Sherwood Forest Hospitals NHS Foundation Trust

Community health inpatient services

Kings Mill Hospital
Mansfield Road
Sutton In Ashfield
Nottinghamshire
NG17 4JL
Tel: 01623622515
www.sfh-tr.nhs.uk

Date of inspection visit: 16 - 19 June 2015
Date of publication: 20/10/2015

Ratings

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

Summary of findings

Community health inpatient services

Requires improvement

Summary of this service

We rated it as requires improvement because:

Systems and processes were not always reliable or appropriate to keep patients safe. Medicines administration practice did not always ensure patients had received their medicines correctly.

Care and treatment did not always reflect current evidence-based guidance, standards and best practice. Care plans did not reflect the patient's individual needs and preferences. Patients did not always have sufficient support to ensure their nutritional needs were met. There was no effective pathway in use to identify and treat sepsis in patients.

Patients' mental capacity to make decisions was not assessed in line with guidance and legislation. There was little evidence that patients and their relatives had been involved in the decision-making process.

The flow of patients through the hospital was affected by inappropriate admissions and delayed discharges. Patients transferred from Kings Mill Hospital were not always suitable for the rehabilitative care provided at Mansfield Community Hospital. There were delays in discharges where patients were waiting for community care services to be arranged.

The care for patients living with dementia did not meet current guidance and recognised good practice. There were no learning disability care pathways in place to inform staff how to support patients with a learning disability.

Recognised safer staffing nursing staff levels were not met for afternoon or night shifts. Recruitment was underway to address this. Staff were unclear about the vision or strategy for Mansfield Community Hospital. There was an increasingly diverse use of beds which meant the identity and role of the hospital was not clear.

Safety incidents were reported, and appropriate action taken. Staff had feedback and learning from local incidents, but not from incidents at Kings Mill Hospital.

The hospital appeared to be clean and there were systems in place to manage the prevention and spread of infection. There were effective multidisciplinary working relationships to support patients' progress towards discharge. Staff had access to training to ensure they were competent to meet patients' needs. Patients told us they were encouraged to be independent and were also well supported by staff when they needed care. Staff generally treated patients in a kind and respectful manner.

There were three wards providing medical care, including older people's care, at Mansfield Community Hospital. They were part of the Sherwood Forest Hospitals NHS Foundation Trust's division of emergency care and medicine.

There were 141 admissions to medical care services at Mansfield Community Hospital in 2014/15. Most admissions (91%) were transfers from Kings Mill Hospital for rehabilitation and treatment. The remainder of patients were planned admissions who were admitted from the community or from other hospitals. planned admissions for rehabilitative care and treatment.

During our inspection we visited all the wards providing medical services at Mansfield Community Hospital: Oakham Ward and Lindhurst Ward with 24 beds each and Chatsworth Rehabilitation Ward with 16 beds.

Summary of findings

We spoke with 22 patients, 25 staff, eight visiting relatives/friends and one paid carer. We also looked at the care plans and associated records of 13 patients.

Is the service safe?

Requires improvement

We rated safe as requires improvement because:

Systems and processes were not always reliable or appropriate to keep patients safe. There was localised but not trust wide learning to incidents. Medicines administration practice did not always ensure patients had received their medicines correctly. There was inconsistent practice in ensuring medicines requiring refrigeration were stored at the right temperature. The system for checking emergency equipment was not always effective as out of date equipment had not been identified on one ward. Chemical cleaning products were not kept securely on one ward.

There were some inconsistencies and delays in the assessment and treatment of sepsis. . Equipment was in place to deliver sepsis treatment but this was not supported by the availability of medical staff or facilities for diagnostic tests.

Assessed minimum nursing staff levels were not always met for afternoon shifts on Oakham Ward. Recruitment was underway to address this. Shifts were being supplemented by having additional healthcare assistants on duty.

Safety incidents were reported and appropriate action taken. Staff had feedback and learning from local incidents, but not from incidents at King's Mill Hospital.

The hospital appeared to be clean and there were systems in place to manage the prevention and spread of infection.

Consultant reviews took place weekly. Doctors or advanced nurse practitioners provided medical care to patients during the day with out of hours services provided by a visiting General Practitioner (GP).

Incidents

- Incidents at Mansfield Community Hospital were reported by staff through an electronic reporting system. Feedback was provided by email for the incidents staff reported. Staff told us they were encouraged to report incidents. Some staff we spoke with were not clear who reviewed the incidents reports that were submitted.
- Between January 2014 and January 2015 there were three serious incidents requiring investigation. Two related to outbreaks of infection and one to an accident to a patient.
- Ward leaders completed root cause analysis (RCA) investigations if there were serious incidents. We were told that the most recent one was in January 2015. The incident involved an injury to a patient which was not recognised by staff immediately. Staff told us that relatives had been informed of the investigation process and had received a copy of the report.
- The matron told us that staff had received guidance on the duty of candour and felt they knew what to do. The duty of candour requires organisations to be open and transparent with patients when things go wrong.
- Staff told us learning boards had recently been introduced. These were standard across the trust to ensure staff received the same information. We saw these were in place.
- Staff knew about local incidents and learning. An example we looked at was following an incident where there was a lack of response to the fire alarm. . Training had taken place to ensure that there was learning from the incident.

Summary of findings

- We were told mortality and morbidity meetings had been held for older persons care for the past three months, however, no minutes had been taken. The lack of documentation did not ensure that actions were identified or taken forward.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool used for measuring, monitoring and analysing patient harms and 'harm-free' care. Information was recorded on one day each month. The safety thermometer captures information on the number of pressure ulcers, venous-thromboembolisms (blood clots), falls and catheter acquired urinary tract infections.
- The harm free care rate for May 2015 was 100% for Lindhurst Ward and Chatsworth Rehabilitation Ward. For Oakham Ward the harm free care rate for May 2015 was 91.6%.

Cleanliness, infection control and hygiene

- All wards appeared to be clean. When equipment had been cleaned, labels were attached to identify it was clean and ready for use.
- Staff had access to plentiful supplies of personal protective equipment including disposable gloves and aprons. Staff were also bare below elbow in accordance with the trust policy.
- Sanitizing hand gels were available for staff and visitors to use when entering or leaving ward areas.
- There had been one case of clostridium difficile infection and three cases of Escherichia coli (or E. coli) at Mansfield Community Hospital for the period April 2013 – March 2014. Infections by clostridium difficile and E. coli bacteria affect the digestive system.
- MRSA (methicillin-resistant Staphylococcus aureus is a bacteria responsible for several difficult-to-treat infections). Routine screening of patients for MRSA was completed with further screening repeated after 21 days.
- In January 2014, the incidence of MRSA was rated as green, meaning low risk because there had been no cases. Recent information showed that there had not been any further infections.
- Staff compliance with the hand hygiene audit was 99% to 100% between December 2014 and January 2015
- Side rooms were used to care for patients where a potential infection risk was identified. This could be to protect other patients from the risk of the spread of infection, or to protect patients from infection where they had compromised immunity to infection.
- A range of pedal operated waste bins were available to segregate waste into correct bins and recycle where possible.

Environment and equipment

- On Lindhurst Ward the kitchen was unlocked and chemical cleaning products were accessible to patients and other people visiting the ward. A general environmental risk assessment of the ward was in place but this did not include the risk of cleaning products not stored securely.
- On Oakham Ward we were told that there was no dishwasher available. The procedure for washing patients' crockery involved taking it on a trolley to an adjacent ward. Staff told us this had caused difficulties when wards had been closed due to infection outbreaks. Staff told us this concern had been escalated numerous times but they were still without a dishwasher. This presented an infection control risk.
- Resuscitation equipment was available on each ward. Records showed staff signed that they had checked the trolleys each day. However, we found some out of date equipment on one out of three trolleys.
- Ward corridors were cluttered with equipment. Staff told us the equipment was in constant use throughout the day.

Summary of findings

- Communal space was available on each ward, providing radios and televisions and also used as a space to offer therapies.
- Moving and handling equipment service checks were up to date. There was a washing machine available for moving and handling slings to be washed.
- Staff told us specialist equipment, such as special beds could be accessed within 24 hours.

Medicines

- There were suitable and secure storage arrangements for medicines. Up to date medicine information books were available.
- Refrigerators were provided for medicines needing cool storage. The temperatures were checked daily but there was inconsistent practice between the three wards. Some ward staff recorded the maximum and minimum temperatures, but others did not. Room temperature checks were not recorded so it could not be assured that all medicines were stored at the correct temperature.
- Patients told us they received their medicines on time. Accountability handovers took place at each shift change where medicine records were checked. This ensured it was quickly identified and communicated where patients had not received their medicines.
- One tablet crusher we saw appeared dirty with particles of medicines. This increased the risk of cross contamination of medicines.
- Staff checked patient identification wrist bands and asked patients their name before administering medicines. We observed that nurses left medicines with patients to take later, and signed by the nurse as being taken. One relative told us that medicines were left with the patient and were later found around their bed, having not been taken. This practice did not ensure patients received all their medicines safely and staff had signed to confirm medicines had been given when they hadn't. This practice was against trust policy and against guidance issued to nurses through their regulatory body, the Nursing and Midwifery Council.
- Emergency medicines were available in sealed boxes. These were marked with an expiry date; all medicines we looked at were in date.
- There was weekday pharmacy support for all wards. Pharmacists reviewed medicine administration records and ensured there were sufficient stocks of medicines available.
- For urgent medicines a secure fax number was used to ensure patient confidentiality was protected. Medicines deliveries were made four times daily to Mansfield Community Hospital ensuring medicines were available when they were needed.

Records

- Patient records were securely stored, apart from some patient observations records which were held at patient bedsides.
- Most records we looked at were up to date and accurate but there were examples where records were not accurate or complete. Of the 13 sets of records we looked at this affected eight records. We found nutritional intake records were not always complete, inaccurate weight and height records and an assessment of a patient's vision was not accurate. Three of the records had errors or deficits which had the potential to affect the accuracy of risk assessments and so the care a patient received. Five of the gaps were likely to have less impact on care such as not recording a patient's preferred name.
- Where patients were transferred from King's Mill Hospital their records were transferred with them.

Summary of findings

- Not all pages had a patient identification label on them. This meant there was a risk they could be lost and it would not be known which patient they referred to.

Safeguarding

- Safeguarding training was included as part of the annual mandatory training programme. All staff told us they had received this in the past year.
- The trust target for the completion of safeguarding adult training was 80%. All medical wards had exceeded this target.
- Staff knew how to report safeguarding concerns but could not recall any recent referrals. We were told that as most patients were transferred from King's Mill Hospital, safeguarding referrals were usually made earlier in the patients' stay.

Mandatory training

- Staff told us they attended mandatory training annually. This was delivered at King's Mill Hospital. Staff said they had raised concerns that some of the training, for example fire safety training, was not specific to the arrangements in place at Mansfield Community Hospital. We were unable to assess data on the compliance rate of staff attending mandatory training at the hospital as the data was captured across the trust.

Assessing and responding to patient risk

- There was an electronic system to record patients' physiological observations, the national early warning score (NEWS) system. We saw that where NEWS scores indicated patients may be deteriorating nurses had requested medical reviews.
- Patients were in the rehabilitation phase of their illness so for most patients physiological observations were taken on a daily basis. If there was concern relating to a change in the patient's condition the frequency of observations was increased.
- The trust audited the frequency of clinical observations. The audit recorded where patients experienced delays of more than 33% of the observation protocol or 30 minutes late (whichever was greater).
- For the period Monday 15 June 2015 to Sunday 21 June 2015 on Lindhurst Ward all observations were recorded in a timely way apart from on Friday 19 June where 1.5% of patients experienced delays. On Chatsworth Rehabilitation Ward for the same week between 1.5% and 5% of observations were taken late. On Oakham Ward for two days of the week 2% of patients' observations were taken late, the remainder were timely.
- Sepsis boxes were available on each ward and were in date. Sepsis is a common and potentially life-threatening condition triggered by infection. The sepsis boxes contained medicines and equipment to help with the prompt treatment of patients.
- There were some inconsistencies and delays in the treatment of sepsis due to GP visiting times and patients needing transfer to Kings Mill Hospital. Delays in the treatment of sepsis occurred as medicines had to be prescribed prior to administration. As there were occasions when no doctors were on site, staff told us this could delay treatment. We were told of one patient whose treatment for sepsis was delayed because they had to be transferred to King's Mill Hospital for treatment.
- Staff told us there were typically two transfers per month where patients required acute medical care.
- Facilities were not available at Mansfield Community Hospital to carry out the necessary blood tests to assess patients for sepsis.

Summary of findings

- Incident reports were completed when patients fell. We saw neurological observations had been completed after some falls but in two out of 13 care records neurological observations had not been completed following falls, so inconsistent practices were seen.
- We saw blood sugar level monitoring was completed regularly where patients had diabetes.
- We looked at the records of one patient and saw there had been a gradual decline in their condition regarding weight loss and incontinence. This was reflected in some risk assessments, but not others, such as tissue viability (skin condition) and moving and handling risk assessments. This meant the patient may not have received appropriate care and treatment as the level of risk may not have been accurately assessed.

Nursing staffing

- A staffing review had taken place in December 2014 where staffing levels were increased and minimum staffing levels for the three wards were agreed. Staff confirmed that the improved staffing levels had mostly been maintained and felt they were sufficient to meet patient's needs.
- The planned staffing levels had been assessed by the trust as being the number of staff that were required to deliver safe care and treatment.
- There were some nursing staff vacancies. Staffing levels were being maintained by nursing staff working extra shifts and the use of bank and agency staff. The majority of staff were permanent and ward leaders told us there was good staff retention.
- For morning shifts on Oakham Ward the planned ratio of one nurse to eight patients was maintained. For afternoon and night shifts staffing levels were currently one nurse to 12 patients.. The ward leader told us additional healthcare assistants were on duty where the nurse staffing levels fell short of the one to eight ratio. Ward leaders usually worked on a supernumerary basis but there were occasions when worked as part of the staffing numbers.
- Staff told us that increases in staffing had improved patient care.
- New staff were being recruited and some new staff had planned start dates.
- Where shifts were short of staff there was an escalation process in place to alert the matron. Staff told us that the escalation process did mostly result in additional staff being made available but for short notice absences this was difficult.
- Some patients required increased observation from staff to maintain their safety. We saw on occasions, this affected the number of staff available for other patients. Staff completed incident reports where staffing levels were not considered to meet patient needs. During our visit one incident was reported and resolved with increased agency staff.
- Handovers provided all staff coming on duty with an overview of all patients on the ward. Individual handovers then took place with the nurse taking over the care of each patient.

Medical staffing

- Medical staffing arrangements were specific to each ward depending on their speciality.
- All out of hours services for evenings, nights and weekends were provided by an on-call GP service. Staff told us that response time varied and patients could wait for long periods as there were no agreed response times in place. Each patient's condition was considered individually so the GP service and response times were determined from this. The trust did have a contract in place with the GP service which included a timely response to visit requests. It was not clear how this was being monitored.

Summary of findings

- We saw incidents reports had been completed where staff considered that there were delays in patient's receiving medical reviews. Where delays were experienced staff had made calls to the GP service to escalate any concerns.
- For medical emergencies staff used the 999 emergency service number at all times. The response time from the emergency service was determined by the severity of need of the patient.
- On Oakham Ward consultant led ward rounds were held weekly. On other weekdays medical reviews were undertaken by advanced nurse practitioners. These are nurses who have undertaken additional training to develop additional competencies in order to expand their scope of professional practice.
- Chatsworth Rehabilitation Ward and Lindhurst had staff grade medical staff available everyday between 9am and 5pm with out of hours medical services provided by a visiting GP.
- Locum (temporary) medical staff were used extensively. On Lindhurst Ward staff told us the consultant post was covered by locum doctors for the past three years. We were told that attempts to recruit medical staff had been made but were not successful.
- There was access to consultant opinion by telephone when consultants were not on site. Should a patient's condition deteriorate significantly transfer to King's Mill Hospital was arranged where acute medical care could be delivered.

Major incident awareness and training

- The trust had a major incident and business continuity policy. This was last reviewed in August 2014. Each department's role was described in the policy. We saw major incident action cards on ward areas for staff to refer to if there was a major incident alert.
- There was a range of fire safety equipment available to evacuate patients in the event of a fire. This included special equipment to move immobilised patients safely from the upper floor of the hospital.

Is the service effective?

Inadequate

We rated effective as inadequate because:

Care and treatment did not always reflect current evidence-based guidance, standards and best practice. Care plans did not reflect the patient's individual needs and preferences. The lack of personalisation meant that it was not always possible to establish the care needs of each patient from the care plans in place. Patients did not always have sufficient support to ensure their nutritional needs were met. There was no effective pathway in use to identify and treat sepsis in patients. Patient outcome data were measured at trust level so did not reflect the patient outcomes for Mansfield Community Hospital.

Patients' mental capacity to make decisions was not assessed in line with guidance and legislation. Assessments did not describe how communication had been attempted with the patient or how patients were supported to make decisions. There was little evidence that patients and their relatives had been involved in the decision making process.

Patients' pain was monitored and managed. There were effective multidisciplinary working relationships to support patients' progress towards discharge. Therapy staff worked five days each week so patients therapy was provided by the ard based nursing staff at the we, patients we spoke to missed this.

Staff had access to training to ensure they were competent to meet patients' needs.

Evidence-based care and treatment

Summary of findings

- Staff accessed National Institute for Health and Care Excellence guidance on trust's intranet. We saw patients were assessed using nationally recognised tools.
- Core care plans were in use on wards. These contained general instructions on care delivery but the majority did not reflect the patient's individual needs and preferences. The lack of personalisation meant that it was not always possible to establish the care needs of each patient from the care plans in place. The exception to this was falls prevention plans which were usually individual to the patient.
- Each ward had an emergency sepsis box to treat patients who were identified as having infections in their blood. The sepsis six care bundle was not in use. The sepsis six care bundle is a set of diagnostic and treatment steps for a fast and effective response to sepsis. The bundle should be delivered within one hour of the initial diagnosis of sepsis.
- Staff used a recognised rehabilitation assessment tool which was reviewed weekly to monitor patients' progress. Most patients on the neuro rehabilitation ward received physiotherapy each weekday. The duration of this varied, depending on the stamina and ability of the patient.
- Patients were screened and assessed in line with National Institute for Health and Care Excellence (NICE) guidance for alcohol related disorders.
- All patients were assessed to establish if they were at risk of falling. Where risks were identified, individual care plans were in place to promote the prevention of falls.
- The NICE guidance on pressure ulcer management was followed. A recognised risk assessment tool was used to assess each patient's potential risk of pressure ulcers. A pressure ulcer care bundle was in use which provided a guide to staff on the type of equipment that should be used and positional changes were recorded.
- There was a trust guideline in place for the detection and management of acute confusion/delirium in adults. However, we did not see any evidence of how this was being implemented and found no care pathways or screening taking place for patients with delirium.
- The NICE guidance for caring for patients living with dementia was not being adhered to as there was a lack of individualised plans in place.

Pain relief

- Patients were asked regularly about their level of pain and this was recorded on the electronic early warning score system.
- Patients told us they were also asked at each medicines round if they were in any pain.
- Care plans did not always describe the pain as individually experienced by the patient or how this was to be effectively managed.
- One patient told us their pain was not currently well managed but staff were trying to address this by changing their medication.

Nutrition and hydration

- The risk of inadequate nutrition was assessed for all patients. We found inaccurate and inconsistent information recorded in some of these assessments. For example, one patient's height was not correctly or consistently recorded and this changed the overall risk rating. We also saw significant recorded weight loss but this was not reflected in the patient's care plan and their food intake was not monitored. One patient did not have a care plan about their nutritional needs despite an increase in their risk of inadequate nutrition.
- For one patient, a dietician had visited following weight loss and a food supplement was recommended. This was not prescribed in accordance with trust policy so the patient did not receive the supplement they required.

Summary of findings

- Patients were weighed weekly but this did not vary in relation to any increased assessed risk of inadequate nutrition. This meant staff may not be alerted quickly to significant changes in the patient's weight.
- There were examples where concerns about weight loss were recognised and appropriate referrals made to dieticians and speech and language therapists.
- Fluid balance and food intake charts were in place for some patients. Most records were specific in recording the quantity of food patients consumed, but others were not. This meant that there was a risk that patient's fluid and food intake was not accurately monitored.
- Where patients required staff to assist them to eat this was done in a sensitive manner.
- On all wards most patients sat together in the dining room at mealtimes, unless there were clinical reasons or the patient's personal choice not to do this. Staff regarded this as part of the rehabilitation process as it encouraged patients to move around the ward and to socialise. This was good practice.
- Coloured place mats were used to identify patients at risk of malnutrition.
- Patients could make their own toast and drinks in the dining rooms if they wished to.
- On Oakham Ward the meal time we observed was poorly staffed with one staff member serving food and one care assistant delivering meals to 24 patients. Two other care assistants were assisting patients to eat.
- At a different mealtime on Oakham Ward there was a staff change during the meal as it coincided with staff break times. The fragmented support for patients at mealtimes meant there was a lack of consistent supervision and monitoring of what patients ate. We saw one patient leave the dining room after eating part of their meal. This patient had recently lost weight and was not being sufficiently supported or monitored.
- One relative told us they had unexpectedly been asked to help the patient with their meal as there were not enough staff. Whilst the relative was happy to help in a planned way, the unexpected request was difficult for them to meet.
- Patients told us the choice and quality of meals was good. All patients had jugs of water provided but we saw a few of these were out of patients' reach.
- Protected mealtimes were in place to allow patients the time to eat without interruption. One relative told us that there was inconsistency from some staff as to how this was implemented. The relative told us they liked to stay to support the patient with meals, but some staff allowed this and others didn't. This was not in accordance with the ethos of the protected mealtime ethos.

Patient outcomes

- Some patient outcome data was captured in trust wide audits so were not specific to Mansfield Community Hospital. It was therefore not possible to establish patient outcomes from the care received at Mansfield.
- Staff told us that some patients were transferred to Mansfield Community Hospital even though rehabilitative outcomes were not realistic. This was affecting the availability of beds, particularly on Chatsworth Rehabilitation Ward. Individual incident reports were seen but we did not see any evidence of overall monitoring of inappropriate admissions.
- The length of stay for patients was significantly higher than the national average. Staff told us that delayed discharges and admissions for patients with complex needs who were suitable for rehabilitative care contributed to this.

Competent staff

Summary of findings

- Staff were able to get advice from the tissue viability team at King's Mill Hospital. Tissue viability learning days had been provided for staff at Mansfield Community Hospital. Tissue viability is about the maintenance of skin integrity, specialising in acute and chronic wounds and prevention and management of pressure damage.
- Dementia awareness training was included as part of mandatory training. The duration of the training was 30 minutes and staff told us they felt this did not ensure they were sufficiently knowledgeable or skilled to provide care for patients living with dementia. This was evident as there were inadequate care plans in place for patients living with dementia.
- Occupational therapy staff told us they held regular meetings to share good practice and learning.
- The trust policy recorded that it was the expectation of the trust that registered nurses should have access to clinical and management supervision on a regular basis. Staff told us they didn't get access to supervision. Following the inspection, the trust told us that clinical supervision was offered and encouraged by the matron to all nursing staff. Two of the three ward managers had attended leadership development which included action learning and clinical reflection. The Matron attended and offered supervision every six weeks and was trained to provide clinical supervision. We did not see any records to demonstrate how many staff had received supervision or how frequently this took place.
- Ward leaders told us they received emails to alert them when renewal of staff's professional nursing registration was due. They then checked that staff had completed their re registration.
- Some nursing staff had completed training about caring for acutely ill patients. This included bladder scanning, electrocardiograms (ECG – heart monitoring), and venepuncture (getting access to veins for taking blood samples or giving medicines). As a small community hospital situated away from the acute hospital these skills were vital in ensuring patients received timely care and treatment.
- Staff appraisal rates for the three wards varied between 81% and 95%. Staff told us they took part in annual appraisal and they found appraisal useful to discuss training and personal development.
- A corporate induction programme was in place for new staff. Staff we spoke to had attended this and considered it was suitable in ensuring they were familiar with their role and knew what was expected of them.
- Agency staff were provided with an induction which when completed was verified by the issue of a green card. We saw agency staff carried these cards with them. The induction was renewed every three months.
- Staff told us they had a mentor allocated to them when they started working on the wards to provide them with support.
- Some staff told us they had the skills to give intravenous antibiotics, which is the treatment for sepsis. Other staff told us they did not have the skills to deliver sepsis treatment.

Multidisciplinary working

- Staff we spoke to considered they worked well together to plan patient discharges.
- Some services, for example dietetics and speech and language therapy, were provided by another trust. Referrals were competed electronically. Staff told us patients were usually seen within four days or sooner if there were particular needs or concerns.
- Multidisciplinary meetings were held five times weekly. These were attended by therapy staff, doctors or advanced nurse practitioners, and social workers.
- One relative described a good working relationship between the hospital staff and social services to arrange the post discharge support required.

Summary of findings

- Therapy staff used the same care record as nursing staff to ensure all staff involved could see the progress made by patients.
- If patients required assessment or input from mental health services, referrals were made to a specialist team, the Acute Care Liaison Team. Staff told us the team usually responded to the referral within 48 hours.

Seven-day services

- Out of hours medical services were provided by a local GP service.
- Therapy services such as physiotherapy, speech and language therapists, and occupational therapy operated Monday to Friday 9am to 5pm. Seven patients we spoke with told us they missed physiotherapy at weekends. We were told that ward staff continued patients therapy at the weekend within the ward area.
- Social workers were available between 9am and 5pm on weekdays only.

Access to information

- Diagnostic tests, such as blood and urine tests, were checked at King's Mill Hospital which was approximately two miles away. There were regular collections in place to transport specimens each day. For urgent tests a taxi was used to transport the specimens.
- Staff could see diagnostic test results using an electronic system. This meant test results were easily and promptly available.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information to help patients to understand consent was displayed prominently on the wards.
- For patients able to give consent, records indicated that verbal consent was sought before staff provided care and treatment.
- Where there was a Power of Attorney agreement in place, a copy was included in the patient's records. This was to ensure staff were aware of relatives or other appointed people legally able to make decisions on the patient's behalf.
- Patients' mental capacity to make decisions was not assessed in line with current guidance and legislation. We looked at the care records of six patients considered to lack capacity. There was no clear evidence that staff had attempted to involve the patient in decision making and it was not clearly documented what had been considered in determining care was being delivered in the patient's best interests. There was little evidence that patients and their relatives had been involved in the decision-making process. We saw one patient record where relatives had been asked about the patient's views regarding medicines, but this was an exception and most did not include the patient or relatives' views. Staff carried out a 'mini mental state' assessment for another patient identified as possibly lacking capacity. This is an assessment of memory and cognitive impairment, not of the patient's mental capacity to make a decision.
- Where staff considered a patient may be deprived of their liberty there was a process to apply for a Deprivation of Liberty Safeguards (DoLS) authorisation. The applications were reviewed by the executive director of nursing and quality before being referred to the local authority. Staff were clear about the DoLS application process and aware of the restrictions in place for patients.

Is the service caring?

Good

We rated caring as good because:

Summary of findings

Patients told us they were encouraged to be independent and were also well supported by staff when they needed care. Staff generally treated patients in a kind and respectful manner.

Most patients told us they were involved in their care and knew about treatment and discharge plans. Patients were positive about the progress they were making and particularly valued the physiotherapy input as they felt their mobility improving.

Compassionate care

- Most patients we spoke with were happy with the care they received. They told us the atmosphere at Mansfield Community Hospital was better and more relaxed than at King's Mill Hospital.
- Patients considered the care to be good. One patient said, "I couldn't wish for better." Patients told us their privacy and dignity was respected by staff. Patients were mostly out of bed and dressed unless they were not well.
- Patients described care being given in a kind and caring manner. We observed this was mostly the case. We saw one nurse present food to a patient where relatives told the nurse the patient did not like the meal offered The nurse took the cover off the meal and left it with the patient, knowing the patient did not like the food.
- Patients told us staff call bells were responded to quickly.
- Patients told us 'comfort rounds' where staff checked patients' care needs were completed regularly, although the clocks to indicate when the next round was due were not always changed.
- Patients told us they were encouraged to be independent and were also well supported by staff when they needed care.
- We observed the housekeeper asking each patient what meals they would like to order for the following day. This was done in an unhurried manner with general chat included.
- The Friends and Family test results for the rehabilitation wards were largely in line with the national average. All wards had achieved scores of 94% or above of patients who would recommend the hospital to family of friends for the period September 2014 – October 2014. The Friends and Family test asks patients a single question which is, would they recommend the hospital to friends and family
- The trust had introduced the 'My name is…..' initiative to ensure staff introduced themselves to patients. We saw staff make patients aware of their name.

Understanding and involvement of patients and those close to them

- Patients told us they were given a choice of what they wore and what they ate.
- Most patients told us they were involved in their care and knew about treatment and discharge plans. Patients were positive about the progress they were making and particularly valued the physiotherapy input as they felt their mobility improving.
- Patients could set up a password to allow relatives and friends to telephone the ward and access information on their condition. This ensured patient confidentiality was not breached.
- If patients had a fall on the ward their relatives were made aware of this.
- One paid carer told us they considered that staff understood the patient's needs.
- One relative told us their spouse had been moved to Mansfield Community Hospital and they were not told of the transfer. The relative said they were going to raise a complaint about this.

Summary of findings

- Two relatives told us that whilst largely satisfied with the care patients were given there were aspects of communication that could be improved.
- Staff told us that one family had remained overnight with a patient where it was identified they were near to the end of life.

Emotional support

- Patient's spoke to us about the encouragement and support offered by staff when they found the rehabilitation hard.
- We observed kind support and engagement with patient's at time when they were anxious.
- Patient's told us there was a positive and relaxed atmosphere at Mansfield Hospital.
- Staff were observed asking patient's how they were and if they needed anything. One relative complimented the staff of the time they spent trying to engage the patient in stimulating and interesting activities.

Is the service responsive?

Requires improvement

We rated responsive as requires improvement because:

The flow of patients through the hospital was affected by inappropriate admissions and delayed discharges. Patients transferred from Kings Mill Hospital were not always suitable for the rehabilitative care provided at Mansfield Community Hospital. There were delays in discharges where patients were waiting for community care services to be arranged.

There were some shortfalls in how the needs of different people were taken into account. The care for patients living with dementia did not meet current guidance and recognised good practice. There were no learning disability care pathways in place to inform staff how to support patients with a learning disability.

Interpreters were available for patients who did not speak English or required British sign language translators.

End of life care was not routinely offered at Mansfield Community, but if a patient's condition deteriorated and they wished to stay at the hospital this care was provided to them.

Service planning and delivery to meet the needs of local people

- Admissions were co-ordinated by the Early Discharge Assessment Support team (EDAS). The majority of admissions were from King's Mill Hospital with admissions from community settings being exceptional.
- There were admission criteria in place for Mansfield Hospital with the majority of patients being admitted from King's Mill Hospital. Staff told us that the admission criteria were not always adhered to. In the past three months on Chatsworth Ward there were four incidents reports where admissions were not considered to have met the criteria.
- Staff told us they could challenge the appropriateness of admissions and sometimes patients were not admitted but there were occasions when patients were admitted who did not meet the admission criteria. Staff felt that the pressures for beds at King's Mill hospital contributed to inappropriate admissions.
- Chargeable parking was available at the hospital. There were also good public transport links to the hospital to make visiting for relatives and friends easier.
- Transfers to Mansfield Community Hospital from King's Mill Hospital were not always well planned with delays in transport and a lack of communication with relatives being reported.

Summary of findings

- On site services included a café for relatives and visitors.
- If patients had outpatient appointments at other hospitals during their stay, transport was provided to enable them to receive the care and treatment they needed.

Access and flow

- Ward leaders told us that bed occupancy was always high as when patients were discharged other patients were always waiting for beds. The data we received on bed occupancy rates was for the trust as a whole so we could not tell if the ward leader's assessment was accurate or not.
- There was a focus on discharge planning with meetings held each day to discuss patient's progress and expected discharge dates were set. Links with community staff were being built and nurse assessors who determined patient's community needs were visiting twice each week.
- Staff told us that some patient's had complex care needs which required multi-agency co-ordination. Due to the complexities involved discharges could take time after the patient was medically fit.
- Staff told us that some patients were waiting for community social care packages. They described the process to arrange these as long and difficult with some delays in discharging medically fit patients.
- In May 2015 there were eight patients who were considered to be medically fit but awaiting discharge. The reasons for the delayed varied and there was no identifiable trend.
- If a patient was receiving end of life care there was a fast track discharge system in place which was accessed through King's Mill Hospital's integrated discharge advisory team. This allowed patient's to die at home if they wished to.
- Unpredictable transport services were reported with some patients waiting all day to be transferred.
- Staff told us that there was a dedicated multidisciplinary discharge team in place at King's Mill Hospital but this was not in place at Mansfield Community Hospital.
- The majority of patients were admitted from King's Mill Hospital after the acute phase of their illness had improved sufficiently for rehabilitation to proceed.
- Some patients waiting for social care to be arranged were discharged to care home beds commissioned for this purpose. This helped to improve the flow of patients through the hospital.

Meeting people's individual needs

- The care for patients living with dementia did not meet current guidance and recognised good practice. We asked to see care plans about how staff should meet the needs of patients living with dementia. We were shown care plans relating to anxiety which did not specifically refer to dementia care needs. This meant it was not consistently communicated to staff how a patient living with dementia was to be cared for. A symbol was placed on the patient board to identify if a patient was living with dementia.
- There was a library of resources available such as reminiscence resources and boxes which promoted sensory stimulation for patients living with Dementia. On Lindhurst Ward there was a homely lounge area that included familiar items for people living with dementia such as a turntable record player.
- Staff told us they had on occasions cared for patients who had a learning disability. They told us that 'This is me' books were given to relatives to complete so staff were aware of the patient's preferences and needs. There were no learning disability care pathways in place to inform staff how to support patients with a learning disability.

Summary of findings

- End of life care was not routinely offered as the aim of admissions was to rehabilitate patients. However, if a patient's health deteriorated unexpectedly and they expressed a wish to remain at Mansfield Community Hospital, staff told us this would be respected wherever possible. To facilitate this there was access to the pain and palliative care teams to provide care to the patient.
- Occupational therapy staff completed home visits with patients to assess if any aids or adaptations were needed on discharge.
- Staff told us there were few patients who did not have English as their first language. During our visit interpreter services were used to communicate with a patient and a board with pictures was also used.
- Patients were supported to stop smoking, or use nicotine patches if they were experiencing the withdrawal effects of smoking. One patient told us they had found this useful.
- The bedside lockers did not provide any lockable storage to protect patient's valuables.

Learning from complaints and concerns

- The matron told us they responded to complaints relating to Mansfield Community Hospital. They told us there were very few complaints.
- Information leaflets were on display to inform patients and relatives how to complain.
- Between March 2015 and May 2015 there were no complaints received about the wards at Mansfield Community Hospital.

Is the service well-led?

Requires improvement

We rated well-led as requires improvement because:

Staff were unclear about the vision or strategy for Mansfield Community Hospital. There was an increasingly diverse use of beds which meant the identity and role of the hospital was not always clear.

Links and relationships with King's Mill Hospital were improving although staff told us they had to go to King's Mill Hospital to meet senior staff and that staff meetings and training were held at King's Mill Hospital. There were some shared governance meetings and there were also local standard operating procedures in place which had been developed which were not trust wide.

Local managers were highly regarded and staff felt supported. There was an open culture where staff worked together throughout the hospital.

Vision and strategy for this service

- Staff we spoke with were unsure about the vision or strategy for Mansfield Community Hospital. We were told meetings had been held with senior managers, but that a vision for Mansfield Community Hospital had not yet been developed. We were told that staff had worked hard to raise the profile of the hospital within the trust.
- As a rehabilitation service, staff told us they considered the ethos of Mansfield Community Hospital did not always fit well within an acute trust but staff were proud of the service they offered.
- Some staff told us that the admission of patients who were not suitable for rehabilitation pathways meant that the hospital's role and identity was not clear.

Summary of findings

Governance, risk management and quality measurement

- Ward leaders held monthly governance assurance meetings to share good practice and learning.
- We were told that any identified risks at Mansfield Community Hospital were included on the trust risk register. There was no separate risk register for the hospital. We looked at the trust wide risk register for the division of emergency medicine and surgery. There were no risks on this register for Mansfield Community Hospital.
- A monthly ward assurance audit was compiled. This provided information on a wide range of aspects including incidents, infections, complaints and completion of a range of records. Results were coded as red, amber, or green depending on the findings. There was mostly positive finding for the wards at Mansfield Community Hospital but some occasional aspects where percentages were lower than was expected.
- We were told of changes that had been made in response to identified risks. For example, security doors had been fitted to restrict access to parts of the hospital at night.
- There was a system where staff signed to confirm they had read policies and procedures. This was a local system that had been introduced. A ward initiative called 'policy of the month' was in place to introduce staff to new or changed policies.
- Staff could not recall getting information on trust wide learning from incidents. Staff could not tell us about learning from incidents that occurred at King's Mill Hospital.

Leadership of service

- Staff told us that members of the trust executive team visited the hospital, but not all staff had met them.
- Ward leaders told us they worked well together and were supported by the hospital matron. The matron also had responsibility for some of the wards at King's Mill Hospital and divided their time between the two sites.
- Staff told us that there were improved relationships and integration with King's Mill Hospital over the past year. They told us they were kept up to date with what was happening within the trust.
- Staff told us that there was not always an appreciation that Mansfield Community Hospital worked a little differently, for example supplies had to be ordered and these were sometimes delayed as they were not held onsite.

Culture within the service

- Staff of different disciplines at Mansfield community Hospital told us they worked well together and it was like an extended family. We were told staff respected each and worked well to support each other as there were occasions where there were no managers on site.
- Staff told us they could approach ward leaders if they had any concerns.

Public engagement

- Chatsworth Rehabilitation Ward held a monthly users and ex-users patient group. The aim of this was to promote on-going rehabilitation.

Staff engagement

- Staff told us that links and relationships with King's Mill Hospital were improving. However, staff were disappointed that they had to go to King's Mill Hospital to meet senior staff and that staff meetings and training were held at King's Mill Hospital.
- Staff told us there were awards where staff were recognised for their achievements. The awards were presented by the Chair of the board. Staff on Oakham Ward proudly told us they had recently won 'Team of the Year Award'.

Detailed findings from this inspection

Areas for improvement

Action the hospital MUST take to improve

- Ensure staff have opportunities to learn from incidents across the trust.
- Ensure medicines are safely administered to patients in line with local policies and procedures and current legislation.
- Ensure care plans are individual and specific to the patient to ensure staff are aware how to deliver care to patients which meets their needs.
- Ensure the care of patients living with dementia is in line with current guidance and recognised good practice.
- Ensure patients' mental capacity to make decisions is assessed in line with current guidance and legislation.
- Ensure the sepsis care pathway is followed so that patients with sepsis are identified and treatment is delivered.

Action the hospital MUST take to improve

- The temperature of the fridge check should include the daily maximum and minimum temperature.
- The room temperature should be monitored where medications are stored.
- The dementia training programme should be developed to ensure staff are suitably knowledgeable about dementia and the care that patients require.
- Ensure the dishwasher on Oakham ward is replaced.

Our inspection team

Our inspection team was led by:

Chair: Dr Nigel Acheson, Regional Medical Director, NHS England

Head of Hospital Inspections: Carolyn Jenkinson, Care Quality Commission

The inspection team comprised 20 members of CQC staff, 30 specialist advisers and three experts by experience who have experience of or who care for people using healthcare services. CQC members included the deputy chief inspector of hospitals, two heads of hospitals inspection, four inspection managers, a pharmacy manager and 12 inspectors. Our specialist advisers included: heads of governance and patient safety, specialist nurses, medical consultants, and anaesthetist, a histopathologist, a junior doctor, allied health professionals and clinical managers.

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 18 HSCA (RA) Regulations 2014 Staffing