. We noticed that one patient had refused a new medicine. She said that she had not been told about the medicine and therefore did not want to take it. When the patient was given information about the medicine she decided that she would start the new treatment. This meant that patients were not always included in decisions about their treatment.
- We looked at 27 prescription and administration records across six community hospital inpatient wards. We saw 22 gaps in the administration records. Staff had not recorded they had given the medicine and had not recorded the reason if it had been omitted. The staff we spoke to could not say if the omitted doses had been noticed and we did not see any evidence of actions taken following a missed dose. This meant it was not clear whether patients had always received their medicines as prescribed. The pharmacy technicians collected data on missed doses. This information was reported in the Medicines Management Report (August 2015). We did not see any action plans associated with the Medicines Management Report and the ward managers we spoke to were not aware of the report. We did not find any evidence that the Medicine Management Report improved patient safety.
- On one in patient ward the prescription and administration records showed that on four occasions patients had been given the wrong dose of one of their

medicines. The mistake had not been reported on the patients' electronic care records or the electronic reporting system and the ward manager was unaware of the errors. This indicated that nurses had not noticed the administration errors or had not acted on, or reported, the errors when they had been identified. This meant that the working practices were not adequate to keep patients safe when something went wrong with their medicines.

- Systems were in place to record medicine errors through the trust on-line systems. We saw examples of three medicine error reports on the incident reporting system. Action had been taken to reduce the chance of similar incidents recurring in future. The nursing staff we spoke with were all aware of how to report a medicine error. The ward managers we spoke to were all aware of the trust medicine incident management process. We were shown two examples of the procedure being used at ward level. There were some inconsistencies in what was classed as a medicine error by staff. The matrons and ward managers considered missed doses to be a medicine error but the pharmacy technician on one ward informed us that it would take too much time to record all missed doses on the incident reporting system. This meant that incidents may not have been reported consistently and the Trust may not have had a complete picture of the medicine risk on in patient wards.
- Three wards had a low number of medicine errors reported on the incident reporting system: Burnham-on-Sea War Memorial Hospital had one medicine incident report (August 2014 to July 2014); Minehead Community Hospital had one medicine incident reported (November 2014 to April 2015); and Crewkerne Community Hospital had nine medicine incidents reported (August 2014 to July 2014). The ward managers thought there may be reluctance amongst staff to report errors. The ward managers told us that historically medicine errors had been treated with a 'heavy hand' and that as the nurses worked in small teams they may be uncomfortable to highlight errors made by colleagues. The chief pharmacist recognised that the trust had a low medicine error reporting rate. It was therefore difficult to assess the track record on managing medication errors as the evidence indicates that the trust was not being made aware of the extent of the medicine risk at ward level.
- We saw a trust policy for the management of NHS prescription forms dated January 2014.The trust policy was not always followed accurately. For example, the record book was stored with the prescription pads and the details of the person receiving the prescriptions were not always recorded. This meant that if the NHS prescriptions went missing it would have been difficult to investigate thoroughly.
- At Burnham on Sea War Memorial Hospital the sister in charge said they would be trialling self-administration of medicines for some patients. This was as a result of a patient going home and completing their course of medicine at home before starting on the ones provided by the hospital on discharge. Some of the tablet doses had changed and the patient had not realised. They became ill and were readmitted to hospital. Following investigation it was thought if the patient had self-medicated whilst in hospital as they did at home they would have been more aware of the changes and not taken to old medication.

Environment and equipment

- Bridgwater Community Hospital, Wincanton Community Hospital, Frome Community Hospital and Burnham on Sea War Memorial Hospital, were all newly refurbished or newly built. Other hospitals such as Chard Community Hospital and Dene Barton Community Hospital were not as well maintained or designed in a way to keep people safe from harm.
- At Dene Barton Community Hospital the day room was small and cramped. There was not enough space to get a wheelchair into it and furniture within it was aged. Also at Dene Barton Community Hospital there was a physiotherapy gym and a quiet room available for patents. However, they were some distance from the ward. Between the ward and the gym there was expansive corridor and a waiting room for the outpatients department meaning that patients privacy was compromised by having to go through this area. We found at Chard Community Hospital that the environments were not fit for purpose. Side rooms were small and cramped and did not allow for effective support from staff in the en-suite bathrooms. Showers required patients to step into them which some may have found difficult and may have put those patients at risk of falling.

Requires improvement

Are services safe?

- Of the new or recently refurbished hospitals we found there were en-suite facilities in single rooms and male and female toilet and bathrooms near to male and female specific bays. There were large day rooms with access to safe outside spaces. Shepton Mallet Community Hospital was older and was due to be refurbished. Despite that the day room was brightly painted and provided a good area for dining and activities. There were adequate male and female toilet facilities throughout the unit.
- Staff at all the hospitals talked about their individual League of Friends who raised money for their local hospital and were able to help provide equipment such as specialised mattresses and safe patio flooring and garden furniture.
- At West Mendip Community Hospital we found that there were large amounts of space either side of the beds to allow people with frames to easily move. We saw that one patient used his own electric chair and had ample room to maneuver in the ward.
- The environment at Bridgwater Community Hospital was designed in such a way to reduce the risk to patients with dementia. For example, doors which were for staff only were coloured the same as the walls so they blend into the wall reducing the risk of someone wanting to go through them. The walls in the dining room were orange to promote appetite, and the chairs were striped to mimic a deckchair so encouraging someone to sit down. At Williton Community Hospital we found that handrails were coloured differently to walls to allow people with visual impairments to see them clearly. We found multiple examples of adjustable equipment for comfort such as chairs. There were bathing facilities available to patients which were all adjustable with assistance.
- We found that generally equipment was within its service dates. However, some equipment at South Petherton Community Hospital, for example, scales and moving and handling equipment and ceiling track hoists were overdue for service. We were informed after the inspection that the hoists were managed by an external company and that records showed they were all in date. Stickers to show this were not put on the equipment and replacements were being ordered.
- We found that all of the resuscitation trollies were checked on a daily basis. However this check was not completed appropriately at Chart Community Hospital as a piece of equipment was missing form the trolley. There was a stopwatch missing from the required equipment and had been missing since May 2015. A stopwatch is a requirement, to support treatment decisions, by accurately recording the length of an emergency. The senior sister said they would to take action to replace the missing piece of equipment. At Wincanton Community Hospital there was only one emergency resuscitation trolley for the whole hospital that included two wards and an outpatient department. It was situated on the female ward. Staff on the male ward said it was a long way for the trolley to travel especially under stress which may result in a delay in emergency treatment to a patient if required.
- We found that at West Mendip Community Hospital corridors were cluttered with equipment restricting access to the hand rails for patients wishing to move around the ward.

Quality of records

- Patient care plans were developed and maintained on the trusts electronic patient record system. Records kept at the bedside included medicine charts, observation records, round the clock care records and fluid charts.
- Out of the 29 medical records we looked at all but three had a fully completed care plan. We spoke with one patient who had no care plan in place. They were able to describe their care needs to staff and were very involved in their own care needs anyway. We told the sister about the lack of care plan who told us before we left the hospital that a member of staff had started to complete one. Another patient had their next of kin details missing. This was raised with the nurse in charge and it was immediately rectified.
- We looked at seven bedside records (where basic observations are recorded) and found that all but one record was fully completed. Progress notes showed where concerns had been escalated to the GP for example if a patient had deteriorated. Medicines charts we looked at were all completed, with codes used to describe why a patient may not have taken a medicine at a particular time.

Requires improvement

Are services safe?

- Paper records that came with a patient from an acute provider, but were not in use during the patient admission, were stored securely in locked trolleys, or locked cupboards designed for that purpose.

Cleanliness, infection control and hygiene

- Patient led assessments of the care environment (PLACE) results were collected by the trust. The average cleanliness score was 100% which was higher than the England average of 97%.
- Monthly hospital cleanliness audits were completed and scored within the trust target of 95% compliance. We saw different practices around infection control awareness. We were told that infection control questionnaires were periodically given to staff to complete to highlight gaps in their knowledge which would be analysed by the matron who would identify areas of greatest improvement and implement an action plan around this.
- All of the sites we visited were clean and tidy. There were paper towels, liquid soap and pedal bins at each hand washing sink. There were hand gel dispensers placed at all ward and hospital entrances. We saw these being used by visitors and staff. However, this was not always clearly signposted. We also saw information on noticeboards about the importance of good infection control.
- We spoke with domestic staff who were very clear about their cleaning schedules and maintaining patient's privacy and dignity. They all felt part of their hospital team.
- We saw some poor infection control practices at some of the community hospitals. At Williton Community Hospital linen was on the wards in uncovered trolleys allowing easy access for staff when delivering care to patients. The trust laundry policy stated that clean linen should be stored in a designated cupboard. At Dene Barton Community Hospital we were told that there were two cats which regularly got onto the wards. This posed an infection control risk to patients. When asked about infection control concerns we were told that they had not considered informing the infection control team but they were reassured by the RSPCA that they had been wormed and de-flead. Since the inspection the infection control team have supported the hospital in removing the cats and contacting the owners. At Shepton Mallet Community Hospital we saw urine bottles on the patient's bedside table where they had their drinks and meals served.

Mandatory training

- Compliance with mandatory training was varied in the community hospitals. In June 2015 eight of the 13 community hospitals were within the trusts 90% completed training target. The worse performers were Bridgwater Community Hospital (at 83% compliance), Wellington Community Hospital (at 84% compliance) and West Mendip Community Hospital (at 82% compliance).
- Both matrons at West Mendip Community Hospital and Bridgwater Community Hospital told us that this was due to staffing issues and availability of time to complete the required training. Any staff that were repeatedly non-compliant with completing mandatory training would be supported by management to ensure this happened.
- Staff, including administrative and housekeeping staff at all community hospitals were all very positive about the trusts e-learning system. They said it was easy to access and informative. At Frome Community Hospital the matron's secretary, along with other administrative staff had set up some laptops in the training room and had made themselves available to all grades of staff who needed help with computer skills and therefore accessing the e-learning system with confidence. This was said to be very successful and ensured staff accessed their training when required to.
- Staff told us access to training "is very good here". Staff told us reminders were sent out to staff when they were due to renew their mandatory training.

Assessing and responding to patient risk

- Of the 29 patient records viewed all but one had completed risk assessments including bed rails assessments, falls risk assessments and skin condition assessments. An early warning system to track and trigger changes in a patient's condition was in place to monitor patients' health and identify patients early who were at risk of deteriorating. These were kept in an observational chart at the patient's bedside.

Requires improvement

Are services safe?

- We were told that the electronic system was not intuitive enough to have templates for all risk assessments needing to be carried out. One nurse told us that in order to do a mouth assessment they had to create a new assessment form based on a paper version.
- Information about patients' allergies was recorded on the computer system. If the allergies section was not filled in the form could not be closed ensuring compliance. Where allergies had been disclosed, additional personal protective equipment practices were introduced. For example, at South Petherton Community Hospital housekeeping staff changed their gloves if the patient had an allergy when serving food.
- During our inspection we observed several staff handovers. The quality of the handover was good and went into detail about each patient's condition and status. They discussed details such as the quality of their chewing and swallowing to determine how much assistance was needed during meal times. It was arranged to have a health care assistant to support a patient as their swallowing had deteriorated during the morning. Relatives and carers opinions and concerns were voiced in this meeting and had a positive effect on how the patients were cared for, particularly when they were close to or awaiting discharge. Communication books were discussed and updates recording all communication with external agencies ensuring that all members of staff were fully informed of the processes.
- At West Mendip Community Hospital increased monitoring had been introduced for high risk patients. This is where patients had observations taken every four hours during their first twenty four hours of admission to monitor and assess care needs.

Staffing levels and caseload

- Staffing was sufficient on the wards we observed based on the needs and acuity of the patients. However, the safer staffing guidelines were not always met.
- Staffing was the highest risk relating to community hospitals in the corporate risk register. The main concern was a shortfall in registered general nurses employed by the trust. Divisional managers stated that there was a 40% vacancy rate for registered general nurses which had resulted in a high dependency on agency staffing to manage the shortfall.
- We found through looking at staff rotas that there was a high use of agency staff, particularly covering the late shifts. At Bridgwater community during the three weeks leading up to our inspection, agency staff were used on two thirds of late shifts.
- Most of the bank and agency staff had worked at the hospitals for a length of time and were used to the way the hospital worked and trust policies and procedures. Some staff said an issue with agency staff who did not have access to the electronic patient record meant they had to write notes for the nurse in charge to write in the electronic records at a later time. This meant more work for the permanent staff members.
- Matrons said that staffing wards was the biggest challenge. However, they felt well supported by their divisional leads as daily telephone meetings were held to discuss staffing and where the shortfalls were.
- The levels of vacancies varied greatly between the community hospitals. For example, at Bridgwater Community Hospital there were ten staff vacancies of an establishment of twenty two. However, at West Mendip Community Hospital there were only two staff vacancies of an establishment of 20 with the view to filling these posts in the near future.
- Divisional managers felt that the rate of change was not sufficient to the risk shortfalls in staffing as they were aware that the complexity of patients was increasing with an ageing workforce which they will need to replace after retirement. We were not informed of any long term staffing plans to mitigate an aging workforce.
- We saw recruitment was ongoing. Some staff told us there was a trust recruitment and retention action plan in place. Frome Community Hospital had held an open day for the local population to learn about the services the hospital offered. The staff said they hoped it also may encourage nurses who lived in the local area to apply to the hospital. One of the community hospital matrons told us they were going to visit a local school to talk to GCSE students to raise the profile of nursing and encourage people to apply.
- Senior managers stated that they had worked hard to ensure that safer staffing had been considered in its establishment achieving a radio of 1:7 during the day and 1:10 during the night for patients, and 1:6 for stroke patients through the day and night. At Bridgwater

Community Hospital we found that safer staffing levels had not been met during the day for the last 6 months and in the most recent month only met safer staffing levels 80% of the time. This reduced the numbers of staff available to provide care to patients.

- All senior staff we spoke with said that if the dependency of patients increased they were able to get additional nurses or healthcare assistant staff to meet the needs of patients. We saw examples where patients who needed supervision at all times were. The average bed occupancy for all of the community hospitals between October 14 and March 15 was 92%. All but one of the community hospitals had a bed occupancy greater than the accepted levels with the highest occupancy being at Crewkerne Community Hospital (bed occupancy of 98%) and the lowest being Shepton Mallet Community Hospital (bed occupancy of 82%). It is generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of the care provided to patients and the orderly running of the hospital.
- In some of the wards we found that at night there was a single registered general nurse working with two health care assistants. At Chard Community Hospital this had been risk assessed and it was recognised that the staff member would not get a break in a 10 hour shift. This prolonged working would have an effect on the wellbeing of the nurse. We were told that although the nurse could get small breaks they were unable to leave the health care assistants for any prolonged periods of time.
- To manage the shortages it had been agreed between the trust and the Clinical Commissioning Group to close a proportion of the beds to match the availability of staff so decreasing the risk to patients. During May2015 there was a total of 61 beds closed out of 252 beds. An additional 20 beds at Dene Barton Community Hospital were closed the previous year and the ward was being used by a local acute trust.
- Bridgwater Community Hospital had the highest sickness rate with 9% out of a total 136 substantive staff members. Shepton Mallet Community Hospital had the lowest sickness rate of all inpatient services with 4%.

Managing anticipated risks

- Staff told us during bad weather they would get to their nearest hospital to work if at all possible. Staff said there was access to 4 wheel drive vehicles that would help get staff into work and there were staff able to sleep on site if necessary to ensure they were available for their shift the next day. Staff said they would ensure there were extra supplies of food, drinks and medications if bad weather was anticipated to ensure they could continue to meet patient's needs.
- We saw patients who were having 24 hour one to one care. Staff reported no problems in being able to get extra staff if one to one care was assessed as being necessary.

Major incident awareness and training (only include at core service level if variation or specific concerns)

- We saw a significant risk to patients at Chard Community Hospital as the design of the building and the numbers of staff working at night would result in an ineffective evacuation during a fire. The ward was on the first floor of a building. We found that one of two fire exits were blocked with equipment which was immediately removed. In order to evacuate patients the stairs would need to be used. Equipment was available for this. However, none of the staff were not trained to use the equipment. The evacuation and shelter assessment was not dated with no review date so we were unable to determine when this was last assessed.
- Staff we spoke with had received training on major incident awareness. We saw a major incident policy, patient evacuation plan and fire risk assessment were available to staff at all times.
- A major incident was declared at Burnham on Sea War Memorial Hospital in 2014 after a water main burst locally resulting in the hospital having no water supply and no guarantee when it would reconnected. Meetings were held and patients were evacuated from Burnham on Sea with their care records and medicines to Bridgwater Community Hospital. All families were informed and the patients returned to Burnham on Sea as soon as the water was reconnected.

Good

Are services effective?

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

Summary

We judged the effectiveness of the service to be good. We saw good examples of where evidence base and audit results were having a positive effect on care and treatment and found that best practice guidance was being followed. However, where there was good practice this was not effectively shared and used throughout all of the hospitals.

Patient outcomes collected were limited to length of stay and audit results which reduced the understanding of how effective the treatments they were giving were. Staff we spoke with all had appraisals and competency training and were being given opportunities to develop further in their careers.

Staff recognised when a patient required pain relief and analgesia was quickly given. Patients nutrition and hydration needs were met. Consent processes were followed appropriately and staff had a good understanding of the mental capacity act.

Evidence based care and treatment

- Matrons and senior sisters we spoke with told us all of the trusts policies and procedures were updated in line with best practice guidance such as National Institute for Health Care and care Excellence (NICE) guidance. Guidance we saw included prevention and management of pressure ulcers and stroke rehabilitation. There was a reference at the end of each policy to show where the guidance had been drawn from.
- The trust undertook ten clinical audits within the community hospitals. Six of these audits were managed by the trust team (decontamination of medical devices; falls; nutritional support in adults; pressure ulcers; high risk drugs on inpatient wards; and physiological observation charts audits). Four audits were managed by the community hospitals (handover audit; clinical assessment audit; supporting people with dementia audit; and record keeping audit).
- We were told that there was a central audit department who requested audits to be competed. Many of these audits were based on commissioning quality and innovation requirements from the clinical commissioning group (the trust sharing with the commissioners how well they were performing with key audits).
- At Dene Barton Community Hospital the falls audit had identified improvements to be made. An action plan had been created. However, we were told that the sister responsible for this action plan had moved to a different hospital and nothing had been done to monitor compliance with the action plan.
- There were best practice groups which had been developed to have an multi-disciplinary team approach to best practice and changes in guidelines. One example of this was with the management of sepsis which led to an improved pathway for patients and training for staff which led to a better understanding of sepsis.
- A leaflet had been developed in partnership with the local clinical commissioning group with information for patients on pressure ulcers informing them of the risks, management, prevention and contact details for patient if they have any concerns. This was developed in line with the National Institute of Clinical Excellence guidance documents on pressure ulcers.

Pain relief (always include for EoLC and inpatients, include for others if applicable)

- The notes we reviewed had care plans detailing patient's pain level and the plans in place to manage that pain. However, at Chard Community Hospital there were multiple pain scoring systems in place which staff found confusing which was not in line with trust policy.
- Patients we spoke with said their pain was well managed and that they were rarely in pain for very long. Patients said they felt able to request pain relief and would have it quickly administered when requested. One patient commented that they were on regular pain relief and that staff were very accommodating when the pain worsened ensuring that they had appropriate pain relief. Another patient said they had pain in their leg. They said the staff were very good at providing medication for their pain when they needed it.

Good

Are services effective?

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

- In the patient records we looked at, most had completed and appropriately reviewed nutritional screening tools. Food and fluid charts were in place where they were required and we saw that GPs prescribed supplement drinks for patients whose risk assessments required that action. However, in Chard Community Hospital we saw that food and fluid charts were not completed appropriately meaning that patients were not properly assessed for food and fluid management.
- At the community hospitals we visited we saw patients who were in bed had access to water at all times. We saw staff carrying out drinks rounds at various stages throughout the day. We saw staff and volunteers had time to spend with patients who needed help with eating and drinking.

Patient outcomes

- Staff told us they completed provided information for national audits but did not always know how that information fed into improved outcomes for patients. They said that team and ward meetings were where they sometimes found out about new initiatives based on good practice recommendations.
- We saw on hospital dashboards that the length of stay targets varied between different hospitals. We were told that this was based on the previous year's average stay. We were told that the trust were working with data analytics to produce a more accurate target based on previous year's data and complexity of patients.
- All community matrons we spoke with discussed the number of days a patient spent in a community hospital after a target date (otherwise known as lost bed days) as the main outcome for their hospitals. Reasons behind these delays were mainly around complications with social services and delays in obtaining ongoing packages of care.
- The trust did not benchmark outcomes against other services. Divisional managers felt that this could be something to take forwards in the future. Other than using key performance indicators set by the clinical commissioning group it was commented that they could do their own benchmarking.
- Quality and outcome information collected at each site showed local audits were ongoing. For example, Burnham on Sea War Memorial Hospital along with Bridgwater Community Hospital had carried out a capacity and consent form audit. The results showed improvements could be made. An action plan was developed that included: staff watching a training DVD about the Mental Capacity Act 2005; reminding staff to follow the prompts on the electronic patient record; and ensuring staff knew how to contact the safeguarding team for advice. The senior sister said that improvement had already been made and a follow up audit was to be carried out in November 2015. However ,practice improvements, made as a result of the local audits, were not shared between all of their community hospitals to benefit all patients using the services despite discussions in best practice meetings.
- At Burnham on Sea War Memorial Hospital focused reducing the risk of urinary tract infections and promoting independence of patients by reducing the number of urinary catheters used. The hospital got a commendation for their hard work from the Community Hospitals Association Innovations and Best Practice initiative. We did not see that this good practice being used effectively in other community hospitals.

Competent staff

- At all of the community hospitals we visited staff of all grades told us they felt supported to complete mandatory and role specific training. Records confirmed that staff had received their annual appraisals and received regular clinical supervision and mentorship from their peers. Where there had been difficult situations we were told about de-brief sessions which were held to both support staff and to discuss learning.
- Staff we spoke with commented on the high quality of the appraisals and the clinical supervision and thought it was good that supervision by people outside of their own ward was possible when being supported through difficult situations.
- The matron at West Mendip Community Hospital commented positively that the staff were benefiting

from being combined with a mental health trust as they have access to training that they would not normally see. This included a range of support services, resilience training, coaching and mindfulness training.

- Senior staff told us that there was also a leadership programme for matrons and ward sisters to further develop their skills. At South Petherton Community Hospital and at Frome Community Hospital a junior sister role was being introduced to allow career progression. Senior staff were also encouraged to partake in the Mary Seacole programme of leadership care to develop staff further. This is a one year course to develop skills for leadership roles.
- Staff were encouraged to progress and develop their learning both to develop careers inside of the trust and out of it. We were given examples where healthcare assistants had been trained to be dementia champions, stroke care and at Williton Community Hospital were being trained to perform more complicated procedures. Also we were given examples where healthcare assistants had been encouraged to progress their careers. One assistant was supported to undertake their nursing training and had secured a job at Williton Community Hospital upon completion. At West Mendip Community Hospital one healthcare assistant was being supported to pursue their choice of career to be a paramedic and offered in-house training to improve their skills at the hospital and to progress further.
- We found that the learning and development department offered various courses to develop staff competence. Courses we were informed about were in catheterisation and catheter care, leg ulcer management, wound management, conflict resolution and promoting safer therapeutic services, customer care training, and clinical supervision training as well as others.
- We spoke with a nurse who was going through their preceptorship. We were told that generally they were well supported by their peers and managers however this support was inconsistent depending on the workload. However, they went on to say that they mostly get meetings, feedback and discussion of strengths and weaknesses.

Multi-disciplinary working and coordinated care pathways

- We observed an multidisciplinary team (MDT) meeting at Bridgwater Community Hospital where nurses, ward sisters, social workers, a GP, a physiotherapist from the independent rehabilitation team, a discharge specialist and a medical secretary worked in corroboration to decide optimum rehabilitation goals and packages of care. Where they were discussing new patients great length was taken to discuss individual risk assessments on mobility, falls, and medications with the individual patient's wellbeing being considered. Where there was lack of clarity around a subject the medical secretary would refer to the computer system to efficiently find the information. Social circumstances and packages of care were also discussed as part of the MDT meeting ensuring that the care delivered was coordinated both with the hospital social services and the GP. The discussions from the MDT meeting were directly transcribed into the computer system for all members of staff to see.
- At MDT meetings many of the hospitals had input from a mental health nurse who was able to provide specialist knowledge in the management of these conditions. One example where this benefits the patient was with discharge planning and having capacity assessments conducted in a more timely way. Two of the hospitals told us they had weekly meetings with a community psychiatric nurse to discuss patients and how to best meet their needs.
- Patient records demonstrated the involvement of the multidisciplinary team (nursing, medical, therapies, and social work) in their care. Staff said that having all of the information in one place allowed different teams to know what the other was doing.
- We saw ward rounds with GPs and nursing staff at two of the sites we visited. The GPs we spoke to and nursing staff said they worked well together. They said they tried to include the patient and/or their relatives in discussions about the ongoing care and support required. We also observed positive communication between therapies staff and nursing staff to enable effective communication with a patient. This helped relieve anxieties of the patient and allowed them have more confidence in themselves when conducting the task asked of them.

Good

Are services effective?

Referral, transfer, discharge and transition

- The Primary Link service (a team of people where all care provided by the trust was coordinated. This was the single point of access for all patient from GP's or from an acute provider) was able to facilitate admissions from the community to community hospitals when a person was not able to stay at home but did not require admission to an acute hospital. They spoke with the referring GP about the patients immediate needs, saw where there were empty beds and discussed with the hospital whether they could take the patient. Primary Link then informed the GP, patient and relatives of where they were to be admitted and organised transport for them.
- We saw that discharge plans were started as part of the admission process. This informed staff about the short and long term plans for patients. We saw one patient's discharge plan which was being reviewed because the patient's condition had deteriorated. All of the discussions about where their needs would best be met were documented.
- We were told by divisional leaders that they were challenged in the county because of delays in the availability of care packages, access to carers, and placements to care homes. The trust was working closely with the local authority and the clinical commissioning group to manage the scale of the delays, this included escalation calls on a weekly basis. The divisional managers had a good understanding of where the challenges lay and could describe these for particular areas in the county and particular community hospitals. For example, in the south of the county there was limited access to domiciliary care.
- The trust undertook a 'breaking the cycle' week in partnership with the local authority to allow them to better understand the challenges associated with discharge and discharge targets. This led to improved communication and a better understanding of the challenges both organisations faced.
- Where there were lengthy delays the divisional management team had a good oversight of the individual and the reasons behind the delay. This was discussed at board meetings and identified where additional support was required. Managers could discuss with inspectors the names of individual patients, the circumstances of their delay and ongoing actions for discharge.
- During the 12 months prior to the inspection there were a total of 23 transfers from an acute provider which resulted in being transferred back within 24 hours. There was a stringent referral and transfer criteria in the community hospitals which the acute trusts were aware of. Staff we spoke with commented that these patients were deemed fit for transfer to the community hospital. However, became unwell/ deteriorated upon transfer and went back to the acute hospital. These processes ensured that patients inappropriate for the community hospital setting were quickly back in an acute hospital.
- We were told about the daily call between the in-reach service, Primary Link and wards to assess the bed situation and possible admissions and discharges that day. Staff felt this was very useful and saved time later in the day.
- The activity co-ordinator at Frome Community Hospital said she was able to add to the electronic patient record. This meant that the patient's activity choices formed part of the discussion about their discharge plans and equipment and assessment that might be needed at home.
- At Williton Community Hospital one of the side rooms, was equipped with en-suite facilities. There was a patient staying this room who was due to be discharged. Nursing and healthcare assistant intervention was minimal but controlled as they were trialling out the patient's package of care to see if he could cope when he moved home.

Access to information

- All nursing staff and GPs all of the community hospitals had access to the electronic patient records system ensuring that all information was recorded in one place. Staff told us some agency staff did not have access to the system and this led to the permanent staff member having to input patient information of the agency nurses behalf.
- On the computer systems staff had access to medical systems used by the local acute hospitals to access

pathology results and diagnostic imaging results. Where information was required from outside the area communication was made with the hospitals and information quickly acquired.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- Staff were able to describe what this meant in relation to capacity assessments and keeping the patient safe. Staff described how to assess capacity and were aware that a person's capacity to make decisions and choices changed and as a result their capacity assessments had to be reviewed regularly.
- Patients told inspectors of how their own individual choice had been considered with medications and that if a patient did not wish to take a medication this was respected by all staff. Where this had occurred staff informed the patients of changes to their care plan as a result of the medication refusal and informed the next best time to take the medication.
- Staff were aware of the Deprivation of Liberty Safeguards (DoLS) and their responsibilities under them. At Wincanton Community Hospital we saw a Deprivation of Liberty Safeguard had been applied for. The reasons why had been detailed on patients progress notes and risk assessments.
- Patients said that whenever a procedure was carried out staff always asked for consent. However, one patient said that although consent was gained additional information was rarely given. For example, details about the side effects of medications.
- We saw seven completed do not attempt cardio-pulmonary resuscitation (DNACPR) forms. Not all had not been reviewed appropriately meaning that decisions may not be up to date. When this was pointed out to a nurse they said they would get the GP to review it that day.

Good

Are services caring?

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

Summary

We judged care provided by staff to be good.

We observed compassionate care from all of the staff at the community hospitals and patients were complimentary about the care being given. When talking to patients and staff we were given multiple positive examples of how staff were working with compassion, were involving the patient's relatives and carers and were providing emotional support. The therapies teams (occupational therapists and physiotherapists) were highly regarded by the patients and we observed good care when watching interactions with patients.

We spoke with volunteers who work at the community hospitals. Their interactions with patients were having a positive effect on patients wellbeing. If patients didn't have visitors volunteers would go and sit with them and have conversation or do puzzles or play games with them.

Compassionate care

- We saw staff acting with compassion when interacting with patients. We observed good practice at West Mendip Community Hospital where staff member took time to communicate with a patient who had a speech impediment. It was clear from our observations that the staff member understood them well and was able to express information about his treatments in a way that suited him.
- Patients we spoke with commented positively on the compassion and caring nature of the staff. They said that staff showed an interest in them and asked about visitors and interests. One patient in Bridgwater hospital said "Staff are very kind to me, marvellous. I feel like they are old friends." Patients also commented about the positive attitude of the therapies teams. A patient said "I have a fear of falling and they do try to give you confidence but you have to take some risks".
- We did receive some negative comments about the care given. At West Mendip Community Hospital some patients said that some staff could be curt and abrupt in their manner. Although all patients were respected, some patients noticed that staff spent longer talking to and treated certain patients differently.
- All patients we spoke with were positive about the way their privacy and dignity were maintained. Patients said that privacy and dignity was always respected. One patient said that they always ask and draw the curtains before doing anything. We observed staff knocking on patient rooms and bathroom doors before entering. We also saw that staff carried out personal care behind curtains or in single rooms with the door shut. Staff ensured engaged signs were in place when patients were using toilets and bathrooms.
- We were told about and met some of the volunteers who worked at the hospitals we visited. They told us they sat with people who had no visitors, if they wished them to. They talked with the patients, read to them or helped them with puzzles. We also saw volunteers, who had appropriate training, help patients with their drinks and meals.
- We also observed that sometimes call bells were ringing for a long time before they were answered. On one occasion in Bridgwater Hospital we found that a call bell had been ringing for eight minutes before it was answered. At Williton Community Hospital one patient commented that regularly call bells went unanswered for prolonged periods of time. However, at Wiliton Community Hospital some patients told us that staff respond to the call bells and if they cannot assist at that moment will either get another member of staff or if it is non-urgent they will let the patients know how long they will be.

Understanding and involvement of patients and those close to them

- Patients we spoke with explained how staff take time to communicate with their relatives and involved them in discussions about care and treatment. We observed an occupational therapy assessment where a relative was concerned about the patient managing the stairs. The staff member reassured them and then encouraged the patient to show their family how well they could manage the stairs during the assessment.

Good

Are services caring?

- One patient said "They listen and take on board what you're saying." Another patient said that they include their relatives in discussion and that "Yes they are very sensitive and this morning we had a long chat with Consultant and the occupational therapist."
- Patients told us they and their relatives were aware of their discharge plans and staff had fully discussed the plans with them. We spoke with patients who managed their care at home and were able to continue to do so in the hospital in conjunction with the staff.

Emotional support

- We saw staff, including therapy staff, supporting and encouraging patients in maximising their independence. Patients were supported by staff. One patient at West Mendip Community Hospital described the staff as being excellent at answering difficult questions and where there were concerns raised by patients they said staff were quick to take action.
- At West Mendip Community Hospital we observed good practice where a patient was distressed. The staff managed the situation well and reassured the patient. Actions included a nurse putting their arm around the patient to guide them to the quiet room where they could have a confidential conversation. It was clear that the nurse wanted to listen to what was troubling the patient. A healthcare assistant returned with a cup of tea and was also reassuring. When we spoke with the patient they commented that "if I am worried I will tell them and they do comfort and reassure me".
- We were told of an example where staff had concerns about a patient living with dementia going home. To support this person's well-being during the journey to their discharge destination, a student nurse who had developed a good rapport with the person travelled with them.
- Some patients we spoke were anxious about going home. Most said that they were reassured and supported by staff. However, one said that the staff were not helping with their anxiety. For example staff were telling them that there were sometimes issues with the attendance of district nurses after discharge but did not go into detail of what can go wrong or what to do if that situation arises.

Requires improvement

Are services responsive to people's needs?

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

Summary

We rated the responsiveness of the service as requires improvement.

We found that where there was an active and affluent league of friends there was a vast array of activities available to patients for stimulation (for example, at Williton Community Hospital and South Petherton Community Hospital). However, we found that in other community hospitals there were none for example Chard Community Hospital and Dene Barton Community Hospital.

We also found that personalised care was only applied to those who most needed it and not everyone. There was flexibility in how patients were managed and the Primary Link Service always tried their best to place patients at their preferred choice of location.

We found that if a complaint was received through patient advice and liaison service thorough investigations were done with learning shared between community hospitals. However, if a complaint or concern was raised in a community hospital every effort was taken to resolve the issue locally. This restricted the level of learning taken from the incident and didn't allow staff to pick up on, monitor, or introduce mitigating actions from these incidents.

Planning and delivering services which meet people's needs

- Primary Link service and the in reach service ran seven days a week from 9am until 7.30pm. Primary Link ran a telephone service to help prevent admissions to the local acute hospitals. They had patients referred to them (usually from GP's) who needed some support at home or admission to a community hospital until they were fit for discharge.
- We saw the Primary Link services were flexible in trying to place people who needed admission to a community hospital. We saw they negotiated with patients, where there was not a bed in their nearest community hospital, to be admitted to another one nearby with a plan they would be transferred to their nearest one when a bed became available. The service also arranged the relevant transport for the patient.
- Staff on the wards told us they worked really well with the service as the Primary Link staff understood their pressures and tried to stagger admissions for example when one hospital were taking more than one patient.
- The in reach service helped to place patients who were fit for discharge form the local acute hospitals to Somerset Partnership trust community hospitals. These patients were often on a waiting list for a community hospital bed to become available. The in reach team worked closely with the Primary Link team to ensure the patients with the most urgent needs were admitted to the community hospital beds. The in reach team told us they tried to ensure patients in hospitals in other areas of the country were placed nearer to home as soon as possible. This often helped in their recovery as relatives could visit and they might be in more familiar surroundings.
- All of the community hospitals we visited told us discharges were often delayed due to waiting for packages of care (plans of care after discharge for care workers and the community teams) at home to be set up. Two of the hospitals said some of their discharges were delayed because they were waiting for a social worker to be allocated to the patient's case.
- Delays outside of each hospital's control were having an effect on how long patients were staying in hospital. During the week prior to our inspection a total of 15 patients had a delayed discharge. This means that patients who were fit for discharge were still in the hospital resulting in a total of 80 bed days lost. Data around this showed that 65 of these lost bed days were as a result of social services delays and the remaining 15 were contributed to by delays in social services.
- One side room at West Mendip Community Hospital was not for ward use as they had converted it into an ambulatory care room. We were told that this room was rarely used but could also be used by the minor injuries unit in the hospital if a patient needed to lie down or under greater supervision.

Requires improvement

Are services responsive to people's needs?

- Three patients at West Mendip Community Hospital commented that the mobile phone reception was poor which made it difficult for them to communicate with friends and relatives. They also commented that they were not offered an alternative.

Equality and diversity

- All of the sites we visited were accessible to wheelchair users or people who used mobility aids. There were ramps, automatic doors and lifts to other floors where services were on more than one level. There were disabled parking spaces near the main entrances of all the sites we visited.
- We saw information about translation and interpretation services available to patients displayed in public areas of the hospitals. The information indicated patient information and leaflets could also be provided in different languages and with large print if required.
- We spoke with patients who required particular diets for health or cultural reasons and were told the hospitals catered for their individual needs. At Bridgwater Community Hospital if a patient required any specific diets the chef would visit them to discuss this personally.

Meeting the needs of people in vulnerable circumstances

- There was inconsistency between community hospitals of how well services were delivered to account for people with complex needs. For example dementia or those with a learning disability.
- We found that 'This is me' documents were not used consistently with patients at the community hospitals and only patients who were deemed 'high risk' had it completed. This meant that likes and dislikes of patients were not identified at admission.
- We found that there was a contrast in the community hospitals as to how needs of patients were met. Staff we spoke with at West Mendip Community Hospital said they always encouraged patients to have their meals in the dining room. However, all of the patients we spoke with said they were not encouraged to do so or asked. One patient who spent long amounts of time in the dining room watching television and reading newspapers had to go to their bed for their meals. Also at West Mendip Community Hospital none of the patients we spoke with had been offered to take part in any activities and hobbies and interests had not been explored by staff. Patients said they were very bored as they only had crosswords and puzzles to do. We observed one patient and her daughter playing a board game in the day room however the choice of board games was limited.
- At Dene Barton Community Hospital there were no scheduled activities for patients. The matron said that the patients were not engaged enough for activities but recognised that more could be done to encourage them. Activities are beneficial for the welfare of patients and has been proved to improve mood.
- We were told of examples by patients where there had been delays in responding to specific issues. For example one patient at West Mendip Community Hospital told us that when their vac drain had come loose it had taken until the following day for it to be replaced. The patient said "I felt this should not have been left so long with it leaking".
- At Bridgwater Community Hospital we were told by two patients that they had their hearing aids sent back to their homes in case they got lost. This meant that they both were without the appropriate equipment for their needs.
- We saw activity co-ordinators, volunteers and staff engaging patients in activities that included cake icing and reminiscence time. We saw Burnham on Sea War Memorial Hospital had a secure and safe outside patio for use by patients and their relatives.
- We saw the shift handover sheets. They were very detailed and used symbols to identify patients at risk either because they had a form of dementia or due to poor mobility.
- Many of the community hospitals had activities which were supported by local League of Friends groups. This included a reminiscence group, a visitor for those without visitors, carer support, personal shopping, and a library trolley. Three league of friends volunteers had received reminiscence training to support their voluntary work. During our visit, the lead volunteer was facilitating a keep fit session. This included hand and arm exercises, which the patients enjoyed.

Requires improvement

Are services responsive to people's needs?

- In some hospitals, there were activity co-ordinators, in other hospitals activities were carried out by volunteers or a member of staff. During our visits we saw patients engaged in cake icing. We saw that all of the hospitals had reminiscence areas in the day rooms that had items that patients living with a form of dementia might relate to such as radio sets, old telephones, vintage newspapers and kitchen. At Wincanton Community Hospital staff said the dementia champion had organised monthly themed tea parties that included Wimbledon and The Battle of Britain.
- The league of friends at South Petherton Community Hospital had raised funds for pressure mattresses, computer equipment for stroke rehabilitation and bariatric riser and recliner chairs. They had also funded Tai Chi classes to be held for patients at the hospital.
- At Williton Community Hospital we saw a notice board with details of activities done on the ward. These were facilitated by the League of Friends and included visits from dogs every week and a hairdresser once a week. While we were on the ward we also saw an exercise class taking place for patients. We also saw gardens which were made safe for patients to access if they felt they wanted too.
- There were symbols used on the board above patient's beds to identify their conditions. For example an eye was used for visual impairment or wears glasses and an ear was used for hard of hearing or uses a hearing aid. These symbols were on everyone's day sheet to allow staff to understand individual patient's impairments.
- Patients who were at risk of falls had sensors placed on their chairs to inform staff when they were getting up. This allowed staff to assist patients if necessary and ensure their safety.
- The trust had identified a need to improve the environment of the wards in the community hospitals to meet the increasing numbers of people living with a dementia.. The dementia friendly steps taken regarding the environments varied across different wards. Other community wards had also made some changes, for example, at Williton Community Hospital colour was used to help distinguish different rooms, and calendar clocks were on the walls to help a patient to be orientated.
- One patient at West Mendip Community Hospital commented that the staff encouraged independence and praised them when they were more independent. Another commented that as a result of rehabilitation they were now able to complete their own personal care and that encouraged independence by getting them to do more on their own.
- Patients we spoke with were generally positive about care plans. Some patients said that themselves and their relatives and carers were fully involved in the process in preparation for discharge and knew exactly what they should be doing. However, one patient at West Mendip Community Hospital commented that they had little involvement and 'told' that what they needed to do when at home.
- At the time of our visit, a patient was using a side room in preparation for going home, where visits from staff would be at intervals rather than on ringing a call bell. The patient was at an appointment at the time of our inspection, but ward staff reported this facility to be of great value with patients making discharge planning decisions.
- One patient we spoke with in Bridgwater spoke to us about being cold when they woke up. The nurse found them an extra duvet and pinned the call bell to it to allow the patient to reach it better.
- At Williton Community Hospital we observed volunteers asking patients if they wished to attend activities. The tone of this conversation was encouraging but not forceful. One patient declined to go and it wasn't pursued by the volunteer.
- Volunteers at Williton Community Hospital have knitted sensory pads to allow patients to feel different sensations and to stimulate them in different ways.
- At Bridgwater Community Hospital we were told that there was a memory café held on a weekly bias in the dining room with tea and cakes provided for patients, friends and families.
- At Deane Barton Community Hospital we saw a leaflet for patients with information for both visitors and patients. This leaflet clearly described expectations of both staff and patients, a uniform guide, visiting and

meal times, facilities, and infection control practices ensuring that patients and visitors were fully informed of al basic information. We did not see this leaflet used at any of the other community hospitals.

- We were told by different grades of staff that the hospitals provided good care for people nearing the end of their life. Staff said they had received no specific training in this area. We saw patients admitted specifically for palliative care and staff described how they met with the patient and family regularly to discuss progress and their wishes around their care. Care plans confirmed these discussions took place. We saw that some hospitals provided rooms where relatives could stay overnight if their relative was very poorly.
- Staff at all the hospitals said patients at the end of their life who wanted to go home could have a rapid discharge organised. They said the process of working with social services to organise packages of care at this time worked well.
- There was a leaflet on a notice board identifying the availability of a snack box for patients who had been admitted after meals had finished or who had missed a meal because they had been taken for an appointment in a clinic or a different hospital.
- We saw there was a wide choice of food available to patients either from the kitchen or from food trolleys staffed by volunteers. We saw that picture menus and large print menus were also available for patients who needed it. Most patients were positive about the food, some saying it was better than they got at home. However, one patient at West Mendip Community Hospital commented that "Although there is a selection of foods on offer I am not impressed with the food. The portions are very small. There is a good variety but lots that I cannot eat." Meal times were protected to allow patients to eat without distractions. During these times the ward was quiet. Meals were served and set on the plates in an appetising way but desert was served before patients had finished their main. This was cold by the time they had finished their main course.
- We observed patients being fed in a supportive way. No one was rushed and there appeared to be a good rapport between the staff and patient. Staff asked patients if they required assistance and took the time to help them if required. We saw examples of staff going to the kitchen to find replacement food if the patient did not want to eat what they initially ordered. Tea and coffee was served after the meal.

Access to the right care at the right time

- We found that the availability of medical cover was varied between hospitals. Some hospitals had GP cover during the day. We saw GPs carrying out a weekly ward round at two of the hospitals we visited. Staff told us some GPs visited daily once they had finished their own surgery at which point they could assess patients and make any changes to medications or treatments as required.
- West Mendip Community Hospital and Minehead Community Hospital had immediate access to the mental health crisis team if they were required and we were told that they could be in the ward within minutes of being called. Also at Chard Community Hospital there was access to a consultant geriatrician and at Williton Community Hospital there was access to a stroke consultant which provided additional specialist care to patients.
- Staff reported out of hours medical support was responsive to their calls. On call GP service has provided telephone advice and came to the hospitals to assess and treat patients as required.
- We were told of examples where there were gaps in the medical cover provided. These were often filled by the medical director for the trust to ensure constant availability of care.
- If a patient deteriorated and needed to see a GP staff had to call the 111 service to request a visit. Staff said this was not always the quickest way to get a visit arranged if the GP surgery was on the same site as the hospital.
- If a patient needed urgent help then staff had to call 999 for an ambulance and transfer to an acute provider.
- At Dene Barton Community Hospital one whole ward had been transferred for use by the local acute trust. This meant that remaining ward(s) in the hospital could only accommodate female patients. Male patients who lived near the hospital had no choice but to go to a

community hospital further away. When male patients were admitted to the hospital they were accommodated in two rooms at one end of the ward with a separate bathroom between them.

Learning from complaints and concerns

- In the twelve months prior to our inspection there had been a total of twelve formal complaints made against the community hospitals, ten of which had been upheld.
- The complainant was kept informed of the outcome of the investigation. If necessary an apology was offered and an explanation about how things would be improved and the learning that had come from the incident.
- Of the formal complaints we looked at, investigations had been carried out and mitigating actions taken. Staff were informed of learning when a complaint had been made. Staff told us lessons learned were shared at team, sisters and matrons meetings. Discussions then took place to ensure the lessons learned were embedded into practice. The matrons fed into the Community Best Practice Group who met with the divisional lead monthly to discuss audit results and outcomes of complaints investigations.
- Several matrons in the community hospitals discussed how they would manage concerns or complaints on the ward. We were told that many complaints were handled locally and only formal investigations were done when they were reported through patient advice and liaison service. We were given examples where complaints had been made and records made in individual patient care plans but were not recorded for wider learning. One example included a patient who made an informal complaint about not being escorted to the car upon discharge. This had become standard practice for staff. When asked, matrons could not identify themes of complaints or concerns nor could provide any evidence of learning or information sharing from the locally resolved complaints.
- We saw that complaints leaflets were available. However, they were not always easily accessible to patients. They had information on raising a compliment, raising a concern, or raising a formal complaint and were available in multiple formats. We also saw leaflets for external organisations to raise concerns too. Most patients we spoke with said that they would not know how to make a complaint if they felt they needed to but would discuss directly with staff.
- Staff said they often had a good relationship with the patient and family and if they thought they were concerned about something they would approach them and ask if everything was alright. They found that this gave the person time to voice their concerns and staff said they could then act to improve or investigate the situation.
- We saw multiple examples of thank you cards from patients which were displayed on the wards. Comments were overwhelmingly positive from these in all of the community hospitals and themes included staff being very caring and attentive to patient's needs.

Requires improvement

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

We judged the inpatients service to require improvement in its leadership.

We found that the governance systems and practices were not providing effective governance, risk management and quality measurement and did not allow effective communication between different community hospitals or to different levels in the organisation despite having cross cutting meetings in place. Risk management was reactive when an incident occurred rather than proactive in mitigating potential risk. Understanding of governance varied between the community hospital matrons. One matron discussed having items on the risk register to keep external contractors available to quickly fix infrastructural issues and another said that risks were managed locally without recording them.

The leadership and culture of the service varied greatly between the community hospitals. Innovation wasn't shared effectively and there was little understanding from the divisional leads of issues, risks and concerns in the community hospitals. Matrons felt well supported with any issues that arose by senior staff and staff in the community hospitals felt well supported by their matrons and ward sisters.

Senior staff we spoke with felt well supported by divisional management with the operational management of the hospitals and staff in the community hospitals felt well supported by their matrons and ward sisters.

Service vision and strategy

- We were told that the strategy for the community hospitals was on hold awaiting a community service review by the local clinical commissioning group which could lead to opportunities for the community hospital buildings to be used in a more diverse way.
- Staff did not talk about a trust vision or strategy. They knew the trust was undergoing changes and were aware of short term plans for their particular hospital but had no sense of vision for the trust as a whole.
- Staff were aware of the trust values and they were displayed around the hospitals.

Governance, risk management and quality measurement

- There was not an effective arrangements for identifying, recording and managing risks, issues and mitigating actions.
- There were four items relating to community hospitals on the trusts risk register. They included concerns about pressure ulcers, patient falls, medical cover in community hospitals, and high vacancies and sickness.
- The highest risk of these was vacancies and sickness in the community hospitals with a risk score of 15. Actions to mitigate risk were introduced and updates were made to the risk register regularly. Examples of these actions included reducing the number of beds in the community hospitals to match the staffing establishment. The trust was in regular communication with the clinical commissioning group to monitor these bed closures.
- We were told by senior managers that falls appeared on all local risk registers. We found falls was not on the Deane Barton Community Hospital risk register. We were also told by senior managers that there will be falls risk assessments in place in all community hospitals. At Dene Barton Community Hospital there were no risk assessments in place. When asked about this we were told that there were no risks at Dene Barton Community Hospital and that risk assessments had not been completed for several years. If there were any risks these were managed locally without recording on risk assessments or in the risk register.
- We were shown the risk register at West Mendip Community Hospital. We were shown risks on there around the building and its infrastructure. The matron told us that these risks were on there to allow flexibility with the private finance initiative responsible for the building and getting issues fixed when they occur rather

than being based on risk. Staffing was the highest item on the risk register at a risk of 15. However, we were told that this was copied from the corporate risk register so was not accurate for the hospital itself.

- Risk registers were completed and updated at Williton Community Hospital. The Matron discussed the risk register at a monthly liaison group meeting she chaired. This meeting included heads of departments at Minehead Community Hospital nearby to Williton Community Hospital. Items included on the agenda included reviewing the risk register, audit feedback and departmental updates. Included in the distribution list for the minutes of these meetings were the GP surgeries supporting the wards and senior nurse for clinical practice. The distribution of the minutes did not include all the Community Hospitals in Somerset or more senior staff above the Matron in the trust for awareness, and for shared learning to be possible.
- The quality of risk assessments varied between community hospitals. At Dene Barton Community Hospital we asked to see the risk register and were originally presented with a risk register that this was last updated in June 2014. The matron spent time looking for the most up to date version and eventually contacted the trust who emailed the most up to date version.
- We were presented with a risk assessment for a single registered general nurse working at Chard Community Hospital overnight. The mitigating actions were appropriate however did not indicate timeline for completion. Also it was noted that the residual risk after mitigating actions was higher than the original risk.
- Local audits took place at Burnham on Sea and Bridgwater Community Hospitals, for example a capacity and consent form audit which we were not informed about at other hospitals. Although sisters had meetings together and matrons had meetings together none of the good practice and learning arising from audits or complaint investigations seemed to be shared and adopted across the trust. Therefore each hospital was achieving good standards of patient care with some excelling in areas where others weren't.
- Each hospital had a monthly 'dashboard'. This included details of compliance in mandatory training and sickness rates for example. We were told there was a trust wide audit of every new patient's electronic records. This indicated where assessments had not been completed and was shown on the dashboard. For example if nutritional assessments had not been carried out and for how many people. This was discussed with matrons monthly at the community best practice group and solutions about future compliance discussed.

Leadership of this service

- We observed that there was a disconnect between the divisional managers and the community hospitals resulting in a poor understanding of risk and transference of information. For example the divisional lead was unsure how many matrons she was responsible for and could not accurately describe common themes on risk registers. We had risks at particular hospitals described to us by divisional managers however they did not appear on local risk registers meaning that risks may not be properly assessed and managed.
- We were told by the divisional team that all community hospitals were given equal opportunities for funding and development but recognised that hospitals were at different stages in this development. We were told by managers that Chard Community Hospital was currently being looked at by the trusts capital group. Staff in the community hospital said that they had received no information from the capital group for the last two years.
- The matrons were highly supported by their divisional leads for the day to day operations of a community hospital and held daily conference calls to discuss challenges for the upcoming day around staffing and discharge
- All of the matrons said that their door was always open to staff who wished to speak with them and felt that any concerns were raised with them. Staff said that they felt well supported by their manager to raise concerns or to discuss ideas which could be taken to best practice development groups.
- We found local leadership to be good. Staff we spoke to said they felt supported and informed by their ward sisters and matrons. Staff felt the local managers were

visible and approachable. During tours of the hospitals we saw that ward sisters and matrons knew staff and patients by name so it was clear they were often on the wards.

- Staff were all very proud of the hospitals they worked in and their local achievements. They did not talk as if they felt connected with the other community hospitals run by the trust apart from the ones geographically closest to them.
- Staff said the chief executive and members of his team had visited their hospital and understood their concerns about the shape of community services in the future.
- Staff told us they felt able to contact the divisional lead to discuss any issues or concerns. It was not clear if they made regular visits to the community hospitals.
- One GP thought the teamwork between the medical staff and ward staff, at the hospital he worked at, was very good and staff were experienced and supportive. The GP added that the trust leadership did not involve the medical staff in any proposed developments.

Culture within this service

- The trust provided sickness rates as at 31 March 2015 for the preceding 12 months. The overall sickness rate reported for this time period was 5% for 3,827 substantive members of staff. For the community hospitals the average sickness rate was 6% which was marginally higher than the trust average.
- Most of the community hospitals had photo boards of staff members to allow patients and visitors to know who was working at the hospital, what their jobs were and who was in charge at the time.
- Staff we spoke with who worked in the newer buildings such as Bridgwater Community Hospital and South Petherton Community Hospital were extremely proud to work in such environments.
- Staff told us at West Mendip Community Hospital said that the 'See Something, Say Something' campaign had brought the team together and has got them discussing where practice could be improved. This was a campaign to raise awareness of speaking up when you see poor practice. All staff we spoke with, regardless of the seniority, knew about the Duty of Candour regulation and that it meant being open, honest and making an apology when necessary. Staff felt they were supported and therefore had an open culture which many said led to them reporting concerns about incidents or near misses.
- During staff handover at West Mendip Community Hospital time was spent reflecting on what went well and what did not go well to debrief and maintain the wellbeing of staff.
- One member of staff at South Petherton Community Hospital stated that all staff from all levels were supportive of each other when things went wrong such as sickness.
- Staff told us the trust were interested in their wellbeing and offered access to physiotherapist and counselling services if necessary.
- Matrons told us that poor performance was managed by one to one support, appraisal and extra training if required. If that was not successful then there was a disciplinary route to follow.

Public engagement

- Peoples views and experiences were gathered and acted upon to improve the services the community hospitals offered.
- Each site we visited had a number of local volunteers who helped with fund raising, support of patients and in some cases activities with patients.
- At Wincanton Community Hospital patients and the local community were asked how they would like their day room to be designed.
- Frome Community Hospital held an open day for local community to show what services they were able to offer. The matron said it was very well attended and they had positive feedback about the day.
- Some of the hospitals we visited there was a very active league of friends who raised money for equipment for their specific hospital. We saw money raised had been used for a new patio area with sturdy furniture and a safe flooring, pressure relieving equipment and items for the reminiscence area in day rooms.

Requires improvement

Are services well-led?

- At Shepton Mallet Community Hospital the local community were engaged in discussion about the proposed 'health campus' that would house a new community hospital GP surgery and care centre.

Staff engagement

- The trust executives rotate their board meetings around the community hospitals to improve visibility and engagement with staff. The matron of West Mendip Community Hospital commented that it did not seem as if senior management were "living in an ivory tower" and that they were visible. We were told that the board rotated their meetings between the community hospitals and spent time talking with staff and patients.

Innovation, improvement and sustainability

- We found staff at local level were continually striving to improve the quality of their care. For example the introduction of four hour observations for all patients at West Mendip Community Hospital. They had local team meetings to discuss new ideas and innovations as well as the best ways to introduce new best practice advice. This was discussed at matrons meetings where ideas where shared and encouraged by the management.
- At Burnham on Sea War Memorial Hospital staff had worked hard to achieve a catheter free inpatient service. They had been recognised for this innovative work by the Community Hospital Association.
- At West Mendip Community Hospital we saw information displayed on a clinical trial on pressure mattresses. This research was being done in partnership with Leeds University. This research had led to better quality mattresses for patients and a better understanding of what is considered best practice for the management of pressure ulcers.

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 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements in this part. Without limiting paragraph 1, such systems or processes muse enable the registered person, in particular to – assess, monitor and mitigate the risks relating to health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Understanding of governance at a senior and local level limited how risks were managed at the community hospitals. Risks were not assessed and continually monitored appropriately increasing the risk of harm to patients. The threshold of incident reporting was high, particularly around medication errors, resulting in a poor oversight of risks and scale of risk associated with this.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises All premises and equipment used by the service provider must be suitable for the purpose for which they are being used. At Chard Community Hospital a fire exit was blocked limiting escape routes in the event of a fire. Equipment was provided to get patients down the stairs. However, no staff at the community hospital was trained to use it increasing the risk of harm to patients during an evacuation.