Buckinghamshire Healthcare NHS Trust

RXQ

Community health inpatient services

Quality Report

Buckinghamshire Healthcare NHS Trust Mandeville Road Aylesbury Buckinghamshire HP21 8AL
Tel:01296 3150
Website:www.buckshealthcare.nhs.uk

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXQ61	Buckingham Community Hospital	Ward	MK18 1NU

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

Summary of findings

Ratings

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

Overall we rated this core service as requires improvement. We found the service was good in the area for caring, effective and responsive. We rated safe and well led as requires improvement.

We rated the service as requires improvement because:

- Medicines were not always managed safely, included emergency drugs, and this had the potential to impact on patients' safety.
- There was limited pharmacy support and medicines reconciliation was not completed.
- There were not always adequate allied healthcare professionals and pharmacist's to meet the assessed needs of patients.
- Records such as assessments and goal settings were incomplete which posed risks of patients receiving inconsistent care.
- Equipment was not always managed safely and in line with the trust's operating procedures. There was no system for identifying clean and dirty equipment to minimise risks of cross infection.
- Staff had not completed appropriate levels of mandatory training.
- Staff told us they did not feel they were part of the wider trust and worked for the community hospital.
- The governance oversight was not always effective as risks were not always identified. These included risks relating to equipment and medicines management which we found during the inspection.

However

- Staff reported incidents about safety relating to patients. Incidents were investigated although it was not evident how learning was shared to improve practice.
- Staff followed infection control prevention and practices such as handwashing and using personal protective equipment to prevent the spread of infection.
- Care and treatment for patients took account of best practice and evidence based guidelines when delivering care.
- Patients were involved in their care and treatment, and we saw in records staff had obtained consent prior to providing care or treatment.
- Staff were aware of what constituted abuse and the action they needed to take to safeguard the patients.
- Patient's pain was well managed, although there was no specific tool used to assess pain for people who may not be able to verbalise this.
- There was effective multi -disciplinary working which resulted in co-ordinated care for patients.
- Staff treated patients with care and compassion and ensured their privacy and dignity was protected when receiving care.
- Patients' care records were stored safely and securely and were available for staff to use to when providing care to patients.
- There was a clear governance structure and there was a commitment to address the concerns raised by staff.

Summary of findings

Background to the service

Buckingham Community hospital is one of five community hospitals and forms part of Buckinghamshire Healthcare NHS Trust. The community inpatients service are part of the division of integrated elderly care division. The trust offers a range of acute and community services, and is the main provider of community services across Buckinghamshire. This report reflects the findings following the inspection of the 12 bedded inpatient ward at Buckingham Community Hospital. It provides care for patients who may need rehabilitation prior to being discharged home, they were admitted from the acute trust. The ward also provides a step up service where patients are admitted from home for a short period by GPs from the community and the staff worked closely with the community nursing team.

Our inspection team

Our inspection team was led by:

Team Leader: Lisa Cook, Inspection Manager, Care Quality Commission

The team consisted of three staff including an inspector, a physiotherapist and a community matron.

Why we carried out this inspection

We inspected this core service as part of an unannounced community service inspection following receipt of whistleblowing concerns.

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?

We carried out an unannounced inspection on 6 September 2016. As part of the inspection we spoke with seven patients and a relative. We spoke with 11 staff of all grades, including nurses, a physiotherapist, an occupational therapist, healthcare assistants and physiotherapy assistants. We also spoke with administrative staff, housekeeping and kitchen staff.

Prior to the inspection we reviewed a range of information we hold about the service. This included documents relating to the management and performance of the trust and other information we received post inspection.

Summary of findings

What people who use the provider say

We spoke with seven patients and a relative. Patients told us the community hospital was part of their local community and they were "very satisfied" with the care they were receiving.

Relatives told us they were always made to feel welcome. They appreciated being involved and supporting their family members. They also liked the flexibility with visiting times.

People told staff gave them a good level of information and they were involved in their care.

Patients described the staff as "kind and caring" and they said they felt safe.

The results of the Friends and Family Test data showed 100% of patient who responded would recommend the hospital as a place to receive care.

The hospital Patient-Led Assessment of the Care Environment (PLACE) audit from September 2016 showed the hospital scored 71% for privacy, dignity and wellbeing against a national average of 84%.

Patient lead assessment of care environment (PLACE) survey showed 85% of patients were satisfied with the meals provided which was lower than the national average of 88%.

Patient-led assessments of the care environment (PLACE) for September 2016 showed the hospital scored 73% for dementia care

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure medicines are stored and managed safely including emergency drugs.
- The trust must ensure pharmacy support is available to ensure medicines are managed safely.
- Emergency equipment is checked and maintained in line with the trust's policy and safe for use.
- There are adequately trained and sufficient numbers of allied healthcare staff to meet the assessed needs of patients.
- Review the governance process used to monitor the quality of the service and ensure it is safe, to assure they are robust and effective.

Action the trust SHOULD take to improve

- Ensure there is a robust system for checking equipment and the area for storing equipment is reviewed.
- Consider introducing a process for the ward for recording concerns and complaints and these are audited and outcome shared as part of lessons learned.
- Ensure a process is developed so that learning from trust wide incidents can be shared and lessons learned.
- Ensure there is the correct number of competent nursing staff on duty at all times.

Buckinghamshire Healthcare NHS Trust

Community health inpatient services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- Medicines were not stored safely as storage temperatures were not monitored and some medicines were out of date.
- Some equipment had passed their service due date and some emergency equipment was out of date.
- Some parts of the ward were cluttered and equipment stored on the floor which did not follow good infection control practice. Some equipment was shared between patients, however there was no process to identify if these had been cleaned and were ready for use.
- Safety thermometer information was collected and submitted to the trust. This information was not displayed and staff were not able to tell us how the results were used in practice.
- The ward did not always have adequate allied healthcare professionals and pharmacist's to meet the assessed needs of patients.
- There was little evidence of shared learning from trust wide incidents.
- Staff were not all compliant with mandatory training particularly basic life support.
- The quality of the patient's records were variable, and some were incomplete with gaps in the admission and assessment and care plans were not fully developed.

However

- Staff were reporting incidents and incidents were reviewed and action was taken to mitigate further incidents of a similar type.
- All staff were aware of what constituted abuse and the action they needed to take to safeguard patients.
- Staff adhered to infection control practices such as handwashing and the use of personal protective equipment to prevent the spread of infection.
- Records were stored safely and securely and were available to support patients' care.

Requires improvement

Are services safe?

- Staff were clear about their responsibility to be open and honest although they were not able to provide any examples of when the principles of duty of candour had been followed.
- The national early warning score (NEWS), a scoring system which helps to detect deterioration in a patient's condition, was being used to help ensure the early detection of any deterioration in a patient's condition. This would alert staff to the need to seek assistance in a timely manner.
- There were adequate numbers of nursing staff to meet patient's needs. To achieve this the trust relied on agency staff. The trust was aware of the risk associated with nursing staffing levels and an active recruitment campaign was being run.
- The service had appropriately reduced the number of beds in response to staff's shortage.

Safety performance

- The ward manager collected safety thermometer data in relation to care provided to patients. The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harms. It also provides a means of checking performance and is used alongside other measures to direct improvement in patients' care. This included pressure ulcers, falls and catheter related urine infections (UTI).
- The ward manager told us safety thermometer data was collected and submitted. However, no safety thermometer information was displayed for visitors to see. Staff were not aware of the results and there was no evidence that this information was used to ensure patients were protected from the risks of harm. For the month of August 2016, 10 out of 11 patients were recorded as receiving harm free care, one patient had a new VTE classified as harm, and no further information was available.

Incident reporting, learning and improvement

- Incidents were recorded and reported A never event is a serious incident which is wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Incidents were reviewed and investigated. For examples there had been a staffing incident where a member of bank staff was absent. This had left one nurse to care for patients who required two members of staff to meet their needs. This incident was escalated to the clinical site management team, and another member of staff was identified to provide support. The investigation concluded the risk was mitigated. A second incident relating to a medication error had led to staff retraining to try and mange the risk of reoccurrence.
- Following the last inspection, the report identified that the trust should have a system in place for sharing learning from incidents. The staff received feedback from incidents reported at local level but not trust wide. The ward manager told us they were looking at measures to improve access and sharing lessons learned. This included adding this to the staff's meeting agenda.
- As part of lessons learned, coroner post mortem reports were routinely requested and reviewed on a monthly basis by the divisional managers
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with told us about being honest and reporting incidents. They were unable to tell us of any examples when the duty of candour had been initiated.
- Training in understanding the duty of candour was available to the staff. The latest data as of September 2016 showed 89% of staff with no direct patient contact had completed the e-learning module and 72% of staff who had direct patient contact. The trust's target was 90%.

Safeguarding

- Staff including medical, nursing and ancillary were required to attend safeguarding training. Training records showed 81% staff had completed adult safeguarding training and 89% had completed child safeguarding level 1 training in the previous 12 months against a trust target of 90%. However, only 66% of staff in division of integrated elderly care had completed safeguarding children level 2 training. In accordance

with the Intercollegiate Document - Safeguarding Children and Young People: Roles and Competences for Health Care Staff 2014, all clinical and non-clinical staff who may have may contact with children or young people should complete level 2 training.

- Staff on the wards, including non-clinical staff, were aware of what constituted abuse and the actions they would take and report their concerns to protect the safety of patients in vulnerable situations. They told us they were able to access the trust's safeguarding policies and procedures as needed.
- Arrangements were in place to safeguard patients from the avoidable harm. This was in line with relevant guidance and local protocols.
- The Department of Health required trusts to have 90% of staff compliant with protecting people at risk of radicalisation (PREVENT)) by 2018. The PREVENT strategy requires healthcare organisations to work with partner organisations to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who may be at greater risk of radicalisation. Trust data showed they had met their target of 100% compliance.

Medicines

- Medicines were not always managed safely and securely. Two medicines trolleys were kept in an equipment room with no ventilation. The room was hot, and cluttered which did not comply with current regulations on storage of medicines such as the Royal Pharmaceutical Guidance and the trust's medicines policy (2015). Staff confirmed that they should inform the pharmacist if the room temperature was above 25c. However, there was no facility to monitor and record the temperature at which medicines were stored in that room.
- We found five medicines which had expired and these included medicines in the resuscitation bag and an intravenous infusion fluid. There was a process for checking these and staff had signed the record. However, they had not identified these medicines had expired. A medicine used for the treatment of anaphylaxis (an acute allergic reaction) had expired on 1 September 2016 and was not stored safely; this was found loose with another medicine in the bag. There was also a risk of emergency drugs may not be available in an emergency as these were locked.
- There are certain medicines which once opened should have the date of opening clearly marked as they have a short shelf life. The medicines trolley contained a number of liquid medicines which were opened with no date of opening recorded. Staff told us they knew they had to put the dates on the bottles once opened but had not done so. Patients were at risk of receiving out of date medicines as safe medicines' management processes were not followed.
- Staff told us they carried out a monthly check of other medicines such as injections on the first weekend of each month and recorded this. The record showed the checks had not been completed in September 2016.
- Staff did not check the medicines' fridge temperature daily in line with good practice guidelines and the trust's medicines policy. The record showed this had not been done for the last three days prior to the inspection. The fridge contained a number of medicines which were in use. The efficacy of medicines can be affected if they are not stored at the correct temperature.
- Patient medicines reconciliations were not carried out on admission to ensure patients had all the appropriate medicines to meet their needs. National Institute for Health and Care Excellence (NICE) guidelines recommend all patients should receive medicines reconciliation within 24 hours of transfer of care. Medicines reconciliation is the process of identifying an accurate list of medicines for the patient on admission. Staff told us they had been without a pharmacist for the last two months. Prior to this the pharmacist visited on a weekly basis to support patients and the staff. There were 13 whole time equivalent (WTE) vacancies for the pharmacy service across the trust which impacted on the level of service.
- Medicine charts were complete and medicines were available to patients. GPs provided support to patients and prescribed medicines for patients including out of hours. We saw there were two gaps on the medicines' administration record (MAR) charts for a patient. We raised this with the staff and they were unable to tell us if these medicines had been administered. There was no

audit of MAR charts and no process in identifying gaps on MAR records in order for actions to be taken and ensuring patients received all their medicines as prescribed.

- Controlled drugs were stored safely and securely. Access to medicines was limited to designated staff to minimise the risks of others accessing these drugs. There was a process that the staff followed and controlled drugs were checked in line with the trust's policy and records were maintained. We carried out a random check of the controlled drugs and found the stock matched the balance and this was recorded appropriately.
- Staff completed medicines management and awareness and training data showed only 75% of staff had achieved this which was short of the trust's target of 90%.

Environment and equipment

- The staff told us there was a process to service equipment regularly.We found a hoist and a scale which were past their service date according to the label on the piece of equipment. Staff told us this was how they would know if the equipment had been serviced.This meant that staff could not be assured the piece of equipment had been checked to ensure it was safe to use.
- We found two pieces of equipment which were for single use that had expired. The disposable hand suction machine had expired in January 2016 and a child resuscitator/ambu bag had expired in 2015. Staff followed their process for checking equipment and records of these were seen. However the process not effective as these items had not been identified as requiring replacement until we raised this with the staff.
- Emergency equipment such as basic life support equipment was available on the ward. The access to emergency equipment could be compromised, as the area was cluttered with hoists, scales and frames which may impede swift access to this emergency equipment
- The emergency portable oxygen cylinder was kept in a bag which was not marked and easily identifiable and was not stored safely. There was no sign to identify oxygen was stored in that area as oxygen is combustible.
- Other equipment, such as blood glucose monitoring machines, staff confirmed to us had not been tested. This was to ensure they were correctly calibrated, reliable and test results were valid and safe to determine treatment required.
- Staff used an electronic system to order equipment. However equipment had not been requested in a timely way for a bariatric patient at the time of the inspection. The patient told us they had brought their own equipment from home.
- Pressure relieving mattresses were available for those patients who were at risk of skin breakdown. However, there were no pressure cushions available and two patients, who had been assessed at risk of skin breakdown, did not have pressure cushions when they were sitting in their chair.

Quality of records

- Medical and nursing records included details of the patient's admission and the transfer information from the referring hospital. The ward used a paper based records' system and we reviewed six sets of patients' records. These were legible although not always up to date and complete such as gaps on admission assessments and "All about me"
- The physiotherapy and occupational team had introduced new documentation to provide person centred care. This was a detailed document which contained assessments, goals and plans of care.
- The quality of the patients' records was variable and two of the six records were incomplete which could impact on continuity of care delivery. One record showed two goals had been recorded; however the rest of the record was incomplete. Staff told us the health care assistants were responsible for completing this and they were "often too busy". Another record did not contain any joint assessments, goals and rehabilitation treatment plans.
- A patient's record contained details of their past medical history including surgery, a therapy staff member told us the record of the patient's surgery was inaccurate. Staff had not raised this as a concern as this record was made prior to the patient's transfer to this ward.

Requires improvement

Are services safe?

- Records were held safely and securely with restricted access including electronic records which were password protected in line with data protection guidelines.

Cleanliness, infection control and hygiene

- The ward was visibly clean. Hand sanitisers were available at the entrance and at different points around the ward.
- Staff adhered to the trust's bare below the elbow policy. We observed staff used personal protective equipment (PPE) such as gloves and aprons, which included different colour coded aprons for providing care or supporting patients at meal times .
- Staff followed hand hygiene procedures such as washing their hands and using sanitising gels as part of infection control in between patients. In May 2016 the trust took part in a hand hygiene day in support of the world health organisation (WHO) in raising awareness with patients, visitors and staff regarding the importance of good hand hygiene.
- We found some equipment which was not clean or stored tidily. There were approximately five pieces of equipment in the sluice which were shared between patients and there was no process to identify if these had been cleaned. For example they did not have 'I am clean' stickers on them showing the last date and time they had been cleaned. Staff told us all equipment was cleaned after use.
- We found approximately 12 pieces of equipment covered with layers of dust and others stored on the floor increasing infection control risks.
- There were no cases of hospital acquired Meticillin Resistant Staphylococcus Aureus (MRSA) and acquired Meticillin-sensitive Staphylococcus Aureus (MSSA) for integrated elderly and community care. The division monitored the incidence of hospital acquired MRSA and Clostridium difficile as part of the division scorecard, assessing compliance with the agreed local target.
- The latest hand hygiene audit result showed 96% compliance with hand washing prior to patient's contact. The result was discussed at team meetings and action plan would be developed for non- compliance.

Mandatory training

- The trust had an induction programme for newly appointed staff that included health and safety, safeguarding, fire procedures, basic life support and information governance awareness. Staff told us they had access to and undertook e-learning training modules for some mandatory training; although there was no protected times for this.
- Trust wide training data received showed as of August 2016, 69% of staff had completed basic life support, health and safety training 81%, and fire safety at 85% against trust's target of 90%. Eighty one percent of staff had completed summoning emergency help training.

Assessing and responding to patient risk

- The ward used the national early warning score (NEWS) to identify deterioration in a patient's condition. This consists of a scoring system which helps to detect deterioration in a patient's condition. An audit completed in July 2016 showed 100% compliance with recording the patients' identification,100% observation recorded for previous 48 hours and 90% where all five criteria were met. As a result an action plan was developed and further staff training provided on the use of the NEWs score.
- Staff knew how to seek help and advice from managers to report patients' concerns and also seek medical assistance out of hours.
- The community hospital did not have on site 24 hour medical cover therefore, outside of normal working hours it was reliant on nursing staff to provide basic life support (BLS) until help arrived. Data from the trust showed there was a low uptake of BLS training which could place patients at risk, as staff may not have the skills and confidence to provide this level of emergency care.
- Physiotherapists carried out moving and handling assessments of all patients admitted to the ward. A fall risk assessment was also completed and patients at risk of fall were in a bed closer to the nurses' desk so they could more easily monitored order to monitor them.

Requires improvement

Are services safe?

- Healthcare assistants supported the patients with their exercises as therapists were notavailable such as at weekends. There were no exercise sheets available and staff could not tell us how they managed these exercises.
- Patients were assessed for the risk of pressure injury using the 'Waterlow' standardised assessment tool. Staff completed this on admission. However, there were gaps in reviewing the assessment in some records we reviewed.
- Staff told us when a patient developed a pressure ulcer in hospital, a debrief meeting was launched within 72 hours to identify causes, instigate remedial measures to mitigate future risks and to share learning from the incident.
- Staff were aware of the process they needed to follow if they required support from the community GP services and would dial 999 for all emergencies.

Staffing levels and caseload

- There are nationally defined minimum safe staffing levels for inpatient care wards. These include Safe Staffing: A Guide to Care Contact Time (NHS England, November 2014) and Direct Care Measurements (NHS England, January 2015). NHS Trusts are required to publish their safer staffing data on their websites. However, there was no data published for January, February, April, May and June 2016.
- Following the last inspection in March 2015 the hospital had introduced an acuity tool to assess the staffing level in June 2016. This provided guidance to staff about the acuity level of patients and scores. Trust managers described the acuity tool as being used to inform staffing level, however two staff members told us they felt there was no correlation between the acuity of patients and the number of staff available.
- Staff said they used the internal electronic reporting system to escalate their concerns about increased acuity of patients and lack of staff.
- Information provided by the trust indicated when the number of patients was increased; there was an additional member of staff available on the late shift. The number of beds was decreased back to 12 after 6 months when staffing changed.
- The planned staffing rota for the ward was two registered nurses (RNs) and two health care assistants for daytime cover. Night duty had two registered nurses and one healthcare assistant. These were the agreed number of staff. The duty roster for August 2016 indicated all shifts were staffed as planned except for three when there was one RN for three day shifts, this was escalated at the time. Staff said that staffing remained a challenge and they relied on bank and agency staff to cover shortfalls and this impacted on care.
- Staff told us that night duty was staffed mainly with agency registered nurses, who were regularly left in charge of the ward with no employed RN for support. Records showed there were 11 different RNs on night duty in one week and for four nights there were two agency staff in charge of the ward. The ward manager told us that they tried to book regular agency staff. However, they were not always available.
- Staff told us there was also a shortage of physiotherapists and occupational therapists across almost all services at the trust. Allied healthcare professionals did not provide a seven day service at Buckingham community hospital which staff said could impact on patients' care including discharges.
- The hospital had increased the number of patient beds to 15 from January 2016. On average there were 14 - 15 patients admitted to the ward. The number of patient beds was reduced in May 2016, to 12 due to staffing shortage
- The trust's risk register had identified that staff vacancies remained a concern. This included the risk of patient's care being compromised by unsafe staffing levels caused when temporary staffing was unreliable and with shifts cancelled at last minute. Other concerns were staff working double shifts and/or increase reliance on agency staff to fill vacant shifts at the last minute. The trust was planning a community focused recruitment campaign through workforce planning. Recruitment was on going to fill the vacancies with two new staff members due to start.

Major incident awareness and training

- The hospital had a corporate business continuity plan which identified actions staff should take for low, medium and high impact on in patient sites. There were

Requires improvement

Are services safe?

clear action to inform staff's practices, for example for severe impact, this included use of identified private hospitals and transport of patients involving the voluntary services to convey patients as needed. Staff were aware of the plans and how to access support from the acute trust for incidents such as power failure or adverse weather conditions.

- Staff completed annual fire safety awareness training as part of their mandatory training. Information received from the trust showed as of August 2016, 91% of staff had completed this training. The trust had identified a fire safety risk on the ward being unable to evacuate patients safely in event of fire on night shift. An action plan was put in place which included "Ski" sheets placed under mattresses and support from the community healthcare team.

Good

Are services effective?

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

Summary

We rated effective as good because:

- Staff provided care which took account of national guidelines.Patients were assessed for risks such as pressure injury, nutrition and falls in line with .
- Allied healthcare professionals carried out thorough assessments of the rehabilitation needs of patients prior to their admission.
- Patients received appropriate pain control when required and said their pain was well managed.
- Patients were offered a choice of food and fluids which met their needs and were referred to dietitians for additional support, although this was not always consistent for patients.
- Staff were supported with training and had appropriate appraisals.
- There was good multi-disciplinary working between the allied healthcare professionals, the medical and nursing staff to support coordinated care.
- The handover between teams was comprehensive and staff were engaged and shared information appropriately to ensure continuity in the patients' care.
- There was some evidence that out comes were monitored and action taken were required.

However

- Staff had an awareness of the Mental Capacity Act (2005) but the procedures for renewing the Deprivation of Liberty Safeguards (DoLS) approvals were not always clearly understood and applied.
- Some staff were not clear about the best interest process and how to access the advocacy service.

Evidence based care and treatment

- There was a range of policies and guidance available on the trust's intranet to assist staff in their clinical roles. Staff provided care and treatment to patients based on national guidance such as the National Institute for Health and Care Excellence (NICE). Minutes from the clinical governance meetings included a slot for the discussion of compliance with NICE guidance, however in the two sets of minutes we reviewed discussion had not taken place due to time constraints.
- The National Institute for Health and Care Excellence (NICE, 2010) recommends that all patients should be assessed for the risk of developing thrombosis (blood clots) on a regular basis. Patients' records showed they were assessed on admission for the risk of venous thromboembolism (VTE) in line with Clinical guideline CG92. Depending on the level of risks; patients were prescribed treatment for the prevention of blood clots.
- There was an anti- coagulant (blood thinning) pathway for patients who were on long term anticoagulants. This included frequency of blood tests and guidance on prescription of anti –coagulant medicines.
- Staff used the Malnutrition Universal Screening Tool (MUST) to assess patients' risk of malnutrition. This was in line with the NICE clinical guideline 32 'Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition'.
- We reviewed the trust clinical audit programme. The division of integrated elderly and community care had participated in four audits in 2015, including the national audit of inpatient falls. The falls audit plan 2015 identified a number of areas for improvement which the trust had acted upon.
- The community speciality team had started an audit in April 2016 which was a patient survey of chronic pain programme and was due to be completed in April 2017.

Pain relief

- Staff could access advice from the specialist pain management team who provided support to patients with pain management on the ward and in the community. If patients were admitted and required pain relief medicines, this was accessible via the on call GP.

Good

Are services effective?

- A random sample of medicines' charts showed patients received regular pain control as prescribed. Patients and a relative confirmed that pain control was available when required and they did not have to "wait long "as the staff were responsive.
- Staff used the national early warning score system (NEWS) which includes a numerical scale to assess and record patients' pain and patients received pain control as needed. There was no specific tool used to assess those patients who were unable to verbalise their pain and posed risks these patients may not receive adequate pain control.
- During the nursing handover, we observed that pain control was also discussed to ensure staff were up to date with any pain management concerns.

Nutrition and hydration

- Patients' nutritional needs were assessed on admission and staff used the malnutrition universal screening tool (MUST). This is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition or obese. We saw patients identified as at risk of malnutrition, using this tool were referred to the dieticians.
- Patients assessed as at risks of not maintaining an adequate diet intake were prescribed supplements, and records showed these had been administered.
- The patients were offered a choice of food and fluids and those we spoke with had mixed views regarding the quality of the food available. We were told the food was served hot and we observed meals looked well presented. A patient told us they preferred smaller portions and the staff were aware of that. Some patients had been in for a long time and they said the choice could be better. Patients told us they were offered hot and cold drinks. We observed water and juice were available to patients and these were replenished.
- Patients and relatives told us they were asked to choose from a menu and could ask for snacks if they did not want the main meal. However, one person told us they did not have the cooked meals as they did not like gravy and most meals were cooked in gravy. They regularly had bread and crisps for lunch. We raised this with the staff and staff confirmed they had not referred this person for dietician's input. This person may not be receiving an adequately nutritious diet to meet their needs.
- The latest patient lead assessment of care environment (PLACE) survey showed 85% of patients were satisfied with the meals provided which was close to the national average of 88%.

Patient outcomes

- The expected date of discharge was usually set on admission to the ward. Patients were involved in their rehabilitation plan as appropriate and goal setting on admission to the ward. This included the discharge dates as a goal dependent on individual needs and rate of recovery. This was discussed and agreed at multi-disciplinary meetings and could be revised during at this meetings as needed and according to the patients' needs.
- The average length of stay was around 21-48 days for step up beds (patients who were admitted directly to a community hospital ward via the emergency department, direct referrals from GP referrals or transfers from other community hospitals.)This was considerably longer between 28-199 days for step down beds (patients who were on an acute ward before a direct transfer to a community hospital ward.). This was reported to be due to the lack of suitable social care beds for people requiring nursing or care home's care in the community.
- The trust target for this hospital was for a length of stay of 20 days. Information provided by the trust indicated that this had not been met for April to June 2016, when the length of stay for discharged patients varied from 28 to 33 days. This was being considered by the trust as part of the consultation on the review of community services.
- The trust was taking part in the National Dementia Audit – Community Hospital, data collection was on going with initial reviews due to take place in December 2016.
- The trust's performance in the national inpatient falls audit 2015 was below the national average. The trust

had developed an action plan to address the poor performance by, for example, the introduction of a multifactorial risk assessment tool. The action plan was monitored by the trust falls steering group.

- Local audits had been carried out such as hand hygiene, patients' records and NEWS and the records showed good level of compliance.

Competent staff

- There was a system in place to support regular and bank staff with training in order to maintain their skills. Registered nurses told us they undertook regular training and updates in order to fulfill their registration requirement and the trust supported them through the process of revalidation.
- All staff completed an induction to the trust at the start of their employment and also had a local induction.
- The ward manager was responsible for the appraisals of allied health care professionals and registered nurses.
- Physiotherapy staff had a continuing professional development portfolio (CPD). A staff member told us they had undertaken acupuncture training which was part of their CPD requirement. A staff member told us there was no oversight of their CPDs to ensure these were completed and linked to learning and business needs.
- Physiotherapy staff told us they observed the physio assistants but did not maintain any record. They also carried out appraisals of the healthcare assistants.
- Data we have received from the trust showed that as of August 2016 they had achieved the 90% target for staff appraisals.
- The ward was using a high level of agency staff to cover staff's shortages. There was an induction folder for agency staff that included information about escalation and action to take in an emergency. A high number of agency staff were left in charge at night and it was unclear what the process was for checking these staff were happy to undertake this role. Agency staff had to supply evidence of completed training to their employment agency prior to being able to complete shifts at the trust. There was an expectation it was the agency's responsibility to ensure agency staff had the required level of training and skills for the role they were employed for. Senior staff told us the agency booking the shift would know the person would be in charge of the ward, and where possible staff who knew the ward would be used. There was a system for escalating any concerns about an agency staff's performance and we were told that were concerns were identified they would not be used again.
- Healthcare assistants also provided rehabilitation support to patients at the weekend. They helped patients with their exercises and assisted them with splints. The healthcare assistance worked with the physiotherapist so they had experience and knowledge to undertake this role.
- Staff said there were opportunities to undertake other training related to their jobs; although this had not happened recently due to staff shortages.

Multi-disciplinary working and coordinated care pathways

- There was good multi-disciplinary working between the allied healthcare professionals, the medical and nursing staff. We observed good interaction and staff were supportive of each other. Staff told us there was good multidisciplinary working between the different teams who were involved in a patients' care and treatment.
- We saw that the physiotherapist and occupational therapist had carried out initial assessment of patients and recorded their findings, such as mobility and falls assessments.
- There were twice weekly meetings held with the multidisciplinary teams to review patients' outcomes, progress and actions to be taken. Staff had access to dieticians and speech and

  language therapists.
- Staff were positive about the support from the community nursing team and said they had developed a good working relationship and felt supported.

Referral, transfer, discharge and transition

- Allied healthcare professionals assessed the patients from a rehabilitation point of view and staff said there was no nursing input during the initial assessment to ensure that care was coordinated and patients nursing needs were also considered.
- When a patient was transferred from the ward to A&E, the ward would hold the bed for up to 24 hours if the

Good

Are services effective?

patient was under A&E care such as for observations and had arrived out of hours. However, once the patient was accepted under a consultant care in the acute hospital, the bed would be released.

- Staff told us they had accepted patients when the acute hospital was on black alert (hospital is at full capacity and unable to admit patients). However this was not the usual pathway for admission. It was expected that patients would still meet the admission criteria, however in these circumstances they may also accept patients identified for care home placement and waiting for placement or long term packages of care.
- When patients were discharged, staff ensured discharge letters were sent to the patients' GP. This contained details of any changes of medicines and care and treatment provided. Staff told us that discharges worked well as patients were known to their GPs.
- There were good links with the community nursing teams and they were informed of patients' discharge if the patients needed ongoing care in the community. Staff said they worked well as often patients were referred via the community teams and they were known to the staff.

Access to information

- Patients' records were available and included transfer information when patients were transferred from the main trust. Patients admitted from the community had referrals letters from the referring GP. Sometimes there were delays in GP referrals and these would be faxed to the ward.
- We observed handover between teams and this was comprehensive and staff were engaged and shared information appropriately to ensure continuity in the patients' care.
- Staff said they were able to access information on the trust's intranet and they were aware of the provider's newsletter.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Systems and procedures for the recording of patients' consent to information sharing and care and treatment were in place.
- We observed staff gaining patients consent prior to providing support.
- Staff we spoke with had knowledge of the working process of mental capacity assessment and deprivation of liberty safeguards (DoLS). They said they would involve the patients' relatives if appropriate. However, two staff members we spoke with were not clear about the best interest process or how to access patient's advocates.
- Clinical governance minutes from August 2016 showed the integrated community care nursing team had identified that the DoLS process was not robust which may lead to patients being deprived of their liberty without authorisation. They were planning to carry out an audit of DoLS documentation
- A patient's record showed they had a DoLS in place which was due to expire on the day of the inspection. Staff were unable to tell us if this had been extended or if it still appropriate to continue with the DoLS. The manager said they would follow this up when we raised this.
- Staff told us they completed mental capacity training as part of their induction and equality and diversity training data showed 90% compliance.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Staff treated patients with respect, and compassion at all times. We received positive comments from patients and their relatives about the care they had received from staff
- Patients told us they were at the centre of their care and staff were caring and compassionate.
- It was evident from the interactions we observed staff had developed good relationships and trust with those they cared for.
- Staff took time and ensured patients and their relatives were fully involved in their care and provided them with information as needed.

However:

- Patients' personal information including their names was displayed on the whiteboard at the nurses' station on the ward.

Compassionate care

- Staff were passionate and committed about the care and treatment they provided and we saw positive interactions with patients on the ward.
- Staff took into account the patients' religious and cultural needs although they were not sure if certain religious dietary needs could be met if required.
- The results of the Friends and Family Test data demonstrated overall that patients had high degree of satisfaction with the service provided and 100% recommend the hospital as a place to receive care.
- Following feedback from patients, the trust had extended their visiting hours enabling patients more time with their families. Patients told us this was good and allowed their relatives and friends flexibility. Other patients had relatives visiting at lunch time and supported them with their meals which a relative said "made a big difference".
- The hospital Patient-Led Assessment of the Care Environment (PLACE) audit from September 2016 showed the hospital scored 71% for privacy, dignity and wellbeing against a national average of 84%.
- Patients and relatives told us they received the support they needed to manage their treatment and hospital stay. A relative said the staff had been "very good" as they had received "great care".
- The hospital had trained volunteers to provide extra support for the patients which staff said worked well and was seen as the "community".
- One patient was not provided with appropriate equipment and used their commode to mobilise in their room. This may impact on their dignity and staff had not identified this as an issue when we spoke with them.
- Patients' personal information including names and types of diets was displayed on the whiteboard at the nurses' station on the ward. This did not take into account patient's privacy.

Understanding and involvement of patients and those close to them

- Patients we spoke with felt involved in their care. A patient said staff discussed their plan of care and goal setting formed part of their treatment plan.
- We observed staff providing information to a relative in a sensitive manner ensuring they were not rushed and were given time to ask questions.
- The multi- disciplinary teams had planned meetings with patients and their relatives on admission and as part of their discharge planning.
- We observed an occupational therapist providing support and fully involving a patient in a discussion about equipment as part of their discharge planning.

Emotional support

- There was a chaplaincy service available for patients of different religious denominations to offer additional emotional and spiritual support to patients as required.

Good

Are services caring?

- There was a process where patients would be referred for psychological support via their GPs as needed.

Good

Are services responsive to people's needs?

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

Summary

We rated this service as good for responsive because:

- The trust worked in partnership with the commissioners and community team to deliver services to meet the needs of the community.
- Patients were admitted appropriately for inpatient community care.
- There were clear policies and procedures for dealing with patients' concerns. People were confident to raise any concerns with the staff.
- Arrangement was in place to support patients such as interpreter service was available and information was available in different formats.

However:

- The environment did not fully meet the needs of patients living with dementia (although one to one support was provided). Equipment required to meet the needs of a bariatric patients was not ordered in a timely way
- Patients did not receive therapy care over the weekends except if they needed urgent treatment. This increased the risks for patients who were unable to mobilise.

Planning and delivering services which meet people's needs

- The trust worked closely with the local commissioners to plan and deliver services in order to meet the needs of the local community.
- The trust had undertaken a series of public engagement sessions with carers, patients and local community group to explore the development of community hubs to support and meet people's needs.
- There were different pathways for patients' to follow to be admitted to the ward. Most patients were admitted from the local acute hospitals following assessment by the allied healthcare team and once deemed as suitable for rehabilitation. Other patients were admitted by GPs from the community into the step up beds. Patients were sometimes transferred from the wards when deemed as medically stable.
- An audit completed in February 2016 showed 97.5% of patients audited were an appropriate transfer / admission to one of the community hospital wards. Of these, 71% had rehabilitation recorded as one of the reasons for admission. Thirty four percent of patients were there for management of a mild to moderate long term condition.

Equality and diversity

- Arrangements were in place to support people with mobility problems and there was easy access to the hospital. There were designated parking spaces for people with limited mobility.
- Staff had access to the link nurse for dementia when they needed advice and support. Staff said they did not normally care for people a learning difficulty and they would approach managers for help and support if needed. Staff were not aware if there was a learning disability link person who they could contact.
- Staff said they could access information on the trust's internet if they needed an interpreter although this was very rare. We found patient's information was in English and information was available on how to access these in other formats including large print.
- Records showed staff completed equality and diversity training and had achieved 90% compliance.

Meeting the needs of people in vulnerable circumstances

- There were appropriate arrangements in place to ensure male and females patients were cared for separately, with designated bays and facilities. Staff confirmed they adhered to the trust policy and there had been no same sex breaches.
- There were insufficient arrangements to meet the needs of bariatric patients at this hospital as appropriate equipment was not always available to ensure all their needs could be met. This was particularly evident when a wheelchair was required.

Good

Are services responsive to people's needs?

- Staff said they involved the family of people who were living with dementia to gain a better understanding of their needs and plan their care. When caring these patients staff nursed them close to the nurses' station where they could be monitored.
- The design of the ward allowed for patients to walk around freely and safely. The trust carried out an assessment of the ward and recognised that the ward environment was not designed to meet the needs of patients with dementia. This included lack of appropriate signage; colour coded communal doors and pictures, no windows in the bays and no natural lighting. Staff told us they would request 1:1 support patients as needed and the occupational therapist would be involved in supporting patients.
- Staff had access to the link dementia nurse at the trust for support and information. A staff member told us the trust was developing a booklet for dementia care although this was not yet available.
- Patient-led assessments of the care environment (PLACE) for September 2016 showed the hospital scored 73% for dementia care. This was lower than the England average of 75%. The score for disability access was 78% which was in line with the England average.

Access to the right care at the right time

- The ward accommodated patients as step up (patients who were admitted directly to a community hospital ward via the emergency department, direct referrals from GP referrals or transfers from other community hospitals.) The step down (patients who were in an acute bed and transferred to a community hospital ward).
- The bed occupancy data we received from the trust showed that the trust had increased their bed numbers to 15 patients from January 2016. The bed occupancy within the community hospitals had been significantly higher than the national average of 88%. This had been constant until May 2016 when the number of beds was reduced to 12.
- An audit in February 2016showedfor88% of step beds and 97% step down beds the patients were in the right place to have their needs met.
- Therapists were not available at weekends, but staff could access the community team in an emergency. Patients admitted out of hours on a Friday waited until Monday before they had therapy assessments. Staff told us that this may increase risks for patients who were unable to mobilise; however they could access the community therapy team if patients needed urgent treatment such as chest physiotherapy.
- The ward was unable to support patients requiring intravenous antibiotics and these patients were transferred to the acute trust.

Learning from complaints and concerns

- The trust had a complaint's policy in place, which stated that complainants should receive a response to their complaint within 25 working days. In July 2016, the trust contacted 82% of complainants with a completed written response within 25 days. Although slightly below the trust target of 85%, this result was a significant improvement from the previous month (62%).
- Staff followed the trust's complaint policy and said they reported complaints from patients or their relatives to the ward manager. The nurse in charge initially would deal with any concerns raised and report as needed.
- Patients could also access the patient advice liaison service (PALS). Staff said there would direct patients to this service and information about the service was also available on the trust's website.
- Patients said they were confident to raise their concerns and said they would speak to the staff. Two patients were keen to tell us they had no complaints about the care they had received. A relative also said "you can't get any better care".
- Staff told us any concerns raised were recorded in the patients' records and discussed at handover to ensure local learning. They did not maintain a separate log and there was no way of auditing locally raised concerns in order to look at any trends. The trust's data showed there were no formal complaints for the ward in the last 12 months.

Requires improvement

Are services well-led?

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

Summary

We rated this service as requires improvement for well-led because:

- There was a trust wide governance structure and evidence some indicators of a quality service were monitored. However, the system for the monitoring of the quality of the service was not effective at a local level. Risks were not always identified including those we found during the inspection. Although the trust had instigated engagement meetings with staff in the community hospital to listen to their concerns and establish what they needed, staff still told us they felt disengaged with the wider trust.
- Learning from incidents was not consistently cascaded to staff in order to effect lessons learned and improve practice.
- Staff were not aware and could not describe the vision and strategy of the trust or their local service and they told us they did not feel part of the wider trust.

However,

- There was a clear governance structure at service delivery unit and divisional level.
- Staff were committed and felt supported by their immediate line managers and their peers.
- There was good engagement with the local community and they were proud of the hospital and care provided.
- The trust had ensured staff had been given the opportunity to raise their concerns; some actions to address the staff concerns had already been taken. There was a commitment to engage with the staff and address issues affecting them.

Leadership of this service

- Each division was chaired by a consultant and the leadership included an operational director and divisional chief nurse. The community inpatient wards were part of the medicine for older people and community service delivery unit (SDU).
- At local the service was led by the ward manager with support from the community inpatient Matron. The lead nurse for elderly care had been identified as a person to offer further support.
- The ward manager was positive about the support they received from the Matron. However, they told us they were unable to attend the monthly manager's meetings as they were providing cover on the ward. This resulted in less or insufficient time for them to complete the administrative responsibilities of their role.
- Staff told us that they felt supported by their immediate line manager who was new to the service. However, they said they felt they were not engaged with the wider trust and there was an overall feeling that staff worked for this particular hospital not the trust.
- The trust had recognised issues brought by staff and had set up engagement meetings. When the first round of meetings did not result in change further meetings were set up with the support of the human resources department. The trust was listening to the staff concerns and had taken some action and was developing an action plan to further address the concerns raised. For a ward manager had been recruited, as well as a community matron to oversee the hospital and work across the other community hospitals.

Service vision and strategy

- The trust vision was to provide safe and compassionate care, every time. There was a strategy in place to support the achievement of this vision, as part of the trust's five-year plan (2015-2020). One of the trust's key priorities of the five year plan was bringing care closer to home with a plan to invest in the community services.
- The trusts vision is to provide health and wellbeing support to help people enjoy a healthy lifestyle; support people to take greater power and control over their care and treatment, making sure the trust meets their long-term needs. Enhance the support provided to patients with complex needs; develop new roles and ways of working for staff, improving the skill mix to make sure the right care is delivered in the right setting at the right

time. To work more closely with GPs and other care providers to join-up the care and support people are offered; reduce duplication and inefficiency, making better use of new technologies and looking at ways the trust can work more closely with local communities and other organisations.

- The trust was in the process of developing their community inpatient strategy and had started with a public engagement exercise. So far the public engagement sessions had been helpful in terms of painting a vision for out of hospital support that was wide ranging, supported self-management and did not rely on bed based care. Further consideration was now being given to the provision of the inpatients' service.
- Staff were not aware of the trust's vision and strategy. However they told us they were committed in the development of the ward as a rehabilitation unit.

Governance, risk management and quality measurement

- There was a clear governance structure. The SDU held monthly clinical governance meetings and reported to the division clinical governance board.
- Minutes from the SDU clinical governance meeting showed that the SDU dashboard was discussed, the risk register reviewed and SI investigation and 72 hour reports monitored until the investigation was completed and signed off. Complaints were also monitored and reviewed and feedback from mortality reviews considered. There was also a section for the discussion of clinical audit & effectiveness including NICE guidance and internal and external reviews.
- Minutes from the Divisional Board Clinical Governance Committee for the Division of Integrated Elderly and Community Care covered included review serious incidents (SIs) to ensure investigations were completed and action agreed. There was also a review of 72 hour reports and discussion around incidents where escalation was considered. Complaints; mortality reviews; incidents; accolades; and friends and family responses were also considered.
- The dashboards included information relating to operation including patients length of stay; quality monitoring covering infection rate, pressure ulcer rates and VTE and workforce monitoring sickness levels.
- The community inpatient matron also conducted matron rounds, which covered patient safety patient experience, drug chart observations, medical notes observations and environment observations. Information reviewed for the round conducted in July 2016 did not include any remedial action although one out of five patients had not had their risk assessments completed in line with trust's policy. Therefore it was not possible to determine how this information was used to monitor quality and inform improvements.
- The divisional chief nurse also conducted visit and spoke with patients and staff. We reviewed the report from May 2016. Patient feedback was all positive with patients saying they felt safe and were aware of their care and treatment plans. Areas for improvement related to the use of the 'Get to know me' folders are used effectively and Improving staff engagement. Actions were included in the report.
- Ward staffing at this hospital had been identified as a risk on the current divisional risk register.
- There was little evidence how learning from incidents were cascaded to staff at a local level. Minutes of staff's meetings were not consistently recorded and the ward manager did not attend senior meetings due to staff shortages and having to cover clinical duties. However, there was an integrated elderly and community service divisional newsletter which was sent to the staff. These include reminders about best practice, updates on changes that were occurring and may include learning from complaints and incidents. The trust also held trust wide 'lessons learnt' meetings. These were advertised on the trust intranet held monthly and were open to all staff. Cases were presented around a specific topic. For example we saw the bulletin for February 2016 was titled 'Wandering as a behaviour of dementia'.
- Although there were systems in place to guide staff to follow best practice, such as policies and procedures, staff were not consistently following these for medicines management and consent and acting in the patient's best interest. Emergency equipment checks were not robust posing risks to patients' safety. These had not been identified as part of the trust's quality monitoring program to ensure systems were safe.

Requires improvement

Are services well-led?

Culture within this service

- Staff spoke positively and passionately about providing safe care and good outcome for patients. They told us about having an open culture in raising patients' safety concerns. They were supportive of each other and they felt they worked well as a multi- disciplinary team.
- The ward manager was new to the service and was aware that there were significant challenges in implementing changes and was yet to have a significant impact.
- Staff had raised some concerns with the senior management at the trust and these were long standing issues that management were working with the staff to address.
- We were told that two meetings had taken place which HR and the governance lead facilitated. They were planning to have a return meeting to feedback to the staff and put together an action plan.
- There was a whistle-blowing policy which staff were aware of this. However two staff told us they did not feel confident in using this; although this may change with new management team in place.

Public engagement

- The league of friends had good links with the community hospital and supported the patients. A person commented that they provided "friendly face" and someone to chat to. Staff told us the patients valued this support.
- The trust had made changes following feedback from friends and family such as extending the visiting hours which we were told was well received.
- The trust had completed a community engagement project in April and May 2016 to look at what community services should look like. The trust was planning to produce a consultation document following this.
- There was no process on the ward such as "you said we did" board used at the trust to engage with people using the service and informing them of actions taken following feedback.

Staff engagement

- There was a trust wide award "CARE". This was an award for staff who were nominated by their peers and patients in recognition of their work.
- The latest NHS choice survey in June 2016 showed 54% of staff would recommend this hospital as a place to work.
- Following staff concerns raised by staff, the trust was pro-active and ran three action learning sets in August. As part of their engagement with the staff , it looked at staffing capacity, sickness rates and not being listened to by senior managers and were working through a solution.

Innovation, improvement and sustainability

- The trust was taking part in the national dementia audit which was due to be completed in October 2016. The trust was developing a booklet for dementia care although this was not yet available
- The trust had developed a Mental Capacity Assessment (MCA) prompt card which contained clear details about the assessment process and contact for public guardian office. However staff we spoke with were not aware of this.
- The Sustainability and Transformation Plan for Buckinghamshire Oxfordshire and West Berkshire focuses on a radical upgrade in health prevention, new models of care and a plan to ensure the health and care system remains in financial balance. In the light of this the trust, in partnership with the Clinical Commissioning Groups and the County Council, has engaged with the community to explore new ways of making the best use of the community estate.
- A review of the community in patient service was ongoing as part of the wider community service provision. The trust had acknowledged that this group of patients often stay longer than they should as they are waiting for packages of care or long term care solutions. Agency usage in the community inpatient areas were high and it was difficult to recruit to roles in these services and the age of the estate needed to be considered. There were plans in place to review the model of care and how best to meet the needs of the patients typically admitted to these wards.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1)(2)(g) 2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include- (e) ensuring that the equipment used by the service provider for providing care and treatment to a service user is safe for such use and is used in a safe way. (g) the proper and safe management of medicines. (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; **How the regulation was not being met:** People who use services and others were not protected against the risks associated with unsafe care or treatment. • Staff did not always follow the trust's medicines management policy to ensure the safe administration, prescription and storage of medicines. • Equipment was not managed safely and in line with the trust's operating procedures. There were a number of pieces of equipment in the sluice which were shared with no evidence of cleaning and other equipment was dusty. • There was no system for identifying clean and dirty cleaning to minimise risks of cross infection and safe for use.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed.

How the regulation was not being met: People using services did not have their needs met in a consistent manner.

- There were not planned sufficient numbers of suitably qualified, competent, skilled and experienced allied healthcare staff on the ward to meet the assessed needs of people using the service.

- Vacancies for the pharmacy service across the trust were having an impact on the pharmacy service provided to the wards.