Leicestershire Partnership NHS Trust

RT5

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)
RT5YD	Coalville Community Hospital	Community Health Inpatient Services	LE67 4DE
RT5KT	Evington Centre	Community Health Inpatient Services	LE5 4QF
RT5YE	Feilding Palmer Community Hospital	Community Health Inpatient Services	LE17 4DZ
RT5YF	Hinckley and Bosworth Community Hospital	Community Health Inpatient Services	LE10 3DA
RT596	Melton Mowbray Hospital	Community Health Inpatient Services	LE13 1SJ
RT5YJ	Rutland Memorial Hospital	Community Health Inpatient Services	LE13 6NT
RT5YL	St Luke's Community Hospital	Community Health Inpatient Services	LE16 7BN
RT5YG	Loughborough Hospital	Community Health Inpatient Services	LE11 5JY

This report describes our judgement of the quality of care provided within this core service by Leicestershire Partnership 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 Leicestershire Partnership Trust and these are brought together to inform our overall judgement of Leicestershire Partnership Trust.

Summary of findings

Ratings

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

Summary of findings

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Overall summary

We rated community health inpatient services as requires improvement because:

- Despite considerable effort with recruiting new members of staff, staffing was the top concern for all senior nurses and there was still a significant reliance on agency staff to fill shifts which could not be covered internally. Senior nurses mitigated risk where they could which included switching an agency staff member with a trust member of staff if two agency staff worked together. However, we saw evidence this was not always achieved.
- Staff were open about their poor understanding around the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Our observations during inspection confirmed that staff knowledge and practical application of their knowledge was inconsistent despite training on their electronic learning systems.
- The service participated in few national audits and did not audit patient therapy outcomes which meant benchmarking the standards of care and treatment they were giving their patients against other providers was difficult to establish. The service did however, complete local audits and produced action plans for improvement in care.
- All hospitals were running at a high bed occupancy level of above 85% which national data has linked to increased risk of bed shortages as well as an increase in healthcare associated infections.
- The service had 175 delayed discharges between August 2015 and July 2016, which accounted for 43% of the trusts total delayed discharges. The most common reason for delayed discharges was due to family choices which were beyond the control of the trust. However, delay in paperwork completion was also responsible for a large proportion of delayed discharges.
- Staff were unaware of any service specific strategic direction. This had previously been identified on the CQC inspection in March 2015.
- Concerns about high bed occupancy, record keeping and delayed discharges were identified in the March 2015 inspection and had not been sufficiently addressed.

However:

- The electronic prescribing system which the trust had implemented supported the safe administration of medicines to patients, with staff reporting very few medication errors as a result of this.
- The feedback from patients and relatives was mainly positive about the staff providing care for them. Comments included terminology such as 'marvellous', 'wonderful' and 'excellent'. All patients told us staff respected their privacy and dignity.
- The introduction of activities co-ordinators at Coalville Hospital had improved the patient's experience on the ward and increased the activities that were conducted on a day to day basis.
- Staff told us they enjoyed working at the trust and thought they all worked well as a team. We saw evidence of good team working during our inspection.

Summary of findings

Background to the service

Leicestershire Partnership Trust (LPT) provides community inpatient services for the population of Leicester City, Leicestershire and Rutland, which is estimated at over a million people. The geographical area covered is mainly urban although some hospitals are surrounded by rural areas. There are high levels of deprivation in the geographical area although there are pockets of relative affluence. The majority of patients are admitted from one of the eight surrounding acute hospitals with a smaller number of patients admitted straight from their own homes via their GPs.

There are a total of 231 declared inpatient beds for patients in 12 wards spread across eight community hospital locations. Inpatient services are provided at Snibston and Ellistown Wards at Coalville Hospital, Beechwood and Clarendon Wards at the Evington Centre, General Ward at Feilding Palmer Hospital, East and North Wards at Hinckley and Bosworth Hospital, Dagleish Ward at Melton Mowbray Hospital, Rutland Ward at Rutland Memorial Hospital, Wards One and Three at St Luke's Hospital and Swithland Ward at Loughborough Hospital. Services provided to patients admitted into these hospitals include stroke specialist care, rehabilitation, intermediate care and end of life care.

During our announced inspection we visited all eight locations and all wards at these locations apart from Beechwood Ward at Evington Centre due to a temporary closure of this ward. During our unannounced visit on 26 November 2016 we visited Ward Three at St Luke's Hospital.

The wards are all nurse led with input from rehabilitation specialists including physiotherapists, occupational therapists (OTs) and rehabilitation assistants. Medical input is either reliant on the advanced nurse practitioners (ANPs) or visiting consultant specialists between 9am and 5pm. Out of hours medical cover is provided by the local out of hours service, which all wards had access to.

The trust was last inspected in March 2015 and community inpatients services received a rating of requires improvement. Concerns were identified about the following:

Staffing, bed occupancy, record keeping, data quality, delayed discharges and privacy and dignity.

We checked these areas on this inspection to see if improvements had been made and have included later in the report.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarret

Team Leader: Julie Meikle, Head of Hospital Inspection (Mental Health) CQC

Inspection Managers: Sarah Duncanson, (Mental Health) and Helen Vine (Community Health Services).

The team included CQC inspectors and a variety of specialists: Physiotherapist, Occupational Therapist, Dietitian, Advanced Nurse Practitioner and Experts by Experience (people who had used a service or the carer of someone using a service).

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 7 November 2016. During the visit we held focus groups with a range of staff who worked in the service, such as nurses, health visitors and therapists. We talked with people who use services. We observed how people were being cared for using the Short Observation Inspection Framework (SOFI) and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 26 November 2016.

During the inspection we spoke with 73 staff members, 60 patients and 21 relatives. We also reviewed 33 complete sets of records, 20 additional medication administration records (MARs), an additional 11 nutritional screening tool (NST) records. We also attended multidisciplinary team meetings and ward rounds, patient handovers and focus groups.

What people who use the provider say

People who used the service said:

- Patients told us they felt safe and well cared for. Despite staff appearing busy, patients told us they felt staff made them feel safe in the environment and were kind and caring in their approach of them. All patients felt their dignity was maintained throughout their admission, and staff of all professions showed them respect at all times.
- Patients told us they thought the wards were clean and tidy and noted staff were always around cleaning.
- Most patients were complimentary about the provision of food and drink, with one comment expressing the excellent standard of food service. However, there were comments made from one hospital where the food was not of a standard expected and the amounts of food given to patients were not of an acceptable amount in their opinion.
- Most patients felt involved in their care and treatment, and felt suitably updated during their admission. This also extended to the relatives of most patients who felt they too were updated regularly about progression of their loved ones treatment. There was feedback from some patients though which did not support this and they felt they were always trying to seek staff out for updates on their care and treatment, or that of their relative.
- Patients would often use commendable words to describe the staff and the care they provided, however if they had concerns or complaints, they felt comfortable with expressing them.

Summary of findings

Good practice

- Coalville hospital had introduced activity co-ordinators to the inpatient wards (known as the pink ladies). This improved the patient's experience whilst admitted and increased the activities that were conducted on a day to day basis.
- Rutland Ward had gone the extra mile to locate a husband and wife together on the ward whilst both required the inpatient services. Staff on this ward also facilitated a group of patients to have a socialised lunch with prescribed alcoholic beverages.
- The electronic prescribing system which was introduced in all community hospitals supported the safe administration of medicines as there were additional features which alerted users to actions required.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must ensure staff understand the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards in relation to their roles and responsibilities.

Action the provider COULD take to improve

- The trust should ensure patient outcomes for community health inpatients are monitored and reviewed to ensure services are meeting the needs of the patient.
- The trust should continue to identify relevant national audits which can be completed to benchmark the quality of care provided. The trust should consider ways of sharing audit and outcome results with staff to inform improvement.
- The trust should review the provision of therapy on a weekend to maximise a patient's rehabilitation programme.
- The trust should provide source isolation for all patients with a known infection or provide clear risk assessments for those who cannot be isolated.
- The trust should audit sepsis management to establish performance against national standards and identify areas where further work is required.
- The trust should patient records are securely stored away from public access.
- The trust should review the procedure for transporting specimens to the local acute hospital for testing.
- The trust should ensure all patients who require assistance with nutrition and hydration needs are suitably identified.
- The trust should ensure the safe management of medicines in relation to storage and disposal.

Leicestershire Partnership NHS Trust

Community health inpatient services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- Staffing remained the main concern for all senior nurse managers. There were vacancies throughout the service and there was reliance on bank and agency staff to regularly fill shifts. Staff were usually able to mitigate the risks and were actively involved in recruitment, but concerns were still identified.
- There were concerns around the storage of medicines, with missing opened or expiry dates and inconsistent refrigerator temperature monitoring across all hospitals. Patients' own controlled drugs were not always managed and destroyed in a timely manner.
- We found some resuscitation equipment was out of date and on Ward One at St Luke's Hospital the resuscitation trolley was stored behind a locked door and therefore was not easily accessible in the event of an emergency.
- Patients requiring source isolation for known infectious conditions was inconsistent as patients were not always isolated and risk assessments for not isolating patients were not always documented.
- Not all wards had secure entrances and exits which meant vulnerable patients could leave the wards or unauthorised personnel could gain access to the ward.

However:

- There was a positive incident reporting culture amongst the staff and staff were able to give examples of where they had received feedback and lessons learnt from incidents.
- Community inpatient wards we visited were visibly clean. There were adequate handwashing facilities and staff washed their hands between patient contacts. There was good equipment provision throughout the community inpatient services which enabled staff to complete their jobs safely. Staff cleaned and stored reusable equipment appropriately after use.

Requires improvement

Are services safe?

- The electronic observations system had improved staff awareness and ability to identify a deteriorating patient.
- Compliance with safeguarding training was high and staff understood their responsibilities to keep vulnerable adults safe.
- There were high compliance rates for staff mandatory training in community inpatient services.

Safety performance

- The community inpatients services participated in the NHS safety thermometer programme which is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. Data is collected on a specific day each month to indicate performance in four key safety areas which are new pressure ulcers, catheter associated urinary tract infections, venous thromboembolism and falls.
- Safety thermometer data between August 2015 and July 2016 showed the most harms recorded were for pressure ulcers although this did not differentiate between new pressure ulcers and pressure ulcers patients had acquired before admittance to this trust. The wards which showed the highest percentage of harm due to pressure damage were Wards One and Three at St Luke's Hospital, Swithland Ward at Loughborough, Ellistown at Coalville and East Ward at Hinckley and Bosworth. Although pressure damage caused the most incidence of harm for patients at the trust, they were performing better than the national average.
- All the wards we visited displayed safety crosses which highlighted if there was a new harm due to pressure ulcers. They used a red, amber and green rating to highlight when harm had occurred. Red represented a trust harm, amber represented a harm which had transferred into the trust and green represented no harms.
- There was no consistency in the number of safety crosses displayed which showed days of patient harm/ no patient harm. Some wards displayed just an ongoing cross for the month which staff updated daily, some wards displayed the previous month as well. On East Ward, there were safety crosses displayed as far back as August 2016.
- Senior nurses were required to complete quality performance review for each quarter. Included in these reviews was information around falls, staffing, pressure ulcers and training figures. We saw these reports displayed in public areas in some ward. However, this was not consistent across the service.

Incident reporting, learning and improvement

- There were 679 incidents reported by the inpatient services between October 2015 and September 2016. Of these, the majority of these (438 incidents) were categorised as no harm.
- When asked, staff told us patient falls were the most common reason why they raised incident forms. The data provided by the trust supported this with 102 of the incidents raised as a result of a patient slip, trip or fall. There had been investigation into falls by the lead nurse, the only theme identified amongst the more serious incidents was that all of the patients were at the end of their required stay in hospital and were ready for discharge. There was no formal action plan completed to address this issue, however the lead nurse for falls provided details of wider falls work which they were completing.
- There were six serious incidents (SI) reported between October 2015 and September 2016. Serious incidents are events in health care where there is potential for learning or the consequences are so significant that they warrant using additional resources to mount a comprehensive response. We reviewed one SI report for an outbreak of Clostridium difficile and found the investigation into the incident followed the National Patient Safety Agency root cause analysis investigation process.
- There were no never events reported for this service between October 2015 and September 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Staff at all locations used the trust wide electronic reporting system to report incidents. All staff we spoke with knew of the incident reporting system and felt

encouraged to report any incidents or near misses. All staff told us that if they submitted an incident report, they received feedback about the outcome of the incidents.

- Agency staff did not have access to the electronic incident reporting system. To support incident reporting from these members of staff, paper versions of the report were provided for them to fill in if they experienced a situation which required reporting. These would then be transferred onto the electronic system by ward staff.
- All staff told us incidents and any associated learning from them were discussed at ward meetings. We saw minutes from these meetings during our inspection which supported this. Therapy staff also held meetings where incidents and learning were discussed. From these meetings, they were encouraged to complete reflective practices on what this learning meant for them and how they would embed any changes in practice required.
- The lead advanced nurse practitioner (ANP) consultant nurse had implemented mortality and morbidity meetings to review any incidents and develop learning from them. ANP staff told us these were open to all members of staff. However, senior nurses were not aware these meetings existed.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify and apologise to patients (or other relevant persons) if there have been mistakes in their care that have led to moderate or significant harm. All staff told us the trust had a very open and honest culture and they were aware of their responsibilities to be open and honest with patients about incidents.
- Staff of all bands told us they had not received any formal training for duty of candour.
- A trust wide audit of all serious incidents was conducted in June 2016. This showed staff had completed the duty of candour notification (patients and relatives contacted and supported) and there was evidence of this recorded in the investigation. Recommendations were made as a result of the action plan and further spot checks planned for the future.
- We reviewed four serious incident reports and found no follow up apology letter had been sent out to the patient or their families. Two of the reports had annotated on them, the patient or family did not wish to receive a formal letter of apology.

Safeguarding

- All staff attended safeguarding adults training and safeguarding children level two training. This was conducted on either the electronic learning system or face-to-face training.
- All staff we spoke with had a good understanding of what constituted abuse and the actions they would need to take if they suspected a patient required safeguarding. Some staff were able to give examples of where they had contacted the safeguarding team due to suspicions of abuse (mainly financial abuse).
- All wards had a safeguarding folder which contained information on what staff should do if they were concerned about a patient. Staff told us they were aware of who they needed to contact if they had concerns about patients.
- Safeguarding vulnerable adults training compliance for the inpatient service was recorded as 94% in September 2016. Safeguarding children level two training compliance for the inpatient services was as 94% in September 2016.
- We saw information leaflets and posters in ward areas which highlighted the importance of safeguarding and contained details of external agencies for patients, relatives or staff to contact if they had concerns.
- The trust safeguarding team had recently started to include details about referrals made by the trust, before this; there was no process in place to account for the number of referrals made to the local authority. The most recent report from September 2016 recorded 29 safeguarding referrals from the trust in September 2016.

Medicines

- Pharmacy provision was provided the trusts pharmacy. Most hospitals had at least once weekly visits from

pharmacy staff to maintain ward stock levels and provide additional support through telecommunications when required. Pharmacy staff were able to access electronic prescription charts remotely to advise staff if required.

- Room temperature monitoring was not consistently recorded on all wards within the service. The clean utility room on Rutland Ward where medicines were stored did not have temperature monitoring and staff reported it was always hot in there. However, in Loughborough, the room where they kept their medicines was cold with no monitoring. This could impact on the efficacy of the medicines if the temperature reached above or below the recommended storage temperature.
- Refrigerator temperature range checks were not always performed daily. Staff were only taking daily point temperatures (temperature reading at that time) and not taking maximum and minimum readings. During our unannounced inspection, we reviewed the refrigerator temperature recordings for Ward Three, St Luke's Hospital which was reported as an area only completing point temperatures and this had not been rectified.
- There was no policy in place to assess patients to self-administer their medications whilst admitted. The only medications patients would be allowed to administer with supervision of staff were insulin, eye drops and inhalers. This is important because patients should be encouraged to be as independent as possible and where appropriate manage their own medications on rehabilitation wards.
- There was a competency training package in place for registered staff who administered medicines. New staff members were also supervised on medication rounds before undertaking them alone. Staff however, were unsure how often they should complete the training. Some staff believed it was annual, some believed it was every two years and there were some who thought it was every three years.
- Dossett boxes, a type of medication organising tool, were available for patients on discharge if this was identified as a requirement in their discharge planning.
- Controlled Drug (CD) registers were not always easy to use as staff did not use the index at the front of the register, which also increased the risk of errors occurring. Random checks of CD medicines found most were in date and staff were documenting errors of entries in the book in accordance with local trust policy.
- We found out of date CDs however, at Coalville Hospital as well as excessive amounts of a patient's own CDs for a patient who had been discharged two months previous. Staff told us they had requested the pharmacy service to visit the ward to destroy the items. We also found CD medications for patients who had been discharged at St Luke's Hospital.
- Intravenous fluids (fluids given through the vein) were stored in a cupboard in Coalville which was accessible only to staff, however, the fluids were mixed and we found fluids containing potassium mixed amongst other fluids. This increased the risk of errors occurring with staff picking up the wrong bag of fluids and administering them to the patient. In one store room at St Luke's hospital, intravenous fluids were also stored amongst fluids used to wash out a patient's bladder. This was highlighted to the ward manager at the time of inspection.
- In five hospitals we found medicines which were short dated (had a shelf life once opened) were not always dated as to when they were opened or annotated with an expiry date.
- The staff used an electronic prescribing system for medications. We reviewed 20 medication administration charts (MAR) and found medications were prescribed correctly, staff had entered reasons for omissions when required for most patients, antibiotics had an indication and all patients had allergies or 'no known allergies' documented on their electronic charts. However, we found one patient on Ward Three, St Luke's Hospital who had not had their pain medication administered during our visit but were found to be in pain. The medication was due at 9am and this had still not been given at 1.30pm with no omission reasons entered.
- We saw evidence of the electronic prescribing system supporting safe administration of medicines by alerting staff when a weekly medication was due for administration. Staff also told us the prescribing system would not allow them to administer a medication if the correct time between doses had not been reached.

Requires improvement

Are services safe?

- Medicines were administered by registered staff only. During scheduled medication rounds, the nurse conducting the round wore a 'do not disturb' tabard. These tabards were introduced to reduce interruptions which were related to an increased risk of medication errors. We observed one medication round and this was respected.
- Oxygen cylinders were not always stored correctly. We saw two wards storing oxygen cylinders free standing and this was escalated to the ward sister at the time of inspection. On our unannounced inspection, we saw staff had rectified this in one of the wards we had identified as not storing them correctly.

Environment and equipment

- Across community inpatient services, the environments ranged from older/listed buildings to more modern environments which considered the relevant building guidance. In some wards, there was evidence of ongoing improvements made to the environment and staff told us about plans to modify older hospitals.
- The layout of the wards at Melton Hospital, Coalville Hospital and St Luke's Hospital did not provide staff with visibility to all areas where patients were located. Staff told us they risk assessed the patients and placed only low risk patients into the areas, however, during our announced inspection, Dagleish Ward had an incident occur where a patient deemed low risk fell in one of these rooms.
- Staff told us they had to place tables and chairs in the corridors in Ward Three, St Luke's Hospital at night to mitigate the risk of poor visibility of patients in some areas of the wards. This however, would then partially block the narrow corridors of the ward.
- Melton Hospital was the newest hospital where inpatient services were provided. However, staff told us the ward had experienced several problems with the environment since it opened ten years ago. The ward had cordoned off an area outside a patient's room which contained a trip hazard due to raised flooring. Staff told us this had been reported for several months. However, they were awaiting works to start to rectify this problem and it was identified on the service risk register.
- Both of the bays in Ward Three, St Luke's Hospital had recently been changed from a five bedded bays, to a four bedded bays. It was identified as an infection control risk due to beds not being a recommended 3.6 meters apart and restricting staff from using the hand washing facilities in the bay. However, the curtains were still designed for five beds and therefore still restricted staff from conducting activities in the bed space of the patient.
- Not all wards had secure entrances and exits to them which meant patients who were vulnerable could leave the wards or unauthorised personnel could gain access to the wards. Some wards did have restricted access which required a pass to gain entrance and had a button system to leave the ward. However at Coalville Hospital (Snibston Ward), Loughborough Hospital, St Luke's Hospital, Feilding Palmer Hospital and Rutland Hospital, we gained access to the wards through doors which were open. Staff at Rutland Hospital informed us the entrance we used was secured after normal working hours and the entrance which was used out of hours was secure.
- Resuscitation equipment was standardised throughout the trust, including the mental health inpatient wards, and a check list which staff had to complete daily reflected this. However, the trolleys which contained resuscitation equipment were not standardised. Some trolleys reflected the traditional trolleys which most acute hospitals would use, other trolleys used were similar to those for phlebotomy and venepuncture purposes. All trolleys checked were not locked and therefore could be accessible to the public. The trust policy for resuscitation trolleys stated these were not sealed in any way on the inpatient wards. No explanation for this decision was included.
- In most wards, the resuscitation trolley was readily available for staff to collect in the event of an emergency, and during our inspection we saw staff collecting the equipment in an emergency situation. However, Ward One at St Luke's Hospital had their resuscitation trolley behind a locked door at the end of the ward. Staff on the ward were not aware of any issues regarding the location of this trolley and did not think it was a hindrance when requiring this equipment in an emergency situation. Since the inspection, the trust

have provided information informing us the location of the resuscitation equipment on Ward One has been relocated to a more accessible place within the ward area.

- We found one out of date cannula and a giving set out of its packaging on the resuscitation trolley on Ellistown Ward, Coalville Hospital as well as a further four cannulas and a box of glucose blood vials on the venepuncture and cannulation trolley. We also found one out of date oxygen mask on the resuscitation trolley on East Ward, Hinckley and Bosworth Hospital. This was raised with the nurse in charge at both hospitals at the time and replacements were found. During the unannounced inspection of Ward Three, St Luke's Hospital, we found seven blood bottles used for specific blood samples when preparing a patient for a blood transfusion were out of date. These were given to a registered nurse on duty to dispose of.
- Some of the hospitals had their own blood refrigerators to keep units of blood for patients requiring transfusion. These were serviced and maintained by the blood transfusion services at the local acute hospital. However, we found one refrigerator which no longer worked and two other refrigerators which had not been serviced since 2015. This was highlighted to ward staff at the time of the inspection.
- All wards had access to pressure/sensor equipment which was used to detect movement in patients who were at high risk of falls. Nursing staff on the wards told us that they had adequate amounts to meet patient needs.
- We found some wards had limited storage for equipment and had to result to storing this in the corridors. These items were stored where patients were mobilising and could become a trip hazard. On the ward at Feilding Palmer Hospital, there was just enough room for patients to pass by with walking aids.
- All electrical equipment we inspected had been checked annually as per safety recommendations.
- Staff told us they had access to the right equipment they needed to do their jobs. If they did require anything which was not held at the trust, there were contracts in place to get additional equipment delivered in a timely manner. We saw evidence of this on Dagleish Ward who had ordered bariatric equipment for an expected patient. Bariatric is the medical term used for patients who are clinically obese.
- We observed clinical and domestic waste was correctly segregated and waste bins provided for the wards were compliant with health technical memorandum (HTM) 83 as they were fire retardant as well as being enclosed and foot operated which are requirements under the larger waste management guidance document HTM 07-01 safe management of healthcare waste. The management and disposal of sharps was completed in accordance with trust policy.

Quality of records

- We saw evidence of individualised care plans for each patient, based on the outcomes of risk assessments.
- Daily progression notes were written by all members of the multidisciplinary team involved in the patients care, in the medical notes. These were written in accordance with professional bodies best practice guidance for documentation.
- Patient records were kept in trolleys, which were not locked. Trolleys were mainly located next to the nurses' station and therefore had regular monitoring of the trolleys to make sure there was no unauthorised access to records, however, we did find trolleys which were not always observed and could be accessible to the public.
- During our inspection, some staff commented on the poor quality of the documentation by the attending practitioner from the out of hour's service which provided medical cover. Their concerns mainly centred around the admission documentation. When staff experienced this, an incident report was completed and shared with the provider of the out of hour's service. As a result of previous incidents, unless admitted over the weekend or Friday night, admission documentation was kept for the ANPs to complete.
- The quality of records was audited annually. The most recent results of this audit were produced in May 2016; these showed the service were compliant with four of the 10 criteria (chronological order, legibility of the records, relevant clinical information and evidence of patient or carer involvement) however, they were non-compliant with two of the 10 criteria (identification data

and discharge information) they were deemed partially compliant with the remaining four criteria. The results overall highlighted the service had performed worse than the previous audit in all but one area which was involving the patient or carer. Actions were identified as part of this audit which included spot checks on documentation standards each week. The next full audit was due in June 2017.

Cleanliness, infection control and hygiene

- All wards we visited were visibly clean. Patient-led assessment of the care environment (PLACE) data from 2016 indicated a national average score of 98%. Four services, Feilding Palmer, Melton Mowbray and Coalville hospitals and the Evington Centre scored higher than 98%. PLACE assessments are self-assessments undertaken by NHS and private providers and include members of the public (known as patient assessors) to focus on different aspects of the environment.
- There was adequate hand washing facilities in all clinical areas and we observed staff washing their hands or using hand cleansing gel between patients and when leaving or entering different areas.
- Information provided by the trust showed hand hygiene audit results for October 2016 ranged from 87% to 100%. Areas of non-compliance identified were around hand washing technique, length of nails and not adhering to the bare below elbow policy. This policy insists that all clinical staff should wear no items which can prevent the staff member from carrying out correct hand hygiene procedures.
- Ward teams conducted regular top 10 marker audits for all inpatient areas. Markers included in this audit were hand sanitiser being available at point of care, personal protective equipment being available to staff, cleaning schedules were completed; sharps disposed of at point of care and correct cleaning equipment available for staff. Results from October 2016 showed eight wards had achieved compliance with this audit, two wards had achieved partial compliance and two wards were deemed non-compliant with the standards being audited. For areas where partial compliance or non-compliance was observed, actions to address this were identified.
- The cleaning of inpatient areas was completed by shared services arrangement. Their cleaning schedules and audit compliance was set in line with the National Specifications for Cleanliness in the NHS. Cleaning audit data provided by trust the showed six wards failed to meet the 95% compliance target for high risk areas in the inpatient ward areas in October 2016. No details accompanied the audits to identify what areas the wards had failed to achieve compliance with.
- We observed members of the estate staff conducting routine water testing of wards during our inspection. Staff from the wards were responsible for the daily flushing of their water systems to prevent water borne microorganisms such as legionella.
- Equipment which had been decontaminated after use had 'I am clean' stickers on them.
- Some of the ward areas were using needles and cannulas which did not have a safety device on them which were introduced when the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 came into force. Staff told us they were using up old stock and replacing with the new versions which did have safety devices.
- From April to November 2016 there were five cases of Clostridium difficile (C. difficile) reported for the community inpatient services. C. difficile is a bacterium that can infect a person's bowels. It is also commonly associated with people who have had courses of antibiotics but can also be easily transmitted to other people. The trust trajectory (expected number of cases) for 2016/17 was seven cases of C. difficile.
- From April to November 2016 there were zero cases of MRSA bacteraemia. MRSA is a bacterium that is resistant to a number of widely used antibiotics. The trust trajectory for 2016/17 was zero.
- The lead infection prevention and control nurse told us they completed thorough investigations of all C. difficile infections. Previous theme analysis identified timely source isolation, re-sampling patients unnecessarily and antimicrobial prescribing. Investigation into outbreaks this year had not shown repetition of these themes.
- We saw two confirmed infectious patients being nursed in a bay on two different wards. Staff told us in both cases, this was because they were a high falls risk and therefore could not be isolated in a single room. Staff did not elaborate whether they could not bring in

additional staff to provide supervision for these patients if they had isolated them or if this was because this was standard procedure for high falls risk patients with known infection control issues. They were taking measures to prevent transmission through strict infection control practices (hand hygiene and the use of personal protective equipment) and had informed the infection prevention and control team (IPC).

- We observed open side room doors on Clarendon Ward where patients were receiving care for isolation purposes. This would not normally be expected due to the risk of potential transmission (spread). We were not assured this practice was risk assessed.
- During our announced inspection, Beechwood Ward at Evington Centre had closed temporarily due to an outbreak. The ward staff had worked swiftly with the IPC team to contain the outbreak and prevent further transmission to other patients and visitors.
- Blood samples which were sent from the wards to the pathology services at the local acute hospitals were sent in a screw top plastic container which was not an approved container for biological substances and could place the person delivering the samples at risk of exposure if the samples were to leak out of the container.

Mandatory training

- Staff completed mandatory training on an electronic system and through attendance at face to face sessions. This then recorded all sessions completed and could be accessed by their line managers.
- The overall compliance rate for mandatory training for the community inpatient services was 97%.
- Most staff told us they were able to attend mandatory training sessions. Staff at Rutland Hospital were allocated one hour each week to complete training as part of their working hours, however, staff from St Luke's Hospital and Feilding Palmer Hospital accessed their training online at home, which they would be paid for.

Assessing and responding to patient risk

- The service used an early warning scoring (EWS) system to identify a deteriorating patient. The EWS system was designed to enable staff to recognise and respond to acute illness, clinical deterioration and to seek appropriate medical assistance. There were boards that linked up to the electronic observations and this displayed all observations for patients and their EWS score as well as when observations were next due. During an unannounced inspection visit to St Luke's Hospital, we found five patients were overdue their observations and this was highlighted with a red symbol.
- Staff told us if they had a patient with a higher EWS, they would highlight this to the ANP or if it was out of hours, the out of hours practitioner. Staff were advised to complete a situation, background, assessment and recommendation (SBAR) assessment to provide more information on the patient's condition as this assisted the reviewing practitioner with identifying if further treatment was required. However, we found not all staff were using this process for communicating with other practitioners when a patient was deteriorating.
- Staff had received sepsis training and were confident in identifying a patient who was becoming septic. Sepsis is a life threatening condition that arises when the body's response to an infection injures its own tissues and organs. Information supplied by the trust showed there were no audits completed for compliance with sepsis.
- If a patient triggered (had a high score) on EWS, the electronic observations system would alert the user to think about the possibility of sepsis. This alert would also be sent to the nurse in charge and the advanced nurse practitioner (ANP). Staff told us it would be down to the ANP to conduct a formal sepsis assessment.
- Sepsis boxes were available on all wards containing assessment proforma, medications and fluids which are important when treating a patient for sepsis. The assessment proforma also doubled up as a checklist for completing the 'sepsis six' in patients identified as developing sepsis. Sepsis six is the name used for a bundle of time critical treatment options to reduce the chance of mortality for patients with sepsis.
- Blood transfusions were given to patients who required a transfusion. To ensure the safety of the patient, this was only conducted during the ANP's working hours. If a patient required an urgent transfusion outside of these times, they would be transferred to the local acute

hospital. Some hospitals have their own blood refrigerators to store units of blood in when required; other hospitals will have units of blood brought over from the acute hospitals as they were required.

- The service had introduced frequency of intervention (FIR) charts which recorded when staff had checked on the patient and provided care for them. This was similar to intentional rounding which is a structured approach whereby nurses checked on patients at set times to assess and manage their fundamental care needs. The FIR charts were colour coded for easy identification of how regular the checks should be completed. Yellow charts highlighted the patient required frequent checks due to risk of falls, pink highlighted patients were new admissions and required close observation for the first 72 hours and white charts were for all other patients.
- Wards grouped patients who were at high risk of falls in the bay nearest to the nurse's station. This made them visible to staff at all times. Patients also had equipment provided for them which reduced the risk of falling or reduced the impact if they fell. This included sensor cushions/alarms which sounded if patients moved; beds which would could be lowered to the floor and crash mats around the patient's bed space.
- Staff assessed each patient for their mobility requirements and entered details on boards behind the patient's bed. This enabled safe mobilisation and reduced the risk of patient falls.
- During our inspection, we observed staff responding to two emergency buzzers on two separate wards. Staff were quick in responding to the buzzers and took with them the emergency equipment.
- Each patient had a white board at the head of their bed. Signs were used to indicate, for example, whether a patient was at risk of falling, was diabetic or if there were any specific dietary requirements including the use of thickener for fluids. These boards were not consistently used throughout the wards. Some wards had full details about patient needs and risks; other wards only contained the patient's name and named nurse.

Staffing levels and caseload

- There was a total of 26 whole time equivalent (WTE) registered vacancies and 17 WTE unregistered vacancies as of August 2016 for the community inpatient services. The largest number of vacancies for registered staff was on Clarendon Ward at the Everington Centre and Ward Three at St Luke's Hospital. The largest numbers of unregistered vacancies were on Rutland Ward at the Rutland Memorial Hospital and St Luke's stroke ward (Ward One).
- In all the areas we visited staff told us there were concerns and constraints with staffing levels. All wards had been involved with recruitment drives to try to fill their staffing vacancies.
- All wards displayed their actual and planned staffing numbers at the entrance of the wards. All wards met the planned staffing during our inspection.
- There was an established use of an acuity tool across the inpatient services. An acuity tool is a tool which is used to assess the dependency of patients admitted so that nursing managers can make decisions about staffing levels and skill mix required to provide safe care. Ward managers told us that this was updated once a day at the multidisciplinary board round and the safe staffing establishment was entered three times a day.
- All wards worked with a minimum of two qualified members of staff on each shift, but this increased if acuity required this. During night shifts on the General Ward, Feilding Palmer, there were only ever two qualified members of staff rostered to work as there were only 10 patients. This meant staff were unable to have breaks during their shift. Senior staff was aware of this and were looking into ways this could be managed. This had also been discussed with the staff during ward meetings so they could feedback suggestions on how to manage this.
- Trainee assistant practitioners (TAPs) role had been developed. Interviews were held for these positions which saw some of their own band two staff apply and were successful for this training. One TAP told us the course was hard as expected, but allowed them to complete more clinical skills than they would be able to as an unregistered healthcare assistant.
- Ward managers were supernumerary each day on most wards which allowed them the freedom to help staff out during the shift. If there were short notice staffing shortages which could not be filled, staff told us their

ward managers had stepped in to cover the gaps. The ward manager on one ward where there were known staffing issues worked clinically most days to cover the shortages on the ward.

- There was a senior nurse on call at weekends for the community hospitals. All staff were aware of who this was and how to contact them. Staff told us, the ward manager on call would usually ring each day and make sure they were well staffed and there were no concerns.
- Day to day medical care was provided by advance nurse practitioners (ANPs). ANPs worked Monday to Friday, between 9am and 5.30pm, with an on-call ANP covering 8am to 9am and 5.30 – 6.30 pm. There was no ANP cover over the weekends, although this was something which was being explored.
- Consultant geriatricians and stoke specialists from a local acute trust visited most wards twice a week, with a once a week visit for Rutland Ward. ANPs had a close working relationship with the consultant who covered their wards and would contact them outside of their visits if they had concerns.
- Out of hours medical cover including weekends and bank holidays was provided by the out of hours GP service which covered Leicestershire, Leicester City and Rutland.
- During the previous inspection, concerns were raised around staffing levels and the amount of agency staff required for shifts. Although there were still hospitals where agency usage was high (St Luke's, Evington Centre Loughborough and Rutland), all ward managers during this inspection told us the agency usage had decreased since the previous inspection and for those where there was still a reliance on agency and bank staff, they tried to mitigate any risks associated with this.
- In Rutland and Melton, there was still a reliance on agency staff to cover shifts. Senior staff told us they tried to make sure if they used agency staff, a member of the trust staff would be on shift. This at times meant changing staff from another site to maintain this safety feature. Staff from Evington Centre told us they had regular agency staff work on the wards; so it was less of a concern for them if there were no regular ward staff on shift with the agency staff. On other wards where there had been two agency staff on at the same time staff completed an incident form.
- During our unannounced inspection, we observed only agency and bank staff booked on for a night shift. The nurse in charge from the previous shift had already identified this and had planned for staff from the opposite ward to switch one established member of staff with an agency staff member to provide safer staffing on the ward.
- All new members of staff who interviewed for a position at one of the community hospitals were informed about the possibility of cross site working.
- Staff told us the way bank staff were managed was a much improved system. These staff members were managed by a centralised booking system that was also responsible for monitoring training requirements and the registered staff's personal identification numbers. This made sure only staff that were competent and current with all requirements were available to work shifts.
- All agency and bank staff completed an induction before they started the shift. This included (but was not limited to) familiarising them with emergency procedures and equipment, documentation, electronic observations system and medication administration requirements. Once they had completed the induction, the member of staff signed the induction form and these were kept by the ward manager. We saw evidence of completed forms during our inspection as well as audits of these forms conducted by the matrons.
- There was a mixed response from therapy staff about the staffing numbers. Some therapy staff stated there were enough staff to provide the required therapy for the patients, however, other members of therapy staff were not as positive. Data provided by the trust highlighted only one hospital where there was a high vacancy rate for therapy staff at Hinkley and Bosworth hospital.
- St Luke's Hospital had a 'floating physiotherapist' who worked three days at the hospital and two other days at other hospitals or in community therapy if required. Staff told us this reduced the requirement for locum physiotherapists and also kept consistency across the hospital sites.

Managing anticipated risks

Requires improvement

Are services safe?

- There was a policy available for staff to follow for transferring out of patients who had been identified as deteriorating in their condition. All staff we spoke with were aware of this policy.
- All staff were aware of the business continuity plan for when incidents including power shortages, water incidents and inclement weather problems effected the services being provided. One member of staff also told us the business continuity plan included actions staff should take in other incidents such as missing patients from a neighbouring high security unit and acts of terrorism.

Requires improvement

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 rated effective as required improvement because:

- There was minimal evidence of the service completing national audits making comparisons of quality of care difficult.
- There was minimal data on patient outcomes being collected which was therefore making it difficult to identify if patients were improving following the care they received.
- There was inconsistent knowledge and practice around the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were aware at times that a Deprivation of Liberty Safeguards was required, but had not completed the required paperwork.
- There was inconsistency around protected meal times across the service. Some areas operated a strict protected meal time however, in other areas we observed clinical activities undertaken at meal times.
- Clinical supervision averaged at 69% compliance across the service as of September 2016 against a trust target of 85%, with some areas achieving 100% compliance and others recorded 8% compliance. Management supervision was not provided regularly. Managers managed staff's poor performance under direction from human resources when needed.

However:

- We found positive examples of evidence-based practice used throughout the hospitals.
- There was evidence of good multidisciplinary team working.
- We observed staff seeking informal consent for care and treatment before proceeding with a task.

Evidence based care and treatment

- Staff worked towards National Institute for Health and Care Excellence (NICE) guidelines for the assessment and treatment of pressure ulcers. All inpatients had a pressure ulcer risk assessment on admission with a regular review at least weekly and we saw evidence of the completed reviews.
- Staff provided evidenced based care in line with NICE guidance for falls in older people. Risk assessments and management strategies implemented in inpatient ward areas were in keeping with national guidance.
- We saw evidence of staff conducting comprehensive assessments of patients on admission which covered most health needs including physical, mental, emotional and spiritual health as well as any clinical needs. These risk assessments formed the basis for individualised care plans which were completed for all patients and were regularly reviewed.
- Occupational therapists used the model of human occupation as a basis for their input. This model was evidence-based, client centred and holistic in nature.
- Physiotherapists also used a range of assessments which were evidence based. This included the elderly mobility scale which was a scale for assessing mobility in frail elderly patients, the de Morton Mobility Index tool which assessed mobility at the beginning of a treatment programme and at other intervals along the patients pathway and the Berg balance scale which was a way of measuring balance in older patients whilst they performed functional tasks.
- The postural assessment scale for stroke patients was used in both stroke wards to assess and monitor postural control following a stroke.

Pain relief

- Most patients told us staff responded quickly to any complaints about pain. One patient said staff would offer them "top up pain medication" if it looked like they were in pain. However, we did speak with one patient who was not given their pain relief and staff had not responded to their complaints of pain.

- We observed physiotherapy staff asking patients if they required pain relief prior to completing their therapy session.
- Staff assessed a patient's pain using a zero to three scale. This was recorded with each set of observations and entered into the electronic observation system.

Nutrition and hydration

- All inpatient wards we visited used and completed the nutritional screening tool (NST) to assess patient's nutritional needs. The tool assessed a patient's ability to eat, whether there had been any weight loss and the patient's appetite. If a patient scored 15, a referral to a dietitian was required. We reviewed 44 NST assessments and all had been completed within 24 hours of the patient's admission. The NST was reviewed on a weekly basis, and we saw evidence of this.
- Where patients were identified as requiring additional nutrition and hydration support through the use of the NST, we saw evidence of staff referring them to dietitians as directed by the trust policy, most of the time. However we did identify two patients who scored high on the NST, but had not received a referral. This was escalated at the time of inspection to the nurse in charge and a referral was made.
- Where patients had been identified as requiring monitoring of their nutrition and hydration intake, we reviewed 11 food and fluid charts and found there were gaps in all of these records over a three day period.
- All patients were weighed weekly as part of the weekly review of the NST however there were concerns around how staff identified weight loss in patients through the NST. The two patients who had not been referred to the dietitian had both been missed for referral due to errors in calculating weight loss. Staff told us there were plans in place to switch to an alternative method of assessing nutrition and hydration risk in patients which also had a simplified method to calculate weight loss.
- There was no consistency with protected meal times. Some wards were enforcing this however some wards allowed visitors in during protected meal times as this supported improved nutritional intake. All staff told us no clinical tasks or investigations would be performed during meal times. Despite staff telling us this, we observed staff completing a medication round during lunch time at St Luke's Hospital.
- During our inspection, we saw patients being offered drinks regularly. This included the regular hot drinks rounds which the staff completed, as well as staff regularly refilling patients' water jugs.
- For patients who required assistance with eating and drinking, the red tray system was in use to identify this. This system would highlight to staff where additional support would be required. However, we found this practice was inconsistent within ward areas and therefore was not assured patients who required assistance were always identified.
- In most hospitals, patients were encouraged to sit around tables to eat their meals rather than by their beds. We observed a group of patients enjoying their lunch on Rutland Ward around a table with an alcoholic beverage which was prescribed. For some patients a small amount of alcohol can stimulate the appetite and encourage the patient to eat more as well as making the meal a more social experience. Not all wards had a dining room facility for patients to eat their meals.
- Patients had access to literature surrounding healthy eating so they could make informed decisions about the food they wished to select from the menu. We reviewed a selection of menus and found they offered patients a varied diet which included a selection of modified texture diets.
- There were processes in place over the acceptance of patients with a nasogastric tube. Staff from some hospitals told us they could provide care to patients who were fed through a percutaneous endoscopic gastrostomy tube (a tube directly into the stomach through the abdomen wall). However they could not provide care for patients who were fed nasogastrically (a tube through the nose into the stomach). Staff on Ward 1, St Luke's Hospital and Snibston Ward, Coalville were able to provide care for patients who were fed nasogastrically and were supported by frequent dietetic input.
- Most patients we spoke with were complimentary about the choice of food and the amounts of food that they were offered. One patient told us it was the best food

they had ever had, however one patient was still hungry at the end of lunch time and was not routinely asked if they had eaten enough. Staff told us it was uncommon to offer second helpings to patients. We observed on two occasions large amounts of food being returned to the kitchens which could have been offered to patients who wanted additional amounts.

- During our visit to Swithland Ward, we saw patients participating in an afternoon tea session where drinks and cake were served for patients.
- During our inspection, we observed staff serving food to patients. Staff checked food prior to being served to assure it was a correct temperature. All staff wore appropriate personal protective equipment while serving food which they discarded if they went to do another task. The food looked of an acceptable standard with a choice of vegetables for patients. However, on one ward we overheard staff remarking negatively about the appearance of the food which was within the patient environment and could have been upsetting for patients.

Technology and telemedicine

- The wards at Coalville Hospital had introduced a digital reminiscence therapy system to improve the communication, interaction and engagement with patients who had memory problems and who were living with dementia. The software package enabled staff to store non-medical information about a patient which was essential when planning person centred care. It also enabled the patient's relatives to record messages for their family member to assist at times of confusion.
- All staff were issued with a portable device to records observations and update risk assessments on at the beginning of their shift. As these devices looked like a mobile telephone, we observed signs around the wards telling patients and their relatives that these were not staff's mobile phones.

Patient outcomes

- The stroke ward at Coalville participated in the Sentinel Stroke National Audit Programme which aims to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. Trusts are rated are on a scale between A and E, where level E is the worst possible and A the best. Information provided by the trust showed they had improved from a level E in July to September 2015 to a level C in April to July 2016. The trust performance for patient centred indicators was rated between A and C. The stroke unit, standards by discharge and discharge process all achieved an A rating. The team centre key indicator for speech and language therapy scored an E in April to July 2016. Staff were unaware of the results of these audits and we did not see them displayed in the ward area.
- The trust had previously participated in the national audit of intermediate care in 2012 and 2014; however they did not participate in 2015. The decision not to participate was made after discussions within the Community Health Service senior management team.
- All hospitals completed local audits which included infection control audits (including hand hygiene audit and a 10 point audit), venous thromboembolism (VTE) assessment audits, resus trolley audits, documentation audits and nutrition audits. Audit results were discussed at ward meetings where details around action plans for improvements would also be discussed.
- Information provided by the trust showed there were no formal audits of patient outcomes performed by therapy staff. All patients had details of their own initial assessment and end achievement in their records. However, there was no audit of these outcomes which demonstrated effectiveness of the therapy provided by the inpatient therapy services. Further information provided showed there were plans in place to move to an electronic data base which could provide patient outcome data for therapy and the trust intend to compile data on therapy effectiveness once this is in place.
- There was an audit of the transfers out of the service for patients who were identified as deteriorating in their condition. This audit showed that staff assessed patients effectively, however, due to communication issues with the out of hours service; patients were sometimes transferred out unnecessarily.

Competent staff

- Appraisal rates for permanent non-medical staff in the inpatient service were 83% as of September 2016. All staff we spoke with told us their appraisals were

worthwhile and helped them to identify additional training requirements for personal development as well as providing constructive feedback for areas of improvement.

- Clinical supervision rates for all community inpatient staff averaged 69% compliance as of September 2016. This did not meet the trust target of 85%. East Ward, Hinckley and Bosworth showed 8% compliance. However four areas within the service had met the target; these were, inpatient therapy staff at St Luke's Hospital, therapy staff at Feilding Palmer Hospital, inpatient management and ward staff on Swithland Ward. Clinical supervision was reported by staff as being conducted, however there were issues around recording this on their electronic database. We observed two separate group supervision sessions during our inspection. One session explored an issue following a complaint from a relative and was a responsive and engaging session. However, the other session we observed was more representative of an informal training session than clinical supervision. Therapy staff had a more structured clinical supervision process which was recorded and conducted every three months.
- Management supervision was not provided regularly. Managers managed staff poor performance under direction from human resources as required.
- Registered staff had completed acute illness management training to provide them with the skills and knowledge to treat an acutely unwell patient. Senior staff told us they planned to roll out this training to unregistered staff.
- The trust had provided training and support for registered nursing staff on revalidation with the nursing and midwifery council. Revalidation is the process all nurses complete to renew their nursing registrations and continue practising.
- A preceptorship package offered to newly qualified staff and those new to the trust. Feedback from staff that had been through the process was very positive. Preceptorship was the structured period of transition for qualified staff when they start employment.
- Registered staff completed mentorship programmes as all locations had access to student nurses. The service also had sign off mentors as the majority of students were in their third year. Sign off mentors are mentors designated to sign off a student nurse's proficiency at the end of the final period of learning.
- All new unregistered staff were required to complete the care certificate. Staff employed before the mandatory introduction of the care certificate in 2015 were also given the opportunity to complete this. The care certificate was introduced following the Francis report and Cavendish review and assessed individuals against 15 required standards, providing assurance to patients that all unregistered staff were trained to a specific standard.
- The inpatient services had champions for specific services which included infection prevention and control, tissue viability, safeguarding, dementia, privacy and dignity and falls. These champions received a package of, mainly, in-house training to develop education and knowledge in their specific area.
- Staff told us they were supported to seek out additional training to develop professionally. However, funding had been an issue recently, so they were only able to attend courses which did not cost the trust any money. Staff from Feilding Palmer told us they had previously used money from the league of friends to fund study days due to lack of funding from the trust.
- ANPs told us they were able to maintain their competencies around clinical skills by rotating through the local acute hospitals. Staff on Rutland Ward were also exploring the possibility of acute rotations so that all staff could maintain their competencies on clinical skills such as blood transfusion administration, venepuncture and cannulation and intravenous medication administration.

Multidisciplinary working and coordinated care pathways

- During our inspection we observed good multidisciplinary team working throughout the whole inpatient service. Board rounds were conducted in the mornings on all wards within the service and were attended by all members of the multidisciplinary team, including social workers on occasion. Staff on North Ward, Hinckley and Bosworth Hospital were trialling

further multidisciplinary team walk arounds at the end of the day to update on patient status. These walk arounds included unregistered staff who were largely responsible for providing care during the day.

- We observed a multidisciplinary team ward round being conducted on Rutland Ward. The consultant from the local acute trust was passionate that instead of having meetings about patients, all staff should be part of a ward round as this enabled staff to discuss the patient's progress in real time, and if there were any concerns, problem solve at the time and include the patient in the future planning of their care.
- All wards had allocated social workers for their patients. The allocated social worker attended their designated areas for multidisciplinary team meetings and best interest meetings. Staff told us since they had designated social workers for their patients; this had improved communication around discharge requirements and had helped to speed up the discharge process.
- There were external multidisciplinary team meetings between the local acute trust and the stroke wards for the service. This enabled staff to adequately prepare for patients transferring to the community hospitals and engage in early supportive discharge planning.
- The inpatient wards had access to additional members of the multidisciplinary team which included but were not limited to, speech and language therapists, dietitians, tissue viability specialists, infection prevention and control specialists, continence nurse specialists and palliative care specialists.
- Breakfast clubs were mainly run by the occupation therapists on the wards in Coalville Hospital and Feilding Palmer. This enabled the occupational therapists to assess patient independence, and identify the support and equipment required to return to independent living.
- The role of champions or links was undertaken by all members of the multidisciplinary team and not just nursing staff. This was a positive step in achieving a multidisciplinary team approach to patient care.

Referral, transfer, discharge and transition

- The referral process into the inpatient hospitals was usually through a waiting list system from the acute hospitals. There were a total of eight acute hospitals that referred patients into the community hospitals in the trust. Other referrals for community inpatient services came from the GPs, although the majority of the referrals were from the acute hospitals.
- Referrals made from GPs in the community setting would take priority over the referrals in from the acute hospitals.
- Referrals made from most of the acute hospitals were faxed over to the community hospitals. The only exception to this was from one acute hospital that had now gone on to a paperless system and an agreement was made between the trusts to complete an email referral.
- Discharges from the inpatient wards in the trust were completed any day of the week if the patient was discharging to their own home and the multidisciplinary team worked well to ensure that if discharge was imminent, all paperwork and medications were completed in good time. If further packages of care were arranged, staff would liaise with members of the community team to make sure that all aspects of the care package were in place prior to leaving the ward. If a patient was discharged to another care facility, staff would discuss the appropriate time and day for the patient to be transferred. The patient's GP received information about their discharge via an electronic system or via the postal service.
- Staff told us transfers from the acute hospitals usually occurred during the day. However, there was no cut off time for transfers to come over and there was inconsistency across the wards as to an acceptable time for admission. One ward would monitor transfers after 9pm at night and incident report any transfers after this time, however, another ward would accept transfers from the acute until 11pm. Staff were unaware if there was a trust policy for acceptable times of transfer and staff felt it was unacceptable to be transferring elderly patients, especially a patient who was living with dementia late at night. Feedback from patients and their relatives who had been transferred late in the evening (after 10pm) found it quite distressing and disorientating.
- Information provided by the trust showed in October 2016 there were 125 admissions after 6pm into the

inpatient service. Of these 54% were admissions after 9pm. The information supplied did not differentiate between patients admitting from the community (their own homes) and those transferring from the local acute hospitals.

- If there was a patient who required care and treatment that could not be provided by the inpatient wards in the trust, there was a policy for transferring patients to acute hospitals which was well established and staff on the wards were very aware of their roles and responsibilities in completing this.
- Staff told us there was inconsistent assistance from the out of hours service provided. When they contacted them, they told us they rarely visited the patient on the ward and would advise on transfer to the local acute hospital, regardless of if there were escalation plans written in the notes by the ANP. Staff told us they would report any instances where a patient transferred to the local acute hospital and this would be reviewed by senior trust staff to establish if this was an appropriate transfer. However, records of incident reports showed there were only two incidents reported between October 2015 and September 2016 which were directly related to the organisation or provision of out of hours care. There were other incidents involving issues around communication however, there was not enough information provided to directly link these with out of hours services.
- There were inconsistent practices around estimated discharge dates (EDD) for patients. In Loughborough Hospital, all patients were given an EDD of 12 days from their admission. This was reassessed at the earliest opportunity and if this was not feasible, a new estimated date of discharge was given. Other hospitals did not give patients an EDD and would concentrate on the treatment programme and tailoring it to their needs. Reasons behind no EDD being given was because of giving patients false hope about their length of stay.
- There was a falls prevention programme which was available to patients from Rutland, Melton Mowbray and Feilding Palmer Hospital. Patients who were ready for discharge from the hospital, but would benefit from further rehabilitation to increase their stamina and education about falls prevention were referred for this programme. Staff told us this was very popular as it helped to reduce the risk of further falls; however there was a waiting list for this programme. Patients who attended this programme had transport provided by the trust.

Access to information

- The inpatient services used a combination of written and electronic records. Daily reviews by nursing, medical and therapy staff were written in patient notes which were kept at the nurses' station. Risk assessments and observations, medication administration records and discharge records were all kept on separate electronic systems.
- Registered agency staff were required to complete an assessment before using the electronic medication administration records. If they did not pass this assessment, they did not have access to the information regarding medications. Access to the risk assessments and observations and discharge records was completed through 'signing out' a username and password for the systems. This would annotate they were agency staff however, each ward kept a record of which username and password the staff used.
- Discharge summaries were completed on an electronic system which was commonly used by most GP practices. Whilst this facility had the ability to send electronic discharge summaries staff reported that they were only in the first stages of using this system, so they still had to send discharge summaries off in the post. The next stage of implementing the electronic system would give staff the ability to electronically submit discharge letters to the patients GPs. This would enable GPs to access patient information relating to their hospital care and treatment in a timely fashion.
- Staff told us that they had good access to information. Staff used the trust intranet regularly to locate all policies. During our inspection, we observed staff accessing the intranet for policies and procedures, however, poor connectivity made this task a slow process.
- Staff also told us they regularly received updates from their immediate managers by emails or through trust newsletters which informed staff of relevant information. We saw copies of trust newsletters displayed in ward areas.

Requires improvement

Are services effective?

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff told us the Mental Capacity Act was an area they had not felt confident with previously. However, the introduction of training had increased their confidence in identifying patients who may lack capacity. Data showed training for the inpatient services was recorded as 88% compliant. This training was conducted on their electronic learning system.
- There were 39 Deprivation of Liberty Safeguards referrals made between March and September 2016. Matrons told us they met quarterly to discuss issues around capacity and Deprivation of Liberty Safeguards.
- There appeared to be a lack of consistency with the application for Deprivation of Liberty Safeguards for patients using sensor cushions. Some wards completed this for all patients who lacked mental capacity and were using a sensor cushion. In other wards staff were aware they should be applying for Deprivation of Liberty Safeguards, but did not. Staff told us this was due to a perceived back log of Deprivation of Liberty Safeguards which required assessment by the local authority.
- Staff were able to give examples of where Deprivation of Liberty Safeguard applications had been made, however we reviewed the Deprivation of Liberty Safeguards paperwork for one patient and saw their condition had changed but the paperwork did not reflect this.
- On admission documentation, there was a question asking whether a patient had capacity or not. The presence of this this question on admission documentation which is required to completed for all patients goes against the first statutory principle of presuming capacity for patients, not incapacity. If there were concerns around capacity, the advanced nurse practitioner conducted a two stage assessment for inpatient based care. Capacity was assessed by social workers around discharge planning.
- All patients underwent an abbreviated mental test on admission. The test uses 10 simple questions to highlight if there is any cognitive impairment. If there were concerns following the test, ANPs would conduct further tests including the six item cognitive impairment test or the Montreal cognitive assessment tool to establish if impairment would impact on the patient's capacity to consent to treatment.
- We observed a patient with learning disabilities but found to have capacity who wanted to self-discharge. Staff respected this, but highlighted the requirement to ensure that a mental capacity assessment had been completed.
- We saw evidence of verbal consent being obtained before care was delivered. Staff performing observations asked patients permission to undertake observations before putting any equipment on the patient. We also saw evidence in patient records where therapy staff had requested consent for treatment from patients prior to starting their therapy sessions.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Patients told us staff treated them with dignity and respect and praised them for their kind ways of treating them, using words such as 'marvellous', 'wonderful' and 'excellent'.
- Friends and Family Test results were high and had not dropped below 93% in the previous 12 months.
- Data from the two Short Observational Framework for Inspections (SOFIs) completed was mainly positive. SOFI is a specific way of observing care to help us understand the experience of people who use the service, including those who are unable to talk with us.
- Patients on Rutland Ward were awarded with a trophy if they were identified as the most improved for rehabilitation. This was a positive re-enforcement approach to involving patients in their care.
- Staff at Coalville Hospital had introduced digital reminiscence software to the ward which also enabled relatives to record supportive messages for patients who required emotional support.

However:

- The inpatient services were below the national average for privacy and dignity on the Patient-Led Assessments of the Care Environment (PLACE) assessment.

Compassionate care

- During our inspection, we spoke with 60 patients and 21 relatives about their experience with the service. All patients reported positive experiences about their care and told us how happy they were with the way staff treated them despite acknowledging that at times staff were busy. Comments made by patients included the words such as 'excellent', 'wonderful', 'respectful' and 'marvellous'.
- During the inspection, we carried out two Short Observational Framework for Inspection (SOFIs) at Coalville and St Luke's Hospital. SOFI is a specific way of observing care to help us understand the experience of people who use the service, including those who are unable to talk with us.
- The SOFI performed at St Luke's Hospital on Ward Three showed positive interactions between staff and patients. One of the patients was living with dementia and appeared distressed at times. Members of staff sat with them and provided warmth and reassurance to them and appeared to reduce the patient's distress.
- The SOFI performed at Snibston Ward, Coalville Hospital, was conducted during lunch time and showed mainly positive interactions of warmth, genuineness and validation with a group of patients. Staff interacted with the patients to make sure their meals were alright for them and if they could help them in anyway with their meals. However, we witnessed some negative interactions during this time where staff members delivered food to patients and did not engage in any way with the patient. This demonstrated an 'ignoring' interaction where they carried on in the presence of the patient as if they were not there.
- The trust used the NHS Friends and Family test to obtain feedback from patients. The test is a single question survey which asks patients whether they would recommend the NHS service to their friends and family.
- The results for the inpatient services ranged between 93-100% between August 2015 and August 2016. The most recent results from September 2016 for the community inpatients services showed 95% of patients would recommend the service to their friends and family.
- All patients told us staff maintained their privacy and dignity at all times when they were providing care. During our inspection we observed staff maintaining patient's privacy and dignity whilst providing care by closing the curtains around their beds and closing doors to bathrooms. Patients who we spoke with also told us staff was very respectful towards them as well.

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- There were 548 compliments recorded for the community inpatient hospitals between August 2015 and August 2016. During our inspection, we saw many thank you cards to the staff for the care they provided the patients and relatives.
- There was mixed feedback from patients and relatives about the responsiveness of staff to patient's needs, with the length of time it takes to respond to a call bell being the main topic. Some patients felt they were answered quickly whereas relatives and patients at other hospitals felt the bells rang for a long time before anyone came to see them.
- The Patient-Led Assessments of the Care Environment (PLACE) results from 2015 showed the inpatient wards achieved 79% for their privacy and dignity assessment which was below the national average of 84%. There were however, two hospitals that achieved results around the national average; these were Hinckley and Bosworth that achieved 87% and the Evington Centre with 89%.
- Patients told us all members of staff encouraged them to be independent and were very patient with them, however if they required help they were very accommodating and warm whilst helping them. One patient told us "they are patient with me, they never rush me, they let me take my time".
- On the wards we visited the call bells and water jugs were all in reach of patients. Comments made by patients reinforced that staff would regularly check to make sure they had enough water as well as being able to reach it.
- We saw evidence of staff respecting patients' social needs. Patients were encouraged to socialise with other patients during their time on the ward. On Swithland Ward, we observed an afternoon tea and cake session where patients gathered in the dining room and socialised over their afternoon tea. This was well received by patients, with many of them telling us they thought it was a wonderful experience.

Understanding and involvement of patients and those close to them

- There was an inconsistent approach to involving the patient in treatment options and understanding their illnesses. The majority of patients (approximately two thirds) were happy with the way staff have involved them, however, about one third of those patients we spoke with felt they had not had a lot of information on what was going on.
- If patients had not understood fully their care and treatment, patients and their relatives were confident to ask staff questions.
- There was mixed feedback from relatives about their involvement with the patient's care and treatment. Some relatives were encouraged to be involved in the care and treatment of the patient. One patient told us they had let their sister take the lead on arranging their discharge arrangements with the nursing staff and they had also been kept informed of all the arrangements made. However, relatives from different hospitals felt they had not been kept up-to-date about their family members care and if they wanted to know anything, they had to actively seek staff out to get the information.
- In areas where there were no protected meal times, ward staff encouraged relatives to join the patients during meal times and help them with their meals.
- Patients and relatives we spoke with made reference to staff involving them by asking them for their permission and consent before doing something. Comments made for example were "staff will check if I am ready and not just do it".
- Staff in Rutland Ward awarded a patient each week with the 'most improved' award for their rehabilitation purposes.This helped patients understand the requirements of their programme and realistic goals in terms of their rehabilitation, but also recognised the efforts that patients made in their care. During our inspection we saw a patient being awarded this and they were overwhelmed with how supportive and caring the staff have been.

Emotional support

- Pet therapy was used on the wards where patients living with dementia were accommodated. The pets usually invited into the wards were dogs. Pet therapy calmed patients living with dementia, but also brought out a more social and interactive response from the patient.
- Staff on Rutland Ward had co-located a husband and wife in a bay together whilst they both required inpatient care. They acknowledged this was technically

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a breach of the single sex accommodation requirement; however, the emotional needs of the patients were prioritised. Feedback from the patients was very positive and they were thankful for the opportunity to be together in the hospital. They were however treated as individuals by the staff and they maintained their privacy and dignity whilst providing personal care.

- The digital reminiscence therapy software was also able to record messages or be used to contact relatives through video messaging. Staff told us they used this to provide emotional support to patients who experienced confusion and distress however we did not see this in use for this purpose during our inspection.
- In most ward areas, there were posters displaying contact details for patients who required spiritual and pastoral care to provide emotional support. This also included details of planned services or planned visits to the ward areas.
- There was feedback from some relatives about the lack of provision for them at the hospitals. Some wards were able to provide drinks to relatives whilst visiting, however, this was not consistent across the service. One relative told us how they felt this was disappointing as they had to travel quite a distance to see their family member and were unable to get a drink when they arrived.

Good

Are services responsive to people's needs?

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

Summary

We rate responsive as good because:

- Coalville Hospital had introduced the role of activities co-ordinator to their wards. This improved the engagement of patients in activities and also the activities completed were meaningful.
- Patients were able to access the service in a timely manner and care and treatment was co-ordinated well with other providers.
- Staff were encouraged to resolve complaints and concerns locally. When formal complaints were made, there was evidence of learning from complaints.
- Staff had accommodated a husband and wife together on a ward to meet their individual needs for the right care at the right time.
- Patients admitted to the inpatient wards from the community were a priority for admission and were admitted at all times of the day as they were considered to be in an unsafe environment.
- All wards had clear pictorial signs which helped patients living with dementia or other cognitive impairments to identify relevant facilities such as toilets and bathrooms.

However:

- The service recorded 175 delayed discharges between August 2015 and July 2016.
- All wards recorded high bed occupancies of above 85% between August 2015 and July 2016.

Planning and delivering services which meet people's needs

- The trust worked with three main clinical commissioning groups to plan and deliver services to the population of Leicestershire, Leicester and Rutland.
- The main focus for inpatient care moved from general rehabilitation to sub-acute care due to the changes in services provided at the local acute trust. This was discussed with the trust especially as this would impact on the care that the community hospitals would be expected to provide.
- The trust tried to meet the needs of the local population and minimise the risk of having an admission out of area. If patients were allocated in a community hospital that was not near to their home, trust staff liaised with each other to try and relocate them to their nearest community hospital if this was appropriate for the patient.
- There was a community integrated neurological service available for patients who had suffered from a stroke and/or who had other long term neurological conditions. Previously this was referred to as integrated therapy services however this was not specific enough for patients with some neurological conditions so changes to the pathway were implemented.

Equality and diversity

- Policies were in place to ensure that the equality and diversity of staff was respected.
- Staff could access translation services 24 hours a day if necessary and knew how to do this. In relation to this, we saw posters displaying "your rights to an interpreter" which was written in different languages detailing what patients who required interpretation services could expect.
- Equality and diversity training was part of the mandatory training package. Information provided by the trust showed 98% of all community health service inpatient staff had completed equality and diversity training.
- There was an equality and diversity lead for the trust that would provide support to all staff including those within the community health services. There was no nominated member of staff in community health services for staff to approach with any equality and diversity related concerns.

Meeting the needs of people in vulnerable circumstances

- Activities co-ordinators (also known as 'pink ladies' because of their uniforms) were introduced at Coalville hospital. The activities co-ordinators provided a programme of activities for all patients on the wards.

They made sure all activities completed with the patients were meaningful activities and would complete them on a one-to-one level or group activities. Due to the success of the activities co-ordinator at this hospital, other ward managers were hoping to recruit an activities co-ordinator for their wards.

- Activities equipment was available at all inpatient locations; however, we did not see many activities being conducted at other locations. This was supported by some patient feedback which said there was not much to do during the day.
- The most recent result from the Patient-Led Assessments of the Care Environment (PLACE) from 2015 relating to dementia was 78% which was above the national average of 75%. The assessment for how facilities meet this requirement is new to the PLACE assessment and looks at how the environment is designed to meet the requirements of a patient living with dementia.
- Dagleish Ward had twiddlemuffs donated from members of the local population for patients living with a dementia. Ward One at St Luke's Hospital had similar items called twiddle mats in place for patients living with dementia. As these were made from wool and could not be decontaminated after each patient use, these were designated as single patient use and would accompany the patient on discharge. Twiddlemuffs are double-sided knitted muffs with various soft items attached both inside and out. People living with dementia often have restless hands and like to have something to keep their hands occupied.
- The environment on each ward was bright with patients being encouraged to use the dining room for meal times. At some of the hospitals that we visited, there were garden/outdoor spaces which patients were encouraged to use. The senior managers at Rutland Ward told us they had received funding from the league of friends to improve the outdoor area for patients and encouraged them to use this area with their visitors as much as possible, weather permitting.
- All wards had clear pictorial signage to aid patients living with dementia or who had cognitive impairments. This included signs to help patients identify where bathrooms and toilets were. Staff on Ellistown Ward had also made a sign for a patient who was confused which helped them find their way back to their own bed.
- The layout of the wards in the inpatients services varied from hospital to hospital. Some hospitals had bays for up to three patients and other bays for up to six patients. Some bays had their own bathrooms, whereas larger bays would have nearby toilet and bathroom.
- Patients who were visually impaired had talking newspapers delivered for them and other talking books.
- There were patient information leaflets available for elderly patients who were going into a care home. These were provided by a charity and helped patients to choose a home which would meet their own needs.
- In some of the hospitals, there were rooms available for patients who were on an end of life pathway. This included a large en-suite room with an additional sitting room for relatives to stay in and drinks facilities for relatives to help themselves to. These were located on Swithland Ward, Loughborough Hospital, Ward One, St Luke's Hospital, General Ward, Feilding Palmer Hospital and Dagleish Ward, Melton Mowbray. Staff told us that these rooms were regularly used.
- There were group physiotherapy sessions for patients to attend. Coalville Hospital ran a 'move it or lose it' group once a week as well as balance sessions for stroke patients.
- Staff from Snibston Ward had ordered new tables for stroke patients. The tables which were currently in place made it difficult for patients to access their belongings and drinks so the staff had sourced tables which best suited their needs.
- There was an in reach system for patients with mental health needs. Staff told us they were able to get patients reviewed in a timely manner if they had mental health requirements.
- There was a provision on most ward areas where staff could speak to patients and their relatives in private, especially if they were breaking bad news.
- Some wards we visited had their own therapy room attached to the ward. This enabled patients to meet

their individual needs by participating in therapy sessions which were required as part of their rehabilitation. The rooms were generally large enough to provide group therapy sessions if required.

Access to the right care at the right time

- There were 175 delayed discharges between August 2015 and July 2016 for community inpatient services. This made up 47% of the total delayed discharges for the whole of the trust. The main reason behind the delayed discharges was attributed to family choice, however completion of assessment and awaiting public funding also caused high delays.
- During our inspection, we saw a varied length of stay for patients between 11 days up to 64 days. There was no consistent feedback from staff over an identified length of stay by the trust, some staff thought it was between 20 and 25 days, however other staff did not think there was an identified length of stay. Feedback from staff indicated less focus on the length of stay for patients and more making sure the admission met the needs of the patient to prevent any potential readmission into healthcare services.
- All 12 wards were above 85%for their mean bed occupancy rates between August 2015 and July 2016. Swithland Ward had the highest mean occupancy rate of 94% and Rutland Ward had the lowest mean bed occupancy rate of 90%. National data has shown when bed occupancy rates reach above 85%, there is an increased risk of regular bed shortages and an increase in healthcare associated infections.
- Patients coming into the inpatient services from the community would be admitted at any time of the day. This was because these patients were seen as being in an unsafe environment and therefore admittance into a safe environment was essential.
- At the time of inspection, there had been two mixed sex breaches since August 2015. The most recent mixed sex breach however, related to the husband and wife who were admitted on Rutland Ward. Although this was technically a breach, the staff felt this was an exception to the rule and the right thing to do for the patients. All the required paperwork was completed by the ward manager and no negative feedback had been received from the heads of service.
- Therapy services were provided Monday to Friday. The therapy team at Coalville Hospital trialled seven day working for three months and found it to be positive, however there was no increase in funds or staffing to allow this service to continue.
- There was a standard operating procedure in place for patients requiring blood tests out of hours. If deemed urgent, blood samples would be delivered to the pathology services at the local acute hospitals through the use of a taxi company.

Learning from complaints and concerns

- The trust received 354 complaints between August 2015 and July 2016, of which 218 (62%) of these were upheld. There were 22 complaints for the community inpatient service of which 16 (73%) were upheld.
- We saw posters available in ward areas which contained details of how patients and relatives should complain and who to complain to. Despite this, most patients told us they were not sure of the complaints process if they had any concerns about their care, although most would talk to the immediate staff on the ward to start with. One patient told us it would depend on what the issue was as to who they would approach.
- Staff told us they were aware of the complaints process and that they would all try to resolve any complaints or concerns locally. If they could not resolve it themselves, they would escalate to their managers. Staff received feedback about complaints during ward meetings as well as identifying any lessons learnt which would influence future practice. One ward manager we spoke with also told us how they planned to complete some supervision sessions around a complaint scenario they had been involved with.

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 rated well-led as requires improvement because:

- Staff were unable to tell us about any strategic direction for the community health inpatient services.
- Concerns about high bed occupancy, record keeping and delayed discharges were identified in the March 2015 inspection and had not been sufficiently addressed.
- There was little participation in national audits so there was no way of benchmarking their performance
- Staff were open about their poor understanding around the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

However:

- Local leaders were visible and staff told us they felt supported and valued and their managers were approachable. There was an open culture with local management and staff felt they would be able to raise any concerns with them.
- Matrons felt they had the autonomy to manage their own services.
- Staff were encouraged to approach their managers with ideas for service improvement or innovation.

Service vision and strategy

- Staff were aware of the trust's overall vision and strategy. However, staff were unaware whether there was a community inpatient services strategy. This was identified on the previous inspection conducted in March 2015.
- The vision and values of the trust were displayed throughout the services, and staff were knowledgeable about them.
- A key priority in the trust's Quality Strategy 2013-2016 was around effectiveness of patient care and providing excellent clinical outcomes. However, the service provided little information on how they were contributing towards achieving this.

Governance, risk management and quality measurement

- Governance arrangements to monitor quality, performance and safety were in place and provided assurance to the trust board. There were governance meetings at all levels which were held on a regular basis to discuss key issues such as incidents and complaints, risks, best practice guidance, audits and lessons learnt. These meetings were minuted and there was a clear demonstration of information being shared with all staff members from these meetings.
- All wards had regular ward meetings where important information would be cascaded down. We saw minutes from these meetings which demonstrated a clear cascade of information down from senior level to ward level.
- The service had their own risk register which was reviewed regularly at the monthly senior meetings. The risks were red, amber, green (RAG) rated according to severity. Risks with a residual rating of red (high risk) were information technology and difficulties with connectivity in some hospitals. All other risks were rated as moderate or low risk. Each risk had identified named responsibilities, actions and review dates.
- The ward managers were consistent in acknowledging their own concerns about staffing; however, this had not been comparable with the risks on the risk register. Only some wards had highlighted staffing as a risk on the service's risk register despite them telling us it was their biggest risk/concern.
- The trust used self-regulation as a way of identifying improvements and providing internal assurance, using the Care Quality Commission framework of safe,

Requires improvement

Are services well-led?

effective, caring, responsive and well-led. All staff were required to complete self-regulation of their service; however, there were some senior members of staff who were unsure what self-regulation was.

- There was clear evidence in the governance minutes that auditing was important to the service, with many local audits being conducted. However there was minimal participation in national benchmarking audits. This meant that the service found it difficult to make comparisons in regards to the quality of care they provided compared with other providers. There was also no data collected on patient outcomes from a therapy perspective indicating no ability to formally identify the effectiveness of their clinical input and assuring they were meeting patient needs.

Leadership of this service

- There was inconsistent information about the visibility of the trust executives. Most of the senior staff were aware of the executives, but did not see them very often. Other areas were not aware of any of the executives. Staff from one ward had told us the chief nurse had completed a clinical shift there to get full appreciation of the challenges they faced at times.
- Members of the executive team conducted regular board walks (informal visits to the wards). These were opportunities for them to review practice within the ward areas as well as an opportunity to speak with staff and patients and gain feedback about service provision. Most staff spoke positively about the board walks, however, there were some who felt the senior management team should spend more time within the clinical areas to get a better appreciation of the issues which they faced and an understanding of the service.
- Staff spoke highly about the support their immediate managers gave them. On one ward, the manager had sought out additional support for members of staff who, for different reasons were identified as requiring it. All staff members told us they thought their managers were approachable and could go to them with any problems. All staff spoke highly about the leadership of the service at all levels, from their immediate line managers to the service level lead.
- Staff we spoke with told us it was very common for their ward manager to help them out in the wards if they were experiencing periods of increased activity or if the acuity of patients had increased.
- Medicines management, storage and destruction of old medicines concerns were not acted upon and produced unsafe practice
- Isolation of patients was applied in an inconsistent way and this was not being addressed.
- All matrons had a lead role which staff would approach them for if additional support was required from them. This included lead for training, falls, recruitment, discharge co-ordination and pressure ulcer prevention.
- Ward managers were not improving staff knowledge of the Mental Capacity Act and its application.

Culture within this service

- Staff from all wards we visited spoke about a positive, supportive culture amongst them. If any staff member required any help or advice, they knew they could contact their colleagues, even if they were not on shift, and get the help and support they needed.
- On the wards, staff told us there was an open door culture with their managers and they felt comfortable to raise any concerns with them in person.
- There appeared to be a high level of morale across the service with staff saying they enjoyed working for the trust as there was an open and patient centred culture. All staff told us the thing they were most proud of was the high standards of patient centred care they provided.

Public engagement

- We saw a variety of ways for patients and relatives to provide real time feedback to the wards. This included the use of trees which had leaves containing feedback and wipeable boards for patients or their relatives to write directly on to. We also saw evidence where staff had taken on board feedback and implemented new ways of working as a result.
- We saw posters in all wards encouraging patients to complete the Friends and Family Test feedback.
- The ward managers at St Luke's Hospital had started public engagement sessions where relatives and

patients (past or present) were invited in to discuss care and treatment with the ward manager. Any pertinent points raised were displayed on the ward with details on how they planned to overcome them.

- We saw volunteers from the local community coming into the hospitals to provide support or help with activities for patients. During our inspection, we saw volunteers arranging flowers and providing drinks to patients. Staff also told us members of the local clubs and schools would come into the hospitals to provide help with activities.

Staff engagement

- The trust had maintained engagement with staff through 'Listening in Action' (LiA) forums to enable staff to participate in discussions. Staff who had attended LiA sessions described them as positive opportunities for them to have their say. They told us sessions were published on the intranet and they could book to attend. We saw evidence of an upcoming LiA event around inpatient nurses rotating into the local acute hospital to maintain their competencies.
- We saw a trust newsletter called the Hospital Herald. This was sent to all staff as a way of updating them on important trust matters.
- There were annual staff recognition awards called 'simply the best' awards. Staff told us nominations had recently been made and they were awaiting details of those short listed.

Innovation, improvement and sustainability

- The ward manager on Snibston Ward, Coalville Hospital had improved the way patients were engaged in activities through the introduction of the first activities co-ordinator. Due to limited budgets, the ward manger had adapted the role of one of the funded unregistered positions so the duties they performed were centred around providing a meaningful activities programme for inpatients.

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 11 HSCA (RA) Regulations 2014 Need for consent • Staff did not always understand the requirements of the Mental Capacity Act 2005 in relation to their roles and responsibilities. • Patients' capacity was not always suitably assessed. • Staff did not always complete a Deprivation of Liberty Safeguard when necessary for patients who had sensor cushions despite being aware they should complete one as they were restricting the movement of these patients. This was a breach of regulation 11