County Durham and Darlington NHS Foundation Trust

RXP

Community health inpatient services

Quality Report

Darlington Memorial Hospital,
Hollyhurst Road,
Darlington,
DL3 6HX.
Tel: 01325 380100
Website: www.cddft.nhs.uk

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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)
RXPBA	Bishop Auckland Hospital		DL14 6AD
RXPCC	Chester-le-Street Community Hospital		DH3 3AT
RXP35	Richardson Community Hospital		DL12 8HT
RXPCL	Sedgefield Community Hospital		TS21 3EE
RXP69	Weardale Community Hospital		DL13 2JR
RXP11	Shotley Bridge Community Hospital		DH8 0NB

This report describes our judgement of the quality of care provided within this core service by County Durham and Darlington NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by County Durham and Darlington NHS Foundation Trust and these are brought together to inform our overall judgement of County Durham and Darlington NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall, community in patient services were good. Medical cover was provided in different ways at each location. Advanced nurse practitioners held responsibility for inpatient services at night, but in some locations the most senior member of staff on duty was a band 5 staff nurse. Services did not use a nursing dependency tool to calculate numbers of nursing staff required. On most wards there were two qualified nurses on duty for all shifts. When the ward was full this meant that there was a qualified nurse ratio of 1:11 or 1:12 (1 qualified nurse for 11 or 12 patients). This falls outside the recommended Royal College of Nursing (RCN) ratio of 1:8.However, managers supported staff to access additional nursing and healthcare assistant staff when clinical needs or new complex admissions required extra staff. Staff told us that their managers were supportive and trusted them to make clinical decisions regarding staffing.

Most patient records were appropriately completed, care plans were individualised and we found evidence of goal setting and discharge planning. However, medical nursing documentation received from the acute site with patient transfers was not always complete and all pages were not always sent to the community ward. We found that nursing assessments and risk assessments were in place and where risks were identified relevant to scores and patient status, appropriate action plans were in place and regularly reviewed during inpatient stays.

Incidents were reported, managed and investigated. There was evidence that learning and subsequent changes had taken place as a result of incidents. Staff understood their personal and professional responsibilities and applied the principles of the Duty of Candour legislation as part of their working roles.

Staff followed infection control principles and were seen to wash their hands and use hand sanitising gel appropriately. All staff were 'bare below the elbow'. Staff felt involved and were encouraged to give feedback on patient care both informally and at ward handovers.

Peer review was carried out across the care closer to home directorate using an observational site visit tool. This gave a rating against each quality assurance target and recommendations for actions where appropriate. Staff told us that this activity was valued by all senior staff as an opportunity to share good practice. There was little evidence that community hospitals benchmarked their outcomes or quality of care against national guidelines or standards.

Admission criteria and pathways were in place and patients were mostly admitted appropriately for nursing care and/or therapy input, although there were some inappropriate admissions to the community wards from the acute services, especially A&E. Access to therapy was inconsistent between services. Some had access to part-time therapy support on weekdays while others carried out assessments prior to admission but on-going maintenance therapy was not available. Discharge planning was integral to the care of patients and home visits were incorporated into the plans to help assess the patients' moods, wellbeing, safety and mobility needs. This allowed sufficient time to identify any equipment required and to allow efficient ordering prior to a formal discharge. Delayed transfers of care throughout the trust were due to a range of causes, most of which scored equally or considerably less (better) than national averages.

Patients and visitors told us that the care they received from staff was excellent and that patients felt safe and cared for during their stay. We observed staff speaking to patients in a sensitive and compassionate manner. There was a good range of quality information leaflets for patients and families to read and keep. Staff ensured they were as involved as possible about making decisions about their care and feeling empowered to care for themselves as soon as they were able.

Staff understood the trust's overall vision, but there was no clear vision or strategy for the future regarding community services. There had been recent changes within community inpatients and staff expected further change in future. Risk management meetings were held monthly, but staff awareness and the engagement of risk management was inconsistent. Staff we spoke to were very positive and proud of the service, the team and provision of care to patients. Ward staff encouraged patients to complete a questionnaire prior to discharge. Although low numbers of patients completed the questionnaires the results were good overall and all patients commented that the staff had been kind,

considerate and caring. Staff felt they provided a good link between acute services and the community and had good connections with therapy teams who followed up patients' progress at home.

Summary of findings

Background to the service

As an integrated healthcare provider, County Durham and Darlington NHS Foundation Trust provided acute and community healthcare services for the population of County Durham and Darlington. The trust operated two major hospital sites at Durham and Darlington and had a network of five community hospitals across County Durham. Community services were delivered from a wide range of clinics and operating bases across the area. County Durham and Darlington NHS Foundation Trust currently employs around 8,000 staff.

Bishop Auckland Hospital had a 24-bedded ward that is dedicated to rehab of patients similar to the community hospitals and had been developed as a nurse-led step down ward for admissions from the acute sites for patients who have reached their optimum rehabilitation potential and were awaiting long-term care placements, as well as orthopaedic patients who are non-weight bearing and unable to return home.

Chester-le-Street Hospital provided 23 inpatient beds with care led by consultants from University Hospital of North Durham and Shotley Bridge Hospital. Out-of-hours medical cover was provided by the local GP out-of-hours service. Nursing care was led by the Clinical Services Manager. They predominantly provided rehabilitation care with some palliative and respite care.

Richardson Hospital provided two wards with 17 beds on each, plus capacity for an additional 10 patients if winter pressures arose. They predominantly provided rehabilitation, step-down care for mainly elderly patients and some palliative care. The service was nurse-led with medical cover from the local GP practice.

Sedgefield Community Hospital provided 26 beds (currently reduced to 22 due to staffing levels) and predominantly provided rehabilitation for orthopaedic trauma, stroke and neurological rehabilitation support. This was a nurse-led unit with a locum staff grade doctor and a palliative care specialist GP attended once a week.

Shotley Bridge Hospital provided 24 inpatient beds with care led by consultants from University Hospital of North Durham and Chester-le-Street Hospital. Out-of-hours medical cover was accessed from via the medical admissions unit at University Hospital of North Durham or via triage over the telephone. They predominantly provided rehabilitation care including stroke and medical rehabilitation.

Weardale Community Hospital provided 20 inpatient beds. The hospital was remotely situated and relied on the local GP surgery for medical cover, which was available four and a half days a week. A consultant in elderly medicine visited from the acute site once every two weeks. They provided step-down care and took admissions from University Hospital of North Durham, Darlington Memorial Hospital and Bishop Auckland Hospital. Some patients were admitted direct from the accident and emergency (A&E) department or from acute wards for rehabilitation.

Our inspection team

Our inspection team was led by:

Chair: Iqbal Singh, Consultant Physician in Medicine for Older People.

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: doctors, nurses, therapists, a health visitor, district nurses, community matrons, a GP and Experts by Experience (people who had used a service or the carer of someone using a service).

Summary of findings

Why we carried out this inspection

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

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 held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the trust and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well-led. We carried out an announced visit from 3 to 6 February 2015.

We held listening events on 26 January and 2 February 2015 in Darlington and Durham to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

What people who use the provider say

Patients consistently told us that the care they received from all staff was excellent and that patients felt safe and cared for during their stay. Comments cards were returned for community hospitals where patient experience was consistently rated as high.

County Durham and Darlington NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Medical cover was provided in different ways at each location. Advanced nurse practitioners held responsibility for inpatient services at night, but in some locations the most senior member of staff on duty was a band 5 staff nurse. On most wards there were two qualified nurses on duty for all shifts. However, when the ward was full this meant that there was a qualified nurse ratio of 1:11 or 1:12 (one qualified nurse for 11 or 12 patients). This falls outside the recommended Royal College of Nursing (RCN) ratio of 1:8. However, managers supported staff to access additional nursing and healthcare assistant staff when clinical needs or new complex admissions required extra staff.

Incidents were reported, managed by local managers and investigated. There was evidence that learning and subsequent changes had taken place as a result of incidents. The trust completed root cause analysis (RCA) investigations on serious incidents or where trends were identified and wards received feedback from patient safety meetings where information needed to be shared across all locations. Staff guidance and training, audit and discussions took place on how staff could escalate concerns in order to prevent similar incidents in future. Staff understood their personal and professional responsibilities and applied the principles of the Duty of Candour legislation as part of their working roles.

The rate of harm-free care from January to December 2014 ranged between 87% and 95% across all community hospital inpatient wards.

We looked at 28 patient records, 26 medication charts and 10 do not attempt cardio-pulmonary resuscitation (DNA CPR) forms; most were completed appropriately.

The controlled drugs registers were generally found to be accurate except at Shotley Bridge Hospital, where times of administration were omitted in two entries. We identified

Good

Are services safe?

six drug administration errors during our inspection. Each error was responded to appropriately. Pharmacy support was inconsistent and a pharmacy technician was available once a week.

Resuscitation trolleys were checked daily, and all equipment and materials were found to be in good condition and in date.

Staff followed infection control principles and were seen to wash their hands and use hand sanitising gel appropriately. All staff were bare below the elbow and checked that inspectors followed the same principles while working in clinical areas.

Medical and nursing documentation received from the acute site with patient transfers was not always complete and not always were all pages sent to the community ward.

Ward managers reported that all staff had completed mandatory training and annual updates were either completed or planned to take place before the end of March 2015.

Detailed findings

Incident reporting, learning and improvement

- Incidents were reported using the trust 'Safeguard' system. All staff were trained how to identify an incident or a near miss and to use the system. We found that qualified nursing staff in all locations were confident in reporting and recording incidents. Some junior staff preferred to report to their ward manager, who would then record the event. The system required each ward manager to complete their actions for every incident and the level of harm caused.
- Staff gave examples of incidents they had reported and their outcomes. They told us teams and the organisation as a whole learned from incidents and there was evidence of clear action planning following reviews.
- The trust completed root cause analysis (RCA) investigations on serious incidents or where trends were identified and wards received feedback from patient safety meetings where information needed to be shared across all locations. Staff guidance and training, audit and discussions took place on how staff could escalate concerns in order to prevent similar incidents in future.
- Minutes from the most recent governance meeting were viewed and included details of serious incidents discussed by the team, root cause analysis and lessons learned.
- The rate of harm-free care for the previous 12 months ranged between 87% and 95% for all community inpatient wards.
- Twenty-nine deaths in community hospitals were identified as requiring review. This was a slight increase in comparison to quarter 4 2013/2014, over which period there were 27 deaths. In summary, the reviews identified that 28 deaths were expected, one unexpected.

Bishop Auckland Hospital

- There had been no new patient harms and no new avoidable pressure ulcers recorded in the six months prior to the inspection.

Chester-le-Street Hospital

- Staff told us that, occasionally, when a patient was transferred from the acute setting without paperwork, or with the wrong patient notes, they reported it on the trust's electronic incident reporting system and linked the incident for the hospital matron's attention and actions.
- Harm-free care was 92%. There had been one avoidable pressure ulcer and 23 falls, none of which resulted in patient harm.

Richardson Hospital

- A safety huddle took place every morning where all members of the team were informed of any incidents or results of risk assessments. Lessons learned were displayed on the office noticeboard and in team meeting minutes.
- Junior staff reported concerns to the ward manager or qualified staff and any trends noted were discussed at regular team meetings.
- Safety Thermometer findings were 100% for the previous six months.

Sedgefield Community Hospital

- Data from January's Safety Thermometer was displayed on the ward noticeboard. There had been zero complaints and 20 incidents reported (some of which were pressure ulcers present when patients were admitted to the ward).

Good

Are services safe?

Weardale Community Hospital

- Staff were aware of the process of reporting and what to report, although they did not seem to receive any feedback unless first passed onto their unit manager.
- There had been two falls on the ward during the month of January 2015 and zero during November and December 2014.

Falls

- All services were fully engaged in the falls steering group, thus providing them with the opportunity to understand the wider falls agenda. A thematic review of falls RCAs had been undertaken to establish if any further actions were required in relation to falls management. Following analysis of the results of the review it was evident that there were no significant emerging themes to address in relation to falls management, however, it was noted that the reassessment of patients following a fall was not always conducted in a timely manner. Furthermore, a review of the incident report forms indicated that 35% of the falls reviewed related to patients who had suffered numerous falls. Additional resources to support 1:1 nursing for high risk patients had been provided to date; this was being considered further by the falls steering group, due to current financial pressures. A further trend analysis was underway, reviewing incident data for the previous 12 months. This was to be presented and discussed at the care group patient safety meeting.

Falls performance data

- During quarter 2 there was a total of 93 falls. This was a 31% increase in comparison to quarter 1. In relation to harm rates, there had been a 37% decrease in moderate harm incidents. However, there had been a 15% increase in no/low harm incidents being reported. Although there had been a rise in falls, when comparing information to the same period within 13/14 there was a 12% decrease in the number of falls reported.

Bishop Auckland Hospital

- In relation to Ward 6, there was a total of 15 falls reported during Q2, all of which were reported as no/ low harm incidents.

Shotley Bridge Hospital

- In relation to Ward 2 there was a total of 19 falls reported during Q2, all of which were reported as no /low harm incidents

Weardale Community Hospital

- The majority of patient falls were found to take place when bringing patients to the day room. This had been monitored and falls reduced more recently with only two falls in the past three months. A computer on wheels was available for staff to update records. This allowed staff to move locations to enable better observation of patients. Staff had implemented an escalation process for one to one care, or to cohort patients with staff.

Duty of candour

- All staff we met understood the term and its meaning in practice. We were told at every location we visited that the trust required all staff to display an open, honest and transparent culture and to communicate with patients and families when incidents occurred.
- During our visit a patient was assessed by the GP following a fall the previous evening. An x-ray was requested and, although the family had visited since the fall, a member of staff telephoned a relative to update them and offered to inform them when the patient returned to the ward so that they could visit later and not have a wasted journey.

Safeguarding

- The trust safeguarding policy was available to all staff via the intranet.
- Staff reported safeguarding concerns and alerts within the trust via the safeguard reporting system and direct to the Local Authority. Advice was provided by the Safeguarding Adult Lead if required. Matrons, team leads, service leads and ward managers investigated concerns on behalf of the trust. Staff were able to identify the different types of abuse and circumstances appropriate to making a report. They explained the role of the trust safeguarding lead who would investigate any concerns raised.
- Staff told us that if they were concerned about the safety or welfare of patients being discharged home they would refer the concern to Social Care Direct.
- All staff had received Safeguarding Adults level 1 and Safeguarding Children level 2 training.

Good

Are services safe?

- Staff at Weardale Community Hospital gave an example of making a safeguarding alert when a patient's family was preventing their admission to a nursing home for financial reasons.

Medicines management

- The majority of medicines were administered correctly and appropriately.
- The controlled drugs registers were generally found to be accurate except at Shotley Bridge Hospital, where times of administration were omitted in two entries.
- Controlled drugs storage was checked weekly and drug stocks checked every 24 hours by night shift staff.
- Drugs fridge temperatures were checked daily and results were within parameters and no out-of-date drugs were found in fridges.
- We identified six drug administration errors, during our inspection. Each error was responded to appropriately.
- Pharmacy support was available once a week.
- Due to limited pharmacy cover for community hospitals medicine reconciliation did not occur in 19 patients within 24 hours of admission/transfer.

Bishop Auckland Hospital

- Pharmacy support was provided on site, with clinical pharmacy services across the site, including an inpatient warfarin dosing service, associated medicines review and pharmaceutical advice to the ANPs on ward 6. Additional support is obtained from the Bishop Auckland Hospital pharmacy staff or the University Hospital of North Durham pharmacy staff.
- Advanced nurse practitioners were qualified nurse prescribers. There was a robust system for the issue of FP10 forms medicine prescription form. These were kept locked away for security purposes.
- Medication administration records were accurate.

Chester-le-Street Hospital

- Locked drug cupboards were installed on a solid wall within a room with a security key pad. Stock was rotated and a log was kept when old stock was returned to pharmacy.
- Fridge temperatures were checked daily and logged consistently.
- Pharmacy support was provided one day a week and they audit the controlled drugs register, stocks and storage. A flow chart was displayed showing staff how to follow the protocol.
- Competency checks were recorded for all newly qualified staff and preceptorship nurses underwent regular drug round observations.
- There was evidence that staff had been asked to identify and report any risks in practice with a syringe driver.
- There had been two recent medication errors, both of which had been investigated and lessons learned were shared with the team, other community inpatient services and the trust.

Richardson Hospital

- The pharmacy technician visited once a week and was present during our visit. They undertook regular medication reviews of patient transfers from acute sites. They checked patient compliance and understanding of medication and offered advice on discharge for administration and storage of medicines in the home.
- The pharmacy technician prioritised their visit around patients with complex regimes or concerns raised by the ward staff.
- The pharmacy technician carried out a full controlled drugs audit every six months and annual spot checks on safe and secure handling of medication, cupboard locks, fridge stock and temperatures and correct storage on the ward.
- In line with Nursing and Midwifery Council guidance and the trust's transcribing policy, qualified and trained nurse prescribers copied prescriptions onto medication charts when patients transferred from one ward to another. However, some transcribing errors had occurred and these had been immediately reported on the trust incident reporting system and reviewed with ward staff. The pharmacy technician told us that the reporting of medication incidents was open and transparent and even the smallest "near-miss" was reported.
- Registered nurses swapped medication rounds to peer review and check for medication errors.
- A medication round register showing which nurse had been responsible for each round was kept daily. This helped teams identify and check responsibility when incidents occurred.

Sedgefield Community Hospital

- Medication rounds were protected and aprons worn to advise staff that the nurse should not be disturbed.
- We found a number of signature omissions on drug charts and it was not clear if medication had been given

or simply not signed for and, on questioning, the nurse responsible for the drugs round could not be sure which drugs had been administered. The ward sister counselled the member of staff, reported the incident of the trust Safeguard system and planned to deal with the errors in line with the Drug Error Management policy.
- We looked at all 22 patient medication charts following the previous findings and no further errors were found. Previous documentation audits had not identified any drug chart omissions.
- There was a patient group directions folder, which included one form for drugs relating to hypoglycaemia.

Shotley Bridge Hospital

- We checked four medication charts and found them to be complete fully and correctly. They had also been checked as part of the local record audit process.
- We found raffle money locked in the controlled drugs cupboard and we informed staff. This was removed and placed in an alternative secure location during our visit.
- The controlled drugs record book had two incomplete entries where time of administration had been omitted.
- Staff felt they were not well supported by the pharmacy and there was no pharmacy technician support.
- There was no self-assessment tool for medication in use.

Weardale Community Hospital

- Medicines and drugs trolleys were stored in a room with a keypad lock. The drugs cupboards were metal and lockable, but were mounted on a wall which was not solid and controlled drugs cupboards were stored within each of them.
- The visiting pharmacy technician had provided details on each drug, recording stock levels and packets due to expire.
- A medicine reconciliation issue arose when a patient was transferred from the acute site without their medication chart. This was investigated and managed appropriately.
- Despite the hospital's remote location there were no resuscitation drugs stored on the resuscitation trolley and staff were not trained to Intermediate Life Support (ILS) or Advanced Life Support (ALS) level.

Safety of equipment

- Resuscitation trolleys were all checked daily, and all equipment and materials were found to be in good condition and in date.
- Sufficient and appropriate equipment was available to meet patient needs, including hoists, stand aids, blood pressure machines and defibrillators. Staff reported no issues with access to appropriate equipment and supplies.
- Staff received training on medical devices and records of staff competency checks, in particular for new equipment, were kept.
- Equipment was all well-maintained, ready for use and clean. Some PAT testing labels were difficult to interpret; some showed the date the last test was carried out and others showed the date the next test was due. However all service logs were complete and up to date.
- Staff reported that the trust had implemented a quick and informal process to replace equipment such as slings that were no longer safe or fit for purpose.
- Where portable appliance testing (PAT) dates were unclear, the ward manager had developed an action plan to establish a robust monitoring system and to inform the estates team and community managers.
- Medical devices training was organised and delivered to ward staff. New equipment required 100% of staff to be trained and competency checked.

Chester-le-Street Hospital

- Although the hospital building was only 10 years old staff felt that there was insufficient storage for equipment. An adjacent ward had closed and more equipment had been inherited. Plans for a new sluice had been made but we were told these had been stopped.

Richardson Hospital

- A healthcare assistant interested in health and safety had volunteered to take on the responsibility of keeping service and safety records for all ward equipment up to date.

Sedgefield Community Hospital

- Patients were provided with their own televisions.
- The day room was pleasant and well equipped and several patients spent time there, particularly in the mornings.

Good

Are services safe?

Shotley Bridge Hospital

- The resuscitation trolley was found to be in good order, but not all daily checks were documented. The ward manager explained how she intended to manage the omissions by checking which staff were on duty on those dates and holding a discussion about their responsibilities.

Weardale Community Hospital

- Patient televisions were situated very high above beds and one patient complained that it hurt their neck to look up at it.
- Oxygen was stored in a locked room next to reception and was not compliant with regulations. Staff were aware of this and had begun action to resolve the problem. The trust were aware.
- Staff reported a lack of storage and that hoists had to be stored in the bathroom and the corridor. This had been risk assessed and was included in the trust risk register. An unused storage room was being considered for reconfiguration to help resolve the problem.

Records and management

- Records were stored appropriately and were readily available when requested.
- We looked at 28 patient records, 26 medication charts and 10 DNA CPR forms. Most records were appropriately completed, however, we found some omissions on drug charts, which were highlighted to staff and managed appropriately.
- Documentation was usually completed fully and individualised for each patient.
- The trust had recently introduced comprehensive admission documentation and an assessment pack, which was completed for every patient. However, staff reported that it was cumbersome, duplicated effort in some areas and contained several tools to complete the same task with no guidance on which tool to use.
- Care plans were individualised and we found evidence of goal setting and discharge planning.
- Therapy and nursing notes were kept together at the end of patients' beds.
- Documentation audits were carried out monthly, action plans were used to address compliance issues and improvements were made.
- Evaluations showed active management of risks and reviews within appropriate time scales.
- "Falls bundles" were in place where risk assessments identified a need.

Bishop Auckland Hospital

- Regular audits for errors and omission in record keeping were carried out. Recorded nursing assessments of safeguarding issues had dipped to only 50% compliance and plans to improve staff awareness were in place.

Chester-le-Street Hospital

- Staff told us that they had recently requested administrative support because some important calls had been missed due to nursing staff spending more time on paperwork.
- Two sets of patient records showed clear evidence of transfer and handover notes between the acute and community settings.
- Therapy notes were complete and up to date.
- Patient notes showed clear planning and information regarding future interventions and evidence of discharge planning having commenced.

Richardson Hospital

- Four DNACPR forms were completed fully and showed documentation of discussion with families and patients with best interest decisions recorded. All had reviews planned.
- Documentation audits were carried out every weekend and results had improved significantly since these were implemented.

Sedgefield Community Hospital

- Patient notes were kept in separate folders for each discipline and the doctor reported that they often found it difficult to locate records for patients.
- One DNACPR form was completed in which the patient did not have capacity, but there was no record of discussions taking place or the process that led to a 'best interest' decision.

Shotley Bridge Hospital

- Medical nursing documentation received from the acute site with patient transfers was not always complete and all pages were not always sent to the community ward.
- All assessments were completed subsequently, with appropriate care plans.

Good

Are services safe?

- One fluid balance chart was incomplete, with no instruction regarding a fluid restriction. This would have been found on the handover sheet but was not recorded on the chart.
- One comprehensive care record was used by all disciplines.
- When a patient triggered an early warning score the actions taken were documented.

Weardale Community Hospital

- The general standard of record keeping was consistent and high.
- Regular audits for omissions and errors in documentation had resulted in action planning to address non-compliance.
- Three DNACPR records were completed fully.
- DNACPR was checked prior to admission. The GP would check and reauthorise, as necessary, but it was difficult to initiate a DNACPR, due to medical cover.
- The trust admission pack was completed in all patient notes and risk assessments were used and completed appropriately. Intentional rounding was completed as planned.
- Nursing goals were recorded and individualised and consent for nursing intervention was documented on a care plan.

Cleanliness, infection control and hygiene

- The clinical environment and equipment were regularly checked and we found all areas to be clean and equipment was correctly labelled as such. Domestic staff had access to, and used, the correct colour-coded equipment.
- Staff followed infection control principles and were seen to wash their hands and use hand sanitising gel appropriately. All staff were 'bare below the elbow' and checked that inspectors followed the same principles while working in clinical areas.
- Infection control audits were carried out by a peer review process and results were displayed for all staff, patients and visitors to see.
- Personal protective equipment (PPE) was available and was used appropriately.
- There was good management of dirty linen.
- Sluice areas were clean and well organised. Although one sluice was small it was clean and safe.
- There had been no cases of MRSA in the community hospitals.
- Hand hygiene audit results were mainly good and where previously results had been poor there was evidence of action planning, further audit and significant improvement across all sites.
- Taps were flushed for Legionella prevention and this occurred during our visit at one site.
- There had been no healthcare-acquired infections in the previous 12 months.

Richardson Hospital

- Housekeeping schedules were robust and well documented.
- The housekeeper demonstrated an excellent understanding of infection prevention and provided up-to-date Legionella schedules.

Mandatory training

- Ward managers reported that all staff had completed mandatory training and annual updates were either completed or planned to take place before the end of March 2015.
- Mandatory training compliance was generally good at 90% with plans in place for those outstanding to complete before 31 March 2015.
- Staff reported that additional mandatory training days had been programmed to meet the need for staff to attend before the end of March 2015.
- Training records were discussed with ward managers and it was noted that most community inpatient wards kept their own records. Where staff had not attended training there was a valid reason recorded, such as maternity leave or long-term sickness.
- Staff were given sufficient time to attend training by including it in off-duty rotas.

Assessing and responding to patient risk

- We found that nursing assessments and risk assessments were in place and, where risks were identified relevant to scores and patient status, appropriate action plans were in place and regularly reviewed during inpatient stays.
- Early warning score system charts were in place and completed appropriately.
- We observed the care of a patient who had experienced a recent fall and noted that all actions taken were appropriate and had been recorded correctly. The GP was present and explained the process followed, actions taken and outcomes to date.

Good

Are services safe?

- Staff understood and knew how to follow escalation processes when a patient's condition deteriorated. Where medical cover was not available staff had contact details for alternative support. If patients required urgent transfer back into the acute setting then the 999 ambulance service was used.
- Inpatient wards contributed to consistent achievement of the trust target for 95% venous thromboembolism (VTE) assessment.

Staffing levels and caseload - medical staff

- Medical cover was provided in different ways at each location.

Bishop Auckland Hospital

- There was access to an on-call consultant.
- The advanced nurse practitioner (ANP) and a GP from the Urgent Care Centre (UCC) attended crash calls at night.

Chester-le-Street Hospital

- This was a consultant-led service with a consultant in elderly medicine providing support from the acute site. Two specialty consultants provided cover on weekdays shared with Shotley Bridge Hospital. Evening and night-time cover was accessed via the GP out-of-hours service.

Richardson Hospital

- This was a nurse-led service with GP cover provided by the local GP practice every weekday morning.
- GPs undertook medical rounds on weekdays and received a full handover from the ward manager. This included medical and nursing concerns, medication, investigations, discharge plans, district nurse referrals and social services requirements.
- Weekend and night cover was provided by the local GP out-of-hours service for telephone support or visits and for urgent medical assistance the staff accessed paramedics via the 999 service.

Sedgefield Community Hospital

- Medical cover was good during the day on weekdays and was provided by a locum staff grade doctor whose contract was reviewed every three months. Staff could access additional day-time and evening medical cover from the GP at the UCC on site.
- An incident had occurred recently when a patient was bleeding excessively and the only GP for the UCC was out of the hospital on visits. There was a considerable delay and advice was sought by telephone from A&E.

Shotley Bridge Hospital

- This was a consultant-led service with a consultant in elderly medicine providing support from the acute site. Two specialty consultants provided cover on weekdays, shared with Chester-le-Street Hospital. Evening and night-time cover was accessed via the GP out-of-hours service.
- Staff felt well supported from a medical perspective.
- Evening, night and weekend cover came from the medical investigations unit (MIU) from the acute site if they were visiting the ward or there was a contingency plan that the medical staff on Ward 3 at Durham would support with triage over the telephone.

Weardale Community Hospital

- Medical cover was provided by the local GP practice four and a half days a week.
- A consultant in elderly medicine visited the ward once every two weeks to see patients identified by ward staff.

Staffing levels and caseload - nursing staff

- Advanced nurse practitioners held responsibility for inpatient services at night, but in some locations the most senior member of staff on duty was a Band 5 staff nurse.
- On most wards there were two qualified nurses on duty for all shifts and the numbers of healthcare assistants met the staffing needs for the time of day. However, when the ward was full this meant that there was a qualified nurse ratio of 1:11 or 12:1 (1 qualified nurse for 11 or 12 patients). This fell outside the recommended Royal College of Nursing (RCN) ratio of 1:8.
- Staffing shortfall was managed in advance by ward managers offering extra shifts to permanent staff. They could access the trust staff bank, other community hospital wards or agency staff.
- The new nursing staff bank was a valued facility and provided a better use of staff time as a single point of contact.
- Ward managers were usually supernumerary to nurse staffing, but would step in if complex patient needs were identified.

Good

Are services safe?

- Most inpatient ward teams worked three shifts per day, but some staff preferred to work long shifts to fit in with personal circumstances.
- Staff sickness rates were acceptable across all community hospitals. A return to work interview for a member of staff with a poor sickness record was planned to take place on the day of our visit.
- All inpatient areas we visited were busy, but there was a calm atmosphere and we were told that teams felt that although they were kept busy, they had sufficient staff to provide good quality patient care.

Bishop Auckland Hospital

- There was one ANP on duty at night and they were responsible for the whole hospital after 9pm.
- The ANP provided cover for surgical, orthopaedics, gynaecology and care closer to home wards.
- The nursing staff split into two teams, each led by a Band 6 nurse with three healthcare assistants. These were overseen by a ward manager and discharge planner.
- There was ward administrative support from 8am to 2pm Monday to Friday.

Chester-le-Street Hospital

- Agency nurses brought proof of identification before starting their first shift. The ward received assurances in writing of Disclosure and Barring Service (DBS) checks and kept an agency staff file with a checklist for staff to follow.
- The ward manager told us that the unit was fully staffed and retention of staff was good.
- Staff told us they finished shifts on time and took appropriate and regular breaks.

Richardson Hospital

- The staffing ratio was 1:11. Staff felt this was sufficient for the environment and met their patients' needs. However, this fell outside the Royal College of Nursing (RCN) recommendation of 1:8.
- At night there were three Band 5 registered nurses to cover two wards.
- Prior to strategic changes there had been a matron on site and they had been replaced with a clinical services manager.
- A healthcare assistant spent some time in an administrative role to support the discharge sister.

Sedgefield Community Hospital

- There were some on-going staffing issues with shifts generally having a staffing ratio of 1:11 with two qualified nurses on duty at any time.

Shotley Bridge Hospital

- There were 13 members of staff off sick at the time of our visit and this had been reported and added to the risk register as an elevated risk. An action plan had been prepared and a proactive approach was evident.
- There were no current vacancies in the nursing team.
- Bank staff were trained and were treated as part of the team.

Weardale Community Hospital

- The majority of staff worked 12 hour shifts due to the location of the hospital.
- The staffing ratio was 1:10 for all shifts with two qualified nurses on duty and between two and four healthcare assistants depending on the time of day.
- Agency staff were providing full-time cover, due to long-term sickness in the nursing team.
- One new registered nurse had recently been appointed but the ward manager reported difficulties in recruitment due to the remote location of the service.
- The off duty rota was checked for the previous six weeks and this showed that, occasionally, there was only one registered nurse on duty. A healthcare assistant had undertaken witness training for controlled drugs administration to cover this gap.
- The ward used the discharge coordinator as registered nurse back-up if necessary.

Managing anticipated risks

- All community inpatient services had regular fire checks and no risks had been identified by the fire officers. All services had plans for horizontal evacuation and processes were understood by staff. Contingency plans were in place, where necessary. For example, in the case of a lift breakdown, an alternative lift was identified and emergency services would be informed.
- Security and access at night were a cause for concern at most community hospital locations.

Weardale Community Hospital

Good

Are services safe?

- The ward operated under security lock-down at night. Staff had undertaken fire warden training and a business continuity plan was in place. There was an on-call manager available. The nearest police station was 13 miles away.

Major incident awareness and training

- Major incident and business continuity plans were in place and each ward had an emergency mobile telephone and clearly labelled kit to hand. Telephone numbers were included to make contact with managers and the acute site when escalation actions were necessary.

Good

Are services effective?

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

Summary

Peer review was carried out across the care closer to home directorate using an observational site visit tool. This gave a rating against each quality assurance target and recommendations for actions, where appropriate. Staff told us that this activity was valued by all senior staff as an opportunity to share good practice. There was little evidence that community hospitals benchmarked their outcomes or quality of care against national guidelines or standards. Clinical audits were carried out regularly with good levels of compliance recorded.

All patients had nutrition and hydration needs assessed and charts were completed competently.

Clinical supervision was led by the service managers and carried on to nursing staff, although we were told that there was not a formal process for clinical supervision at some sites. However, there was an action plan in place to ensure this was formalised. Wards had identified link nurses for equipment, falls, neurological long-term conditions, palliative care, health and safety, palliative care, infection control and tissue viability.

Detailed findings

Evidence based care and treatment

- Staff had easy access to policies and guidance on the trust intranet and internet, and current guidance was displayed on noticeboards.
- Patients were assessed using nationally recognised tools.
- National Institute for Health and Care Excellence (NICE) guidance was shared across teams and new information and guidance was cascaded from trust level by the community matrons and community managers.
- Local audits included documentation, Safety Thermometer, Health Innovations Alliance (HIA), the quality and clinical strategy 'Quality Matters', the clinical quality information tool and physical quality of care, which was displayed with an action plan for improvements.
- National audits were completed for falls and fractured neck of femur.
- Staff felt involved and were encouraged to give feedback on patient care both informally and at handovers.

Pain relief

- There were four different pain assessment tools in place and documentation for each one was included in the patient admission and assessment packs. Some staff said that they felt confused when deciding which assessment tool to use and there was no guidance on which tool to choose.
- Patients were offered analgesia when they reported pain.
- Patients at more than one location told us that their pain had been controlled very well and this contrasted greatly with their experiences at the acute sites.
- None of the patients we spoke to reported any pain.

Nutrition and hydration

- The F4 (Focus on Food and Fluid First) initiative had been piloted across the trust. The trust informed us: "A review of nutritional care planning has showed (sic) a clear need for a nutritional bundle which incorporates weekly screening, seven days food charts, clear care planning regarding no referral to dietetics, observe and follow care plan and refer. We are working towards commencing this work in quarter 2 of 2015 and it will include documentation of oedema, daily weight charts and all aspects of nutritional care (screening, nil by mouth (NBM), feeds, cultural practices, texture modifications). This has been agreed with the executive director of nursing and discussed with the nutrition and hydration team and passed as a concept. The findings will be discussed at nutrition steering committee and reviewed every six months. The advantage of this bundle is clear signposting and documentation of all nutritional areas of care, including protected patient meal times."
- All patients had nutrition and hydration needs assessed and charts were completed competently.
- Staff could access nutrition support by telephone at the acute site.

- Staff were trained to support nasogastric tubes and a percutaneous endoscopic gastrostomy (PEG) emergency kit was kept on the ward.
- Malnutrition universal screening tool (MUST) scores were used and nutritional needs were catered for by staff.
- Patients were offered choice and a good range of hot and cold meals depending on their preferences and appetite.
- Staff were observed checking that food and drinks were within reach of patients and adjusted furniture if necessary.
- Most patients told us that they enjoyed the food and that it was well presented and appetising.
- We observed a meal produced with food moulds to make pureed foods look like the type of food they contained. The meal we saw consisted of a pork chop, carrots, peas, mashed potato and gravy.
- Staff showed pride in serving meals and lunch was clearly an event to look forward to.
- Patients were supported and encouraged to eat and drink with respect. Care was shown to avoid spills onto patients' clothing.

Technology and telemedicine

- Community inpatient wards were making use of height adjustable (Hi/Lo) beds, floor mats and chair sensors especially within the first 24 to 48 hours of admission. This equipment was used with patient consent to alert staff and enable patients to learn when an activity might cause a risk to their safety. Once patients had adjusted to the environment the sensors were removed.

Richardson Hospital

- The League of Friends had purchased alarmed floor mats to prevent falls and a special air mattress to transfer patients safely to a bed or chair if they should fall.

Approach to monitoring quality and patient outcomes

- Staff used the information from the ward-level dashboards to benchmark their patient outcomes against local guidelines and to check performance in comparison with the other community inpatient wards and over previous months.
- Results were discussed at monthly governance and management meetings.
- Peer review was carried out across the care closer to home directorate using an observational site visit tool. This gave a rating against each quality assurance target and recommendations for actions where appropriate. Staff told us that this activity was valued by all senior staff as an opportunity to share good practice.
- There was little evidence that community hospitals benchmarked their outcomes or quality of care against national guidelines or standards.

Outcomes of care and treatment

- Clinical audits were carried out regularly with mostly good levels of compliance recorded.
- Evidence and outcomes of audits were displayed on ward noticeboards for staff, patients and visitors to view.

Bishop Auckland Hospital

- A bariatric patient was admitted and an extra width bed was obtained which used two bed spaces in a bay. The patient was fit to be discharged, but could not access their own home due to the equipment they would need. The fire, ambulance and social services assessed their needs and requirements and, following the patient's decision, the bariatric dietary team supported them to attain mobility and eventually return home.

Sedgefield Community Hospital

- There was a day ward based at the hospital that facilitated an early discharge. Outcomes for patients were monitored in an informal way, but services were not tailored to improve outcomes generally.

Weardale Community Hospital

- Outcomes were not routinely monitored. And there was no evidence that the ward benchmarked their results against other local or national standards. An example of this was that the average length of stay was 30 to 40 days, but this had not been considered high because there had been no benchmarking against other providers.
- There was some limited discussion of outcomes at weekly multidisciplinary team meetings.

Competent staff

- Wards had identified link nurses for equipment, falls, neurological long-term conditions, palliative care, health and safety, infection control and tissue viability.

Good

Are services effective?

- There was no link nurse for dementia at Bishop Auckland Hospital, although there were long-term patients with dementia. All staff had, however, undertaken dementia awareness training.
- Staff competencies were assessed and recorded by senior ward staff and ward managers.
- Clinical supervision was led by the service manager and passed on to nursing staff, although we were told that there was no formal process for clinical supervision at some sites. However, there was an action plan in place to ensure this was formalised.
- Healthcare assistants had group supervision sessions where they could discuss objectives and problems as a team. They also accessed private meetings with their ward manager if required.
- The wards offered placements for student nurses.
- All staff had appraisals in 2014. Staff competencies were linked to outcomes from their appraisals.
- All bank and agency nurses were given a local induction.
- Staff were supported to access and complete mandatory training, much of which was available via e-learning modules.
- Senior staff on some wards had completed Acute Illness Management (AIM) training, which was provided internally by the trust cardiac arrest prevention team. This course was designed to replace the advanced life support training for nursing staff.
- Senior nurses were nurse prescribers.

Multi-disciplinary working and coordinated care pathways

- Ward handovers took place three times a day and, on GP-led units, a separate handover took place prior to the ward round. Where therapists were part of the ward team they joined the handover.
- Multidisciplinary team meetings took place once a week and teams usually included the doctor on duty, a discharge nurse (supernumerary for the day), an occupational therapist, a physiotherapist and a social worker from the Integrated Short-term Intervention Service (ISIS) team.
- Staff used guidance developed by the Northern England Strategic Clinical Networks, 'Guidance for care of patients who are ill enough to die', June 2014 as a replacement for The Liverpool Care Pathway.

Bishop Auckland Hospital

- Patients had limited access to physiotherapy and occupational therapy on the ward. Therapists carried out assessments prior to admission but on-going maintenance therapy was not available.
- There were good links to specialist services, including stoma care, body mass index (BMI) assessors and Deprivation of Liberty Safeguards specialist nurses, who were available as required.

Chester-le-Street Hospital

- The ward manager also managed the day hospital, which replaced an adjacent ward. The nursing and therapy teams worked closely together as a multidisciplinary team to enable patients to be rehabilitated and to return home.
- There were two physiotherapists and two therapy assistants, all of whom were available to support inpatients in the mornings. They provided therapy at the day hospital and organised home visits in the afternoons.
- All staff attended the ward handover and contributed to the assessment of patients' needs.
- Staff referred an average of one or two patients per week to the mental health team, who visited the ward one morning per week.

Richardson Hospital

- Therapy was provided by a physiotherapist and two therapy assistants on weekday mornings.
- A dietician supported the ward one day a week.
- Ward clerks from the two inpatient wards organised and carried out their own handover every morning to ensure they each had all the necessary information to carry out their role, including admissions, planned discharges, staffing changes, reception cover and general ward communications.
- Housekeepers were qualified in healthcare support services NVQ level 2 and had also received additional training in sensory loss awareness to increase their understanding of patient needs and quality of care offered by the whole team.
- Staff maintained good links with the local Macmillan nursing team.
- Support from a palliative care consultant from the primary care trust (PCT) had been discontinued when the service was transferred to the trust.

Sedgefield Community Hospital

Good

Are services effective?

- The physiotherapist continued her therapy with some patients after discharge, working in the community in the afternoons.

Weardale Community Hospital

- There were a full-time physiotherapist and a part-time therapy assistant available from Monday to Friday. There were therapy plans in place throughout the week.
- The occupational therapist provided support to the ward for eight hours per week.
- Speech and language therapy could be accessed via referral.

Referral, transfer, discharge and transition

- Average length of stay varied depending on the service, but patients appeared to feel no pressure to leave the ward environment.
- Delayed transfers of care throughout the trust were due to a range of causes, most of which scored equally or considerably less than national averages. However, the number of patients awaiting community equipment and adaptations was twice that of national scores and those waiting for completion of assessments were the cause of 59% of all delays. This was three times the national score.
- Each community inpatient ward had identified a lead discharge nurse. Some had dedicated members of the team and others rotated staff into the role. This position was often supernumerary to nurse staffing, but could be added in if complex patient needs arose.
- For planned discharges the ward staff used handover sheets to refer patients to the district nursing teams and 24-hour care services. If the patient required intermediate care services upon discharge an intermediate care nurse would assess the patient and the care plan would go with the patient on discharge.
- Discharge planning was integral to the care of patients and home visits were incorporated into the plans to help assess the patients' moods, wellbeing, safety and mobility needs. This allowed sufficient time to identify any equipment required and to allow efficient ordering prior to a formal discharge.
- Patient information packs gave a range of contact details should patients or families require support after discharge.

Bishop Auckland Hospital

- Advanced nurse practitioners assessed patients within two hours of admission and formal reviews of non-acute patients were carried out every three to four days. Patients who became unwell were assessed at least every 24 hours.
- Nurse practitioners screened potential admissions with nursing teams at the acute site to ensure all admission criteria were met before transferring patients.
- There was a robust system for assessment of mental capacity on admission. A low score would instigate a referral to the mental health trust and if the patient had insufficient capacity to give consent to treatment a Deprivation of Liberty Safeguards standards assessment would be applied for.
- The average length of stay was planned at the service's inception in 2009 to be around seven to 10 days. Due to considerable changes in the service and the type of patients admitted, the length of stay could reach up to six months.
- Continuing healthcare applications ran smoothly with good liaison and close working between assessors and the ward team.
- Patients' individual preferences and families' opinions were observed on discharge plans.

Chester-le-Street Hospital

- The average length of stay was 20 days, although staff felt it was nearer 14 days. Patients with complex discharge needs may have had to wait for two to three weeks for a continuing healthcare decision support tool meeting. This led to much longer inpatient stays than necessary and discussions were being conducted at managerial level to reduce this waiting period.
- Equipment required for discharge was usually sourced within 48 hours.
- Where discharges were delayed staff reported them to the community rehabilitation manager.
- A patient and their relative told us that discharge was planned with equipment ordered in advance and a home visit planned to prepare the patient and family for discharge.

Richardson Hospital

- Relatives were offered the opportunity to stay on the ward to learn to care for the patient in preparation for discharge.
- Home visits were planned in a timely manner, prior to patient discharge, by the therapies team.

Good

Are services effective?

Sedgefield Community Hospital

- There were some inappropriate admissions to the ward from the acute services and the locum staff grade doctor was in the process of auditing admissions. There had been a number of patients admitted direct from A&E who had diagnosis of urinary tract infection (UTI) without investigations having been carried out. Staff considered the assessment of patients had been poor and major conditions, for example, pulmonary embolism or deep vein thrombosis (DVT) had been missed.
- The average length of stay was 10 days.

Weardale Community Hospital

- There were some inappropriate admissions to the ward from the acute services. The GP on duty gave an example where a patient was admitted with an unstable neck fracture and had to be transferred back immediately. The GP felt there was on average of one inappropriate admission per month and he was unaware of any audit of these.
- Discharge problems were caused by the inability to organise multidisciplinary team meeting discharge planning meetings. The discharge coordinator regularly organised virtual meetings to facilitate this and there had been no move to improve this.

Availability of information

- Record-keeping audits were carried out monthly and results were sent to the care group. Key messages and action points are distributed to all community hospitals weekly.
- Patients were usually admitted with medical records from the acute site but, if these did not arrive, staff used the Safeguard system to report it as an incident and ensure the acute site ward manager was aware and action taken.
- Patient information notices were displayed on all community inpatient wards.
- Staff had access to trust bulletins and the intranet and access to wider information on clinical guidelines and pathways, policies and procedures via the internet.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff involved patients in their care and obtained verbal consent before carrying out any interventions.
- Deprivation of Liberty Safeguards documentation was in place, with associated risks highlighted and review plans in place.
- 'Best interest' assessments were carried out and staff understood their responsibilities regarding consent for patients who may lack mental capacity.
- We found one Deprivation of Liberty Safeguards assessment document was awaiting authorisation and staff told us that the response rate was generally slow.
- Patients told us that staff told them what they needed to do and checked for verbal consent before continuing.

Good

Are services caring?

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

Summary

We spoke to 16 patients and nine visitors, who all told us that the care they received from all staff was excellent and that patients felt safe and cared for during their stay. We observed staff speaking to patients in a sensitive and compassionate manner. Staff knocked on doors before entering private areas and used privacy screens where available.

There was a good range of quality information leaflets for patients and families to read and keep.

A patient told us they were waiting to be discharged. They were kept informed about what was happening and how community services would continue their care at home.

Staff allowed time for patients to discuss their feelings and anxieties, showed empathy and supported them to talk about problems. Staff cared for many patients who had experienced trauma and they ensured that patients were as involved as possible in making decisions about their care and that they felt empowered to care for themselves as soon as they were able.

Dignity, respect and compassionate care

- We spoke to 16 patients and nine visitors, who all told us that the care they received from all staff was excellent and that patients felt safe and cared for during their stay.
- All the patients we spoke to told us that staff strove to maintain their dignity at all times, and especially when carrying out personal care, by ensuring privacy and closing doors and curtains.
- Patients and visitors told us that all staff were respectful of their needs and preferences and took time to understand personal requirements and to explain the care being administered.
- We observed staff speaking to patients in a sensitive and compassionate manner. Staff knocked on doors before entering private areas and used privacy screens where available.
- We observed staff supporting patients to attend dining rooms and providing sufficient support and protection for patients to eat their lunch safely and comfortably.
- To support eating for a patient with Huntingdon's Disease staff sat with the patient at eye level.
- Staff sat and read with a patient with dementia.
- A relative told us: "Dad always looks clean and well cared for and I know that they are helping him to eat and drink." They also told us they were glad he was able to recover in the community hospital away from the busy acute hospital.

Understanding and involvement of patients and those close to them

- Staff told us that they had accessed interpreter services and took care to try to understand each patient's personal needs and cultural preferences.
- There was a good range of quality information leaflets for patients and families to read and keep.
- Within care closer to home, patient experience feedback, in a number of services, was facilitated via the NHS Friends and Family Test supported by iWantGreatCare (a healthcare review site). During a three month period there had been a total of 1,504 responses received from patients completing the iWantGreatCare comments cards, which was a 43% increase in comparison to the previous three months.
- One patient told us she felt as if she had been staying in "a five-star hotel or a spa".
- A patient told us they were waiting to be discharged. They were kept informed about what was happening and how community services would continue their care at home.

Bishop Auckland Hospital

- There were well documented discussions about, and the use of an interpreter with British Sign Language (BSL) skills for, a profoundly deaf patient regarding major clinical decisions. The patient had a fractured humerus, but surgery would prevent them from using sign language. The documentation indicated identification of risks, issues and the patient's choice on the type of treatment.
- A patient was offered thickened fluids to aid swallowing and their choice not to have these was clearly documented.
- One patient wrote in a thank you card: "Found out more information within 10 minutes of being here than months of care elsewhere."

Good

Are services caring?

Community Hospital comment card summary results

- A total of 250 comments cards were returned for community hospitals where patient experience was consistently rated as high. There was an average score of 79% for Quarter 2 with an average star rating of 4.8. There were many examples of comments demonstrating high quality individualised care, which was delivered with compassion. There was, however, a theme related to a perceived lack of staff, which was being addressed through a comprehensive community hospital review and a trust-wide review of staffing levels being led by the executive director of nursing.
- Community hospital matrons continued to review patient feedback provided via the cards with any issues highlighted by patients being acknowledged and improvement actions being implemented.

Richardson Hospital

- Patients were provided with a professionally produced information pack containing a welcome to the ward, the philosophy of care, information on staffing, specialist services and therapists, who's who and uniforms, visiting times and contact information following discharge.
- A main road had been closed for almost a year and staff had organised flexible visiting times for families who needed to travel longer distances on rural roads, especially during the winter.

Emotional support

- Staff allowed time for patients to discuss their feelings and anxieties, showed empathy and supported patients to talk about problems.
- Chaplaincy support was available at most sites on a weekly basis and would come to the wards if needed. The chaplain could access support for all faiths and denominations as required.

Bishop Auckland Hospital

- A patient was admitted with a fracture and was unable to weight-bear. The staff learned that their elderly mother was nearing the end of life at a nursing home some distance away. The ward arranged for the patient to be transferred to a service close to their mother.
- A lady wanted to care for her husband at home but, following assessment, the ward team did not consider the couple able to manage. A trial discharge to assess their needs at home was arranged.

Richardson Hospital

- The trust provided chaplaincy support via on-call facility and the ward accessed local spiritual support for patients, if required.
- Two rooms had been designed with pull-down beds for family members to stay overnight with patients who received end of life care. One patient had had their husband stay every night for the past week. These rooms also had fridges for relatives to use.

Weardale Community Hospital

- Staff recognised that there was a need to provide palliative care beds for local patients and regularly accepted palliative care patients. Staff had taken on extra training in response to this and provided support to families when visiting the ward and at discharge.
- A viewing room was available to enable families to spend time with patients who were recently deceased. The temperature in this room was monitored and the room held two trolleys side by side with a curtain between the two for privacy. Staff told us that patients had stayed there for three to seven days in the past.

Promotion of self-care

- Staff cared for many patients who had experienced trauma and they ensured that patients were as involved as possible in making decisions about their care and that they felt empowered to care for themselves as soon as they were able.
- Staff told us that the rehabilitation environment on community hospital wards encouraged patients to become independent and more mobile. The nature of this brought risks of falls and similar incidents which were discussed with patients. Any incidents and near misses were reported on the trust Safeguard reporting system.

Bishop Auckland Hospital

- Patients were dressed and wore their own clothes on the ward.

Richardson Hospital

Good

Are services caring?

- A visitor told us that their husband had been a patient for three weeks since transfer from the acute site and the care on this ward had helped him make good progress to get his mobility back.
- The patient dining room and lounge area were well designed and equipped. The majority of patients were supported to eat their meals and to interact in this environment.

Shotley Bridge Hospital

- Staff encouraged patients to use the dining room at meal times to encourage interactions.

Weardale Community Hospital

- Gentle encouragement was given to patients to do individual tasks, such as walking with aids, and they were allowed to move at their own pace.

Good

Are services responsive to people's needs?

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

Summary

Facilities and equipment were available to meet the needs of the patients.

Admission criteria and pathways were in place and patients were mostly admitted appropriately for nursing care and/or therapy input. All patients were treated as individuals and families were welcomed to the ward environments.

Staff felt they provided a good link between acute services and the community and had good connections with therapy teams who followed up patients' progress at home.

Therapy staff supported patients from Monday to Friday. There was no therapy input at weekends and this often resulted in a break in the continuity of treatment and progress.

In the previous six months there had been no formal complaints across community inpatient services and staff were unaware of any patient advice and liaison enquiries. Staff felt that concerns at ward level were their responsibility and most problems were solved by listening and talking to patients or relatives about their concerns. They were aware of the complaints process to be followed if necessary.

Detailed findings

Planning and delivering services which meet people's needs

- Ward managers attended the community hospital review group meetings to discuss needs of the community services with a vision to meet the needs of the local clinical commissioning groups (CCG). Ward managers explained that each of the five community hospitals had different medical cover and work was being carried out to look at how this might work best. There was also a need to identify palliative care beds available across the community.
- Facilities and equipment were available to meet the needs of patients. For example, rehabilitation equipment was available at most locations and hoists were provided.
- Staff demonstrated a good understanding of the local population and the services available to patients from local authorities as well as voluntary organisations and hospice care.
- Staff gave examples of liaising with specialist workers including the community mental health team and Macmillan nurses.
- Admission criteria and pathways were in place and patients were mostly admitted appropriately for nursing care and/or therapy input.
- The admission criteria was adhered to in partnership with hospital consultants and local GPs and was planned to provide intermediate care to patients. This included patients who were transferred from the acute hospital following medical or surgical care and patients admitted from the community who required additional care but did not require acute hospital care.

Bishop Auckland Hospital

- The ward had 24 beds for patients admitted from the acute sites who had reached their rehabilitation potential and were awaiting long-term care placements and for orthopaedic rehabilitation patients. There were often eight or nine orthopaedic patients on the ward at any one time.

Chester-le-Street Hospital

- The ward had 23 beds for patients requiring rehabilitation and intermediate care, with separate accommodation for male and female patients.
- A visitor told us that after 2pm they were unable to access a hot drink.

Richardson Hospital

- The hospital had 34 beds on two wards (with capacity for a further 10 should winter pressures arise) for rehabilitation, step-down care (mainly for elderly patients) and some palliative care patients.
- Ceiling track hoists were provided and used appropriately.
- There were two rooms allocated and furnished appropriately for palliative care patients, with pull down beds, en-suite bathrooms and fridges for relatives to use.

Good

Are services responsive to people's needs?

Sedgefield Community Hospital

- The ward had 22 beds for rehabilitation for orthopaedic trauma, stroke and neurological rehabilitation and palliative care patients.
- The hospital had recognised a need to provide palliative care beds for local patients and staff responded to local and individual needs.
- There was a relatives' room available for those who wanted to stay with patients and for use to teach relatives how to care for patients. This was set up to facilitate faster and more appropriate discharges.

Shotley Bridge Hospital

- The ward had 24 beds for rehabilitation care including stroke and medical rehabilitation patients.

Weardale Community Hospital

- The ward had 20 beds for patients requiring rehabilitation and palliative care, with separate accommodation for male and female patients.
- We were told that most admissions ran smoothly, but sometimes patients could sit all day at the acute site waiting to be transferred and they would arrive on the ward cold and tired. One patient was significantly delayed and had to be readmitted to the acute ward until they could be transferred the following day.

Equality and diversity

- All patients were treated as individuals and families were welcomed to the ward environments.
- Ward staff allowed flexible visiting times according to personal circumstances and patient needs. However, meal times were protected.
- Staff knew how to access interpreter services when required and, in the past, had asked a family to help staff make flash cards for a patient who did not speak English.
- Staff were aware that the trust catered for many different diets and cultural choices and staff knew that they could make requests for specialist foods for patients.

Meeting the needs of people in vulnerable circumstances

- Some wards made good use of dementia-friendly signage and blue colour coding around doors.
- Staff felt they provided a good link between acute services and the community and had good connections with therapy teams who followed up patients' progress at home.
- Noticeboards displayed information about support available for carers.
- One ward had a patient with a learning disability and they were treated and spoken to in the same way as all other patients. The learning disability lead nurse would attend if the patient had special needs.
- Learning disability passports were in use and understood at Bishop Auckland Hospital.

Chester-le-Street Hospital

- The ward provided respite care for two patients who had utilised the service long-term and this agreement was continuing in order to meet the needs of the patients and their families.

Richardson Hospital

- The local hospice used a seminar room for meetings and therapy on the ward and provided liaison for current patients and families whose relatives were receiving end of life care.

Access to the right care at the right time

- Therapy staff supported patients from Monday to Friday. There was no therapy input at weekends and this often resulted in a break in the continuity of treatment and progress.
- Patients and staff told us that they were happy to be on a ward close to home and relatives.
- When patients' conditions deteriorated in community wards staff referred to the trust early warning score (EWS) system policy and used their professional judgement to assess the presentation of the patient. Since urgent medical cover was not always available nursing staff had instructions to contact A&E or to call 999 for an ambulance.
- The multidisciplinary teams were present in all the services and their efforts were evident throughout our visit.
- A specialist transfusion practitioner was available to support and train staff.

Chester-le-Street Hospital

- The ward had experienced a high proportion of patients with confusion. The ward manager had requested extra

agency night staff support and the team had noticed that there were fewer incidents at night. Following this an extra healthcare assistant was added to the staffing at night.

Learning from complaints and concerns

- Patient feedback was encouraged on discharge from all community inpatient wards and patients told us that they could ask questions or raise concerns with any member of staff at any time during their stay. However, the rate of successful completion of formal feedback forms was low.
- In the previous six months there had been no formal complaints across community inpatient services and staff were unaware of any patient advice and liaison enquiries.
- Staff felt that concerns at ward level were their responsibility and most problems were solved by listening and talking to patients or relatives about their concerns. They were aware of the complaints process to be followed if necessary.
- Information on how to raise a concern or make a complaint was displayed in ward areas and included in patient information packs.

Good

Are services well-led?

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

Summary

Staff understood the trust's overall vision, but there was no clear vision or strategy for the future evident regarding community services. There had been recent changes within community inpatients and staff expected further changes in the future.

Governance processes were in place and a risk register was maintained. Senior staff felt able to raise issues surrounding incidents and concerns at directorate level. Staff told us that community managers provided good support and senior management was available, effective and supportive in line management. The trust chief executive was well-respected and visible.

Staff we spoke to were very positive and proud of the service, the team and provision of care to patients.

Ward staff encouraged patients to complete a questionnaire prior to discharge. Although low numbers of patients completed the questionnaires, the results were good overall and all patients commented that the staff had been kind, considerate and caring.

Detailed findings

Service vision and strategy

- The vision and values were displayed on noticeboards.
- Staff understood the trust's overall vision, but they were less clear on the future strategy regarding community services. There had been recent changes within community inpatients and staff expected further change in future.
- Ward philosophy was included in patient information packs.

Chester-le-Street Hospital

- Staff told us that there was work going on to look at how medical cover might work best in future.

Weardale Community Hospital

- There was no clear strategy to move the service forward other than plans for a possible extension and interior improvements, such as a visitors' toilet.

Governance, risk management and quality measurement

- Clinical service managers reviewed trends and serious incidents and results were cascaded to staff through ward managers' meetings.
- Risk management meetings were held monthly but staff awareness of and engagement in risk management was inconsistent.
- A risk register was maintained and most senior staff felt able to raise issues surrounding incidents and concerns at directorate level.

Leadership of this service

- A professional forum had been established within care closer to home, which brought together all specialties. The forum centred on the quality agenda and had a key focus on sharing lessons learned and best practice across a range of clinical specialties.
- Managers supported staff to access additional nursing and healthcare assistant staff when clinical needs or new complex admissions required extra staff. Staff told us that their managers were supportive and trusted them to make clinical decisions regarding staffing.
- Information regarding the monitoring of safety issues and audits was submitted corporately and ward dashboards were updated on a monthly basis.
- Staff told us that community managers provided good support and senior management was available, effective and supportive in line management.
- Staff reported that the trust chief executive was well respected and visible and that the executive team had made a round of community hospitals using the trust bus.

Bishop Auckland Hospital

- The core ward team had established good stability since the service was set up in 2009. The ward manager was integrated into the team and led by example.

Richardson Hospital

- The ward managers were skilled, motivated and organised ward leaders.

Good

Are services well-led?

- We spoke to groups of staff from all levels within the team who told us they felt they were part of a highly functioning, mutually supported and valued team.

Sedgefield Community Hospital

- There was a desire by staff to increase the workforce and, therefore, increase the number of beds available to 26 again. However, there was no clear vision or strategy for the future evident.

Weardale Community Hospital

- The ward manager had taken over responsibility for the ward three months prior to the inspection. Prior to this the responsibility was shared between two managers. There was good line management support in place and a good working relationship was apparent.

Culture within this service

- Staff we spoke to were very positive and proud of the service, the team and provision of care to patients.
- Senior staff told us that they felt empowered and trusted to provide good quality and effective care.
- Ward managers were encouraged to make decisions, such as ordering replacement parts for equipment. The community managers had ensured this process was quick and simple to follow.
- Healthcare assistants told us that they felt supported, valued and cared for within ward teams.

Public and staff engagement

- Patient-led assessments of the care environment (PLACE) results were generally good and were equal to, or better than, national average results. However, results for privacy, dignity and wellbeing were lower than the average scores for three locations: Chester-le-Street Hospital, Shotley Bridge Hospital and Weardale Community Hospital. (This information relates to the whole hospital sites and not just inpatient areas.)
- Care closer to home care group had implemented across inpatient and community services a Clinical Quality Improvement Framework (CQIF). This initiative enabled teams to review quality standards against a framework and provided a selection of improvement tools for the team to use. The framework built in patient feedback/comments, which the trust felt were vital to improving services. In addition, a series of observational site visits were undertaken on a biannual basis. These were completed by senior managers within the care group and provided individual teams with the opportunity to share and discuss key topics.
- Ward staff encouraged patients to complete a questionnaire prior to discharge. Although low numbers of patients completed the questionnaires the results were good overall and all patients commented that the staff had been kind, considerate and caring.

Richardson Hospital

- The hospital League of Friends provided televisions and telephones at every bedside for patients' use.

Innovation, improvement and sustainability

Bishop Auckland Hospital

- Patients whose MUST risk assessment identified nutritional needs were given red or amber identifiers on the ward whiteboard and on their care plans. They were offered a diet of fortified foods with nutritionally enriched snacks and milkshakes between meals. The overall aim was to reduce the use of unpalatable supplements and identify those at nutritional risk on discharge.

Richardson Hospital

- Friends of the Hospital had raised funds to purchase a HoverMatt air mattress to enable patients who had fallen to be supported and raised from the floor and transferred to a bed or chair in a safe and controlled way.