Clay Cross Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected, information we hold about quality, and information given to us from patients, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

Clay Cross Hospital provides rehabilitation services for patients admitted from home or following discharge from acute hospitals. There was one inpatient ward at Clay Cross Hospital. Alton ward offered 17 beds and patients were supported by a multi-disciplinary team.

We saw that the care provided was planned and delivered in a safe manner because the Trust had processes in place for identifying, reporting, investigating and learning from patient safety incidents. The reporting process was well embedded at Clay Cross, and we saw that staff reported incidents on the Trust's electronic reporting system. There was only one qualified nurse on duty at night which might not always be sufficient .

Care was planned and delivered using evidence based guidance and good practice, and nationally recognised assessment tools were used to provide effective care and support for patients. Patients we spoke with told us they were very satisfied with the care they received and said the staff were kind, compassionate and treated them with dignity. Patients told us they were involved in decisions about the care they received and the plans that were made for them. Staff did not consistently follow the correct procedures in respect of people's advance decisions not to be resuscitated in an emergency.

Discharge planning started when people were admitted to the wards to ensure the rehabilitation they received prepared them to return to their homes independently, with support or residential care. There were governance and risk management arrangements in the Trust which were implemented at ward level. Staff were aware of the Trust's vision called the "DCHS Way" and most felt empowered to raise concerns if required.

Summary of findings

The five questions we ask and what we found at this location

We always ask the following five questions of services.

Are services safe?

Care provided during our inspection was safe. Staff were confident about reporting adverse incidents and shared learning within their teams. People were assessed for risks on admission and appropriate measures were put in place when potential risks were identified. However, we were concerned that there was only one qualified nurse on duty at night which might not always be sufficient .

Are services effective?

Care was delivered effectively through the use of evidence based guidance and nationally recognised recording tools. The wards provided effective rehabilitation services to support discharge home, or if appropriate residential support. Discharge was planned from the time of admission and processes were in place to review the discharge planning regularly.

Are services caring?

All of the patients we spoke with said that staff treated them with respect. We observed staff speaking with people in a kind and compassionate manner. We saw patients' privacy and dignity were maintained during personal care. Patients told us they felt involved in their care. However, staff did not consistently follow the correct procedures in respect of people's advance decisions not to be resuscitated in an emergency. Patients were encouraged by staff to maintain their independence.

Are services responsive to people's needs?

The multi-disciplinary team worked together to meet the needs of the patients on the wards. Full assessments of people's individual needs were completed on admission and were updated in response to any changing requirements. People's discharge plans were discussed daily to ensure they remained relevant. Patients we spoke with told us the staff recognised and responded to their needs and supported them towards their discharge goals.

Are services well-led?

We saw that the ward was well managed by the deputy manager. Information was shared with patients and their relatives through open and transparent processes. The Trust had governance processes in place which were well embedded at a local level.

Summary of findings

What we found about each of the core services provided from this location

Community inpatient services

We found that staff were committed to providing high quality services to the patients on Alton Ward at Clay Cross Hospital. Comments from patients, their relatives and representatives confirmed this. The care being provided met the rehabilitation needs of the patients.

During our inspection we saw the care being provided was safe, although we had concerns regarding staffing levels overnight. Processes were in place to ensure any adverse incidents were reported and acted upon. Patient's risks were assessed on admission and reviewed regularly. Management plans were in place to reduce the identified risks.

The multi-disciplinary team worked effectively together to achieve patient discharge in a timely manner. Patients and their relatives were happy with the care provided. Staff treated people with compassion, dignity and respect. Patients were involved in decisions about their care and staff knew the people they cared for well.

Summary of findings

What people who use the community health services say

Derbyshire Community Healthcare Trust had implemented the Friends and Family Test in April 2013. We reviewed the most recent figure for October 2013 which placed the Trust's inpatient scores in the top 25% for England.

Patients we spoke with told us they were happy with the care they received. One person said, "They (the staff) do a little bit more for you". Another person said, "The staff care about you".

Areas for improvement

Action the community health service SHOULD take to improve

- Ensure senior clinicians follow the Trust's policy on "Do Not Attempt Cardio-Pulmonary Resuscitation" (DNACPR) Decisions, by involving patients in the decisions, recording the discussions, and reviewing the decisions on a regular basis.
- Improve qualified staffing levels at night
- Review the storage of clean equipment in a dirty sluice area.

Action the community health service COULD take to improve

- Improve signage for people with dementia

Good practice

- Multi-disciplinary teams worked effectively to ensure the best outcome for patients.
- Patient discharge was very well managed

Clay Cross Hospital

Detailed findings

Services we looked at:
Community inpatient services

Our inspection team

Our inspection team was led by:

Chair: Helen Mackenzie, Director of Nursing and Governance, Berkshire Healthcare Foundation Trust

Head of Inspections: Ros Johnson, Care Quality Commission

The team included a CQC inspector, a therapy specialist advisor and an expert by experience. Experts by experience have personal experience of using or caring for someone who uses the type of service we inspected.

Background to Clay Cross Hospital

Clay Cross Hospital is managed by Derbyshire Community Health services NHS Trust which delivers a variety of services across Derbyshire and in parts of Leicestershire. It was registered with CQC as a location of Derbyshire Community Health Services NHS Trust in May 2011. Clay Cross Hospital is registered to provide the regulated activities: Diagnostic and screening procedures, Family Planning, Surgical procedures and Treatment of disease, disorder or injury.

At the time of our visit there was one inpatient ward, Alton, which provides rehabilitation services for up to 17 adults.

Clay Cross Hospital had not previously been inspected by the CQC.

Why we carried out this inspection

This provider and location were inspected as part of the first pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

To get to the heart of patients' experiences 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?

The inspection team always looks at the following core service area at each inspection:

Community inpatient services

Detailed findings

Before visiting, we reviewed a range of information we hold about the community health service and asked other organisations to share what they knew about the location. We carried out an announced visit on 27 February 2014.

During our visit we held a focus group with therapists. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients.

Community inpatient services

Information about the service

Clay Cross Hospital provides rehabilitation services for patients admitted from home or following discharge from acute hospitals. There was one inpatient ward at Clay Cross Hospital. Alton ward offered 17 beds and patients were supported by a multi-disciplinary team.

The inpatient ward was situated on the ground floor of Clay Cross Community Hospital and accessed via the main corridor in the hospital. The ward had same sex bays, adequate toilets and bathrooms, and a therapy room. The areas we visited were free from clutter and obstacles.

All of the staff we spoke with were employed by the Trust. Patients' needs were met by a combination of nurses and therapists who made up the multi-disciplinary team.

During our inspection we spoke with patients and relatives. We spoke with the deputy ward manager, a therapist and seven nurses. We held a focus group meeting with 11occupational and physiotherapists. We reviewed patient records, observed care being delivered and reviewed information we had received from the Trust.

Summary of findings

We saw that the care provided was planned and delivered in a safe manner because the Trust had processes in place for identifying, reporting, investigating and learning from patient safety incidents. The reporting process was well embedded at Clay Cross, and we saw that staff reported incidents on the Trust's electronic reporting system. There was only one qualified nurse on duty at night which might not always be sufficient .

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Discharge planning started when people were admitted to the wards to ensure the rehabilitation they received prepared them to return to their homes independently, with support or residential care. There were governance and risk management arrangements in the Trust which were implemented at ward level. Staff were aware of the Trust's vision called the "DCHS Way" and most felt empowered to raise concerns if required.

Community inpatient services

Are community inpatient services safe?

Safety in the past

The Trust used an electronic adverse incident reporting system and staff were encouraged to report incidents to ensure patients in the hospital were kept safe from harm. The Trust reported 202 serious incidents in the 12 months December 2012 to November 2013. The NHS Staff survey for 2012 showed the number of incidents reported by the Trust were in line with other similar organisations nationally.

In 2013 there was a serious incident regarding the maladministration of insulin. We saw that the Trust had reported and investigated this incident fully. A staff training programme had been put in place to reduce the risk of it happening again. Staff we spoke with were aware of the incident and the training which they were required to do including the timescale for completion. We saw that seven staff on Alton Ward had completed the training and the remaining four had booked time to complete it by the end of March 2014.

Staff had attended appropriate training in safeguarding vulnerable adults and were able to explain how they would use the knowledge they had gained to protect people from harm. We saw that a person had been transferred to the ward following a safeguarding referral at another hospital. Staff we spoke with were able to tell us the background to the referral. An update was provided during the staff handover following a visit from the social worker that day.

Learning and improvement

Processes were in place to monitor and report safety incidents. Staff were confident about using the reporting system and could give us examples of incidents they had reported. Incidents were discussed at the weekly ward team meetings and learning shared.

Some incidents, including high grade pressure ulcers require further investigation by Root Cause Analysis (RCA). RCAs were undertaken by the Ward Manager or Matron as other staff had not received training. We saw that an RCA had been completed following a patient fall which had resulted in a fracture.

Systems, processes and practices

There were systems and processes in place to identify and plan for patient safety issues in advance. Staff told us they could refuse admissions if they felt the needs of the incoming patient would affect the care they could provide to their other patients, for example because of complex needs. The staff we spoke with reported that managers were supportive. Staff told us they generally felt empowered to raise any issues with managers without concern.

The wards had identified hand hygiene champions who were responsible for promoting hand cleanliness to reduce the risk of cross infection. The last recorded hand hygiene audit score for the ward was 100%

We observed good practice during our inspection, such as:

- Staff washing their hands prior to providing care and following 'bare below the elbow' guidance
- Adequate hand washing facilities on the wards and in the main corridor of the hospital
- Access to and use of personal protective equipment, for example gloves and aprons
- Arrangements for storage and disposal of clinical waste
- Visitors asked to wash their hands when entering the ward

There was the only one sluice area available which contained clean equipment used for personal care. The cleaning of the room was completed by housekeeping and ward based staff and all of the equipment we looked at was clean but could be at risk of contamination from dirty equipment brought in to the room. The risks posed by combined use had not been assessed.

We looked at the resuscitation equipment on the ward and found it was checked regularly to ensure it was ready for use in an emergency.

There were checks on the monitoring of controlled drugs and medication charts. There were no checks on stocks of other medications however the ward manager and the matron felt confident that anything untoward would be picked up by the pharmacist.

Each ward had a patient information whiteboard in the office which provided detailed information about the patients on the ward. The information included the reason the patient had been admitted, any significant previous medical history, the date the care plan was due for review, history of falls, frequency of dressing, if appropriate, any investigations or appointments due.

Community inpatient services

Monitoring safety and responding to risk

We saw in the care records that safe care assessments were undertaken on admission including risks associated with infection, dementia, falls, skin condition, nutrition, and moving and handling. The information was reviewed again within 48 hours. This meant patients at risk of, for example, falling or developing pressure ulcers were identified during this process and management plans were identified.

Staff completed an early warning score assessment daily to measure people's vital signs such as blood pressure and pulse rate. The assessment included an information pathway to follow if the readings presented any cause for concern.

Patients were reviewed two hourly by a process called intentional rounding which included checks on the patient's position in the bed or chair, addressing pain and personal needs and checking the environment for any risks to the patient's comfort or safety.

The weekly team meeting agenda included information on audits, infection control, health and safety and Trust updates.

Anticipation and planning

Staff we spoke with told us they were aware of the training that was mandatory or essential for their role. Subjects included health and safety, moving and handling and infection prevention. Staff told us the majority of the training was provided as e-learning. We saw from the training matrix that the staff were up to date with their mandatory training.

Care was planned for patients on the wards and risk assessments on admission identified patients at risk of developing for example, pressure ulcers, venous thromboembolism or falling. People's care plans reflected the risks and management plans were in place to ensure the appropriate care was provided.

Are community inpatient services effective?

(for example, treatment is effective)

Evidence-based guidance

The care being provided for in-patients was evidence based and followed approved guidance from the National Institute for Health and Care Excellence (NICE). Nationally recognised screening tools were used such as the Malnutrition Universal Screening Tool (MUST) to assess patients' nutritional requirements and the Waterlow pressure ulcer risk assessment to gauge the risk of developing pressure sores. The hospital had implemented a safe care booklet which was completed within 24 hours of admission and included person centred information and the goals patients wanted to achieve during their stay in hospital.

Staff we spoke with were aware of the requirements of the Mental Capacity Act 2005. Staff told us they usually contacted the Older Person's Mental Health Service to assist assessment of patients' mental capacity, particularly if the person's needs were complex.

Monitoring and improvement of outcomes

We saw there were processes in place to monitor the outcomes for patients and develop the care which was appropriate for their needs. There was involvement with other members of the therapy team to ensure people could meet their planned discharge goals. For example patients would attend physiotherapy sessions to increase their mobility. There were no arrangements on the ward to provide activities for people although one member of staff provided some activities in their own time. One patient on the ward told us, "The ward is too quiet, there's nothing to do".

There were comprehensive assessments of key areas for patients' health including assessment of personal care needs, continence, the patient's ability to self-medicate, tissue viability, nutrition screening and risk assessments for falls and venous thromboembolism. We saw that some of the recording in the care plans had not been completed, for example, we saw that one person who was having their fluid intake and output monitored did not have the totals recorded for several days. This meant they were at risk of deleterious fluid imbalance

Sufficient capacity

There was only one trained nurse on duty overnight. Staff told us being the only trained nurse presented several problems which could impact on the safety of care provided to patients. For example the administration of medication was interrupted if a patient became unwell and needed attention by the trained nurse. The interruption could lead to medication errors and would delay the administration of drugs to patients. Staff also told us the trained nurse was unable to leave the ward to take a meal

break. No risk assessments had been undertaken to identify the level of risk associated with the level of staffing. Staff told us patients who needed medication such as insulin, which required checking by two qualified nurses, would be admitted to another hospital with additional qualified nurses. The staffing skill mix was being reviewed by management.

The ward had a low staff sickness level and short term sickness was generally covered by the permanent staff working extra hours. Bank staff were employed to cover long term sickness and we were told by the ward deputy manager that agency staff were rarely used. This meant there was staff stability to support safe patient care.

Staff told us there was good access to training and they were supported to ensure their mandatory training was completed in a timely manner. We viewed the staff training records which confirmed that staff were up to date with the training required to fulfil their roles. We saw that most of the staff on the ward had received an appraisal and had access to supervision in a variety of forms, one to one, group and during learning practice.

Multidisciplinary working and support

The ward had a multi-disciplinary approach to people's care. We saw from the care records that therapists contributed to the patient's support and planning for future care. There was a daily multi-disciplinary meeting to discuss discharge planning and ensure delays in discharge were kept to a minimum by working together to provide complex care packages. All members of the team had a clear picture of the discharge plan and their own role in achieving it.

Patient records were stored at the end of beds to enable all members of the team access to the information they required however we saw that the therapists did not always complete the daily monitoring information for people they had seen and this had been raised previously at the weekly staff meeting.

Are community inpatient services caring?

Compassion, dignity and empathy

The patients we spoke with said they felt involved in the care they were receiving. We saw in the patient care records we reviewed that patients had been asked on admission what name they would like to be addressed by during their stay and if they had any preference on receiving routine personal care from either male or female staff. We observed personal care being delivered in a discreet and timely manner. A patient we spoke with said, "The staff are marvellous".

Involvement in care

We observed staff gaining people's consent prior to delivering care and treatment. The care records we looked at contained signed agreements for care from patients, for example the photographing of wounds. Some information was stored by the patient's bed so they could have free access to it. Staff asked the patients whose care records we viewed, for their agreement to us looking at their information. We saw, and patients confirmed, that they were involved in reviewing the information within the care record on a regular basis.

We were told it was the responsibility of the doctor or advanced nurse practitioner to discuss with patients what their wishes were in relation to resuscitation should they become seriously unwell. When appropriate, the senior clinician would complete a 'Do Not Attempt Resusciation' (DNACPR) form, which includes a record of discussions with patients and relevant carers. The Trust's policy describes the required involvement of patients and relevant carers, the importance of recording the decision and that decisions should be reviewed weekly. We saw from the care records that this information was not always complete, accurate or reviewed appropriately contrary to the Trust's policy. The date on one record we looked at had been over written, which is not good practice.

Trust and respect

Every patient we spoke with agreed that staff treated them with respect and we observed staff interactions were polite and respectful. We saw staff encouraging people to mobilise and maintain their independence in a positive and encouraging manner. A relative told us, "To say the staff and ward are wonderful is a gross understatement. They look after X(patient) as well as we could at home".

Emotional support

We observed that staff were aware of people's emotional needs and treated people as individuals. We saw positive interactions between staff, patients and their relatives. Staff knew the people they cared for well and had built up good relationships with them.

Community inpatient services

Are community inpatient services responsive to people's needs? (for example, to feedback?)

Meeting people's needs

Patients were admitted to the ward at Clay Cross Hospital for rehabilitation. Care was provided by an integrated team who continuously assessed what was required to enable the patient to become independent. There was evidence within the care records to confirm the staff were meeting people's needs including engagement with other health care professionals such as social workers.

The signage and printed information on the ward was provided in English. The community served by the hospital had a low number of people from ethnic areas, however readily available information in other languages and formats could be beneficial, particularly in an emergency . Staff we spoke with were aware of how to access translation services if they were required.

Staff told us they used assistive technologies in response to patients' needs. One patient had a seat sensor in place to alert staff when they moved from their chair. This was put in place to try and protect the person from falling. Patients told us they were happy with the food they were served at the hospital and said it was generally of a high standard with choices available.

Access to services

Patients accessed services either by referral from an acute hospital or admission via their GP for assessment following, for example, falls. People we spoke with generally felt that the service provided them with the confidence to return to their own homes following a hospital admission, or when their home support needed to be reviewed. One person told us they would like therapy to continue over the weekend as they felt it took time to get back into it after the weekend.

Public access to services at Clay Cross Hospital was good. Care was provided on one level and free car parking was available. Spaces for disabled drivers were provided close to the entrance.

Vulnerable patients and capacity

Arrangements were in place to ensure staff understood the requirements set out in the Mental Capacity Act 2005 and recognised their responsibilities when delivering care. We saw that staff attended mandatory training in safeguarding vulnerable adults, consent and mental capacity. All staff spoke with confidence about the categories of abuse and the actions they would take to escalate their concerns.

There had been a recent safeguarding concern regarding a patient who had been transferred to another hospital and we saw that staff had initiated the process correctly and speedily as soon as concerns were raised with them.

Leaving hospital

People's goals for discharge were discussed as soon as they were admitted to the ward. This meant the multi-disciplinary team could manage the person's expectations and plan together to put a support plan in place. We saw that information on each person's discharge pathway was displayed on a board in the ward office which meant everyone involved could add up to date information. Patients we spoke with told us discharge plans were discussed with them. One person told us, "I've been encouraged to improve my mobility and I'm having a home assessment today".

Learning from experiences, concerns and complaints

There were posters displayed on the ward and around the hospital providing information for people if they wanted to raise a concern. Patients were encouraged to feedback their experiences of care.

Are community inpatient services well-led?

Vision, strategy and risks

Staff we spoke with were aware of the trusts vision the 'DCHS way.' Staff said the Board and particularly the Chief Executive maintained a visible presence and were approachable. Information was cascaded to staff through a variety of channels including emails, the trust newsletter 'The Voice', staff forums and face to face in team meetings. Staff generally felt able to approach the board with any concerns they had.

Risks were reported by staff and we saw the detail of the incidents was shared with patient and their relatives. Incidents were discussed at the weekly team meeting so that lessons could be learnt.

The last assessment by the NHS Litigation Authority (NHSLA) was in 2012. The NHSLA handles negligence claims

made against NHS organisations and assesses the processes trusts have in place to improve risk management .The trust was assessed at level 1 in 2012 which meant they had policies in place which described the actions staff were required to follow. We saw that staff were familiar with the incident reporting system and confident that any incidents reported would be investigated.

Quality, performance and problems

The quality and safety of in-patient care was monitored at all levels within the organisation. The board received regular reports and the results of audits undertaken to measure the quality of care being provided. We saw from ward meeting minutes that performance information was discussed.

We received statistical information from the NHS Safety Thermometer prior to our inspection. The thermometer is used to monitor the four common harms to patients, development of pressure ulcers, falls with harm, catheters and urinary tract infections and venous thromboembolism. The data for the trust shows decreases in all areas of harm.

Leadership and culture

Most of the staff we spoke with were aware of the Trust Board members. All of the staff we spoke with felt well supported at a local level. Staff felt they could raise any concerns locally and were confident they would be listened to.

We saw that the ward manager had worked proactively to lead the team to work together for the benefit of the patients. Staff spoke with confidence about the quality of local management within the hospital and generally felt supported. One member of staff said, “We’re very lucky, we have a good sized ward, a functional team and a good relationship with our managers”.

Although the delivery of care was led by the nursing staff we saw there was effective communication between all the members of the multidisciplinary team to support patient centred care and rehabilitation. Staff told us there had been so many changes they were looking forward to a period of stability. Another member of staff said, “There have been a lot of changes but I feel staff are now settling. There has been good team building”.

Patient experiences and staff involvement and engagement

Communication about changes in the Trust were cascaded to staff through a variety of routes. The Trust issued a weekly bulletin, The Voice and the Chief Executive wrote a weekly update email to staff. There was a staff forum meeting and we were told updates were discussed at the ward team meeting. The team minutes we looked at included information for staff regarding the CQC inspection.

The patients we spoke with were positive about the care they received. Patients and their families were provided with several opportunities to raise any concerns they had and those we spoke with told us they would speak to

Learning, improvement, innovation and sustainability

New staff received an induction into the Trust. Staff told us the format of the induction was due to change from March and staff would. This meant that staff had access to the IT system immediately they started.

Staff told us they had good access to training. In addition to the mandatory training staff received they were able to access other training they identified to support their role. The majority of training was provided through e-learning, a computer generated way of learning during which staff were provided with videos or briefings which they answer questions on. We looked at the training matrix on the wards and saw there was a good uptake from staff on mandatory training.