Care Quality Commission

Cumbria Partnership NHS Foundation Trust

RNN

# Community health inpatient services

## Quality Report

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Date of inspection visit: 9-13 November 2015, 23-24 November 2015
Date of publication: 23/03/2016

# 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) |
|---|---|---|---|
| RNNBE | Penrith Community Hospital | Community Health Inpatient services | CA11 8HX |
| RNNBF | Brampton War Memorial Hospital | Community Health Inpatient services | CA8 1TX |
| RNNX6 | Ruth Lancaster James Community Hospital | Community Health Inpatient services | CA9 3QX |
| RNNX2 | Abbey View | Community Health Inpatient services | LA14 4LS |
| RNNY1 | Workington Community Hospital | Community Health Inpatient services | CA14 2UF |
| RNNLG | Langdale Unit | Community Health Inpatient services | LA9 7RG |
| RNNX7 | Victoria Cottage Hospital | Community Health Inpatient services | CA15 8EJ |
| RNNX9 | Wigton Community Hospital | Community Health Inpatient services | CA7 9DD |
| RNNCB | Cockermouth Hospital | Community Health Inpatient services | CA13 9HT |

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

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

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

# Summary of findings

## Ratings

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

# Summary of findings

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### Summary of this inspection


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# Summary of findings

## Overall summary

Overall we rated this service as requires improvement.

Staff across all locations reported incidents and the service had high rate of reporting of incidents. However we found there was limited evidence of learning from these incidents. Throughout the inspection we saw some care records were comprehensive but we found they were not always individualised and some care records lacked assessments and care plans. We saw the records were not standardised across the service.

Ward areas were very clean and tidy but there was insufficient storage space in a majority of the locations we visited. There was a lack of equipment for staff to use to help keep patients safe and some equipment was not properly checked or maintained.

People's care and treatment was planned following assessment but this was not individualised. There was little evidence of current evidence based guidance being used and no outcome measures were available.

Staff were caring and respected people's privacy and dignity but on occasions we found staffing levels to be low which increased the risk of harm to patients.

Most people were involved in their care and treatment and also in any decisions made regarding their care and treatment. However, there was limited understanding of the implementation of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (2008) across the service. This led to poor recording of individual's mental capacity and any decision making processes where a person lacked capacity.

The service worked actively with local health and social care organisation to ensure patients' needs were met through the way services were organised and delivered but the service lacked an overall strategy and had not fully engaged with the staff regarding plans for the future.

Across the service we found a lack of assurance in governance processes. Many policies were out of date and there was a lack of senior management visibility to most front line staff across the service however the geography of the area covered by the service is very challenging There was a clinical governance structure, but there was limited evidence in the way the service robustly managed risks through action planning and dissemination of information to front line staff.

Some locations we visited lacked nursing leadership and mandatory training and staff appraisal rates were both below the Trust target.

# Summary of findings

## Background to the service

Community in-patient services at the Trust were managed by the Community Care group. There were a total number of 204 inpatient beds in 13 wards at 12 sites across the county of Cumbria.

During the announced inspection we visited nine wards at the following locations:

- Ruth Lancaster James Community Hospital at Alston – seven beds and a Nurse-led Treatment Centre (open 24 hours)
- Brampton War Memorial Hospital – 15 beds
- Eden Unit at Penrith Hospital – 28 beds
- Langdale South and Langdale North wards at Westmorland Hospital, Kendal – 17 beds (beds closed at the time of inspection) and 23 beds respectively
- Abbey View at Furness General Hospital in Barrow in Furness – 24 beds
- Victoria Cottage Hospital at Maryport – 13 beds and a Nurse-led Treatment centre (open 09:00 to 19:00 weekdays and 11:00 to 19:00 at weekends and Bank Holidays)
- Ellerbeck Ward at Workington Community Hospital – 14 beds
- Skiddaw View Ward at Wigton Community Hospital – 19 beds

During the unannounced inspection we visited two wards at the following locations:

- Isel Ward at Cockermouth Hospital – 11 beds
- Victoria Cottage Hospital at Maryport – 13 beds and a Nurse-led Treatment centre (open 09:00 to 19:00 weekdays and 11:00 to 19:00 at weekends and Bank Holidays)

We did not visit any wards at the following locations:

- Mary Hewetson Cottage Hospital at Keswick – 12 beds
- Copeland Unit, West Cumberland Hospital at Whitehaven – 15 beds
- Millom Community Hospital – nine beds

Cumbria was a large, rural county and very sparsely populated in some areas. The community hospital model addressed the challenges of a location such as this by providing a step up and step down service. This service was used by people aged 18 or over from the community and acute NHS Trust hospitals. Cumbria had an older population than the national average with 27% of residents aged over 60 compared to 22% nationally. The proportion of older people was also increasing at a faster rate in Cumbria than it was nationally. In the last 10 years Cumbria's over 60 population had increased by 16.1%; compared to a national increase of just 11.6%. This trend was forecasted to continue.

Some locations provided a minor injuries facility or nurse-led treatment centres for people aged 5 years and over. These units were open at varying hours across the county and were nurse-led by nurses from the wards at Ruth Lancaster James Community Hospital and Victoria Cottage Hospital. In other locations the minor injuries units were run separately to the wards. When required, medical support in the nurse-led treatment centres was provided by the local General Practitioner or salaried GP, but only at times when the surgery was open. All children under the age of 5 years were seen by a GP if they attended these units if there was one available. People were given treatment, advice or referred onto Emergency Departments at the acute hospital if required.

The wards were nurse-led with input from a rehabilitation team consisting of physiotherapists, occupational therapists and rehabilitation assistants. In most locations the rehabilitation teams also provided a service to people in the community. Medical input was from the local GP surgery or salaried GPs and the amount of cover varied across the locations.

During the inspection we spoke to 37 patients, four relatives, and 62 members of staff. We also reviewed 23 care records and six medication administration charts. We also attended six meetings including patient handover, multi-disciplinary meetings, a focus group and two medication administration rounds. We observed care being delivered and meals being provided to people

using the service. We reviewed information supplied by the Trust for the whole service including incident reports, complaints and audits from all the wards at all the community hospitals. We received comments from patients and members of the public who contacted us directly to tell us about their experiences of the service.

## Our inspection team

Our inspection team was led by:

**Chair:** Paddy Cooney,

**Head of Inspection:** Jenny Wilkes, Care Quality Commission

**Team Leaders:** Brian Cranna, Inspection Manager (Mental Health) Care Quality Commission

Sarah Dronsfield, Inspection Manager (Acute) Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultant psychiatrists, experts by experience who had personal experience of using or caring for someone who uses the type of services we were inspecting, health visitors, Mental Health Act Reviewers, a social worker, pharmacy inspectors, registered nurses (general, mental health and learning disabilities nurses), a school nurse and senior managers.

## Why we carried out this inspection

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

## How we carried out this inspection

To get to the heart of patients' experiences of care, we routinely ask the following five questions of services and the provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about Cumbria Partnership NHS Foundation Trust and asked other organisations to share what they knew. We attended a council of governors meeting and a board meeting. We carried out announced visits to all core services on 10, 11 and 12 November 2015. We carried out an unannounced inspection to community inpatient services on 23 and 24 November 2015.

During the visit we held focus groups with a range of staff, such as nurses, doctors, allied health professionals and support staff. We also held focus groups at main hospital sites for detained patients prior to and during the inspection. We also interviewed key members of staff, including the chief executive, chair person, medical director, director of nursing, director of finance. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

# Summary of findings

## What people who use the provider say

The NHS Friends and Family Test (FFT) response rate for the service was 2.1% compared to the England average of 3.6% in July 2015. Eighty four percent of people who had responded said they were extremely likely to recommend the service compared to the England average of 77%

The trust supplied us with information from NHS Choices and PLACE scores for three units in the service (Brampton War Memorial Hospital, Penrith Hospital and Workington Hospital) which showed average scores of 83% for privacy, dignity and well-being of patients using the service which was below the national average of 86%.

The feedback given from patients and visitors on CQC comment cards was positive. We saw 53 out of the 62 cards returned very positive comment were recorded about all members of the multi-disciplinary team and the cleanliness of the ward environments. Some negative remarks were noted regarding doctors not communicating as well as the patient may have liked.

## Areas for improvement

### Action the provider MUST or SHOULD take to improve

**Action the trust MUST take to improve**

- The trust must ensure that staff are trained and are implementing the principles and requirement of the Mental Capacity Act (2005) including the Deprivation of Liberty Safeguards.
- The trust must ensure there resuscitation and emergency equipment is ready for use at all times and have robust systems in place for the checking and replacement of emergency equipment.
- The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines.
- The trust must ensure all patients identified at risk of falls have appropriate assessmentand review of their needs and appropriate levels of care are implemented and documented.
- The trust must strengthen the systems in place to regularly assess and monitor the quality of care provided to patients.
- The trust must ensure where actions are implemented to reduce risks these are monitored and sustained.
- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.
- The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.

In addition the trust should:

- The trust should ensure care records accurately reflect the assessment of patients needs, care planning, treatment and the care delivered.
- The trust should ensure that patients have facilities such as toilets and bathrooms that are gender specific so that male and female patients do not need to share.

Care Quality Commission

Cumbria Partnership NHS Foundation Trust

# Community health inpatient services

**Detailed findings from this inspection**

## Are services safe?

By safe, we mean that people are protected from abuse

**Summary**

Overall we rated the service as requires improvement for the safe domain.

There was inconsistency in the recording of mandatory training. The service was not assured from the records held that staff had completed the appropriate training and, therefore patients were not at risk. Overall, the compliance rate with mandatory training was less than the Trust target of 80%.

There was evidence of resuscitation equipment not being properly checked and/or replaced when required. In the units where children were treated for minor injuries (the nurse-led treatment centres) there was no paediatric resuscitation equipment available for staff to use. Staff did not have paediatric training and were not trained in paediatric immediate life support. These units were not appropriately signposted to alert the public as to what services were provided there.

There were low staffing levels in some units and this had impacted on patient safety with an increase in patient falls reported by the service. Some of the buildings and the environments made it difficult to maintain patient safety. There was a lack of equipment to help keep people safe in some areas.

Nursing staff told us they felt particularly vulnerable at night in the isolated units.

Some locations were not storing medication in the appropriate way and the recording of drug fridge temperatures was not consistent across the service meaning that medication effectiveness could be affected. There was a risk of prescriptions being misused due to recording and governance arrangements lacking the necessary robustness to ensure controlled stationery could be accounted for.

Some items of portable electrical equipment had not had the appropriate safety checks which meant the service was not assured equipment was functioning as it should be.

There was a lack of patient hygiene facilities in some units meaning that patients of both sexes using the same bathroom.

Requires improvement

# Are services safe?

Some Trust policies were out of date and there was a lack of guidelines for staff to use. In some locations there was insufficient equipment available to staff to assist in the prevention of patient falls.

Incident reporting was high and some feedback was received by staff in some units but this was not consistent across the service with evidence that lessons from incidents and audits were not learned or communicated effectively across all locations.

Record keeping across the service was inconsistent with a mixture of paper and electronic documentation in use.

**Safety performance**

- The NHS Safety Thermometer was a national improvement tool for local measuring, monitoring and analysis of patient harm and to assist in working to achieve harm free care. It focused on four avoidable harms: - pressure ulcers (PUs); falls; urinary tract infections in patients with a catheter (CUTI) and blood clots (venous thromboembolism – VTE).
- Within the service there were 17 new PUs, 17 falls with harm (with a peak in May and June 2015 of three falls with harm in each month), 21 new CUTIs with a peak of six in August 2015 and two new VTE in the period September 2014 to August 2015. This information was not on display for staff.
- Across the four areas of harms collected within the Safety Thermometer the service delivered Harm Free Care to 92.4% patients compared to the national average of 90.6%.
- New VTEs affected 0.24% of patients compared with the national average of 0.51% between October 2014 and 2015 and there were fewer New Pressure Ulcers at 0.69% of patients compared with the national average of 0.94% between October 2014 and 2015. However there were a higher percentage of falls with harm at 0.78% compared with 0.66% nationally and CUTIs at 0.92% compared with 0.70% nationally for the same time frame.
- Between 1 January 2015 and 31 October 2015 there were 1402 reported incidents across the service.
- There had been no 'never events' recorded for community in patient services and 12 serious incidents reports between 01 September 2014 and 31 August 2015. Never events are serious, largely preventable patient safety incidents that should not occur if available preventative measures are implemented.
- The serious incidents related to falls with moderate or significant harm and pressure ulcers that were grade 3 or above.
- We reviewed four investigations that had been carried out and saw limited evidence of learning being cascaded to staff at ward level. For example a review of ward meeting minutesshowed that recommendations following an investigation in May 2015 into a patient fall that had resulted in significant harm were mentioned in the minutes from Abbey View but were not mentioned in the minutes from Millom hospital or Ellerbeck ward.

**Incident reporting, learning and improvement**

- Analysis of the reported incidents from the service showed 381 reported patient falls in the 6 months between 01 January and 30 June 2015 which was an average of 2 falls every day in the service.There had been a further 295 patient falls between 01 July and 31 October 2015 which equated to2.4 falls every day in the service. On a number of incident reports low staffing and/or high patient acuity and dependency was recorded by staff as a contributory factor to patient falls during this period. Where it had not been possible to secure additional staff to meet patients need, bed numbers had been adjusted and admissions suspended to mitigate the risk.
- Further analysis of the incident data showed that on a number of occasions there was insufficient pressure mats available to assist in preventing falls occurring in known high risk patients. The trust has not supplied information that indicated these incidents had been reported as RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurances Regulations 2013).
- The Community Care Group had developed Learning lessons bulletins which were sent to staff via email. There was some evidence that these were reaching front line staff for example in ward meeting minutes but this was not consistent. Some staff were able to tell us there had been a change to the admission process as a result of an investigation into a patient fall at another unit.

**Duty of Candour**

# Are services safe?

- The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that had led to moderate or significant harm.
- Staff we spoke to showed a limited understanding of the Duty of Candour at ward level, they were aware of the principles of open and honest care. Some staff were able to give an example of the duty of candour in practise. For example on Langdale South there had been an incident and we were told that a manager had met with patient and the family and a letter sent.
- Senior managers told us that ward staff would inform relatives if something had gone wrong with care and treatment. They were also confident that incidents would be reported.
- The root cause analysis and investigations we reviewed demonstrated an application of the Duty of Candour requirements in the documentation.

**Safeguarding**

- Safeguarding training for adults and children was on the Trust's mandatory training programme but compliance was variable across the service.
- The Trust's target for mandatory training compliance in safeguarding was 85% but this had not been achieved in the service, with less than 60% in some locations.
- Some staff we spoke to had a good understanding of the process for safeguarding and where to seek information on the Trust intranet pages if they had any concerns. On other units staff were less confident and unable to demonstrate knowledge of safeguarding policies and procedures.
- Nursing staff who covered the treatment centres at Ruth Lancaster James Community Hospital at Alston and Victoria Cottage Hospital at Maryport did not all have Level 3 safeguarding children training despite these units assessing and treating children aged 5 to 18 years.
- The trust had a safeguarding committee that met quarterly to discuss and consider safeguarding information. Community adult services were represented on the committee by the associate director of nursing.

**Medicines**

- When a patient was transferred from an acute hospital setting, medication was transcribed onto a medication administration chart. This was done by a doctor or an advanced nurse practitioner (ANP), who was an independent non-medical prescriber. The EMIS web system was used as the electronic patient health record and was used by nursing, medical and pharmacy staff to check a patient's medication history. Not all locations had access to this system and relied on the information sent from the acute hospital or the GP. This information was not always the most up to date or accurate. Staff told us that there were sometimes errors on the medication charts which could result in delays in patients receiving their medicines. These occurences were reported as incidents.
- Staff informed us the supply of medications from the acute trusts when a patient is transferred could be inaccurate or incomplete and often they reported this as an incident.However at Langdale South and Langdale North the supply of medication from the acute trust was good.
- There were delays in the medicines reconciliation process when a patient was transferred out of hours. This occurred at least once a week on most units and could be up to three days when there was a Bank Holiday
- We observed an ANP transcribe medication from an acute hospital medication administration record (MAR) onto a community hospital medication administration record. The ANPs also transcribed medication from the community hospital medication administration record onto the discharge prescription.. We found in the service there was a lack of robust governance arrangements for this practice as this transcribing role was not defined as distinct from their prescribing role within the Trust's prescribing policy and so did not fully support them in this function.
- One patient at Victoria Cottage Hospital did not have an identification wristband in situ – this was pointed out to staff but was not addressed immediately despite us raising it with them. The patient had a drug allergy that staff would need to be aware of when administering medication.

# Are services safe?

- We observed two medicine rounds. The staff conducted these in a safe way with the patient receiving the right medication by the right route and at the right time. We also reviewed six MAR charts which were completed satisfactorily.
- At Ellerbeck ward and Isel ward, the door of the room where medications were stored was not locked. An infection control audit undertaken in October 2015 also found this to be the case at Mary Hewetson Community Hospital. This was not in line with the Trust's medicine management policy on the safe storage of medication.
- Fridge temperature recordings were not being undertaken correctly at Langdale North and Victoria Cottage Hospital at Maryport. The minimum and maximum temperatures were not being recorded and the thermometer was not being re-set. This was not in line with Trust policy and was picked up in the Trust's medicine management audit in April 2015. The issue at Victoria Cottage Hospital was reported to senior managers at the time of our announced inspection and the trust told us they had addressed this the next day. However, on our unannounced inspection at Victoria Cottage Hospital, the correct form for recording the minimum and maximum temperatures was in place from 12 November 2015 but the temperature recorded was out of the safe range. Staff had not taken any action for the high temperature recordings and staff did not know how to re-set the thermometer. Therefore the service could not be assured medication had been stored at the correct temperature.
- The drug fridge at Langdale South had been out of action for a number of weeks and a new one was on order. Langdale South were using the fridge on Langdale North as a temporary measure.
- An incident report at Brampton War Memorial Hospital, related to medication not being stored at the correct temperature which had to be disposed of. A further incident report indicated a situation where insulin was found to be out of date.
- The controlled drugs record books that we checked were completed appropriately with weekly checks in place in line with Trust policy.
- On review of incident reports we found a medication issue at Victoria Cottage Hospital where controlled drugs were not stored in the correct way due to insufficient storage space. This was because out of date controlled drugs and patient's own controlled drugs, who were no longer patients, were being stored.
- FP10 prescription pads which were used by medical staff and non-medical prescribers to order medications from the pharmacy were stored in the CD cupboard. The service lacked a robust system to manage these items of controlled stationery, therefore the service could not be assured that the prescription pads were being used appropriately.
- There were 59 incidents related to medications reported between January and June 2015. There were a further 79 incidents related to medications reported between July and October 2015 - an increase from the previous reporting period. The service had identified that the increased incidents related to a change in process from an acute hospital trust had implemented. A working group had been set up to address this.Each unit had support from a pharmacist although the cover differed across the service. For example a pharmacist visited Eden unit at Penrith twice a week for half a day. At Ellerbeck ward a pharmacist visited three times a week, again for half a day.
- In most of the units we visited the nursing staff were responsible for the monitoring of ward stock and re-ordering. No out of date stock was found during the inspection. Some staff told us that there was a high level of drug wastage, especially on the units where nursing staff were responsible for stock control.
- Oxygen provision differed across the service.There was either piped oxygen or the provision of gas cylinders. All were stored in an appropriate way and doors labelled accordingly in line with medical gases requirements.
- Only Isel ward of the wards we visited offered patients the opportunity to self-medicate with locking medication cabinets in the patients' rooms. Staff on Abbey View reported they had supported a small number of patients to self-medicate but there were no patients doing this at the time of our inspection. This meant the service did not have a consistent approach to supporting patients to self-medicate whilst they were rehabilitating.
- Staff told us that at times covert administration of medicines was required. We did not see this at the time

of our inspection. Staff said that this was always documented and done after discussion with the doctor and pharmacist. There was a process and guidelines within the trust's medicines management policy available to staff to manage this situation but was not easy to find due to no mention of this in the index and an error in the numbering of the relevant appendices.

- The Trust had carried out a medicines management audit in April 2015. . Review of team meeting minutes from the units had not recorded results or actions from this audit so we were unable to tell if staff had been informed of the outcomes.

**Environment and equipment**

- Across the service the physical environment of the wards ranged from Victorian buildings with limited facilities, to newer builds with access to single rooms and en-suite facilities. The trust had a plan for improving their estates to enable safe working.
- Many patients were cared for in individual single rooms which helps maintain dignity and privacy however it was difficult for staff to observe patients in somelocations we visited such as Brampton War Memorial Hospital and Isel ward due to a lack of windows and the layout of the ward.
- We found concerns across the service regarding the stock and management of resuscitation equipment. There were variations in the frequency of checking the resuscitation trolley across the wards some did this twice a day, others once a day which is in line with the Trust policy.
- On review of incident forms we found that the resuscitation trolley at Wigton Hospital had not been replenished for three days after it had been used despite the daily checks being completed. We observed a resuscitation trolley containing out of date cannulation equipment on Ellerbeck ward. Staff were made aware of this at the time of our inspection.
- A resuscitation trolley at Victoria Cottage Hospital had a number of items missing and these items had not been ordered by staff. We raised this at the time of our announced inspection and the stock was ordered. However when we visited the ward again on the unannounced inspection the stock had still not been replaced. This meant in the event of an emergency situation the service could not be assured that all the appropriate equipment was available for staff to use to treat the patient.
- We raised this with senior managers during the unannounced inspection who told us that a trust resuscitation officer had sourced the missing items and delivered them to Victoria Cottage Hospital the following day. The trust also informed us that staff were being reminded they must order replacement items themselves if they do not come from the resuscitation service stock room.
- There were insufficient areas for patient hygiene in some units. For example, there was only one bathroom at Victoria Cottage Hospital for 13 patients. This meant both male and female patients would use the same bathroom as separate facilities were not available.
- Staff told us they had adequate pressure relieving equipment and wards had spare mattresses in cupboards. No problems were reported in relation to pressure relieving equipment being cleaned. Many locations reported that the 'League of Friends' had also supplied equipment such as pressure relieving mattresses and cushions and also contributing to a major refurbishment at the Ruth Lancaster Community Hospital at Alston.
- We found on Isel ward there were insufficient pressure/ sensor mats available for use to detect movement in patients who are at a high risk of falls. Nursing staff told us they had to prioritise which patients had the highest risk for the two mats they had.
- On reviewing incident reports we also found that there were insufficient pressure/sensor mats at Wigton Hospital and Eden unit for patients who were at a high risk of falls. Eden unit had ordered more pressure/ sensor mats in August 2015 but these were still not on the ward in October 2015.
- The Trust had identified problems with the environment and space at Langdale North and Langdale South wards with refurbishments required to enable safe working environments for staff. We found there was no firm plan or timescale for this yet.The Trust had also identified

that there was a lack of space for seven day therapy care, treatments and rehabilitation to be delivered and for communal activity. Again there was no firm timescale for this to be improved.

- We saw during our inspection the therapy room on Langdale North at Westmorland hospital had water damage to the roof. The ceiling was in need of urgent repair and work was being undertaken during our inspection.
- There was no Occupational Therapy kitchen at Westmorland Hospital for rehabilitation needs and assessments this meant that staff had to take patients to their own homes which was time consuming.
- At Victoria Cottage Hospital we found electrical equipment with no portable appliance test (PAT) or out of date testing. The pen used on some of the PAT stickers at Isel Ward was not indelible and had rubbed off so it was not possible to tell when the equipment was last checked.
- Across the service equipment appeared clean and there was a consistent labelling system in place.
- The fridges in the staff kitchen on some wards did not have temperature monitoring in place. Some of these fridges were observed to have yogurts for patient use stored in them.
- We observed food and drink in the ward fridges without names or dates on them despite notices on the fridge door instructing this to be done.
- At Victoria Cottage Hospital we observed opened bottles of food supplements without labelling to indicate the date it had been opened in the ward fridge.

**Quality of records**

- We reviewed 23 patients' records across the service. In some locations a paper system was in use, in others an electronic system (EMISS) was in use or a mixture of both paper and electronic. It was not easy to navigate to the care planning section on EMISS.
- Care plans were not individualised on either system as they were pre-set on the electronic system or pre-printed on the paper system and no changes were made to these to reflect the individual needs of the patients
- Staff informed us that the trust had plans to roll out a new electronic health care records system (RIO) by July 2016.
- The Trust conducted a health records keeping audit in December 2014. This showed that there had been an improvement from the previous year across the Trust in areas such as countersignature of deletions/alterations, reduction in illegible entries and recording patients' NHS number. However, the audit showed no improvement in files being marked as confidential and the capture of patient ethnic origin.
- In the patient records we reviewed we found ethnic origin was often not completed on the patient assessment.
- The trust provided us with information following our unannounced inspection to Victoria Cottage hospital related to a documentation audit. This showed poor compliance with record keeping. Senior managers were aware of this and had planned to meet to discuss this.

**Cleanliness, infection control and hygiene**

- The environment on all the wards we visited was visibly clean and tidy, including dirty utility rooms and communal areas. There were sufficient hand washing sinks and provision of hand cleansing products at all locations.
- Monthly hand hygiene audit information was displayed in most of the ward areas we visited, it was not visible at Ruth Lancaster James Hospital at Alston. On those displayed the compliance rates were over 90%.
- Laundry services were provided by an external contractor who collected dirty laundry and delivered clean laundry. We saw there were sufficient laundry bags in all locations we visited with the appropriate coloured bags.
- Staff were observed using good hand hygiene procedures between patient cares. Staff wore personal protection equipment such as gloves and aprons as necessary.
- We observed a room that had isolation procedures in place with signage and equipment immediately outside for staff and visitors use.
- Infection prevention and control audits in October 2015 identified issues at some locations in the service. This

included lack of appropriate storage space, lack of cleaning schedules and rusty equipment. At Mary Hewetson Cottage Hospital in Keswick the infection prevention and control team had found a large number of out of date consumable stock in the clinical room and on the resuscitation trolley (the ambubag was three years out of date), the drug fridge was not locked, an inadequate thermometer on the fridge and sharps disposable containers were not labelled or dated. We did not visit this location, however ward meeting minutes indicate these findings had been shared across the service and recommendations made.

- Monthly cleanliness inspections were carried out relating to the domestic cleaning and the trust supplied us with information that showed 98% compliance across the service.
- Information supplied to us from the Trust showed that mandatory training compliance in hand hygiene on some wards was low for example 51.5% at Copeland unit and 56.3% at Langdale South in October 2015. Mandatory training compliance for Level 2 infection prevention and control training was also less than 60% at Copeland unit, Ellerbeck ward & Abbey View.
- On review of incident forms after our inspection we found there had been no hot water at Victoria Cottage Hospital at Maryport for four days in October 2015. The incident report indicated this being reported by staff to the estates department on two occasions. Staff used hot water from the kitchen geezer during this time. Patients were not able to shower or be bathed. This was given a score of 1 which meant no injury in terms of impact.
- There were infection control policies on the intranet for staff to access. We looked at three of these policies which were relevant to community based staff. All three policies were out of date for review 2012 and 2013.

**Mandatory training**

- The mandatory training records that we reviewed did not match the information sent to us by the trust as compliance rates were higher on most wards which staff told us was due to the delay in information being inputted onto the central staff training recording system.
- The mandatory training compliance across all locations (without Wigton and Millom hospitals as this information was not supplied) was 74% with a Trust target of 80%.
- There have been a number of changes to the mandatory training courses required for staff to complete during 2015.
- We saw that staff had undertaken mandatory training or were booked onto sessions in the near future.
- Staff told us that travelling to locations where face to face training was delivered took too long and took them away from patient care when wards were short staffed.
- In the information supplied to us from the Trust staff working in community in-patient settings did not have the following training as part of their mandatory training requirements despite this being available to staff working in other services in the trust:
- Mental Capacity Act
- Deprivation of LibertySafeguards (DoLS) – Level 1
- There was also no mandatory training for staff regarding pressure ulcer prevention and treatment.
- This meant the service was not assured that staff had the appropriate level of knowledge to provide the right care and treatment to patients or to protect themselves in the workplace.

**Assessing and responding to patient risk**

- The National Early Warning Score (NEWS) which is a recognised tool to identify a deteriorating patient was in use across the service. We found there was a clear pathway for stepping patients up to the acute trust when a patient deteriorated. We observed this in practice at the time of our inspection at Langdale South with a smooth and timely transfer of a patient to an acute hospital.
- Decisions were made by nurses to escalate care to the acute trust when a patient's medical condition deteriorated. This was without a review by a doctor, particularly out of hours. This situation generated an incident report and we saw evidence of this on the incident report we reviewed.
- Advanced nurse practitioners were employed in some units who were able to review patients who showed signs of deterioration.

# Are services safe?

- We observed the escalation process occur on Langdale South when a patient suddenly deteriorated they were quickly and smoothly transferred to the acute hospital.
- We reviewed 23 records and found that risk assessments for nutrition, falls and skin pressure damage were consistently completed for patients; however these were not consistently reviewed.
- Pressure/sensor mats were used when available to alert staff when a patient assessed as a high risk of falls was moving. Staff also located patients when possible in a bed which was easier for staff to observe.
- We observed four handovers at the change of shift during our inspection. We saw some were very well conducted with good and clear information about patients handed over. However we observed one face to face handover where information about a patient was handed over but no challenge made regarding safety of the patient due to changes in the plan of care. This was raised with managers at the trust at the time of our inspection who reported following the inspection the care of the patient had been discussed with their colleagues in adult social care.

**Staffing levels and caseload**

- We found the wards displayed information about the number of nurses on duty but did not display planned numbers versus actual staffing levels. There is national guidance from NHS England which states staffing levels should be displayed in all in patient areas. Patients and visitors were not able to tell if the actual numbers of staff on duty were the same as those planned to meet the needs of the patients.
- The Trust had developed a dependency and acuity tool in order to determine safe staffing levels and skill mix on the wards. We were told by senior managers that this tool was completed daily by the ward staff.
- Information regarding dependency and acuity was inputted onto the Care group dashboard so managers were able to see the staffing levels and the dependency and acuity of the patients. However, we found some units were not updating the dependency and acuity tool daily so were contacted by managers individually to undertake this.
- The Trust was aiming for a 1:8 registered nurse to patient ratio during the day and at night a ratio of 1:12.This target was not met in some units, particularly at night when there was one registered nurse on a ward for up to 15 patients. On these wards additional health care support workers were used.
- When we visited Isel ward, four beds had been closed due to the acuity and dependency of the patients since 09 November 2015. We were informed by staff that the acuity and dependency had been high for at least two weeks prior to this decision being made. Incidents reports confirmed there had been staffing shortages and patient falls in October 2015.
- The Trust made a decision to suspend admissions to Eden unit in October 2015 due to dependency and acuity of patients along with staff shortages. Langdale South ward also had beds closed due to staff shortages.There is an escalation process to support this decision making.
- Team leaders (Band 7 nurses) on the units felt empowered to make decisions regarding accepting patients to their units based on acuity and dependency of patient and the staff they had available. However, at another unit staff told us this was not the case and they felt under pressure to take new admissions even when staffing levels were low and acuity and dependency was high.
- Information supplied by the Trust showed that staffing levels at some of the wards had been lower than planned prior to our inspection, for example Brampton War Memorial hospital had 87% for day time shifts and 77% for night time shifts. This was also confirmed when we checked the nursing duty rotas. This meant there were less staff than required to care for patients on several occasions.
- Brampton War Memorial Hospital, Isel ward and Mary Hewetson Community hospital had adopted a 11:00 to 19:00 or 10:00 to 18:00 shift for registered nurses to cover the early and late shift gap, however this left only one registered nurse on duty at all other times during the day and night.
- Other information supplied by the Trust showed that ward manager supervisory time at Victoria Cottage hospital and Ellerbeck ward at Workington Hospital was at 0% due to vacancy and sickness. Ward manager supervisory time at the other units varied between 40% at Ruth Lancaster James Community Hospital at Alston

and Copeland Unit at West Cumberland Hospital, 50% at Brampton War Memorial Hospital and 60% at all other units. This meant at times it was difficult for the ward managers in the larger wards to manage the ward effectively.

- The nursing off duty rotas for Millom, Cockermouth, Wigton, Maryport and Alston hospitals did not show the planned staffing for each shift or the actual numbers that were on duty as a total making it difficult to see how many staff were or had actually had been on duty. Staff informed us that gaps in cover were usually filled by their own staff working additional hours.
- The Trust was unable to provide reasons why bank or agency staff were used; however, there was a reported underfill greater than 92% due to sickness, absence or vacancies in September 2015 at Brampton War Memorial Hospital (87.9%), Isel Ward at Cockermouth Hospital (90.1%), Langdale North at Westmorland General Hospital (90.3%) and Ellerbeck ward at Workington Community Hospital (91.9%). This means wards have been left short of staff on a number of occasions.
- Staff expressed concerns to us about staffing levels and the difficulties in recruiting staff in the area. We were told by a senior member of staff that there had been two registered nursing vacancies at Wigton Hospital for two years which had been advertised several times with no suitable candidates.
- Some staff we spoke to indicated that they felt under pressure to work additional hours, particularly part-time staff to cover gaps in shifts.
- Staff were flexible and often did work additional hours in order to keep patients safe; however, we were told by staff that this had resulted in registered nurses working 16 hours without a break on more than one occasion. Staff told us they were not paid overtime and do not have opportunity to take any time back in lieu.
- We asked the Trust how staff were covered for breaks when there is only one registered nurse on duty; they informed us there were arrangements with the local district nursing service to cover for breaks or staff were paid for missed breaks. This did not reflect what staff told us or how the staff were covered on night shifts when there was a very limited district nursing service provided across the county overnight.
- On review of data supplied by the Trust we have found incident reports have been made when wards have been short of staff. (Mary Hewetson Cottage Hospital, Isel ward, Eden Unit, Wigton Hospital) and that staff had worked additional hours to attempt to make the ward safe. For example working until 23:00 on a late shift and starting an early shift at 05:00.
- An incident report indicated that as a result of short staffing patients had to wait for personal care and for pain relief (Copeland unit – October 2015). It was recorded on the incident report that beds were closed to admissions following this incident.
- An incident report showed that a patient had a fall on Langdale South when they were short of staff.
- Vacancy levels in the service are spread between qualified and unqualified staff with a total of 12 whole time equivalent (WTE) qualified nursing staff and 9.6 WTE nursing assistants' posts being vacant in September 2015.
- Langdale South had a high vacancy level (3.58) but we were told by the ward manager that three WTE posts had been recruited into.
- Staff sickness levels across the service were 4.8% which was higher than the NHS national average of 3.9% and higher than the North West region average of 4.5%. Victoria Cottage Hospital had a high sickness absence rate at 11.3%. Staff told us sickness absence was not well managed. The sickness absence rate was also high at Eden unit at 11.6%.
- Staff turnover across the service was variable with no turnover of substantive staff in the last 12 months at Victoria Cottage Hospital and 3.6 WTE staff at the Copeland Unit at West Cumberland Hospital.
- Staff told us of the service's plan to introduce e-rostering in the future.

**Managing anticipated risks**

- All locations used the National Early Warning Score (NEWS) tool and patient's vital signs were checked at least daily. We observed this to be the case on the patient charts we examined.
- There was a protocol in place for actions if a patient's vital signs indicated a deterioration in their condition. Staff we spoke to were aware of the actions required.

Requires improvement

# Are services safe?

- Staff at Ruth Lancaster James Hospital at Alston carried alarms in their pockets which vibrated/alarmed when a patient who was a high risk of falls activated the pressure pad/mat in their bedroom. Other locations did not have such sophisticated alarm systems and had to rely on hearing an alarm when the pressure/sensor mat was activated by a patient.
- Staff told us they accessed assistance and support from colleagues in the mental health teams when there were patients with behavioural challenges on the ward.
- From the information provided no staff in the service had attended any training relating to the management of work related violence and aggression. This was not on the required mandatory training for staff in the service despite staff being in very isolated areas and managing patients with behaviours that maybe challenging for example as a result of a person living with dementia.
- Senior managers identified a risk in relation to the signage informing the public that there was a minor injuries unit at the Ruth Lancaster James Community hospital and the Victoria Cottage Hospital for the nurse led treatment centres. The trust advised us after the inspection there had been changes to the signage and press releases informing the public of the changes in this service in the week prior to our inspection. . However we were told by staff that people may arrive at these units with conditions that could not be treated by the nursing staff on duty.
- There was signage at Cockermouth Community hospital for a minor injuries unit that had previously been run by the GP practice and this was not now available. We were told by staff that people did still come and knock on Isel ward door for assistance.
- There were no qualified decision makers at the nurse led treatment centres at Alston or Maryport hospitals. These are nurses with additional training who can assess, diagnose and treat a number of minor ailments and conditions. There was a risk of patients attending with conditions which were nationally recognised to be within the capability of a traditionally staffed minor injuries unit. Staff had access to GPs in the adjacent surgeries in hours and out of hours patients would be directed to the nearest emergency department. Staff told us there had been little or no communication with the public advising people what service was provided at the treatment centre and there was mixed messages on the internet. The trust advised us after our inspection there had been a number of public engagement meetings regarding the change in service at Alston and Maryport nurse led treatment centres.
- Senior managers in the service acknowledged that staffing on the respective wards was compromised at times when covering the treatment centres.

**Major incident awareness and training**

- Staff were aware of their role and responsibility should there be a major incident in the area. The community beds would be used to step down patients from the acute hospital trusts and the focus would be on discharging any patients in community rehabilitation beds to create capacity.
- Staff could also give examples of when business continuity plans had been implemented as a result of severe weather conditions such as flooding and snow.

Requires improvement

# 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**

Overall we rated the service as requires improvement for being effective.

The Trust recognised inconsistencies in the service and had re-structured in order to address this. There was still some work to be done before these new management arrangements develop a consistent high quality and effective service across the county.

Staff across the service lacked understanding of the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards. The documentation relating to assessment of mental capacity and the decision making processes for people who lacked capacity were poor in most locations.

There was little evidence based practice on the wards and insufficient clinical guidance for staff. Policies were out of date and there were few guidelines available to staff. There were few patient outcomes being measured or recorded and a lack of participation in national audits resulting in an inability to benchmark the service.

Staff appraisals were not up to date so the service was not assured that staff were competent and appropriately trained for the job they did.

The patient experience and continuity of care was good with the service providing both hospital and community based rehabilitation.


**Evidence based care and treatment**

- We found a number of trust policies were out of date, for example infection control, prevention and hand hygiene and management of controlled drugs.
- Care planning documentation did not consistently reference any National Institute for Health and Care Excellence (NICE) guidance. For example in community in patient services it would be appropriate to find guidance relating to wound care, falls prevention and stroke care.
- On Langdale South ward there were easy access folders at both the nurses' stations with information to assist staff; for example, wound assessments; however many of the documents lacked a reference, date or source and there were different documents in each folder.
- All patients were assessed for venous thromboembolism on admission and appropriate prophylaxis prescribed.
- Physiotherapy staff told us they were able to achieve the guideline from NICE in relation to stroke patients at Westmorland Hospital.

**Pain relief**

- We observed patients being asked if they required pain killers when medications were being administered. We observed a pain assessment score on the NEWS chart which was completed for most patients. Pain was not routinely assessed with an in depth pain assessment tool.
- Patients told us they were not in pain and pain relief was offered regularly.
- Medication to relieve pain was prescribed and administered as required for all patients in particular for terminally ill patients. A wide range of analgesic medication was kept in stock in all the locations we visited.
- An incident report in October 2015 indicated concerns raised by nursing staff or patients having to wait for pain relief due to shart staffing on the Copeland unit.

**Nutrition and hydration**

- Staff carried out a nutritional assessment on all patients within 24 hours of admission. This was the Malnutrition Universal Screening Tool (MUST). We reviewed 23 assessments and found that these were all complete.
- The provider of food and meals varied across the service with a number of locations having a frozen meal service

and others had meals made from on-site kitchens. The menus offered a range of meals and patients were assisted with menu choices. Information about nutrition was on display in the dining areas.

- The patients we spoke to were all quite happy with the meals provided. One relative said they would have preferred freshly prepared food rather than frozen but reported that her husband was happy with the meals he had been offered.
- We observed meals times and saw that patients at all locations were encouraged to sit in the dining area for their meals. Drinks were provided at meal times and between meals with the provision of snacks.
- Staff told us that the referral process to a dietician for advice was effective and patients were seen in a timely manner.
- At Westmoreland Hospital (Langdale north and Langdale south) there was a hot drinks dispensing trolley which allowed provision of hot drinks for patients at all times of the day. Patients in other units told us there was an adequate supply of hot and cold drinks provided.
- The national Patient Led Assessments of the Care Environment (PLACE) results for 2015 rated the service between 95.7% at Victoria Cottage Hospital (where the meals, snacks and drinks were supplied from an on-site kitchen) and 83.8% at the Copeland Unit at West Cumberland Hospital giving an average rating of 92.3% which was above the national average for at 89.3%.

**Technology and telemedicine**

- We saw on the trust website that at Millom hospital software was used to provide reminiscence therapy to people with dementia and neurological conditions.

**Patient outcomes**

- The trust had taken a decision not to participate in the National Intermediate Care Audit which was designed to assess progress in services for older people and had the aim of maximising independence and reducing use of hospitals as they did not think this was relevant
- There was no evaluation of any outcome measures or any benchmarking of the service. This meant the service was not able to develop any actions for improvement in quality.
- The staff in the rehabilitation teams told us they did record some outcomes but this was not consistent across the service and there was no collation of the information across the service.
- Senior managers told us length of stay and re-admission rates were recorded along with patient complaints and satisfaction surveys.
- The trust did not record comprehensive data regarding acute hospital admission avoidance. Some information was available that demonstrated the intermediate care service's intervention in preventing admission to hospital but this was not across the whole of Cumbria.

**Competent staff**

- The appraisal rate for non – medical staff in this service was 58%. The worst performing wards were Victoria Cottage Hospital with 21% and Millom Community Hospital with 36% of staff having a performance review in the past 12 months.The best performing units were Eden unit with 80% and Langdale North with 81% compliance.
- Some staff we spoke to had received a recent appraisal. Most of these staff indicated they would be able to attend any necessary training and also had access to external courses if required.
- An incident report made from Isel ward indicated that a bank health care support worker had not had sufficient training on induction to work effectively. This had an impact on patient safety and care as the member of staff was unable to use the manual handling equipment or attend to patients needs without direct supervision resulting in other patients waiting for care needs to be met.
- The Trust was working with the Cumbria Learning Initiative Collaboration (CLIC) to provide training sessions outside the Trust mandatory schedule. This was clearly advertised on all the wards we visited and staff knew how to access these courses.
- Some locations had an Advanced Nurse Practitioner (ANP) working Monday to Friday to support medical and nursing staff. The ANP had received additional training to be a non-medical prescriber and was line managed by a GP.

Requires improvement

# Are services effective?

**Multi-disciplinary working and coordinated care pathways**

- New admissions to wards were seen by a doctor or advanced nurse practitioner as soon as possible after admission. If the patient arrived out of hours the on call GP service would be contacted if needed. On occasions patients were not seen by a doctor for two days if admitted at a weekend.
- Senior managers reported that medical support to the service varied from excellent to quite patchy and was not under the control of the Trust. This was provided through the GP service level agreement system. There was some senior medical leadership to support audit, appraisal and governance throughthe Clinical Director of Unscheduled Care and Frail Elderly.
- The GPs and other medical staff we spoke to confirmed that they did not have any meetings with other doctors in the same role across the care group.
- The wards used a white board to record patients predicted date of discharge and multi-disciplinary input. Information supplied to us by the Trust shows that the average length of stay for patients in the service was between two and four weeks.
- During the inspection we observed good multi-disciplinary working with multi-disciplinary team (MDT) meetings held weekly. The rehabilitation team in most areas worked in the community as well as the ward providing a seamless service for patients. Rehabilitation assistants were trained to provide rehabilitation to patients in both the hospital ward and community setting.
- We observed a multi-disciplinary team meeting which was conducted in a professional manner and the plans were recorded straight onto the patients' electronic record.
- At the Victoria Cottage Hospital in Maryport we observed community based patients coming to the ward and joining ward based patients for activity sessions run by the occupational therapist and the physiotherapist.
- On Isel ward at Cockermouth hospital patients who had been discharged and were continuing their rehabilitation at home returned to the ward for lunch and therapy sessions.
- We observed nursing handovers at different locations some of these were conducted as a face to face handover and in other locations a voice recording was made. There were differences in the quality of the handover information given as some lacked personalisation of the patients' needs.
- Staff we spoke to felt that they had a good understanding of each other's roles and that they worked well as a team.
- Physiotherapists and occupational therapists did not work at weekends but rehabilitation assistants did both on the wards and in the community.

**Referral, transfer, discharge and transition**

- There was a referral process into the service with specific criteria for acceptance onto the units. Patients could be referred as 'step up' from their own home or 'step down' from the acute hospital trusts.
- We were provided with different documents across the service for the admission criteria which were not dated, referenced or with a review date indicated.
- Staff in the community such as district nurses, GP and nurse practitioners in the Primary Care Assessment Service referred 'step up' patients into the service.
- Admissions were taken on any day of the week and accepted by the nurse in charge of the ward.
- Staff on the wards completed a handover document that highlighted any patient risks this information was obtained by nursing staff contacting the referring ward.
- We reviewed the admission and discharge book at one location where the re-admission rates were high and found evidence of patients who required regular admission to have treatment.
- Staff we spoke to indicated that delays could occur with discharges due to the lack of availability of care home places and local authority home care provision to support patients in their own homes.
- Data showed there were up to 23 delayed discharges on Abbey View over the six months between April to September 2015.

Requires improvement

# Are services effective?

- Data provided by the trust showed that on one day, on a 24 bedded unit, there were 17 patients who were medically fit for discharge but were awaiting some social care intervention, either for home discharge or discharge to an alternative supported environment.
- Senior managers informed us there had been a significant increase of 30% in delayed discharges since April 2015. They told us a multi-agency task and finish group was looking at redesigning the use of community hospitals and catering for ambulatory care patients. There was no timescale for completion of this work.
- We saw evidence of working with community services in discharge planning. Community staff and social care staff were invited to MDT meetings and discharge planning meetings.
- We saw patients being prepared for discharge home. Home assessment visits took place regularly and patients and families were fully involved in these.
- Patients could be followed up from a medical perspective by their own GP some of whom would have seen them on the ward which was good for continuity of care.

**Access to information**

- There was variable practice across the Trust and the locations visited. Some locations had access to EMIS web which allowed staff to see the complete patient health record.
- Some computers in the service lacked the facility to 'switch user' so staff could not easily log on. Information from a previous user could also be lost as a result.
- The acting Band 6 nursing sister at Victoria Cottage Hospital did not have access to the staff training records. This was a unit where there was no Band 7 ward manager in post.

**Consent, Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS)**

- We observed patients being asked by staff for their consent for care and treatment. We reviewed 23 patient records and found the documentation for obtaining patients' consent for treatment was standardised and not patient centred. It did not clearly set out whether a patient was able to consent to specific care and treatment at the time it was given.
- We saw no documentation to reflect any discussion regarding best interests for a patient who lacked capacity to consent to having blood taken and was resistant to the procedure being carried out.
- We asked for and the trust had not been able to supply any data for Mental Capacity Act training compliance within community inpatient services. Staff told us this training was available to Band 7 ward managers along with training on DoLS, however this was very limited and not part of the Trust's mandatory training schedule.
- There was limited understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards across all the locations we visited. This was demonstrated in the patient records we reviewed and by speaking to staff. Staff told us they would find out information regarding DoLS on the safeguarding pages of the intranet.
- Information supplied to us by the trust showed there had been five Deprivation of Liberty applications made from the community hospitals in the past 12 months. The ward manager on Langdale South informed us that they had been involved with one application on Langdale North and supported the staff through the process as they had not had the relevant training.
- On review of incident reports we have found that a patient at Mary Hewetson Cottage hospital was attempting to leave the ward and their family had been asked to come in to help, the ward were also supported by staff from the minor injuries unit. Three further incident reports related to a patient at Eden unit who had absconded from the ward. There was insufficient detail on the incident report to establish if this was the same patient on each occasion. There was a DoLS application made for one of the patients in these incident reports. The service had made attempts to provide additional staff to the ward at this time.
- We have reviewed incident reports and found that patients, living with dementia, had absconded from Langdale South and needed to be persuaded to return, or were very wandersome at Wigton Hospital. We observed during our inspection that all the wards were locked with intercom, key code pad or push button access/exit only. We also observed that a number of patients on each unit were assessed as requiring bed rails in order to maintain their safety.

Good

# Are services caring?

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


**Summary**

We rated the service as good for caring.

There was evidence that patients were involved in their care and treatment across most sites. They were able to explain the treatment they had received and their discharge plan to our inspection team.

Staff respected patients' privacy and dignity and their needs were responded to in an appropriate and timely manner.

Patients and their relatives were treated with kindness, compassion and respect; verbal and written feedback from patients and their relatives and our observations confirmed this.

Staff were proud of the care they delivered in their local communities.


**Compassionate care**

- The NHS Friends and Family Test (FFT) response rate for the service was 2.1% compared to the England average of 3.6% in July 2015. We saw that 83.9% of people who had responded said they were extremely likely to recommend the service compared to the England average of 77.2%
- We observed patients being treated with privacy and dignity. However, the screens in use between the patients' bed spaces at Ellerbeck ward did not meet properly due to the handles which could compromise privacy.
- We observed compassionate care being delivered, staff were respectful and kind in the delivery of care and treatment. All patients looked well cared for and comfortable.
- One relative we spoke with was very complimentary about the care their terminally ill relative was receiving. One Band 7 nurse said they were very proud of the care their team delivered to palliative care patients.
- Ward visiting times were relaxed for the relatives of terminally ill patients and where possible the patient was cared for in a single room.
- On one unit staff brought in toiletries for patients who did not have anyone else to do this for them.
- On the wards we visited we saw call bells were in reach of all patients. We observed buzzers being responded to in a timely manner.
- Care and comfort checks had been introduced across the service and we saw that these had been carried out.
- The trust supplied us with information from NHS Choices and PLACE scores forthree units in the service (Brampton War Memorial Hospital, Penrith Hospital and Workington Hospital) which showed average scores of 82.8% for privacy, dignity and well-being of patients using the service which was below the national average of 86%.
- The feedback given from patients and visitors on CQC comment cards was positive. Fifty three out of the 62 cards returned very positive comments were recorded about all members of the multi-disciplinary team and the cleanliness of the ward environments. Some negative remarks were noted regarding doctors not communicating as well as the patient may have liked.
- There was only one bathroom on the ward at Victoria Cottage Hospital and the showering facilities were at the far end of the ward. This meant both male and female patients would use the same bathroom as separate facilities were not available. The side rooms did not have en-suite toilets at a number of locations.

**Understanding and involvement of patients and those close to them**

- One relative of a terminally ill patient on Ellerbeck ward told us a very good provision was made for them and their family. There was a relative's room on Ellerbeck ward with a sofa bed, tea making facilities and comfortable surroundings.
- There were quiet rooms at Westmorland Hospital where there were "faith boxes". However, on other wards such as Isel ward and Victoria Cottage Hospital there was no provision for relatives.

Good

# Are services caring?

- Staff completed Do Not Attempt Cardio Pulmonary Resuscitation documents well with evidence of discussion with the patient and /or family members.

**Emotional support**

- There was an independent kitchen area at Ruth Lancaster James Hospital to promote patient independence in preparation for discharge.
- In a review of a patient's record we found that a decision regarding discharge home had not been recorded well; there was no account of what the patient's wishes were or if any discussion had included the patient. It was not possible from the documentation if the patient had mental capacity to make a decision about going into a care setting or going home.
- There was a range of support available to patients with long term conditions and palliative care needs and staff knew how to access this.

Requires improvement

# 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 the service as requires improvement for being responsive.

There was a lack of patient hygiene and toilet facilities in some units meaning that patients of both sexes using the same bathroom and toilets.

People's needs were met through the way services were organised and delivered as they are close to local communities and integrated. Patients and their relatives told us this was preferable to being in an acute hospital setting.

The service met the needs of vulnerable people and those who required reasonable adjustments. There were limitations at some units due to the confines of the building structure. The needs of people living with dementia were not well met across the service due to staff training and the physical environments. Some locations did not have support facilities on site which meant there was some delay in treatment, assessment and diagnostics.

Bed occupancy rates for the service averaged at 89%. The optimum bed occupancy rate for hospital beds are context dependent and vary between organisations but the National Audit Office suggested that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections.


### Planning and delivering services which meet people's needs

- We saw bed occupancy levels over the period April to September 2015 were high across the whole service ranging from 77% at Millom Hospital and 97% at Eden unit with the service average being 89%. The optimum bed occupancy rate for hospital beds are context dependent and vary between organisations but the National Audit Office suggested that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections.
- The rehabilitation teams worked in the community as well as on the wards which allowed continuity of care for patients and their carers.
- Patients were brought back to the units to continue with their rehabilitation post discharge. We observed this in practice and patients were very comfortable and settled in the surroundings and with the staff who provided the on-going rehabilitation. The service provided good support for patients and their carers.
- The service was designed to meet the needs of a rural and ageing population with community beds available in many of the small towns around the county which meant that patients were cared for closer to home and their families. Staff and patients told us this was preferable to being in the acute hospitals.
- The service also provided terminal care for patients in the end stage of life close to their homes.

### Equality and diversity

- There were "Faith Boxes" on the wards that contained items that would assist a patient to follow their faith and spiritual needs if they requested to do so. However, some patient assessments the section asking about their religious beliefs was sometimes not completed.

### Meeting the needs of people in vulnerable circumstances

- Staff we spoke to knew how to access interpreting services should they need it.
- At the Ruth Lancaster James Hospital at Alston, the staff had facilities to launder patients own clothes if they had no relatives or friends who were able to do this for them.
- All wards areas had clocks and the date displayed to help patients' orientation. Some clocks were not positioned where they could be easily seen from the patient's bed. One patient remarked on this to the inspection team.
- The ward environments we visited were not designed in a way to make them dementia friendly. For example there are no colour schemes to assist orientation or coloured toilet seats.

# Are services responsive to people's needs?

- Some staff we spoke to had received dementia training and Eden unit had a staff member who was a dementia champion. Eden unit and Abbey View had implemented the butterfly scheme which was a nationally recognised system of hospital care for people living with dementia. This was not the case on other wards we visited. Some staff had undertaken dementia awareness training. The trust informed us after our inspection there was a plan to rollout the butterfly scheme but there was no timescale provided.
- There were no separate male and female facilities for bathing and toilet use at Victoria Cottage hospital.
- We saw on the Trust's website that Millom hospital used reminiscence software which provided memory therapy for dementia and neurology patients and at Wigton Hospital there had been improvements made to the garden therapy area.
- The day care unit at the Ruth Lancaster James Community Hospital had previously been funded through the local authority, a charity and the trust. In recent times the local authority and charity had ceased funding but the service is continuing which means that nursing staff were providing a social care function as many of the people attending did not have a health related need.

**Access to the right care at the right time**

- The location of the community hospitals meant the needs of the local population could be met nearer to their home. Some of the hospitals we visited were physically attached to a GP practices such as Ruth Lancaster James Hospital at Alston or had a Primary Care Assessment Service (PCAS) on site such as Westmorland Hospital, Penrith Hospital and Workington Community Hospital.
- Delayed discharges from the service meant that patients waiting in the acute hospitals did not always get to the community inpatient beds in a timely way. Senior managers were aware of this and a multi-agency group were looking at improvements that could be made to access and flow.
- Some units had access to X-ray facilities on site but others did not and patients who required an X-ray had to travel to the nearest facility.
- Patients who had been seen by a GP could be referred directly to the ward following an assessment by a GP in one of these locations.
- Some of the units we visited had a waiting list of patients who had been referred from the acute Trust. These were reviewed daily by the 'bed manager' at Westmorland General Hospital for Langdale North and Langdale South Wards and by the nurse in charge at other units.
- Staff reported at times the acute hospitals sent patients who were not suitable for the community hospital setting. They believed this was a result of bed pressures in the acute trusts. If a patient was unsuitable and their needs could not be met the patient would be returned to the acute Trust and the staff would complete an incident report.

**Learning from complaints and concerns**

- Senior managers informed us they were analysing the readmission rates for Isel Ward at Cockermouth Hospital as these were much higher than other units in the service and the reasons needed to be established. .On our inspection we looked in the admission and discharge book and saw that some patients were returning frequently for planned clinical reasons.
- The service received seven formal complaints in the past six months. Two had been upheld.
- Themes of the complaints were varied and included complaints regarding dietary needs not being met, discharge planning, communication the most common reason and delays in transport. The complaints were from across different locations in the service.
- Staff told us that they received email with lessons learned and the ward manager would also pass on the information verbally. Some lessons learned had been discussed at ward staff meetings and recorded on the minutes. There was a lack of robustness across the service in recording if members of staff who did not attend the staff meetings had read the minutes.

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 the services as requires improvement for being well-led.

The leadership, governance and culture did not always promote the delivery of high quality person-centred care. Staff were not aware of the service's vision or plan for the future. Nursing leadership was varied and staff did not always feel listened to. We found managers did not engage effectively with staff and were not visible to staff on the front line.

There was a clinical governance structure, but there was limited evidence in the way the trust robustly managed risks through action planning and there was a lack of consistency in the dissemination of information to front line staff.

Risks were identified through the use of a dashboard but not consistently managed at ward level due to the lack of suitably trained or experienced staff in post. Escalation procedures were in place but decision making was inconsistent, particularly related to closure of beds. There were gaps in the systematic recording of risks at an operational management level and there were no action plans to address the identified risks such as the signage at the nurse led treatment centre and the lack of appropriately trained staff at these units.

The service was not participating in any national audits and therefore could not benchmark its performance.


**Service vision and strategy**

- The Community Care group had a vision 'to deliver high performing care services that were responsive, safe, clinically effective, viable and well governed'.
- The trust had a vision, mission and strategy which they published for people and staff to see. Their values were known by staff, and the chief executive and their team encouraged people and staff to have a voice and contribute to the way the service developed.The trust was promoting a 'small change, big difference' initiative to encourage staff to contribute to service improvements. The Care Group has been actively promoting the Big Picture and You and the Trusts Vision and Values work.
- The service was part of a nationally led success regime which is looking at redesign of health services in the future.
- **Governance, risk management and quality measurement**
- Ward leaders we spoke to said that the structures, systems and processes that assure the quality, accountability and proper management of the service's operation and delivery was new and not well embedded. The process was informal and roles and responsibilities were not clearly defined.
- Senior managers had introduced quality measures and audits for example monthly nursing care sensitive indicators were completed and were on the Community Hospital Dashboard which could be accessed by the ward teams. However there was inconsistency in the access and use of the dashboard and some staff were not aware of its purpose.
- We reviewed meetings from governance meetings and found that recommendations, action plans or responsible person to take forward any lessons learned were not always recorded. Some governance meetings minutes appeared to sign off investigations only with no action plan for lessons learned.
- We reviewed four investigations that had been carried out following serious incidents that had resulted in patient harm and saw limited evidence of learning being cascaded to staff at ward level. For example a review of the ward meeting minutes from across the service showed that not all refered to recommendations made in May 2015 regarding learning and actions required from a patient fall.
- The risk register did not fully reflect the risks identified by the service or have a management plan in place to address these. The trust had supplied the service's risk

Requires improvement

# Are services well-led?

register which did not have action plans or timescales attached. Review dates on the risk register were lengthy for example a risk identified regarding food hygiene had a 12 month review date with no interim dates for checking on progress or auditing performance.

- We had concerns regarding registered nurse staffing on some of the units we visited. It was unclear how the management team managed these risks across the service. For example we saw on Isel ward at Cockermouth that four beds had been closed due to the acuity and dependency of the patients. Staff told us that the beds had been closed by senior managers on 09 November 2015, but acuity and dependency had been just as high in the three weeks prior to this decision.. It was not possible to establish if a risk assessment had been undertaken to mitigate the risks on this ward.
- We found on many shifts there was only one registered nurse on duty. When we asked the trust how breaks were covered for these shifts the trust told us staff were paid to work through their breaks or district nursing teams covered the ward. However staff we spoke with could not confirm this and district nursing staff were not available overnight to cover breaks overnight. The service did not have a process for managing managing this risk and supporting staff.
- The service dashboards were developed but were not effective at the time of inspection sothe management team could not effectively monitor the quality or performance within the service.
- There was a lack of participation in national benchmarking audits which meant the service could not determine current performance in comparison to similar services nationally.
- The service had few outcome measurement systems in place. Staff told us that very little recording of measures had taken place.

**Leadership of this service**

- Staff told us they did not always feel supported, this was particularly the case in the north of the county. Managers were not always very visible to the wards, however the geography was a challenge to achieving this due to the large area and the location of the various units.
- Senior managers told us they were aware of the challenges of being visible in very isolated units and how difficult it was to cover such small units in remote locations. The Senior Quality and Safety Lead visited individual wards countywide on a monthly basis. There were daily phone calls from the operational team to the wards.The Senior Manager carried out monthly supervision for ward managers and visits by Senior Managers were made outside of these scheduled visits occurs if required.
- All staff we spoke to were aware of who to contact out of hours for advice and support there was a clear process for contacting the “bronze on call” who was a senior manager. We were informed by a manager that if the bronze on call was not a person with a clinical background then the person who was “silver on call” would be. Most managers who undertook bronze or silver on call responsibility had either a clinical background or operational responsibility for clinical services.If a clinical opinion was required in addition to what was available from bronze or silver on call - this was accessed from the out of hours GPs.
- There were two units that we visited without a Band 7 nurse in post due to sickness and vacancy at Ellerbeck ward and Victoria Cottage Hospital. These units did not have a substantive Band 6 sister in post and were not running effectively as a result. There was a Band 5 nurse who had recently started acting up as a Band 6 at Victoria Cottage Hospital.
- The issues related to the nurse led treatment centres at Ruth Lancaster James Community Hospital and Victoria Cottage Hospital had not been effectively resolved. We saw little evidence that the trust had communicated with the public about the type of patients and conditions that could attend the units.
- At Victoria Cottage Hospital a five year old child had attended the unit between our announced and unannounced inspection and was treated despite the trust informing us during the inspection that children were not treated in these units. There was confusion amongst the staff about who they were able to treat.
- Staff told us patients do turn up with injuries or conditions that cannot be treated in the nurse led

treatment centre. Patients did not like being turned away and advised to go to an emergency department or minor injuries unit, which may be some distance to travel.

- There was still signage that indicated there was a minor injury unit at Cockermouth Hospital when this service was not available. There was mixed information regarding the provision and services at the minor injuries units and treatment centres on health and social care websites which meant that patients would arrive expecting to be treated.

**Culture within this service**

- Some staff we spoke to indicated they sometimes felt under pressure to work additional hours when there were shortages of staff on the ward. This was greater amongst the part-time staff.
- Staff worked well as a team and shared an understanding of each other's roles within this. Staff showed a willingness to do their best and were very proud of the service they provided to their local community.
- Staff told us they felt supported to report incidents and raise concerns to their line managers but they did not always feel listened to.
- Many of the staff we spoke with felt that the organisation was a better one than it was two years ago following the changes that had been made.

**Public engagement**

- Patients and relatives we spoke to on the inspection and the comments received indicated a very high regard for the service in the local community.
- People who had completed comment cards as part of the inspection were very complimentary of the service and praised the staff and the care and treatment they had received.
- Wards displayed thank you cards and some patient and carer feedback from the monthly "Here for you" report. The day care centre at Alston was described by one attendee as "a life line".
- Many of the more isolated units were well supported by the League of Friends.

**Staff engagement**

- Most of the staff we spoke to had heard of the Trust's "You and the Big Picture" strategy but could not link this directly to their experience of appraisal. There were posters in staff rooms with "You and the Big Picture" logo visible.
- Some of the staff were aware of the Trust's vision and values and there were posters of this on all of the wards we visited.
- Staff meetings took place on the units, mostly on a monthly basis but not consistently with a four month gap on one ward. Minutes were taken but the quality of these varied with little indication of who was responsible for actions required. It was not possible to establish if all staff had access to the minutes if they had not attended the meetings.
- Staff we spoke, particularly in the south of the county said they felt listened to and most said they had good support from their immediate line manager. Staff in one unit where staff shortages and dependency and acuity had been particularly high said that they did not feel like they were being listened to. Staff we spoke to in the more remote areas said the visibility of senior managers was very low.
- Senior managers told us that the Trust had previously held an annual staff awards event but this had been stopped at the request of staff.
- The service had a Twitter account for staff to use so staff could communicate with each other.

**Innovation, improvement and sustainability**

- Senior managers told us they knew of the challenges of the service and that the new model was seeking to address these. A strategy paper outlining the sustainability of the service has been written but no further developments, action plans or timescales were available. A clinical strategy and service transformational plan was expected to be available by April 2016.
- The project with a local ambulance service had demonstrated positive patient outcomes and a cost effective use of ambulance services, reduced admission to hospital and improved patient satisfaction.

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<br>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (1), (2 a, b, e, g,) Safe care and treatment<br><br>The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines.<br><br>The trust must ensure that emergency equipment is ready for use at all times and have robust systems in place for the checking and replacement of equipment.<br><br>The trust must ensure all patients identified at risk of falls have appropriate assessment and review of their needs and appropriate levels of care are implemented and documented. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance (2 a, b, f)<br><br>The trust must strengthen the systems in place to regularly assess and monitor the quality of care provided to patients.<br><br>The trust must ensure where actions are implemented to reduce risks these are monitored and sustained. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing |

This section is primarily information for the provider

# Requirement notices

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 Staffing (1) (2 a)

The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.

The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.

The trust must ensure that staff are trained and are implementing the principles and requirement of the Mental Capacity Act (2005) including the Deprivation of Liberty Safeguards.