Northamptonshire Healthcare NHS Foundation Trust

RP1

Community health inpatient services

Quality Report

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This report describes our judgement of the quality of care provided within this core service by Northamptonshire Healthcare 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 Northamptonshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Northamptonshire Healthcare NHS Foundation Trust

Summary of findings

Ratings

Overall rating for Community health inpatient services	Requires Improvement
Are Community health inpatient services safe?	Requires Improvement
Are Community health inpatient services effective?	Requires Improvement
Are Community health inpatient services caring?	Good
Are Community health inpatient services responsive?	Requires Improvement
Are Community health inpatient services well-led?	Requires Improvement

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Requires improvement

We found that community inpatient services required improvement.

There were high levels of bed occupancy within community inpatient services. To facilitate patient flow, the service led a twice weekly telephone patient tracking meeting with colleagues from social care.

There were processes in place for reporting and learning from incidents. However, not all risks had been identified on the risk register.

Staffing was not always sufficient. We found wards were short of nursing staff and one to one care was not consistently provided. Significant vacancy rates and high sickness levels put additional pressure on substantive staff. There was no clinical supervision provided for nurses. Despite this, staff told us they worked as a team and enjoyed their jobs.

Patient records across community inpatient services were not always completed fully; consent was not always obtained and recorded.

Staff were not aware of local contingency plans and emergency procedures. The emergency procedure was difficult to locate on the trust intranet and needed to be reviewed.

We saw patients were treated with compassion and respect. All of the patients we spoke with told us they were happy with the care provided by staff. Feedback was invited through an online survey "I want great care" and generally the service received positive comments.

We found good multidisciplinary working on wards. However, whilst there was some evidence of shared learning, the systems in place were not robust or comprehensive for effective shared learning and innovation across community inpatient services and this meant that patient experience, care and engagement varied across services.

Summary of findings

Background to the service

Background to the service

Northamptonshire Healthcare NHS Foundation Trust delivers adult community inpatient services across Northamptonshire. The area includes a large urban conurbation, with high levels of deprivation, as well as pockets of relative affluence. The community division provided health services, including stroke, neurological and physical rehabilitation.

During our inspection, we visited four adult community inpatient services. **Corby Community Hospital,** a 22 bedded inpatient ward and **Danetre Hospital, a 28 bedded** inpatient ward that both provide physical rehabilitation for adult patients following an acute illness or a deterioration of a long-term condition. **We also visited Isebrook Hospital which had two inpatient wards, Hazelwood ward with 34 beds** providing physical rehabilitation for adult patients following an acute illness or a deterioration of a long-term condition; and **Beechwood ward a 15 bedded unit,** providing specialist inpatient rehabilitation for younger adults with neurological and other long-term conditions including brain injury.

Our inspection team

Our inspection team was led by:

Chair: Peter Jarre, Consultant Psychiatrist Oxleas NHS Foundation Trust

Team Leader: James Mullins, Head of Hospital Inspections, Care Quality Commission

The team included CQC inspectors and a variety of specialists: General practitioner; registered nurse; occupational therapist.

Why we carried out this inspection

We inspected this core service as part of our comprehensive acute and community health services 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 the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients.

We carried out an announced visit on 3, 4 and 5 February 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists. We spoke with staff, including nurses, doctors, managers, therapists, support staff and administrative staff. We also spoke with patients and relatives. We observed how patients were being cared for and talked with carers and family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

Summary of findings

Prior to and following our inspection, we reviewed performance information about the trust, and information from the trust.

Our judgements were made across all of the hospitals visited, where differences occurred at particular hospitals we have highlighted them in the report.

What people who use the provider say

We spoke with 30 patients and 10 relatives during our inspection.

Patients told us that that staff were very kind and caring.

Some of the comments received from patients included:

- "I have physiotherapy every day; they really are good. I'm impressed."
- "The physiotherapist is wonderful."
- "Not talked about care plans or discharge planning."
- "They're (staff) perfect at looking after dignity and respect, they're careful to shut everything if you have to change".
- "Staff draw the curtains to give me privacy".
- "It's very clean and if you ask for anything, they'll (staff) get it."
- "Staff normally respond to the call bell, it depends how many are on duty".
- "They're (staff) occasionally short staffed."
- "You can have any amount you want to drink, they're (staff) always bringing fresh water".
- "I'm quite comfortable and staff have looked after me".

Some of the comments received from relatives included:

- "They try hard but they can't do impossibilities. They're not short-staffed but it's hard when they're busy, and they're very busy".
- "There could always be more staff. We hear the buzzers go sometimes but they don't seem to be going for too long."
- "We feel staff have responded to our relative's needs, especially as their needs have changed".

Good practice

- There were examples of good multidisciplinary working across internal services, and with local healthcare organisations.
- We found that staff were passionate about their work and the difference it made to patients. They displayed positive attitudes and said they were supported by their managers to provide excellent care and services.
- Patient feedback was invited through an online survey "I want great care" and generally the service received positive comments.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the hospital MUST take to improve

- The trust must ensure suitable arrangements are in place to ensure staff received appropriate clinical supervision to enable them to deliver care and treatment to people who use the services.
- The trust must ensure staff are able to attend and carry out mandatory training, to care for and treat patients effectively, particularly regarding annual resuscitation training.
- The trust must ensure patient records are always fully completed, for example, consent documentation, to prevent risk to the delivery of safe patient care and treatment.

Action the hospital SHOULD take to improve

Summary of findings

- The trust should ensure that at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff to ensure people who use the service are safe and their health and welfare needs are met.
- The trust should ensure that all staff have a working knowledge of the Mental Capacity Act 2005 and understand its implications for their practice.
- Ensure that all clinical single use equipment is stored safely and appropriately; and disposed of when it has expired it used by date.
- The trust should review the paper and electronic records to ensure that the recordings are accurate and do not contain variances and discrepancies.
- The trust should review the risk register to identify all risks across community inpatient services.
- The trust should ensure that the emergency procedure policy is current and that staff are aware of the policy and where to locate it.
- The trust should ensure that there is robust systems for shared learning across community inpatient services to provide consistency in positive patient experience, care and engagement.

Northamptonshire Healthcare NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

The five questions we ask about core services and what we found

Requires Improvement

Are Community health inpatient services safe?

By safe, we mean that people are protected from abuse

Summary

There were processes in place for reporting and learning from incidents. Staff were clear about what incidents to report and how to do this.

Staffing was not always sufficient. We found evidence where wards were short of nursing staff and one to one care was not consistently provided. Medical cover varied across the four wards. Staff were concerned about the medical provision at Danetre Hospital and incidents relating to medical cover which had been investigated without the input of the trust and no feedback had been provided.

Patient records across inpatient services were not always completed fully, including informed consent to treatment.

Arrangements to minimise risks to patients were in place with measures to prevent falls and pressure ulcers. We saw evidence of good practice including medicine management clean clinical areas and infection prevention and control practice.

Staff were not aware of local contingency plans and emergency procedures. Compliance for annual resuscitation training was insufficient and at Danetre Hospital only 66% of staff were compliant with mandatory training. This placed patients at risk because there were not enough suitably skilled staff to provide care if they needed life support.

Incident reporting, learning and improvement

- Incidents were reported using the electronic DATIX system.

- Staff told us that they were encouraged to complete incident reports, and most staff told us that they had received feedback from the reports.
- Between December 2013 and November 2014, there were nine serious incidents requiring investigation. Three were category three hospital acquired pressure ulcers; three were categorised as a slip, trip or fall; one was an allegation against a healthcare professional; one was a healthcare acquired infection; and the final one was a delayed diagnosis. We saw some learning from incidents. For example, the pressure ulcer review group met monthly to discuss causes of incidents and how they could be prevented or reduced.
- At Isebrook Hospital was saw clear learning from an incident where a patient's pressure ulcer had deteriorated due to incorrect dressings being used. We saw clear documentation on care plans with the history of treatments and dressings used and body maps showed where the pressure ulcer was located. A training need was identified for all ward staff to be educated about how to use and access different dressings. The staff involved in applying the incorrect dressings received formal supervisions following the incident.
- NHS Safety Thermometer was being collected on each ward with **Corby Community Hospital** being the most recent to start in October 2014. Results were displayed outside each ward to enable the information to be were shared with staff and visitors.
- Between October 2014 and January 2015 harm free care across community inpatient services averaged 89%, with Beechwood ward achieving the highest score of 98% and **Corby Community Hospital** scoring the lowest with 81%.

Duty of Candour

- Staff we spoke with were not familiar with the duty of candour but were familiar with the concepts of openness and transparency.
- Senior staff told us that they had not received trust training regarding this regulation and they had in the past unknowingly been following a different process compared to the trust policy. This had been recognised and training was planned. They said they were cascading the requirements of the newly introduced duty of candour regulations to all staff.

Safeguarding

- Staff we spoke with were confident in reporting safeguarding concerns and were aware how to escalate concerns to the safeguarding team. We saw safeguarding policies displayed on staff notice boards.
- In January 2015, all staff on Beechwood ward had received level 2 adult and children safeguarding training. Safeguarding training compliance at the other community inpatient locations averaged at 93% for level 1 and 63% for level 3.
- A matron at Isebrook Hospital told us that when pressure ulcers and falls were reported on DATIX they were automatically referred to the appropriate specialist team to assess if the incident was a safeguarding issue or not. For example, the tissue viability team would investigate if a category three or four pressure ulcer was avoidable or not.

Medicines management

- We found prescription medicines on wards were appropriately stored in locked facilities.
- We observed a drug round on Hazelwood ward and found the nurse checked patient identities, the medication against the prescription chart including the name and expiry date of the medication, before giving to patients.
- We saw records that showed the medicine fridge at Danetre Hospital was checked daily to ensure it was at the recommend storage temperature. We saw records that showed the stock of controlled drugs (medicines which are subject to additional controls as they are liable to be misused) was monitored daily and that controlled drugs brought into the hospital by patients were also recorded.
- As a result of letters from GPs seeking clarification of prescribed medication an audit of the discharge documentation was completed over a three month period and reported upon in April 2014. The findings showed a 6% inaccuracy in relation to medication prescriptions (14/223); these consisted of omission of drug (9/14), no discontinuation date (3/14) and incorrect spelling (2/14). The audit was presented to trust medics and an action plan to improve discharge documentation was implemented.
- A pharmacist attended each community inpatient ward one day a week to undertake a clinical review and check of medication charts. This was being complete by a locum but a permanent pharmacist had been recruited

and it was planned that a benchmarking exercise would be completed to assess if the support of a pharmacy technician was required to enable effective stock control of medicines and patient self-medication.
- Patients were given 28 day supply of medicines when they were discharged. There was sufficient stock to prevent patient discharge being delayed.

Safety of equipment

- Equipment including beds, hoists and wheelchairs, was clean and in working order. Items were labelled with the last service date, and some equipment had decontamination status labels that identified when equipment was cleaned.
- We found an open equipment store room at Danetre Hospital. This meant that equipment, such as catheter equipment, enteral syringes and dressing packs, were not stored safely and securely to prevent theft, damage or misuse.
- We inspected the resuscitation trolley on each ward and saw that they were centrally located, clean, and that defibrillators had been serviced. We saw records which recorded dates and signatures to demonstrate that equipment not locked in the trolley was checked daily and that sealed equipment was checked weekly. However, on Hazelwood ward we found a breathing mask that had expired in 2013. We reported this and this was disposed of. This meant that the equipment checks were not completed thoroughly.
- We saw single use slings and slide sheets were used to prevent the spread of infection.
- The service manager told us that safety of equipment had been a concern but a bid had been approved to replace patient chairs and they were awaiting approval for some beds and mattresses to be replaced. They told us that the medical devices team had established an inventory of equipment and they checked equipment annually or as required.
- We saw at all community inpatient services there was limited room to store equipment and this meant that equipment was stored in patient corridors and day rooms. Staff were concerned that patients could trip over equipment or fall if they used unstable equipment as support when walking. The matron told us that this had been escalated but there had been few resolutions. This had not been identified on the risk register.

Records and management

- Electronic patient records were documented using SystmOne. This is an electronic patient record system which records details for each patient. SystmOne was used across the community inpatient services and by some local GPs. Therefore if patients agreed to share the information staff could access notes across healthcare settings to acquire current care and treatment plans. A nurse told us: “Bank and agency staff that are here regularly will also have access.”
- We looked at three patient records on SystmOne on Beechwood ward and found that information such as patient ethnicity and spoken language was not completed. This had been discussed at team meetings with the aim to improve compliance but meant that records were not fully completed.
- Most patient care plans were up to date. Where staff recorded assessments and information on SystmOne the system automatically populated other areas of the care plan where necessary. This prevented duplicated entries. One nurse told us: “We can scan documents onto the system so we are able to upload information about patients with a lasting power of attorney or a living will.”
- At **Corby Community Hospital** we saw where one patient had a pressure ulcer, the electronic care file contained information about the size, the category, the position of the pressure ulcer and the dressings used. The system also showed when the dressing was due to be changed.
- Each ward had completed a recording keeping audit for quarter three 2014/15. They had individual actions plans to improve compliance. For example, on Hazelwood ward one action was for the admitting nurse to ask for patient consent to share information after five of the 14 records audited showed that informed consent to treatment had not been obtained and documented. The matron was to discuss this at the ward meeting and a re-audit in quarter four would evaluate the compliance.

Cleanliness, infection control and hygiene

- The Health and Social Care Information Centre Patient Led Assessments of the Care Environment data showed that all inpatient services scored better for cleanliness than the national average for small community services. Danetre Hospital scored the highest with 99% compared to the national average of 96%.
- We saw daily cleaning checklists on patient en suites at Danetre Hospital that had been signed to indicate all

tasks had been completed. We saw mattress cleaning and turning checklists and night shift cleaning rotas to ensure equipment was fit for purpose and did not increase the risk of cross infection or pressure damage to patients.

- Staff had access to personal protective equipment such as gloves and aprons. We observed most staff adhering to the trust's 'bare below the elbow' policy, applying gloves and aprons as required, and washing their hands and using hand sanitising gel following their time spent with patients.
- In January 2015, infection control training compliance for clinical staff was 85% or above for all community inpatient locations except for Danetre Hospital, where compliance was 58%. All non-clinical staff in community inpatient locations were compliant with the three yearly infection control training, expect for at Danetre Hospital where only 50% of staff were compliant. This could have placed patients at Danetre Hospital at risk because there were not enough suitably skilled staff to ensure infection control standards were met.

Mandatory training

- Information about how to access mandatory training was displayed across staff noticed boards at each service. Mandatory training included fire awareness, safeguarding, information governance and health and safety training.
- Beechwood ward therapists were 100% compliant with mandatory training in January 2015 and other staff on the ward were 96% compliant. However, compliance with mandatory training at other inpatient locations was below 80%. Only 66% of staff at Danetre Hospital were compliant with mandatory training.
- In January 2015, all staff on Beechwood ward had received annual basic life support training with immediate life support training deemed not applicable for staff. Annual basic life support training compliance at the other community inpatient locations averaged was 85% or below, with only 41% of Danetre Hospital staff being compliant. Compliance with annual immediate life support training averaged at 61%. This meant that a significant number of staff had not received any life support training in the last 12 months. This placed patients at risk because there were not enough suitably skilled staff to provide care if they needed life support.
- There was a lone worker policy. However; lone working had not been identified on the risk register as a potential hazard for staff working in isolation.
- We spoke with occupational therapists across the community inpatient services that had some elements of lone working within their role. Some could fully explain the policy and the actions they needed to follow, whereas others could not explain the policy or how they risk managed lone working.

Assessing and responding to patient risk

- We saw that clinical risk assessments and care plans were completed and followed for each patient. These included assessments for pressure ulcers, nutrition and National Early Warning Score (NEWS).
- Each ward had completed a NEWS audit in September 2014. The results showed that 95% of patients had a NEWS baseline taken within 24 hours of admission. The frequency of observations required was documented for 89% of patients, but of those only 54% of observations required were completed. Where NEWS had been triggered, 44% of patients had not been reviewed indicating that patients had not been escalated appropriately. Recommendations from the audit had been made including that ward managers and matrons share feedback with clinical staff to ensure the frequency of observations are clearly indicated on the charts and completed; and that when NEWS has been triggered a review of patients is carried out with the outcome recorded.
- Each ward completed a quarterly Malnutrition Universal Screening Tool (MUST, a screening tool used to identify patients at risk of malnutrition) compliance audit. Results from July to September 2014 showed that across community inpatient services 92% of patients were screened within 48 hours, with both Beechwood ward and **Corby Community Hospital** scored 100% meeting the trust target. Every patient had a nutritional care plan in place and nurses could tell us how they would escalate nutritional concerns, but MUST review compliance varied across services with Hazelwood ward reviewing 89% of patients as required compared to Danetre Hospital reviewing 75% of patients as required. This did not meet the trust target of 100%. Recommendations were made from the audit to improve compliance and ward MUST training had been initiated.

- All hospitals had side rooms for nursing patients who had an infection. These would be used in the event of any infection control outbreak.
- All staff and patients we spoke with felt patients were safe on the ward. One patient said, "I'm as safe and I can be."

Staffing levels and caseload

- The impact to safe, high quality care by not having sufficient, safe staffing levels in all clinical areas was highlighted as a moderate risk in the September 2014 board assurance framework. Actions were devised to address this.
- The December 2014 adult services risk register identified the safety of patients on Beechwood ward as being at high risk if the one qualified nurse on a late or night shift went on unexpected leave, such as sick leave. An escalation process was in place if this was to happen.
- Each hospital ward displayed a board at the entrance, which showed the number of nursing staff that should be on duty and the number there actually were. The number of therapists was not highlighted to visitors or patients. We saw the established staffing and the actual staffing levels were the same on all wards except for at Corby Community Hospital.
- When we visited Corby Community Hospital early one morning, the team were two agency healthcare assistants short and this meant that the matron was included into the ward establishment rather than being supernumerary. Nurses and allied health professionals told us that agency staff often did not turn up for shifts. The matron was trying to fill the shifts but when we left no extra staff had been recruited.
- The safe staffing fill rate for November 2014 showed that the number of registered nurses on day shift averaged at 93% of the required establishment and for night shifts 97%. However, there was an over establishment of healthcare assistants with fill rates of 103% in the day and 114% at night.
- During this shift Corby Community Hospital was able to continue to provide a healthcare assistant for one to one care of a patient prone to falls. Nurses told us that if patients had high dependency needs such as severe dementia, an additional healthcare assistant could be recruited. However, we found evidence that a healthcare assistant providing one to one care for a patient on a shift earlier in the month had been transferred to another hospital to cover staff shortages. This meant the ward was left short staffed and the patient did not have the specialist cover as arranged.
- Most staff we spoke with felt they were short-staffed. On nurse at Corby Community Hospital commented: "We're very short staffed and use a lot of agency staff."
- Patients told us: "It's difficult to judge, they could probably do with more (staff) but everything is done"; "They're occasionally short staffed"; and: "There could always be more staff. We hear the buzzers go sometimes but they don't seem to be going for too long."
- Bank and agency nurses on Beechwood had a 'buddy' on each shift that was a permanent member of staff.
- There was a skill mix transformation work stream as part of the community hospital beds plan. In the community hospital beds plan October 2014 report, it was noted that the Safer Staffing and Integrated staffing model have been approved to ensure appropriate skill mix and staffing levels were planned, which met the Royal College of Nursing safe staffing guidance. We saw a skill mix staffing risk assessment and guidance about how to escalate risk. Recruitment to posts was underway but managers acknowledged that they were struggling to recruit.
- Medical cover varied across the four wards. At Danetre Hospital cover was provided by three local GP practices Monday to Friday. Out of hours the staff used IC24 (a company that provides a range of primary care services) which was based in the building until 2am; and then 111 and emergency services. The senior matron told us that two incidents relating to medical cover which had been investigated by IC24 but without the input of the trust and no feedback had been provided as a result. Staff told us that they were concerned about the medical cover arrangements and patients did not always receive timely medical attention.
- **Other community services** had staff grades on the ward 9am to 5pm. Out of hours **Corby Community Hospital** were able to use the resources at a local urgent care centre sharing the same site during the hours of 8am to 8pm; and outside of these hours, 111 and emergency services. Out of hours Isebrook Hospital used the 111 and emergency services out of hours. Staff told us that this was a satisfactory arrangement and patients received timely medical attention.

Managing anticipated risks

- We saw manual handling information about the equipment used and the number of staff to support a patient was available on patient boards by their beds.
- We observed nursing handovers on Beechwood ward, Hazelwood ward and at Corby Community Hospital. Nurses starting their shift were given information about the medical needs of the patient, including discharge arrangements and clinical risks. Handover sheets were used to provide staff with brief details of the patients and their needs which were then disseminated to the wider staff team.
- At Danetre Hospital handover was conducted via a Dictaphone. Nurses would record the handover of patients at the end of their shift and the nurses starting the shift would listen to the handover. The senior matron told us that this was the most favourable handover style of all the methods trialled as a result of the productive ward. We received mixed views about the handover, some nurses thought that this was an effective method whereas other felt when receiving handover they did not get a full picture of the patient.
- We saw in the Beechwood unit meeting minutes that staff were encouraged to follow the falls policy and ensure that patients who had fallen were reviewed by a medic.
- At Corby Community Hospital and on Beechwood ward there were 'pods', which were patients rooms in a portacabin style environment to increase bed capacity. On both wards the pods were off the main ward corridor and the matron highlighted concerns that patients were at risk of feeling isolated. All patients in pods had an 'Essential Patient Care Round' form in their care files. This was where staff recorded how often they visited patients and monitored the condition of the patients' skin, the surface they were on, their movement and other factors which may affect their vulnerability to pressure ulcers. None of the forms we saw were completed with any information about how often the patient was supposed to be observed. However, we saw that most patients were observed between two and four hourly. None of the patients staying in pods that we spoke with reported feeling isolated.

Major incident awareness and training

- None of the ward staff we spoke with were aware of any major incident or emergency plan.
- We asked the senior matron to show us on the trust intranet where the major incident or emergency plan was located but they were unable to locate it. After several searches we found an 'Emergency, preparedness, resilience and response' document which outlined emergency plans. However, the review date for the document was October 2013. This meant that staff were not aware of local contingency plans and emergency procedures; and the procedure for this required review.
- When we were on the ward at Corby Community Hospital there was a power cut. The emergency generator restored power within a minute.
- Doctors told us that as a result of a fire at Berrywood Hospital in September 2014 they had received a presentation about major incidents and learning from the incident had been disseminated amongst staff.

Requires Improvement

Are Community health inpatient 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

Patient consent was not always obtained and recorded.

We found good multidisciplinary working. Admission criteria and pathways were in place and patients were, in the main, appropriately admitted to the facilities.

Average length of stay for patients at the community hospitals was in the main better than national average. However, for stroke rehabilitation patients the average length of stay was significantly worse than the target with delayed discharges accounted for 34% of delays.

Physiotherapists had a clinical supervision programme in place but there was no clinical supervision provided for nurses.

Evidence based care and treatment

- Care and treatment was evidence-based and staff followed current best practice recommendations. Patients were assessed using recognised risk assessment tools. For example, the risk of developing pressure damage was assessed using the Waterlow Score, a nationally recognised practice too; and we saw evidence that risks were monitored in line with the assessment outcomes.
- The community inpatient team had developed care plans and nursing documentation that better suits the needs of a community hospital service than those previously used from an acute hospital.
- We saw evidence that the latest evidenced based guidelines were discussed at continuing medical education meetings. For example, the **National Institute for Health and** Care **Excellence (**NICE) guidelines for the management of head injuries released in January 2014)(CG176) were discussed in the August 2014 meeting.

Pain relief

- We saw nurses asked patients if they were in pain, identify the location of the pain and deliver pain relief medication where necessary.
- We saw patient pain levels were assessed and recorded in drug charts. At **Corby Community Hospital** one patient was given pain relief 20 minutes before having physiotherapy to prevent pain.

Nutrition and hydration

- The Health and Social Care Information Centre (**HSCIC**) Patient Led Assessments of the Care Environment (PLACE) data showed that all the inpatient services scored better than the national averaged for small community hospitals for the quality and availability of food and drink.
- Nutrition and MUST compliance was 'topic of the month' at **Corby Community Hospital**. There was an information board in the staff room outlining how to screen for malnutrition and appropriate steps to take for malnourished patients.
- Any specific dietary or assistance requirements were documented on patients' boards by their beds, for example, patients requiring thickened fluids. Staff said, "If patients have a memory loss staff can see anything that should be avoided."
- Patients had a choice of meals and meals to meet cultural and clinical requirements were available, such as Halal or gluten free food. Cold snacks were available for patients outside of meal times and relatives were able to bring food in for patients and store in a fridge.
- Pictorial menus were available to help patients choose their meals.
- Patients at Danetre Hospital told us: "Meals are fantastic, I can't fault this place"; and: "If you don't like something, they get something else." One patient at **Corby Community Hospital** commented: "I couldn't eat before I came here, I can eat soft foods like omelettes and rice puddings now"; and: "I get a choice, there's plenty of food."

Approach to monitoring quality and people's outcomes

- The community in-patient services all participated in the National Patient Safety Thermometer scheme, and this demonstrated that the patient outcomes measured were in line with national averages.

Requires Improvement

Are Community health inpatient services effective?

- Information provided in the community hospital beds progress report in October 2014 showed the average length of stay for patients at the community hospitals was in the main better than national average. For example, for quarter two 2014 the average length of stay for GP admitted patients was 26 days, compared to the target of 36 days. However, for stroke rehabilitation patients the average length of stay in quarter two 2014 was 70 days, significantly worse than the target of 21 days. Delayed discharges accounted for 34% of these patients. This was the subject of review by commissioners.
- A joint physiotherapy and occupational therapy assessment document had been developed and implemented to monitor the patient management plan, intervention and outcomes. This encouraged consistent rehabilitation therapy goals for patients and promoted multidisciplinary team (MDT) working.

Competent staff

- We saw new staff to the ward were given an induction before starting work. They were invited to attend handover meetings where they were able to ask questions.
- Physiotherapists had a clinical supervision programme in place but there was no clinical supervision provided for nurses. Nurses told us, "We're not good at supervision; it's not something we're used to". This did not meet the trust staff supervision policy which stated that clinical supervision was mandatory for clinical staff.
- The service manager told us that a place was in place to establish competencies for staff and that the service had received funding for some healthcare assistants to attend national vocational qualification courses.
- Senior nurses (band 7) had attended a leadership skills course and the matron and service manager had attended a managing transition course.

Multi-disciplinary working and coordination of care pathways

- There was clear MDT working across all community inpatient services. We saw all staff, no matter what their roles and responsibilities, assisting with morning duties helping patients with breakfast. The team included nurses, doctors, allied health professionals, and administration and clerical staff.
- Clinical MDT meetings were recorded directly onto SystmOne in individual patient's records to enable all the team to access the documentation. The meeting was a good example of multi-disciplinary team working. The involvement of other professionals such as tissue viability nurses, interpreters and advocates were discussed as appropriate to the need of the patient.
- We observed a MDT meeting where each member of the team had opportunity to speak and contribute to patients' treatment plan.
- A nurse at Danetre Hospital told us: "We work closely with physiotherapists, speech and language therapists, occupational therapists. We have to, it wouldn't work otherwise."

Referral, transfer, discharge and transition

- Admission criteria and pathways were in place and patients were, in the main, appropriately admitted to the facilities. Occasionally, patients were admitted from the acute hospital were found to be medically unfit for admission to the community hospital and had to be re-admitted back to the acute hospital. Staff told us if this occurred incident reports were completed and contact was made with the acute hospital to report the incident.
- We attended a tracking meeting which were held twice weekly to discuss the discharge needs of patients. Staff considered the use of telecare and care packages to support patients in their own homes. When patients refused suggested placements, the decision was respected.
- We saw that some patients were waiting for care packages before being able to be discharged. Staff told us they were under pressure to discharge patients waiting for a care package to be agreed and that beds in local residential homes were occasionally used to bridge the gap. This meant some patients would have been discharged from an acute hospital to the community hospital, and then moved to an interim residential home bed before moving to their own home with a care package or a care home of their choice. If patients consistently refused to move to interim residential home beds when they were considered fit for discharge, they were sent a letter giving details of a date and time when the bed they were occupying would be required.
- Staff told us: "Patients have family planning meetings to discuss their outcomes and what they want to achieve"; and: "Family meetings include discharge planning and nurses, the multi-disciplinary team and care managers are all involved."

Requires Improvement

Are Community health inpatient services effective?

Availability of information

- Patient information was available to all relevant staff in the form of SystmOne and paper care plans.
- Information boards across the wards provided information regarding dementia, safeguarding, tissue viability and mandatory training dates.
- Staff could access further clinical guidelines and pathways via the trust intranet.

Consent

- We observed staff obtained verbal consent before carrying out interventions. However, we asked patients if staff usually asked their consent before providing care or treatment. One patient told us: "No, I just agree with what staff say"; another commented: "They (staff) don't ask for my consent."
- We looked at three patient records on SystmOne at Corby Community Hospital and found that only implied consent had been recorded and not verbal consent from patients. Nurses confirmed that consent was not recorded in patient care files either.
- We saw one care file at Danetre Hospital which did not have any reference to consent for the use of bed rails. We saw another care file which referred to 'cot sides', this term is considered derogatory and the use of 'bedrails' is preferred.
- Staff we spoke with knew how to raise concerns regarding Deprivation of Liberty Safeguards (DoLS). We saw evidence of a DoLS application escalated appropriately on Beechwood ward.
- During MDT meetings we witnessed patients being referred for mental capacity assessments where appropriate. Most nursing staff could demonstrate their understanding of the Mental Capacity Act 2005. However, this was not consistent and a nurse at Danetre Hospital told us: "I don't know of anyone who's had a capacity assessment done"; and: "We haven't had any training about Mental Capacity Act."
- We saw SystmOne prompted staff to assess if patients had dementia or a learning disability; however we did not see a prompt to assess if patients had mental capacity and initially assumed implied consent, then staff recorded where verbal consent had been gained.
- We saw one patient's electronic care file at Danetre Hospital. The record showed the patient was deemed not to have capacity. However, a mental capacity assessment had not been carried out and consent to treatment had not been recorded. This meant the service was not meeting the requirements of the Mental Capacity Act 2005.

Good

Are Community health inpatient services caring?

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

Summary

We saw patients were treated with compassion and respect. All of the patients we spoke with told us they were happy with the care provided by staff.

We saw staff explaining to patients the treatment and care planned. Relatives told us that they were invited to planning meetings. We saw self-care was promoted where appropriate.

We saw most staff tried to maintain patients' privacy and dignity.

Dignity, respect and compassionate care

- Patients were treated with compassion, dignity and respect.
- We saw staff speak with patients in a respectful way, engaging and laughing with patients.
- All patients and carers we spoke with told us that they were happy with the care they received.
- A patient on Hazelwood ward told us: "Staff are very kind and caring"; a patient on Beechwood ward commented "Staff are brilliant, they really helped me to see some independence was a valuable thing". A patient at **Corby Community Hospital** told us: "Staff seem friendly."
- Nurses at Danetre Hospital told us, "We introduce ourselves to patients and try to keep to the same patients where possible."
- We visited Corby Community Hospital early in the morning and found curtains drawn and lights dimmed where people were still asleep. Nurses told us: "We ensure the area is as private as possible with curtains drawn all round and doors closed"; and: "We always ask people if they would like us to leave them alone in the toilet and ensure they're covered up"; and: "We take patients to the toilet to empty a catheter; they don't want everyone knowing they've got a catheter."
- At Danetre Hospital, we saw one patient being transferred with a standing hoist by two staff member in a patient bay, but no curtains were pulled around to maintain the patient's dignity.
- We witnessed that patients had a drink within their reach to help maintain hydration; and a call bell within reach to alert attention.
- The NHS Friends and Family Test was being carried out. The results showed that 95% of the respondents between April and September 2014 said they were either likely or extremely likely to recommend the trust to friends and family.

Patient understanding and involvement

- We saw from records on SystmOne that patients had been offered a copy of their care plan.
- We saw staff explaining to patients the treatment and care they were delivering.
- Most patients reported being involved in their care planning. A patient at Danetre Hospital commented: "I was involved in care planning originally"; and another: "They (staff) seem to involve you in lots of things." However, a patient at **Corby Community Hospital** commented: "I've not had a chat about care plans or about going home".
- Nurses at **Corby Community Hospital** told us: "We have a sheet for families to fill in giving us information about what keeps people calm, what help they need and their background. It helps us look after people with dementia." Another nurse at Danetre Hospital commented: "I've been to meetings where family members attend. I like to think people are involved."
- Relatives we spoke with on Beechwood ward told us: "We were invited to a care planning meeting and an occupational therapist was involved."
- GP and nursing team leader names were displayed on each patient board at Danetre Hospital so that patients and visitors could identify who was responsible to patient care.

Emotional support

- We saw where appropriate, patients were provided with the services of a psychologist, relatives we spoke with felt this provided emotional support. A chaplain was also available.

Good

Are Community health inpatient services caring?

- Nurse at Danetre Hospital told us: “We have high standards, we listen, communicate and have empathy with our patients.” They commented: “We need patience, time and don’t worry about what’s got to be done; we just sit with patients if that’s what they need.”
- Occupational health was available to provide emotional support for staff. Staff wellbeing was promoted on notice boards, offering staff to participate in ‘learning to relax’ sessions.
- We saw thank you cards, expressing the gratitude of patients and relatives for the kindness and support they had received.

Promotion of self-care

- We saw that therapy was designed to support patients towards independent living when they were discharged. This was prominent on Beechwood ward where patients had ‘flats’ rather than ‘rooms’ with individual kitchen, living and bathroom areas. This helped to assess if patients were ready to be discharged home using an environment similar to the one they would live in.
- We saw on Beechwood ward patients were encouraged to eat in the communal dining area and maintain social links with other patients.
- We saw that staff encouraged patients with patience and kindness to undertake tasks for themselves where this would aid their recovery. For example on Hazelwood ward, patients were encouraged to feed themselves in the communal dining area.

Requires Improvement

Are Community health inpatient services responsive to people's needs?

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

Summary

The responsiveness of community inpatient services varied across each ward. Arrangements to meet the specific needs of patients were variable across community inpatient services, with wards attempting to meet patients' needs with inconsistent methods.

There were high levels of bed occupancy within the community inpatient service that could start to affect the quality of care given to patients.

Community inpatient services led a twice weekly telephone patient tracking meeting with colleagues from social care. They aimed to support health and social care teams to deliver safer patient care and discussed the availability of beds, patient flow and what could be implemented to support discharge.

Staff told us that they tried to resolve complaints locally as they arose. Feedback was invited through an online survey "I want great care" which was reviewed on a monthly basis. Generally the service received positive comments.

Planning and delivering services which meet people's needs

- There were high levels of bed occupancy within the community inpatient service. Between January and September 2014, the trust's average bed occupancy was 94% compared to the England average of 88%. Occupancy rates above 85% could start to affect the quality of care given to patients.
- Three patients at Corby Community Hospital told us that there were no activities except to watch television. Allied health professionals told us that they wanted to organise more activities for patients but that they did not have the staffing and financial resources to do this.
- Beechwood ward provided patients with Zumba and exercise classes, adapted to meet individual patient requirements. Patients told us that the ward organised themed social events such as Chinese nights or cinema nights. We saw a healthcare assistant decorating the ward with hearts for Valentine's Day. They told us that they approached local businesses for donations to fund events and Christmas presents for all the patients. The ward had access to a garden area, where barbeques and garden parties took place in the summer months for patients and their families. However, we did not see this on other wards.
- At Corby Community Hospital patients were provided with a Welcome Pack. This was a folder supplying ward information such as, the philosophy of care, explanation of the different staff uniforms and mealtimes. However, we did not see this on other wards.
- There was a therapy gym on Beechwood ward with equipment to help rehabilitate patients.

Equality and diversity

- The majority of patients we saw at all the hospitals were of white/European ethnicity. Staff informed us that interpreter services were available and would be requested when they were needed.
- We saw a physiotherapist at Corby Community Hospital writing information for a patient about their care because the patient was hard of hearing.
- There was disabled parking available at all sites. There were lifts available in the Danetre Hospital that provided a service above the ground floor. All sites we visited were accessible for people who used a wheelchair or other mobility aids.

Meeting the needs of people in vulnerable services

- Wards had white boards that highlighted patients living with dementia or who were at risks of falls to help nurses tailor the care provided.
- At Danetre Hospital was saw care records for patients who were living with dementia. There was a dementia care form in the notes which staff completed to identify people's preferred routines, preferences and choices. Documentation we reviewed at all the hospitals included information of the patient likes and dislikes. However, we did not see this on other wards.
- Nurses on Beechwood ward told us that for patients with learning disabilities they tried to involve their carers as much as possible to help understand patient needs.
- Adaptive cutlery was available for people with dexterity difficulties.

Access to the right care at the right time

Requires Improvement

Are Community health inpatient services responsive to people's needs?

- Community inpatient services participated in twice weekly regional teleconferences between the trust, local acute trusts, the clinical commissioning group (CCG) and community services including care homes. This aimed to support health and social care teams to deliver safer patient care and discussed the availability of beds, patient flow and what could be implemented to support discharge. This was an example of all relevant organisations working in partnership to deliver efficient and safe patient care.
- Two interim flow coordinator posts had been developed and were being recruited to facilitate patient flow and release clinical staff time to care for the patients.
- The service manager told us that community inpatient services were under pressure from local acute hospitals to admit patients out of hours. They reported that community inpatient services would try to avoid out of hours admissions because there was limited medical provision, they competed incident reports were these had occurred.
- There were no inpatient service response to referral targets in place for the therapists within community hospitals. Wards had dedicated physiotherapists and occupational therapists Monday to Friday. It was expected that they would complete initial assessments of a newly admitted rehabilitation patient within 48 hours of that admission and on-going assessments were tailored to meet individual patient's needs. However, they did not formally collect this information to monitor if this was achieved and therefore, it is difficult to assess if the level of care met patient need
- There was a service level agreement in place for stroke patients to receive speech and language therapy (SLT) and dietetic care. Therapists would visit each location once a week Monday to Friday. Patients referred would be seen on the next visit. SLT data showed that the average waiting time for stroke patients to be seen was two days, between April and December 2014. The average waiting time for none stroke patients to be seen by SLT was three days, between April and December 2014.
- Dietetic data showed that the average waiting time for all referred patients to be seen was six days, between April and December 2014. Waiting times had improved from 16 days in April to six days in December 2014. Nurses told us that they used the MUST guidance to start patients on appropriate nutritional supplements until the dietitian assessed patients.
- There was a plan to introduce seven day working for therapists to provide daily care and treatment with the aim to reduce the average length of stay and improve patient outcomes.

Complaints handling (for this service) and learning from feedback

- All staff we spoke with were aware of the complaints procedure, and told us that they tried to resolve complaints locally as they arose. We saw information about how to make complaints available on wards and that complaints were a rolling agenda item in team meetings.
- There had been eight complaints between October 2013 and September 2014. Four regarding Beechwood ward (three of which were upheld), three regarding Danetre Hospital and one regarding Hazelwood. None had been referred to the Ombudsmen.
- We looked at two complaints regarding poor staff attitude. In both circumstances apologies from the staff members concerned were given, action plans were put into place and monitored by line managers, for example one staff member was asked to complete customer relations training.
- Feedback was invited through an online survey "I want great care" which was reviewed on a monthly basis. The results were displayed on each ward. For December 2014 Danetre Hospital scored 4.95 out of five from reviews submitted by 21 people. Generally the service compared positively with outcomes reported elsewhere in the trust. Comments included: "Staff are always respectful and helpful".
- At Corby Community Hospital we saw patients were given a welcome pack to provide information about the ward including the complaints process. Patients were advised to make complaints to the ward sister or ward matron and information was available about the Patient Advisory Liaison Service (PALS). An information board at Corby Community Hospital showed that there had been 10 compliments and no complaints received since April 2014.

Requires Improvement

Are Community health inpatient 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

Not all risks had been identified on the risk register. Arrangements to monitor governance, risk and quality were in place, but we found evidence that representatives did not always attend meetings and therefore not all aspects of governance, risk and quality were always discussed.

We saw examples of where the trust engaged with the public and staff. Staff we spoke with told us they enjoyed their job and felt the service was well-led by their immediate managers and that managers was approachable and supportive.

However, whilst there was some evidence of shared learning, the systems in place were not robust or comprehensive for effective shared learning and innovation across community inpatient services and this meant that patient experience, care and engagement varied across services.

Staff told us that they worked as one team. Vacancy rates and high sickness levels put additional pressure on substantive staff.

Service vision and strategy

- Staff told us they felt listened to and felt the welfare of the patients and wellbeing of the staff was important to the organisation.
- We saw ward philosophies or mission statements displayed. These included statements such as 'safe, clean, friendly support to rehabilitate patients'. Staff we spoke with were aware of these and felt that they provided care that reflected the statements.
- We found evidence that a new service level reporting system was being implemented and trialled to allow performance management within service. This enabled services to establish service cost down to patient level. Draft reporting was predicted to be available from March 2015 with full reporting in place by December 2015.

Governance, risk management and quality measurement

- We saw meeting minutes of monthly adult directorate governance meetings attended by local service managers, which discussed and monitored the risk, quality and governance across the division. We also saw evidence of monthly adult services directorate business meeting minutes which discussed corporate updates, communication and service reports. These indicated that governance and quality was being monitored. However, at the December 2014 governance meeting there was no representative in attendance to report on quality or complaints and incidents. At the business meeting for January 2015 there was no representative in attendance to report on performance, finance and estates. This meant that these issues were not discussed.
- We saw evidence that patient experience stories were discussed at monthly adult directorate governance meetings. Actions were devised as a result of these to improve patient experience.
- We found that not all risks had been identified on the risk register, for example, the medical provision at Danetre Hospital. However, we saw in the Beechwood ward meeting minutes that staff were asked to contribute any risks they and identified to the risk register.
- The service manager told us that there was no performance monitoring electronic system in place and that managers recorded performance outcomes on paper. This meant comparing the ward remotely as difficult.
- We saw evidence to show that the matron on Beechwood ward completed a monthly infection control quality assurance audit of the ward to identify areas of compliance and areas that required improvement. For example, in December 2014 the matron identified a staff member wearing a necklace which was then removed as an action to comply with trust policy. Results had improved from 84% compliance in December 2014 to 95% compliance in January 2015.

Leadership of this service

- Staff told us the CEO was visible and that they had visited the first day the trust took over community inpatient services.

Requires Improvement

Are Community health inpatient services well-led?

- The service manager and modern matron aimed to visit all three sites on a weekly basis to ensure they were visible and accessible to all the ward staff. The team had introduced one matron across for three wards (Danetre Hospital, Hazelwood ward and **Corby Community Hospital**) to provide greater continuity and a consistent approach to implementing the transformational changes. Beechwood ward had a different matron and staff across all services told us they felt Beechwood was its own service rather than part of the wider picture.
- We found a lack of shared learning between services, for example, the ideas about how to raise funds for patient activities was not shared between services and this meant that patient experience and engagement varied across services.
- All staff we spoke with told us they felt the service was well-led by their immediate managers and most staff told us their manager was approachable and supportive.
- Some staff felt managers could be more understanding of how hard all the recent trust changes had been. One member of staff told us: "It's very stressful"; and: "Morale was low during the changes but its better now."
- Some staff told us that recruitment took a long time to complete. Staff felt that this put pressure on substantive staff to cover vacant posts. At the end of February 2015 there was a 32% full time equivalent vacancy rate across community inpatient services. We saw evidence of vacancy rates being discussed during adult services directorate business meetings and this was to be raised with human resources. However, all staff told us that they worked as a team. One nurse at Corby Community Hospital commented: "We fall down because we tend not to have enough staff, but everyone mucks in".

Culture within this service

- Most staff we spoke with told us that they were happy to come to work and enjoyed their job. Comments from staff included: "It's very welcoming"; "Everyone gets on well, we work well together as a team"; "There's lots of support here"; "I feel at home"; and: "It's really good, only problem is the staffing."
- Nurse sickness levels for Beechwood ward were displayed on the ward information board. For December 2014 the sickness level was 9%, worse than the trust target of 3.5%. We saw evidence in the adult services directorate management team meeting minutes for November 2014 and business meeting minutes for January 2015 that sickness levels were being monitored and there was training available to managers to access relating to the managing absence policy.
- We saw in the Beechwood unit meeting minutes that the unit was planning a team building day for staff based upon the trust values.

Fit and proper person requirement

- The trust had a fit and proper person test action plan in place. For example, there was an annual declaration issued to all board members to assess their fitness for the role.

Public and staff engagement

- We saw minutes that confirmed that staff team meetings took place at each hospital. This meant staff had the opportunity to discuss both local and wider organisational issues, and to be kept updated with trust initiatives and service developments.
- There was an active charity 'Friends of Danetre Hospital' that provided financial support to purchase equipment and improved facilities.
- There were 'You said, we did' comments on display boards on each ward. For example at Danetre Hospital one comment from a relative state that visiting times were not clearly displayed. In response visiting signs had been reprinted and were evidence in more locations.
- On Beechwood ward a patient had designed an information board about the care they would like to receive during their stay.
- The CEO provided a monthly update for staff via the trust intranet. This included a section called 'Hear for you', where staff were invited to feedback experiences and ideas.
- There had been two therapy engagement workshops in September 2014 to discuss the new service model, new ways of working and the potential of seven day working with staff.

Innovation, improvement and sustainability

- There was a lack of innovation throughout community inpatient services. Staff reported that they were so busy doing their day jobs that it was difficult to be pioneering.

Requires Improvement

Are Community health inpatient services well-led?

- On Beechwood ward nurses told us about the new method of recruitment where there was a practical scenario. They felt that this ensured they recruited staff that were compassionate about caring for people. However, this had not been shared with other services.
- The trust promoted health and wellbeing for staff. On the trust intranet there was a section called 'Your health: Your wellbeing' which promoted staff health, such as a free boot camp exercise sessions.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing.** **On order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all time, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.** Northamptonshire Healthcare NHS Foundation Trust: **Appropriate steps were not in place to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff to ensure people who use the service are safe and their health and welfare needs are met. Regulation 22.**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Regulation 23- (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers.** **The registered person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to delivered care and treatment to service users safety and to an appropriate standard, including by –** 1. Receiving appropriate training, professional development, supervision and appraisal. Northamptonshire Healthcare NHS Foundation Trust:

Compliance actions

Suitable arrangements were not in place to ensure staff received appropriate training, supervision and appraisal to enable them to deliver care and treatment to people who use the services. Regulation 23 (1) (a).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 20 - (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 Records. The registered person must ensure that the service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of – (a) an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user. Northamptonshire Healthcare NHS Foundation Trust: Patient records were not always fully completed, for example, consent documentation. This generated the risk to the delivery of safe patient care and treatment.